Trauma-Informed Responses to Adult Sexual Assault Survivors

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Seminar Research Paper

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ABSTRACT

Trauma-informed care is an effective and necessary tool when responding to survivors of sexual assault (Nadeem et. al, 2021). Due to the harmful effects of trauma and re-traumatization by ill provided care within the criminal justice system, it is essential that trauma informed training across fields must be continued, evaluated, and updated. This training will ensure a higher level of care for survivors and address current barriers to justice such as re-traumatization.

This study aims to compile current literature on the topic of trauma-informed care to highlight its impact and importance for sexual assault survivors. This paper explores the impact of trauma on adult sexual assault victims. This is done by analyzing the history of trauma, trauma caused by sexual assault, and the relationship between sexual assault trauma and interactions with the criminal justice system. Key components of trauma-informed care identified though this analysis will be then used to evaluate current trauma-informed care training among criminal justice professionals that respond to sexual crimes. The results of the analysis were then used to create a list of best practices for responders to use in their interactions with sexual assault survivors.

Results of the analysis found that two of the four criminal justice professional training programs did not meet contain the components of an effective trauma-informed care training. Both SANE and Advocate training programs contained all four components identified in the literature for a successful program and additional require this training for all positions. Both Law Enforcement and Medical Emergency First Responder training programs failed to contain all

four components' elements and additional did not have trauma-informed training programs that meet this criterion as a requirement for the position despite research suggesting its importance.

These results suggest current practices and policies surrounding trauma-informed response need reevaluation and implantation to best serve victims and prevent further traumatization.

Introduction

Statement of the problem

Sexual abuse continues to be an enormous problem in the United States, where approximately 570 people are abused every day (Camacho, Adams, Wasco, Ahrens, & Sefl, 2009). The process of reporting these crimes can be a daunting task. There remains a wide range of responses to, and ways to report, a sexual assault. Options within the formal criminal justice system include reporting, pressing charges, and criminal trials. Informal options include medical assistance, therapy services, and crisis management. If one seeks medical assistance, a local hospital will dispatch rape crisis center advocates or other rape crisis center staff such as therapist or volunteers to aid the survivors (After Sexual Assault, 2021).

To successfully serve sexual assault victims, rape crisis responders must meet minimum standards of accredited training. This ensures quality service for survivors as well as guidance for the health and wellbeing of the worker. Research also supports training as being a pivotal tool in the successful operation through quality care and prevention of staff burnout (Beal, 1994). Curriculums for rape crisis response aim to train criminal justice professionals as effectively and efficiently as possible in vital topics that are required to serve the victims of this crime. Without

evaluation of these topics, current programs may become outdated and fail to help responders effectively serve survivors.

One of these topics, trauma-informed care, is not new to the field of victimology, however, understanding of its impact and importance has increased with recent research (Haskell & Randall, 2019). It is important for all professionals in contact with victims as the cooperation and coordinated training efforts of varied responders including officers, advocates, and medical professionals that has also led to improved experiences among adult sexual assault victims (Bennet, Goodman, & Dutton 1999).

Trauma-informed care is sensitive, responsive, and centralizes the unique responses of the victims to create informed responses. This care also highlights mental and emotional wellbeing of the victim and consciously avoids potential triggers that could cause further trauma. (Neufville & Randall, 2017). Trauma is a common outcome of sexual assault and is known to have psychological, physiological, and neurobiological impacts on the victims. Understanding the impact of trauma on survivors of sexual assault can facilitate more informed responses to these crimes and aid in more effective recovery for the survivor (Haskell & Randall, 2019). This is particularly important as those professionals responding to sexual assault cases are often the first point of contact with victims after a crime occurring. This is considered a pivotal time in appropriate responding as first contact can influence the victim's perception of the system, willingness to engage formally with the system, and address apprehension reported by many victims (Patterson & Tringali, 2014). To protect victims from further harm, responders to these crimes should then be well versed in trauma-informed care.

Outcomes of training include the ability to identify signs of trauma, limiting triggers of trauma, and safeguard tactics to prevent re-traumatization. These outcomes are achieved through educational training as well as policies and resources that are sensitive, linguistically, and culturally competent for victims. Providing these services can create empowering and healing environments for victims and those serving them. A closely related issue trauma-informed care addresses also includes vicarious or secondary trauma. Responders to sexual assault may be impacted by their experiences in the field causing distress, figure, and burnout. Techniques taught, and resources given in trauma-informed care training are applicable to responders themselves and can help combat secondary trauma (Neufville & Randall, 2017). Trauma-informed care is therefore an effective and necessary tool when responding to survivors of sexual assault.

This research reviews studies on the need for trauma-informed care by criminal justice professionals when responding to survivors of sexual assault. This paper gives a brief overview of the history and significance of trauma-informed care across fields. The review of literature relating to research and studies regarding the approach of trauma-informed care examines whether further training of response professionals is necessary. The findings are then summarized, and recommendations are made.

Purpose of the Study

The purpose of this study is to compile current literature on the topic of trauma-informed care to highlight its impact and importance for sexual assault survivors. This paper gives a brief overview of the history and significance of trauma, and trauma-informed care across fields. The

review of literature will use secondary analysis to examine trauma-informed care and the need for further training of response professionals. This paper will critically analyze trauma-informed training guidelines from various criminal justice professions to create recommendations for an ideal program. These guidelines are national accredited resources for those professionals responding to sexual assault across the United States. The guidelines analyzed include: The SANE Program Development and Operation Guide developed by the Office for Victims of Crimes and International Association of Forensic Nurses, The Trauma Informed Sexual Assault Investigations Training Curriculum developed by The International Association of Chiefs of Police, Building Cultures of Care A Guide for Sexual Assault Service Programs developed by The National Sexual Violence Resource Center, and Sexual Violence: A Healthcare Priority for EMS Providers developed by The Nevada Coalition to End Domestic and Sexual Violence.

Literature and program analysis will include qualitative and quantitative research to answer the research question. The sources used in this research will include scientific peer reviewed journals, national conference presentations, government publications and websites, and official program guides. The findings are then summarized, and recommendations made on ideal training on the topic of trauma-informed care.

Significance of the Study

Highlighting the importance of trauma-informed care and the creation of an ideal program is of immense value and significance in the field. It is documented that sexual assault survivors face amongst the highest rates of re-traumatization in the criminal justice system (Haskell & Randall, 2019). While responders' intentions are to aid the victim as much as they

can, this positive action is guided heavily on their training and experience. Without a strong foundational knowledge on trauma, its impacts psychologically and biologically, miscommunication and misinterpretations are increased risks (Haskell & Randall, 2019).

Professional understandings of trauma and appropriate response hinge heavily on our medical and psychological understanding of the phenomenon through ever expanding research. Advances in technology and visibility on under researched areas of trauma have led to changes in recommended practices. Culturally specific training in trauma has also been found to impact perception of response in cases of sexual assault as well. These among many other factors contribute to the major obstacles impeding victims from fair and just processes. (Haskell & Randall, 2019).

Highlighting the unique aspects of trauma and trauma-informed care to those affected by sexual assault will also help address the unique challenges those individuals face in the criminal justice system. One such example includes misconceptions on credibility and reporting. Research finds that only three hundred and ten out of every one-thousand cases of sexual assault are reported to police (Rape, Abuse & Incest National Network, 2020). This is in part accredited to a lack of confidence and comfort with police (Haskell & Randall, 2019). Trauma informed training can help responders understand the victim's viewpoint, empathize, and provide educated care to victims experiencing trauma after a sexual assault.

This research will contribute to the current body of literature on the importance of trauma-informed care regarding the treatment and response of sexual assault survivors. Specifically, this research will create recommendations for best practices and creation of an ideal training program. This will result in the ability for criminal justice professionals to implement

trauma-sensitive responses putting victim care first and avoidance of re-traumatization as the primary objective.

Anticipated Outcomes

It is anticipated that this research will identify the impact of trauma-informed care and identify key compliments of training to create an ideal program. With training methods identified and implemented, this would have a positive effect on the quality and success of recovery and assistance given to survivors. This includes minimized re-traumatization of victims, and a victim centered approach creating positive experiences and outcomes for survivors in the criminal justice system. A workforce that has access to the highest quality of training will also feel more confident in their abilities, be more engaged, and assist in prevention of burnout (Benuto et al., 2018). This secondary effect protects the responders, raises awareness of secondary trauma in those responders, and promotes victim care.

Disclaimer

In this research the terms victim and survivor will be used synonymously. Crisis centers have noted the use of each term is specific to the comfort of the individual who has experienced sexual abuse. Both these words have vastly different connotations and are used respectively by the criminal justice system and informal support systems (After Sexual Assault, 2020).

For the purpose of this paper, this research will maintain use of the term assault when referring to various degrees of sexual abuse and victimization. This term includes but is not

limited to attempted sexual assault, rape, incest, sexual exploitation, and any completed or attempted non-consensual sexual acts (Sexual Abuse Legal Definition, 2021).

Labels used do not reflect the researcher's feelings or attitudes towards this population and are used for consistency in discussing topics as most used in criminal justice research.

Research Definitions

To provide insight into trauma specific to sexual assault, terms regarding the assault such as rape, attempted rape, sexual abuse, and sexual assault will be defined. All definitions and legal codes used in this research will be derived from National and Iowa based code and practice. Definitions derived from other state codes and practice may be defined and evaluated if applicable in training evaluation. This research also utilized federal reports and legal definitions to expand upon definitions such as sexual assault and rape to add perspectives of those professionals and accompanying organizations who respond to sexual assault cases. Although many definitions occur and the scope of the legal definition of sexual assault is limited, this research acknowledges that assault-based trauma can occur for reasons outside these definitions and experiences of trauma are not limited to the scope of which the law defines a committable offense.

Sexual Abuse/ Sexual Assault/ Rape

In the state of Iowa, rape and sexual assault are considered sexual abuse. Sexual abuse under Iowa Code identifies three degrees of sexual abuse which are defined though circumstances surrounding the abuse. All sexual abuse crimes in the state of Iowa are felonies,

however, the class of felony and penalties will very on the degree (Iowa rape and sexual assault laws, 2016).

Iowa Code § 709.1A defines Assault as,

" 1. An assault as defined in this section is a general intent crime.

2. A person commits an assault when, without justification, the person does any of the following:

a. Any act which is intended to cause pain or injury to, or which is intended to result in physical contact which will be insulting or offensive to another, coupled with the apparent ability to execute the act.
b. Any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act."

When defining sexual abuse, Iowa Code 709.1 furthers the definition from assault alone through specificities to sexual crime. This Code states that sexual abuse is,

"Any sex act between persons is sexual abuse by either of the persons when the act is performed with the other person in any of the following circumstances:

1. The act is done by force or against the will of the other. If the consent or acquiescence of the other is procured by threats of violence toward any person or if the act is done while the other is under the influence of a drug inducing sleep or is otherwise in a state of unconsciousness, the act is done against the will of the other.

2. Such other person is suffering from a mental defect or incapacity which precludes giving consent or lacks the mental capacity to know the right and wrong of conduct in sexual matters.

3. Such other person is a child." (Iowa Code § 709.1).

Iowa Code 709 breaks down the degrees of sexual abuse into first, second, and third degree sexual abuse. Sexual assault in the first degree, Iowa Code 709.2, is defined as,

"A person commits sexual abuse in the first degree when in the course of committing sexual abuse the person causes another serious injury." (Iowa Code § 709.2).

This felony is considered a class "A" felony and is punishable by life in prison (Iowa rape and sexual assault laws, 2016).

Sexual assault in the second degree, Iowa Code 709.3, is defined as,

"A person commits sexual abuse in the second degree when the person commits sexual abuse under any of the following circumstances:

a. During the commission of sexual abuse the person displays in a threatening manner a dangerous weapon, or uses or threatens to use force creating a substantial risk of death or serious injury to any person.

b. The other person is a child.

c. The person is aided or abetted by one or more persons and the sex act is committed by force or against the will of the other person against whom the sex act is committed." (Iowa Code § 709.3).

This felony is considered a class “B” felony and is punishable by prison time up to 25 years (Iowa rape and sexual assault laws, *2016).*

Sexual assault in the third degree, Iowa Code 709.4, is defined as,

“A person commits sexual abuse in the third degree when the person performs a sex act under any of the following circumstances:

a. The act is done by force or against the will of the other person, whether the other person is the person’s spouse or is cohabiting with the person.

b. The act is between persons who are not at the time cohabiting as husband and wife and if any of the following are true:

(1) The other person is suffering from a mental defect or incapacity which precludes giving consent.

(2) The other person is fourteen or fifteen years of age and any of the following are true:

(a) The person is a member of the same household as the other person.

(b) The person is related to the other person by blood or affinity to the fourth degree.

(c) The person is in a position of authority over the other person and uses that authority to coerce the other person to submit.

(d) The person is four or more years older than the other person.

c. The act is performed while the other person is under the influence of a controlled substance, which may include but is not limited to flunitrazepam, and all of the following are true:

(1) The controlled substance, which may include but is not limited to flunitrazepam, prevents the other person from consenting to the act.

(2) The person performing the act knows or reasonably should have known that the other person was under the influence of the controlled substance, which may include but is not limited to flunitrazepam.

d. The act is performed while the other person is mentally incapacitated, physically incapacitated, or physically helpless." (Iowa Code § 709.4).

This felony is considered a class "C" felony and is punishable by prison term up to 10 years, and a minimum fine of $1,000 and a maximum fine of $10,000 (Iowa rape and sexual assault laws, 2016).

Iowa Code 709 further defines sexual abuse though definitions of evidence relative to sexual abuse, explanations on exploitation by those in power such as therapists and school employees, no-contact orders relative to sexual abuse, and indecent or lascivious acts with a child (Iowa rape and sexual assault laws, 2016).

Although covered under Iowa Code, rape is defined by the FBI's Uniform Crime Report as:

"Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Attempts or assaults to commit rape are also included; however, statutory rape and incest are excluded." (United States Department of Justice, 2014).

Advocate

The position of an advocate is a relatively new role in comparison to other titles within the formal system such as social worker, prosecutor, or officer. To fully grasp what an advocate does, researchers and academics have interviewed and surveyed active working advocates. One unique aspect of advocates work is the focus on the wellbeing and healing of the victim. Through specialized training and focus on trauma-informed care, advocates address common barriers to participation that those without an advocate felt were difficult to overcome (Patterson & Tringali, 2014).

The Washington Coalition of Sexual Assault Programs defines an advocate as a role that provides support in a variety of environments with those sexually victimized across the lifespan and at various stages of the recovery process. This includes the use of crisis intervention, validation, education, psychoeducation, response to cognitive distortions, and board focus on elements of victimization. Advocacy is defined with six principles, safety, trust, choice, collaboration, empowerment, and cultural competence (Washington Coalition of Sexual Assault Programs, 2018).

Due to the new nature of the position, and the diversity of services provided alongside various criminal justice professionals, the definition of a sexual assault advocate may vary by organization. More formal definitions can be found such as the definition of an advocate from The SAFE Alliance, which describes specific confidential crisis services an advocate may provide including: Legal and medical explanation and guidance, orientation to the system for

victims, liaison between the victim and the system, safeguard of respect and trust for the victim, safety planning, accompaniment if desired for medical support including the medical forensic exam, coping and psychological first aid, follow-up services, and education for victim and family on trauma (The SAFE Alliance, 2018).

Trauma

The American Psychological Association notes that trauma can induce short acute or chronic reactions and defines the phenomenon as,

> "Any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place." (American Psychological Association, 2022).

Secondary Trauma/ Vicarious Trauma

There are several synonymous terms to explain the phenomenon of compassion fatigue. This includes secondary trauma, secondary victimization, and vicarious trauma. Secondary trauma can affect relationships, family, emotional, physical, and psychological health of a person. It is understood across fields as "emotional residue," or exposure to the trauma of others including but not limited to hearing stories, witnessing events, or exposure to intense trauma

symptoms of another individual. This term is also coined compassion fatigue as it is seen in working professionals who have the most exposure to trauma such as counselors and first responders (American Counseling Association, 2022). Symptoms of secondary trauma have been identified as being remarkably like cases of PTSD in effects of emotional and cognitive abilities of the individual affected (Benuto, Newlands, Ruork, Hooft, & Ahrendt, 2018). Signs and symptoms noted by The American Counseling Association that are potential signs of secondary trauma include: difficulty talking about feelings, irritation, and anger, being startled easily, difficulty sleeping, fear of failure regarding trauma victim, dreams of victim's experience, diminished joy, feeling trapped, intrusive thoughts, hopeless, and blooming others (American Counseling Association, 2022).

Victim/ Survivor

In this research the terms victim and survivor will be used synonymously. Although both intended to refer to someone who has recently been affected by sexual assault or violence, the term victim has been historically used most commonly by criminal justice professionals. Another common distinction between these terms is the time passed since the assault. Victim is often used to identify an individual recently affected by a crime where survivor is used to refer to an individual who has started the recovery process. Due to the personal and vulnerable nature of the crime, advocacy groups such as the RAINN network suggest best practice is to allow the individual to identify the term, they are most comfortable with and to respect their healing process (RAINN, 2022).

Perpetrator

Specifically relating to sexual crimes, the Government of Quebec defines perpetrator as,

"Any person who commits a sexual assault, regardless of whether the victim is a minor or an adult, whereas sexual offender refers to someone who has been convicted of a criminal sexual offence."

The definition is further broken down into three categories based on the nature of the assault, the relationship to the victim, and the age of the victim. These categories are noted to not be mutually exclusive and include Perpetrators of sexual abuse against children, perpetrators of sexual assault against adults, and minors who commit sexual assault (Gouvernement du Québec, 2016).

Law Enforcement

Law enforcement is defined by the Bureau of Justice Statistics as,

"Agencies and employees responsible for enforcing laws, maintaining public order, and managing public safety. The primary duties of law enforcement include the investigation, apprehension, and detention of individuals suspected of criminal offenses. Some law enforcement agencies, particularly sheriff's offices, also have a significant role in the detention of individuals convicted of criminal offenses." (U.S. Department of Justice, 2021).

In cases of sexual assault, the primary responsibilities of law enforcing includes attending to the victim, being careful not to stigmatize the victim, preserve evidence on the victim, secure

and protect the crime scene, contact local advocacy centers, and apprehend offender if present. Additional responses based on victim consent and situational needs may include investigating contacts driven by victim, assessing special needs if needed for victim, explaining the local investigation process, explanation of next steps and what to expect (New York State Coalition Against Sexual Assault, 2003).

SANE

The Office for Victims of Crime defines a SANE as,

"A Sexual Assault Nurse Examiner is a registered nurse who completed additional education and training to provide comprehensive health care to survivors of sexual assault. In some communities, SANEs are called Forensic Nurse Examiners. Other categories of providers, such as physicians or physician assistants, may use the title Sexual Assault Forensic Examiner, Sexual Assault Examiner (Indian Health Services), or Sexual Assault Medical Forensic Examiner (military). To offer comprehensive care, the role of the SANE includes evaluating and treating the patient in a holistic way, being mindful of both the acute and long-term consequences of sexual violence victimization."

The SANE completes the Forensic Medical Exam, or Rape Kit, if the victim consents. This includes taking appropriate medical history, history of the assault, testing and treatment or prevention of sexually transmitted diseases, follow-up services with community-based sexual assault advocacy, evidence collection, and testify in a criminal or civil trial as a fact or expert witness when necessary (Office of Justice Programs, 1999).

First Responder

A first responder is a trained individual who responds to the scene of an emergency first to provide response including Emergency Medical Technicians (EMT's) and paramedics (Learn, 2022). Regarding sexual assault, these first responders are called to meet emergency medical and emotional needs when applicable. These individuals work with dispatchers, responding officers, and others first responding to a sexual assault (West Virginia Foundation for Rape Information and Services, 2022).

Literature Review

History of Trauma

Definitions

Despite early identification, the practical definition of trauma continues to be an evolving matter. The American Psychological Association, a highly respected organization of mental health and psychological science, defined trauma as an event that is outside the typical range of experience and would be distressing to any reasonable person. Specifically, its definition lists examples including qualifying events such as threats to life and destruction to home, and those events that may be distressing but do not qualify to their standard such as divorce or minor illness (Norris, 1992). Other organizations and academics have argued that this definition, as well as other popular renditions, are not holistic or considerate of the range of human experience. Researchers such as Solomon & Conino have argued a standard definition of trauma should instead be any experience that is shocking or distressing to the individual, rather than a reasonable person. To hold research to a more restrictive standard, the definition used is noted as

an event or encounter that is violent in nature. Violence is further explained as sudden, distressing, and or extreme force that may cause fear or aversion (Norris, 1992).

After its acknowledgment in the medical community, medicine began to incorporate trauma informed care approaches, now known as trauma informed care, to address underlying traumas when diagnosing and treating patients. This movement in considerate care became popular in the 1970s after identification of high occurrences of Post-Traumatic Stress Disorder (PTSD) in Vietnam War veterans. The need to provide proper care for veteran's mental health during this time propelled further studies on the body and brain impacts of trauma and mental health (Curi, 2018).

One such study used to inform current models of trauma-informed care included the Adverse Childhood Experiences (ACE) Study. This study, completed by the Centers for Disease Control and Prevention, and the Kaiser Permante's Health Appraisal Clinic in San Diego turned the eye of research from the study of current traumas to the effects of early childhood traumas as a contributor to adult life problems. Over a two-year period, the study followed 17,000 participants while examining ten categories of trauma including abuse, neglect, and family dysfunction on health and wellbeing over time. The data collected found a significant relationship between the childhood traumas experienced with physical and mental health as adults (Coates, 2016). This study led to the development of institutes and initiatives to address trauma in pediatric care and education including the Donald J. Cohen National Child Traumatic Stress Initiative and the National Child Traumatic Stress Network through the Substance Abuse and Mental Health Services Administration (SAMHA) (Curi, 2018).

Identification

The high frequency and heavy impact of trauma affects people across a variety of demographics at an astonishing rate (Petrak & Hedge, 2004). Studies on trauma show rates as high as 69% of individuals facing potentially traumatic events in their lifetime. Of the trauma types examined in studies by Norris, sexual assault was found to have the highest rate of posttraumatic stress disorder amongst the ten types of traumas inducing events (Norris, 1992). Trauma itself is incredibly common and even more so among those who are sexually victimized. This is particularly important to identify and treat to avoid further re-traumatization, address symptoms that may impact other disorders and prevent healthy mental and physical states throughout life (Substance Abuse and Mental Health Services Administration, 2014).

Identification of trauma through screening and assessment is a valuable tool in treatments and therapy to recognize and address symptoms that may have led to poor patient outcomes, re-traumatization, poor engagement, substance abuse, misdiagnosis, and inappropriate treatments. The first step in identification is often screenings. This involves questioning on the history of trauma experienced by that individual and trauma related symptoms present. These symptoms may include depressive symptoms, sleep disturbance, intrusive thoughts or experiences, mental disorders, violence or disturbing experiences, adverse childhood events, combat experiences, substance abuse, social support, coping, availability of resources, risk of self-harm, and abnormal physical health screenings (Substance Abuse and Mental Health Services Administration, 2014). Due to the complex nature of trauma responses, other signifiers may include dissociative episod2es, lack of trust and difficulty with intimacy, emotional disturbances, anxiety, shame, poor self-worth, and numerous physical symptoms that may require more complex and formal assessments in order to identify specific traumas (Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of

Existing Literature, 2013). Formal assessments conducted by an agency or counselor may be used in the identification of trauma. Assessments are used to determine the nature, severity, and course of action to take for the traumas experienced. This process may include written questions, exams, and clinical interviews with a qualified professional to determine appropriate diagnosis, treatment, goals, and placements (Substance Abuse and Mental Health Services Administration, 2014).

When looking to identify specific characteristics with trauma, it is important to note that trauma can present and be expressed in many ways and affects everyone differently. Individuals may exhibit clear symptoms that clearly fit trauma in assessment and screening criteria while others may exhibit resilience or have symptomatology that fall out of the typical scope. The signs, symptoms, and impact of trauma may range from obvious to subtle, and the impact of those symptoms and the trauma itself may vary based on the characteristics of that person, the event, and sociocultural factors (Substance Abuse and Mental Health Services Administration, 2014).

Many variables typically associated with mental health are not, however, found to be characteristic of trauma. In studies of traumatic responses, partially those with a focus on trauma related to sexual assault, factors such as education level, marital status, and ethnicity found no effect. One factor however was found to have more symptoms, economic status (Petrak & Hedge, 2004). These studies support the need for trauma informed care training among those working with trauma victims, particularly those who have suffered sexual assault, as identification and appropriate care are essential to combat re-traumatization (Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature, 2013).

Types of Traumas

There are a variety of classifications and types of traumas identified due to its diverse range of definitions. Classifications used may differ depending upon those professionals using the terms (Ashley-Gilmore, 2021). Researchers, clinicians, and other mental health practitioners have categorizations of trauma. Clinicians may use "Big T" and "Little T" classifications. "Big T" events are typically single occurrence, shocking, life threatening, and acute in nature. These can include natural disasters, abuse, and terrorism. "Little T" events are those that typically would not classify as traumatic in more strict APA definitions such as loss of a job, moving, or divorce. These events are transitional, non-life threatening, but still can produce stress (Ashley-Gilmore, 2021). This categorization is based on the nature of the event. Researchers and clinicians may also identify trauma based on its occurrence. This includes acute, chronic, and complex traumas. Acute traumas being those from singular events. Chronic traumas resulting from repeated events or prolonged exposure to an event similar in nature. Finally, an occurrence trauma may be identified as complex, or resulting from multiple or compounding events (Substance Abuse and Mental Health Services Administration, 2014).

Specific forms of trauma may also be identified through other factors including scope, nature, who is impacted, and environment (Ashley-Gilmore, 2021). Vicarious or secondary trauma, historical trauma, and inter-generational traumas are forms specific to who is impacted. Secondary trauma, used synonymously with vicarious trauma, is used to describe burnout, or compassion fatigue and explain caregivers and crisis workers shared traumas through their experience with victims. This trauma can occur through exposure to or experience with graphic, gruesome, disturbing, or frightening experiences. This can range from disturbing images seen in a hospital setting to a triggering mention of a graphic assault in the courtroom (Clinical Models

of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature, 2013). Historical trauma is specific to a culture, race, or ethnic group and experienced over multiple generations due to a major event of oppression or harm. Examples include genocide, racism, war, and forced migration. In contrast to this, inner-generational trauma affects multiple generations however, this is confined to a single family across several generations and is passed down (Ashley-Gilmore, 2021).

Trauma may also be identified though the environment or situational circumstances surrounding it, these traumas are considered system-oriented traumas. System-oriented trauma occurs when an individual experiences further trauma or triggers while involved in formal systems such as counseling or the criminal justice system. Environment, settings, actions, or questions may trigger stress and anxiety causing re-traumatization. Agencies working with victims of traumatic experience such as sexual assault often have training and policies in place to address re-traumatization and better outcomes for the individuals participating. Actions that me be re-traumatizing or cause system-oriented trauma may include failure to screen or treat trauma, discounting or belittling reaction or reports of an individual, isolation or physically restraining techniques, humiliation or challenging the individual, confrontational approaches, judging or labeling behaviors, inadequate security or safety planning, or the limiting or restrictions of mental health supports (Substance Abuse and Mental Health Services Administration, 2014).

Treatment of Trauma

Studies on the treatment of trauma, while relatively new, have become increasingly popular. The outcomes of these studies are as fast as the collective whole, making identification of clear and significant methods difficult. One practice, cognitive behavioral therapy however,

has a considerable amount of research-based evidence supporting its success in the treatment of trauma (Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature, 2013). Additional psychological treatments found in evidence-based practice include psycho education, exposure therapy, eye movement desensitization reprocessing (EDMR), psychotherapy, imagery rehearsal, and group therapy. Additional supporting methods found in literature include holistic approaches such as yoga, acupuncture, massage therapy, aromatherapy, grounding techniques, and mindfulness (Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature, 2013).

One current difficulty in the support of practices through research is the complex nature of traumas often co-occurring disorders. Complex trauma may present symptoms of addiction, suicide, self-harm, dissociation, depression, rage, among many others. To appropriately diagnose trauma and other co-occurring illnesses requires a high degree of education and intensive assessment (Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature, 2013). Co-occurring disorders are common for victims of trauma. Many clients with trauma meet the criteria for PTSD, anxiety, mood disorders, major depressive disorder, and impulse control disorders. Trauma can also increase the risk for, and severity of, mental illness. This relationship is considered bidirectional, as mental illness increases risk for trauma, likewise trauma increases risk of mental illness (Substance Abuse and Mental Health Services Administration, 2014).

Until the implementation of trauma-informed care, trauma victims and those patients without trauma were treated with similar practice. With the growth of evidence-based practice, implementation of these practices has expanded and modified services to better meet the needs of

trauma victims. Understanding vulnerabilities, addressing triggers, and creating supportive environments are a few of the methods used to address the cycle of mental health and trauma to provide better outcomes in treatment (Coates, 2016).

Trauma and Sexual Assault

Prevalence of Trauma in Cases of Sexual Assault

The topic of increased training and awareness of trauma-informed care remains in part due to the high rates of trauma and re-traumatization. Studies on trauma show rates as high as 69% of individuals facing potentially traumatic events in their lifetime (Norris, 1992). When researching mental illness, it was found that 81% of people seeking mental health treatment has experienced a form of sexual or physical assault. 67% of these individuals reported assaults in childhood (Coates, 2016).

Sexual assault trauma remains a substantial proportion of traumas experienced with approximately 570 people being abused every day (Camacho, Adams, Wasco, Ahrens, & Sefl, 2009). The high co-occurrence of mental health and trauma related issues in cases of sexual assault make the discussion and analysis of trauma informed practices in the criminal justice system when working with these victims even more important.

Common Experiences

Although trauma has a variety of documented affects and reactions, in cases of sexual assault there are some reactions that are found more commonly. This does not indicate any reaction that contradicts these commonalities is incorrect, inappropriate, or abnormal however as trauma is experienced in diverse ways depending on the individuals experience (Substance Abuse and Mental Health Services Administration, 2014).

It is in the lack of understanding and education on these diverse reactions and sexual assault trauma that can lead to the perpetuation of myths and misconceptions surround sexual assault. While laws and perceptions have continued to change, some myths persist. These may include ideas on female promiscuity, questioning of character, reasons for not disclosing, acquisitions of lying, use of alcohol and drugs, and misconceptions on reactions to sexual assault. Research into the reactions of sexual assault victims do not support these myths however, instead showing a wide range of responses that may include freezing, not reporting, memory loss, struggling with decision making, a lack of physical injury, blame, wanting to protect the perpetrator, denial, appeasing behaviors, and recanting statements made (Haskell & Randall, 2019). What may be deemed inconsistent behavior or atypical or inappropriate behavior in investigations of other crimes are typical in cases of sexual assault. To fairly and appropriately then treat, address, and work with sexual assault victims then, criminal justice professionals must understand trauma's unique psychological and biological effect (Haskell & Randall, 2019).

Among these unique responses includes triggers and flashbacks. Triggers include any stimulus that elicits a trauma response related to the trauma or a memory of the trauma experienced. This can include recent traumas and traumas from the past. Some common potential triggers may be identified by organizations and practices adjusted in their anticipation to prevent potential re-traumatization (Substance Abuse and Mental Health Services Administration, 2014).

The avoidance of triggers is a widespread practice and staple of trauma-informed care (Davies et.al, 2013). Triggers may include stimuli such as noises, temperatures, physical sensations, or visual cues. The trigger does not have to be in direct relation to the trauma and may lead to a flashback. A flashback is the event of re-experiencing a past traumatic event. These experiences feel as though they are happening in current time despite having taken place in the past and may be short or long in duration (Substance Abuse and Mental Health Services Administration, 2014).

There are several unique extreme survival responses to the assaults themselves outside the simplistic explanations of flight, fight, freeze (Haskell & Randall, 2019). These may include dissociation, tonic immobility, and collapsed immobility. With an overwhelming experience such as assault, the brain may dissociate, or split aspects of the experience or the experience itself making them feel lost, or out of body. Another reaction may include tonic immobility, a subset of freeze, in which a state of involuntary paralysis takes over the body. Another form of immobility possible includes collapsed immobility, a state in which the individual feels a limpness or immobility due to a drop-in heart rate and blood pressure. These are only a few of the possible responses. An individual may also switch from one state to another during an experience. Many of these reactions have psychological and biological aspects that prevent an induvial from fighting back or resisting an assault contrasting rape myths and highlighting the importance of education on the unique nature of trauma (Haskell & Randall, 2019).

Neurological and Biological Impact of Trauma

The brain responds to traumatic threats such as sexual assault in a variety of ways. When faced with a life threatening or traumatic event the brain's limbic systems begins a complex

process of alerting the amygdala and hypothalamus, which then sends this information to the pituitary gland, then the adrenal gland or Hypothalamic Pituitary Adrenal axis. Two types of hormones are then released once the signal has been received, adrenaline and cortisol. Cortisol, released in times of stress, controls bodily action including digestion and higher cognitive processes while adrenaline can trigger a fight or flight response. The brain body response is complex in times of stress and trauma leading to altered functions and ways of thinking (Haskell & Randall, 2019).

Memory may also be impacted from the brain body interaction, posing difficulties in cases where accurate information is key to evidentiary support. Research shoes memories in times of extreme trauma as sexual assault may be fragmented and poorly contextualized making linear recall difficult particularly immediately after the event. In normal circumstances, the hippocampus processes and learns contextual information from the amygdala in memoirs that may be fearful. When facing extreme traumas, increase of amygdala activity both impacts and intensifies memory while negatively affecting the function of the hippocampus. Because of these, and many more brain body complexities, trauma-informed care advocates criminal justice professionals adapt approaches and techniques when working with sexual assault victims. Normal techniques of interviewing and assessment may be more stressful to a victim. Likewise, the ability to recall memories or specifics of the assault may be different from those recalling other crimes or events (Haskell & Randall, 2019). These biological findings suggest then that victims of extreme traumas like sexual assault should not be expected to recall or act in the same manner that others who have not experienced a major trauma would.

One common myth in the biological response of sexual assault victims is the expectation that a response would elicit a fighting response. There are more biologically motivated directions

however that may explain the actions, or lack of ability to react, when a victim is faced with an extreme trauma. These include but are not limited to fight, flight, and freezing. Once a two-system framework, the understanding of both conscious and unconscious psychological impacts created an addition of freeze to the biological reaction framework. A crucial factor to note outside the biological explanations for victim reactions is the statistic that most women know their offenders. This can make an assault more alarming, surprising, confusing, destabilizing, emotional, and threatening. Both the psychological and biological explanations support refraining from judgment, bias, or blaming the victim for their actions based on comparison to reactions of those who have not encountered extreme traumas (Haskell & Randall, 2019).

Trauma and the criminal Justice system

Re-traumatization

One of the main goals of trauma-informed care is to combat re-traumatization, or the triggering of feelings or symptoms of trauma brought on by stimuli. This can include the recurrence of traumas with similar circumstances or replicated aspects (University of Buffalo School of Social Work, 2022). Re-traumatization is often unintentional, and triggers can be unapparent. This trauma can happen on the individual level or can be systemic. Triggers may include particular smells, sounds, touch, sensory input, interactions with others, environment and surroundings, or any stimuli (Substance Abuse and Mental Health Services Administration, 2014). Means to combat re-traumatization include the education and implementation of trauma-informed care, where awareness of common triggers and sensitive methodologies are used to abate triggering the victim (University of Buffalo School of Social Work, 2022).

Re-traumatization can also have a domino effect in the health and recovery of a victim as symptoms of trauma last longer and may be more severe in those who have been re-traumatized (Substance Abuse and Mental Health Services Administration, 2014). Re-traumatization within the criminal justice system may also dissuade victims from seeking further treatments or formal justice. This is partially true for those who have a family history of negative experiences within the criminal justice system or intergenerational community traumas (University of Buffalo School of Social Work, 2022).

Secondary Trauma

Secondary trauma, or secondary traumatic stress is also known by several other names. The term is used synonymously with vicarious trauma, and on occasion used to describe burnout or compassion fatigue. Broken down specifically, vicarious trauma is a term first used by Pearlman & Saakvitne to explain caregivers and crisis workers' shared traumas. These researchers specifically note changes in beliefs and behaviors of these workers. Secondary trauma was a term first used by trauma specialist Beth Stamm and Charles Figley in the 90's. Their observations hoped to explain why crisis workers seemed to experience Post Traumatic Stress Disorder (PTSD) like symptoms when exposed to trauma in their work. This trauma can occur through exposure to or experience with graphic, gruesome, disturbing, or frightening experiences. This can range from disturbing images seen in a hospital setting to a triggering mention of a graphic assault in the courtroom (Defining vicarious trauma and secondary traumatic stress, 2021).

This phenomenon can occur in many types of trauma-exposed and high stress fields. This phenomenon has now stretched its scope to relate to civilians as well who witness or are exposed to this material and are traumatized secondarily as a result. Unlike direct trauma, these experiences of professionals and civilians are not a direct result from being affected or victimized, trauma instead stems from witnessing or experiencing the trauma of others or indirect trauma. Notably in research and literature, it has been documented that repeated or extreme exposure to this graphic content can have long term negative impacts on health and mental health. Through research warning signs have been identified to predict secondary trauma, coping skills, treatment, and prevention of secondary trauma in crisis workers such as advocates (Defining vicarious trauma and secondary traumatic stress, 2021).

Secondary trauma has been found to be extremely prevalent in criminal justice staff. In a study of 135 sexual assault advocates, research by Benuto et al. found nearly 50% of all showed occurrence of secondary trauma. Of those factors found to contribute to this, several were significant including: hours worked per week, in person service hours, and type of survivor. This study shows that there is great prevalence and risk in the field, and previous research suggests there has been for some time. Information and further training and resources were suggested as means of intervention for this population based on findings (Benuto, Newlands, Ruork, Hooft, & Ahrendt, 2018).

In a qualitative study, researchers Wasco et al. explore strategies of self-care to combat secondary trauma used by advocates of rape crisis centers. Success of these routines and strategies were categorized as organizational, stemming from the organization itself, or personal. These routines were also categorized as either cathartic releases of trauma materials or improving capacity to integrate traumatic material into the advocate's life. Findings overall saw

greater success for advocates with a variety of organizational support and self-care. Those organizations with higher levels or strategic resources and integrated care for advocates were most successful in supporting and giving skills used also in personal self-care routines to combat secondary trauma (Wasco, Campbell, & Clark, 2002). This research implies the training and support of organizations goes beyond workplace skills to combat secondary trauma, but also gives advocates tools to integrate in personal self-care routines outside the workplace that are essential in their health.

Research also suggests that with adequate resources and training, the emotional and often difficult experiences with trauma in an advocate's work can build resistance and promote growth. In a study of vicarious reliance in sexual assault services, it was found that with organizational support and peer support personal trauma experiences witnessed in work predicted higher levels of compassion satisfaction and vicarious posttraumatic growth (Frey, Beesley, Abbott, & Kendrick, 2017). This research brings a new positive light on advocate work suggesting that with adequate training and support exposure to some degree of trauma can build resilience and foster advocates ability to support survivors.

Trauma-Informed Training and Services

Defining Trauma-Informed Care

In response to identification of biological and psychological components of trauma, human service fields such as psychology and social work began creation of the trauma-informed care approach. This approach adapted practices from being diagnostic in nature to recognizing and responding to trauma victims with sensitivity (University of Buffalo School of Social Work,

2022). This includes recognition to the role trauma plays in the life choices victims make and acknowledging the victim's history in context to their experiences (Davies et.al, 2013). Trauma sensitivity includes looking at what may have happened to a victim rather than asking what is wrong with them or why something may have happened (University of Buffalo School of Social Work, 2022). At its core, trauma-informed care is a philosophy and paradigm shift in current practice rather than a set treatment plan. Any organization can become trauma informed. This may include hospitals, schools, or courts. One of the major goals of trauma-informed care is to combat secondary trauma in providers and re-traumatization of victims.

Key Components of Trauma-Informed Care

To implement trauma-informed care, key components must be addressed by organizations (Davies et.al, 2013). First, responders in the medical and criminal justice systems must understand that as first responders to trauma victims, their actions set the stage for future recovery and engagement with formal systems of justice and care. Setting a precedent for making trauma-informed care, and the care of staff's health, ensures a better prospective outcome for victims and staff (University of Buffalo School of Social Work, 2022).

Second, it is recommended that current policies be reviewed and modified to best eliminate actions that are common sources or common in nature to trauma faced by victims when possible. Eliminating triggers allows for a supportive environment and decreases the possibility of re-traumatization in victims and staff (University of Buffalo School of Social Work, 2022). When looking to address policies, The Substance Abuse and Mental Health Services Administration has created ideal targets to address. These include leadership, physical

environment, engagement, cross-sector collaboration, screening, assessment, treatment services, training and workforce, progress monitoring, quality assurance, financing, and evaluation (University of Buffalo School of Social Work, 2022).

Third, it promotes working collaboratively with partners. This may include other professionals in the criminal justice system, or those outside the system such as medical staff, educators, and more. The goal of collaboration in trauma-informed care is to create a victim centered, sensitive and supportive environment that best supports their needs (Davies et.al, 2013).

Finally, to create comprehensive trauma-informed care it is recommended organizations education on the five principles of trauma care. This framework applies across provider settings to create a physically, psychologically, and emotionally safe environment for victims. This environment is meant to create trust, promote autonomy, and empower resilience within victims. When applied with factors such as policy change, the five principles of care when used reduce re-traumatization and promote the recovery process. These five principles are safety, choice, trustworthiness, empowerment, and collaboration (University of Buffalo School of Social Work, 2022). To be noted, some organizations include a sixth principle for training, cultural competence. In the five-principal model, cultural competence is stressed as a tool to empower, and reaching out to other organizations to create cultural understanding is stressed (Davies et.al, 2013). This paper will explore a five-principal model with acknowledgement of cultural competence as a crucial factor in engaging all five principles.

The first principle, safety, applies to both the victim and staff. This means there is a sense of physical and emotional safety (University of Buffalo School of Social Work, 2022). Physical

safety for victims may include safety planning and making sure services are provided at a safe location. Emotional safety for victims may include accessing the atmosphere of the location of services for potentially triggering affects or providing clear and considerate education materials. Staff, who are potentially vulnerable to secondary trauma should also be addressed in this principle. This includes making sure staff feels physically safe, has access to resources and help, and addressing any concerns or conflicts with superiors and management (Davies et.al, 2013).

Second, a level of trust should be established. Victims and staff can establish trust though healthy boundaries and holding consistent boundaries. To open up and begin the healing process, staff must make a trusting relationship with the victim (University of Buffalo School of Social Work, 2022). Trust can also be held though staff and organizations. Organizations should ask if self-care is encouraged, are staff supported, is there transparency, and are concerns listed to respectfully (Davies et.al, 2013).

Third, a victim has a right to be in control of their healing and services. This is accomplished through allowing them to have options and a voice. Choice is a powerful tool to empower victims and encourage them to engage in services. Choice can be implemented on small and large scales. This could look like asking where the victim would like you to sit in an office space to allow them to feel most comfortable, to a victim making a larger decision such as not reporting an event (University of Buffalo School of Social Work, 2022). Staff can also be supported though choice. Staff choice may look like opportunities to affect their work, flexible schedule, optional training, leadership opportunities, and flexible leave policies (Davies et.al, 2013).

Fourth, collaboration plays a significant role in a victim's ability to access resources. This allows the victim to ensure they are treated fairly, are respected, recognized, involved, have choice, and feel validated (University of Buffalo School of Social Work, 2022). Collaboration applied to staff looks similar to the benefits of collaboration for the victim. Agencies may encourage feedback, value staff, and are supported in their collaboration with other agencies while supporting victims (Davies et.al, 2013).

Finally, empowering victims and the professionals that work with them is an important step in trauma-informed care. This involves developing coping skills, providing healthy foundations, fostering resilience, and promoting individual's strengths (University of Buffalo School of Social Work, 2022). Staff and victims both benefit from an organization that fosters validation and support. Realistic optimism, evaluation of services, training, and support can be positive motivators (Davies et.al, 2013).

Current Practices

One major obstacle in sexual assault response functionality is burnout and turnover. Those working with victims of trauma become emotionally and psychologically unable to handle the stressors of the work, and often are unable to stay with the centers long term. This consistent cycle of re-training new advocates leads to difficulty in community connections, serviceability of victims, and leads to advocates with less experience. One supported answer to why burnout and turnover remains high lies in secondary trauma and lack of support. Research by Benuto et al. found nearly 50% of all rape crisis advocates showed occurrence of secondary trauma (Benuto, Newlands, Ruork, Hooft, & Ahrendt, 2018). While training is provided on secondary trauma to

many criminal justice professionals, it is dependent on the profession, short in nature, and often supplementary (Frey, Beesley, Abbott, & Kendrick, 2017). Despite research acknowledging secondary trauma in responder to sexual trauma, few changes have been made in practice or policy to combat this. Literature on this issue points to several potential solutions to this problem ranging from management involvement to increased mandatory training on trauma-informed care (Nadeem et. al, 2021).

The need for trauma-informed care and calls to action in providing mandatory training across fields goes beyond the criminal justice system. With rising rates of traumatic circumstances for students, the Colorado Department of Education released a statement on the necessity of trauma-informed training for staff and students. This statement highlighted recent research findings on the effect of brain disruption, social, and emotional damage on students impacting academic success and overall health (“Trauma Informed Approaches in Schools", 2018). The high prevalence of trauma in the workforce has also led employers to incorporate trauma-informed care into policy noting stress affects employees both in the workplace and at home (Choitz & Wagner, 2021).

While the implementation of trauma-informed care and its benefits are spreading to other fields, criminal justice professionals and first responders to victims of crimes do not all have mandatory comprehensive programs (Courtois & Gold, 2009). Each state and organization set their own standards for training. Some states, such as Iowa, require any counselor or advocate working with victims to complete a comprehensive 20-hour training though an accredited organization including the Iowa Coalition Against Domestic Violence, Iowa Coalition Against Sexual Assault, Iowa Coalition for Collective Change, or Iowa Organization for Victim Assistance (“Certification and Training Requirements”, 2022). While not all nurses or physicians

working with victims go through trauma-informed training, SANE nurse or Sexual Assault Nurse Examiner and sexual assault advocates do. This is in part to the credential being mandated through a national professional licensing program (Nathan & Ferrara, 2020).

Other criminal justice professionals working with victims however, such as law enforcement, are not mandated to complete a trauma-informed care specific training. Some departments request training, such as the New Hampshire Police Department, giving a full day of training to all officers in their program to help aid in responding to local crisis calls. The department noted in interviews with the Concord Monitor that it is difficult to include everything needed for an officer in the timeframe of basic training and holistic training on the issue is rare in the field (Haime, 2020). While many fields utilize the benefits of trauma-informed training such as schools and the workplace, standardized training and requirements for criminal justice professionals working directly with victims of trauma remains to be implemented.

Program Evaluation: Current Examples Trauma-Informed Care Curriculums for Responding to Sexual Assault

As supported though empirical studies, one way to combat secondary trauma and re-traumatization involves the education and training of professionals in contact with sexual assault victims on trauma-informed care (Nadeem et. al, 2021). Comprehensive training for criminal justice professionals in trauma-care has also been found to increase victim satisfaction and outcomes within the system (Henninger et al., 2019). While trauma-informed training is mandatory for professions such as therapists, social workers, and counselors, its presence in

mandatory training across criminal justice professions and those working with sexual assault victims varies by profession (Frey, Beesley, Abbott, & Kendrick, 2017).

This study looks to evaluate training on trauma-informed care of those professionals responding to sexual assaults within the criminal justice system. This is done though explanation what each profession does, investigation on how those professions interact with victims of sexual assault, and an evaluation of training on trauma-informed care. This evaluation, however, does not include all individuals who work with victims of sexual assault. The training chosen for each profession was introductory in nature and required for participation in the profession and related organizations. It is keen to note that each training, while required materials for each associated organization, may not be required for all professionals in that field. It is keen to note that each training, while required materials for each associated organization, may not be required for all professionals in that field. The programs analyzed include : The SANE Program Development and Operation Guide developed by the Office for Victims of Crimes and International Association of Forensic Nurses, The Trauma Informed Sexual Assault Investigations Training Curriculum developed by The International Association of Chiefs of Police, Building Cultures of Care A Guide for Sexual Assault Service Programs developed by The National Sexual Violence Resource Center, and Sexual Violence: A Healthcare Priority for EMS Providers developed by The Nevada Coalition to End Domestic and Sexual Violence.

Evaluation of the training will be done through identification of several key components found as effective training topics for trauma-informed care in the literature review. Effective components of trauma-informed care training identified included education on responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma informed care. The first, is the stress on the

importance of responding Effective components of trauma-informed care training identified included education on responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma informed care. The second, the modification of policies may include actions to combat common triggers, leadership, resources for staff, physical environment, screening, assessment, quality, and program evaluation (University of Buffalo School of Social Work, 2022). Third, the identification of the importance of cross professional collaboration includes taking advantage of community resources in the aid of victims to create a victim centered, sensitive, and supportive environment that best supports their needs (Davies et.al, 2013). Finally, the training must cover the core principles of trauma-informed care. taking advantage of community resources in the aid of victims to create a victim centered, sensitive, and supportive environment that best supports their needs (Davies et.al, 2013).

SANE Nurses

About the Profession

The Office for Victims of Crime defines a SANE as, "A Sexual Assault Nurse Examiner is a registered nurse who completed additional education and training to provide comprehensive health care to survivors of sexual assault. In some communities, SANEs are called Forensic Nurse Examiners. To offer comprehensive care, the role of the SANE includes evaluating and treating the patient in a holistic way, being mindful of both the acute and long-term consequences of sexual violence victimization." SANE nurses must have a minimum of two years of nursing experience and must hold a registered nurse license. In addition to the nursing

qualifications, these nurses must then complete a SANE program to take on the role (Office of Justice Programs, 1999).

Interactions with Sexual Assault Victims

The SANE completes the Forensic Medical Exam, or Rape Kit, if the victim consents. This includes taking appropriate medical history, history of the assault, testing and treatment or prevention of sexually transmitted diseases, follow-up services with community-based sexual assault advocacy, evidence collection, and testify in a criminal or civil trial as a fact or expert witness when necessary (Office of Justice Programs, 1999).

Evaluation

The SANE Program Development and Operation Guide is an online resource manual used as a blueprint and standard for covered topics in mandatory SANE training. This program is used by all SANE programs in the United States and is required to become a licensed SANE. This manual, due to its overarching nature, includes standards required for other subsidiary SANE institutions such as the National Protocol for Sexual Assault Medical Forensic Examinations, the International Association of Forensic Nurses, and the Office for Victims of Crime SART Toolkit guide (Office of Justice Programs, 1999).

This program consists of ten units. This main units are named, in order, Introduction to the SANE development program, Building Patient-Centered Trauma-Informed SANE Programs, Building a Sustainable SANE Program, Legal and Ethical Foundations of SANE Practice, Management of SANE Programs, Program Operational Costs and Funding, Identifying Essential Components of a SANE Program, Multidisciplinary Response in the Community, Maintaining a

Quality Program, and Expanding Forensic Nursing Practice. Each chapter consists of sub-chapters (Office of Justice Programs, 1999).

Sub-chapters of chapter one, Introduction to the SANE development program, include five sub-chapters focusing on the importance and relevance of trauma-informed care and SANE care to sexual assault. These chapters include What is a SANE, Understanding the Problem of Sexual Assault, History and Development of SANE programs, Are SANEs Effective, and Building a Theoretical Framework for SANE Practice (Office of Justice Programs, 1999).

Sub-chapters of chapter two, Building Patient-Centered Trauma-Informed SANE Programs, include core values of caring for victims and their unique needs. These five sub-chapters include Creating Trust, Patient-centered Care, Trauma-informed Care, Recognizing and Removing barriers, and Preparing to Meet Unique Survivor Needs (Office of Justice Programs, 1999).

Sub-chapters of chapter three, Building a Sustainable SANE Program, includes nine sub-chapters that focus on identifying community members in need of help and examining the need for the program to be successful. These sub-chapters include Partners and Stakeholders, Readiness Assessment, Assessing the Community Need for a SANE Program, Developing an Organization that Looks Like Your Community, Marketing Your Program, Program Models, Program Goals and Objectives, Business Plans, Creating Programs in Unique Community Settings (Office of Justice Programs, 1999).

Sub-chapters of chapter four, Legal and Ethical Foundations of SANE Practice, includes seven sub-chapters providing information on informed consent and laws. This includes federal, tribal, and state laws on sexual assault. These sub-chapters include State Laws and the Nurse

Practice Act, Federal Laws, Tribal Laws, The Impact of Jurisdiction on SANE Practice, Hospital and Agency Practice and Procedure, Forensic Nursing Scope and Standards of Practice, Forensic Nursing Scope, and Standards of Practice, and Ethical Decision Making (Office of Justice Programs, 1999).

Sub-chapters of chapter five, Management of SANE Programs, includes six sub-chapters focusing on staff structures, retention, meeting needs of staff, and working collaboratively with others outside SANE positions. These sub-chapters include Importance of leadership and Management, Sexual Assault Nurse Examiners, Essential Documents of SANE Practice, Models of Collaborative Practice, Collaboration in the Facility where Care is Provided, and Interdisciplinary Collaboration Outside the Facility (Office of Justice Programs, 1999).

Sub-chapter of chapter six, Program Operational Costs and Funding, go over financial requirements for a SANE program and learning how to secure funding. These two sub-chapters include Determining Funding Needs and Creating a Budget, and Financing Your Program (Office of Justice Programs, 1999).

Sub-chapters of chapter seven, Program Operational Costs and Funding, includes thirteen sub-chapters focusing on tools to provide a solid foundation in any SANE program. These sub-chapters include Identifying and Defining Populations Served by the SANE Program, Options for Reporting, Before the Examination Begins- Providing Patient-centered Care, Informed Consent and Patient Confidentiality, Medical Forensic History- Taking and Documentation of the Medical Forensic Examination, Suicide Assessment, Evidence Collection, Photo Documentation, Prevention of Sexually Transmitted Infections, Prevention of Pregnancy,

Discharge and Follow-up Care, Medical Records Maintenance, and SANE Testimony (Office of Justice Programs, 1999).

Sub-chapters of chapter eight, Multidisciplinary Response in the Community, includes four sub-chapters on the significant role SANEs play when working with other criminal justice system members in the care of the victim through a comprehensive and cohesive response. These sub-chapters include Multidisciplinary Team Models, Collaboration with Community Partners, Assuring Quality of the MDT, and Community and Partner Education (Office of Justice Programs, 1999).

Sub-Chapter of chapter nine, Maintaining a Quality Program, includes five sub-chapters evaluating and creating evaluation criteria for critical SANE training and care components. These sub-chapters include Quality Assurance and Quality Improvement, Peer Review, Competency Evaluation, Maintaining Currency of Practice, and Evaluating the Effectiveness of the SANE Program (Office of Justice Programs, 1999).

Finally, sub-chapters of chapter ten, Expanding Forensic Nursing Practice, includes seven sub-chapters on treatment and addressing components of trauma outside the sexual assault. These include Expanding your Program to Include Intimate Partner Violence, Expanding your Program to Include Strangulation, Child Maltreatment, Injuries (Major Trauma, Non-accidental and accidental, Occupational), Lactogenic Injuries and Risk Management, Human Trafficking, and Suspect Examinations. The program also includes a comprehensive conclusion with resource lists for providers, glossary of key terms, related videos for educational purposes, spotlight of successful SANE programs, and endnotes (Office of Justice Programs, 1999).

Identified in the literature, the four major components of a successful trauma-informed care training program were present in the SANE mandatory training guidelines. These include the identification of the importance of responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of Social Work, 2022). Identification and education on the importance of the job and its response was explained in detail through chapter one, Introduction to the SANE Program Development Guide. Modification of policies to serve staff and victims were heavily involved in two chapters. Chapter five, Management of SANE Programs gave education on, and policy practice guidelines for, the development of a program that meets staff needs though providing resources and creating a safe environment. Chapter two created a foundation in the training on patient-centered care that was also identified and further discussed though several other chapters in the program. Personal collaboration has two chapters dedicated to its identification, dividing the in-hospital team collaboration and outside profession and community collaboration. Hospital and care provider collaboration included sub-chapters in chapter five, Management of SANE Programs. Collaboration with other criminal justice professionals and the community was given its own chapter, chapter eight Multidisciplinary Response and the Community.

Finally, the program successfully addressed all five principles of trauma-informed care. These are safety, choice, trustworthiness, empowerment, and collaboration (University of Buffalo School of Social Work, 2022). As mentioned, collaboration was devoted to two chapters in its discussion, chapters five and eight. Choice is addressed in several chapters. Chapter two, Building Patient-centered Care, identifies the importance of choice for the victim. Chapter seven, Identifying Essential Components of a SANE Program addresses choice through sub-chapter on

consent, reporting, and options of the victim. While trust is mentioned throughout the program, trust is given its own educational sub-chapter in chapter two named Creating Trust. Safety is addressed through several chapters as well both directly with the victim and in creating safe programs for staff and victims. These chapters include chapter five, Management of SANE Programs and chapter seven, Identifying Essential Components of a SANE program. Finally, empowerment is a theme throughout the SANE guidebook and mentioned chapters two, seven, eight, and in the concussion of the program guide (Office of Justice Programs, 1999).

Recommendations

SANE nurses have been found to be impactful care providers to those who have experienced a sexual assault. Research on the impact of SANE involvement in sexual assault cases have found increased satisfaction with care and optimism towards justice services including healthcare needs, law enforcement interactions, and prosecution (Helitzer & Crandall, 2003). One factor supported as a catalyst for this impact is the educated, informed, and trauma-sensitive interactions provided by SANE's (Office of Justice Programs, 1999).

Outside a positive impact on the victims' outcomes and healing, comprehensive trauma-informed care has been found to improve the knowledge, views, and outlook of SANE's themselves. This includes improved outlook on longevity and health regarding secondary trauma (Bruce, Kassam-Adams, Rogers, Anderson, Sluys, & Richmond, 2018).

When analyzing the training required for all SANES, it met all four of the criteria for a successful program. These include the identification of the importance of responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of

Social Work, 2022). It is not surprising then that overall patient satisfaction and response was seen improved by the introduction of trauma-informed care practice, but also the success of comprehensive mandatory training on trauma-informed care in SANE licensure is used as support for promoting cross-field trauma-informed care in the criminal justice system (Purkey, Patel, & Phillips, 2018).

Due to meeting the requirements of training and holding this training as a minimum requirement for all new SANES, it would be recommended that this program continue its progress, continue to see evaluations of its material to ensure updated information, and for this program to be accessible and more prominent in all nursing placements.

Advocates

About the Profession

Although the work of an advocate seems straight forward, providing appropriate support to victims of sexual assault is a multifaceted position requiring a varied skillset. Advocates collaborate with diverse professionals including law enforcement, attorneys, medical staff, and property owners. The responsibilities of an advocate may include providing information on victimization such as legal rights and protections, safety planning, community training, activity, and education on the criminal justice system, intervening with others on behalf of the victim, crisis response, and medical advocacy (After Sexual Assault, 2021).

Interactions with Sexual Assault Victims

Educating victims on their legal rights and protections is an important aspect of the advocate's role. Victims of sexual assault are provided several rights according to U.S. Code § 3772. These include the right to not be prevented from, or charged for, receiving a medical forensic examination, have evidence collected and its content preserved without charge for acceptable statute of limitations or 20 years, be informed of any results of the sexual assault evidence collection kit, be informed of the policies of collection and preservation of their kit, upon request be notified by an appropriate official of the intended destruction or disposal of the kit, and upon request be granted further preservation of the kit. By this code, any nonconsensual sexual act proscribed by Federal, tribal, or state law including lack of capacity to consent apply to be considered sexual assault (U.S. Code § 3772). Depending on the timing in which an advocate enters the process desired by the victim, education of rights could include a great deal more than that covered by U.S Code. Rights to release information, explanation on confidentiality, rights for reimbursement, and requirements regarding reporting are just a few. A great deal of these rights pertains to the medical advocacy aspect of an advocate's role (Flynn, 2018).

Medical advocacy includes explanation of medical terms, rape kit procedure, prophylaxis, or reimbursement rights for items taken for the rape kit. The Sexual Assault Forensic Exam, also known as a rape kit, is a medical examination including the collection of DNA evidence from the body and other personal belonging on a person. Victims have a right to complete this exam, decline the exam, or selectively partake in aspects of the exam. The kit can also be done anonymously due to The Violence Against Women Reauthorization of 2013. The advocate also explains this kit to be free of charge and stored by law enforcement (After Sexual Assault, 2021).

Victim advocates also assist in the communication between law enforcement and the victim as part of their role in informing and educating on the criminal justice process, also known as legal advocacy. This interaction could include reporting, interviews, court proceedings, or other investigatory related items (Flynn, 2018). When communicating with police, victims are informed by advocates that they have several rights including the right to privacy, ability to take breaks, to request additional or alternative law enforcement support if uncomfortable, to ask questions, and to have support in the form of an advocate or other trusted person. Within the report, the advocate can explain questions asked of law enforcement. Aspects of the report which may need more explanation can include description of the assault, questions on force, consent, premeditation, and timeline. An advocate may guide a victim through the reporting process directly following an assault or may inform the victim they have no limitation on reporting to the police but must be mindful of statutes of limitation for filing charges which vary on a state-by-state basis (After Sexual Assault, 2021).

Evaluation

Building Cultures of Care: A Guide for Sexual Assault Services Programs is a comprehensive training and guide created by The National Sexual Assault Coalition Resource Sharing Project and National Sexual Violence Resource Center to assist organizations in strengthening their responses to victims. The fifty-six-page document is supported and in use with The National Sexual Assault Coalition Resource Sharing Project, the National Organization of Asian Pacific Islanders Ending Sexual Violence, The Iowa Coalition Against Sexual Abuse, and the Minnesota Indian Women's Sexual Assault Coalition. This guide covers standards and training required for all advocates nationwide; however, the specific document itself is not

required for all advocates and may be supplemented with training approved through state coalitions (Davies, Guarino, Soares, Konnath, Clervil & Bassuk, 2013).

Building Cultures of Care contains Four major chapters. These chapters include an Introduction to Building Cultures of Care, Integrating Trauma-Informed Services- Organization, Integrating Trauma-Informed Services- Services, and Integrating Trauma-Informed Services-Individual. The first of these chapters, Introduction to Building Cultures of Care, contains five sub-chapters and spans eleven pages. These chapters include Introduction, Understanding Trauma, Defining Trauma-Informed Services, and Core Principles of Trauma-Informed Care (Davies et al., 2013). These sub-chapters are meant to define trauma-informed care and supply advocates and organize the fundamentals of trauma.

The second chapter, Integrating Trauma-Informed Services- Organization, spans eighteen pages and contains eight sub-chapters. These chapters include Organizational Culture, Commitment to Staff Growth and Wellness, Commitment to Volunteers and Interns, Supervision, Policies and Procedures, Organizational Change, Establishing a Safe and Supportive Environment, and Developing Goals and Plans (Davies et al., 2013). These sub-chapters are intended to guide organizations and advocates in creating a safe and supportive environment that supports both its staff and victims.

The third chapter, Integrating Trauma-Informed Services- Services, spans two pages, and contains two sub-chapters. These subchapters include Working with Collaborative Partners and Offers Comprehensive Services (Davies et al., 2013). These sub-chapters give explanations of other service providers that may work with victims and models on collaboration to best serve the victim.

Finally, the fourth chapter, Integrating Trauma-Informed Services- Individual, spans two pages and contains a single chapter; Maintaining Self-Care and Well-Being. This chapter focuses on techniques to combat secondary trauma through physical, emotional, spiritual, and intellectual resources (Davies et al., 2013).

Identified in the literature, the four major components of a successful trauma-informed care training program were present in the Advocate training guidelines. These include the identification of the importance of responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of Social Work, 2022).

The identification of the importance and impact of responding was addressed in chapter one, Introduction to Building Cultures of Care. Modification of policies and procedures to serve staff and victims was addressed in chapter two, Integrating Trauma-Informed Services- Organization. This chapter included education on organizational change such as leadership and management support, chapters specific to the care of volunteers and interns, care of staff, growth for staff, creation of safe environments, and policies for proactive change. Additionally, chapter four, Integrating Trauma-Informed Services- Individual, also addressed policy change though providing resources and education for staff and organization on self-care of advocates. Identification of collaboration was addressed though its own chapter, Integrating Trauma-Informed Services- Services. This chapter included information on other professionals that may work with advocates in providing care for sexual assault victims and complies a list of action items to ensure a comprehensive service is given to the victim. Finally, the five-core principles of trauma-informed care are given a sub-chapter in chapter one, Introduction to Building Cultures of Care. This guide also includes a sixth principle, cultural competency, to help ensure

accessibility of service, options that are sensitive, and education on experiences of others (Davies et al., 2013).

Recommendations

To manage such diversity in environment and response, the advocate must possess a wide range of technical and personal skills. Of those personal skills, communication and empathy when working with survivors ranks amongst the most pivotal. In a study of ninety-two survivors who worked with advocates, it was found that those skills most important to survivors included diversity training, warmth, compassion, and empathy and allowing them to have control back (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009). Alongside personal skills, advocates must maintain a vast knowledge of the system, laws, and resources available in their community. This skillset achieved through active practice and diligent training. Training of sexual assault advocates varies from state to state. These are often set by statewide coalitions and follow similar national standards (U.S. Department of Justice, 2021). Laws, rules, regulations, and resources available are consistently changing in the advocates world. For this reason, a strong educational foundation is vital for advocates and volunteers. Advocates and volunteers of rape crisis centers must complete approved training to serve victims, and for many to maintain the right to confidentiality. Each state varies in hours and particular curriculum outlets. Many include in person, online, and direct service components. Often these programs range around 20 to 30 hours to ensure high standards of education when working with victims (Iowa Coalition Against Sexual Abuse, 2021).

When analyzing the training required for all advocates, it met all four of the criteria for a successful program. These include the identification of the importance of responding,

modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of Social Work, 2022). Notably, this training included additional chapters and resources that addressed secondary trauma directly and included training specific to volunteers and interns. A sub-population of staff that can often be overlooked and lack adequate training to prevent re-traumatization and secondary trauma (Davies et al., 2013).

Due to meeting the requirements of training and holding the training provided as a minimum guideline for all new advocates, it would be recommended that this program continue its progress and continue to see evaluations of its material to ensure updated information. This training could also be modified and used by other criminal justice professionals and organizations due to its broad nature and specific focus on trauma-informed standards.

First Responders

About the Profession

Emergency medical services, or medical first responders, are trained individuals who respond to the scene of an emergency to stabilize in cases of medical emergencies. Two of the professions included in the emergency medical service team are Emergency Medical Technicians (EMT's) and paramedics (Learn, 2022).

Emergency medical technicians (EMTs) are educated medical professionals that respond to life threatening injuries on the scene. The Goal of the EMT is to provide medical care to stabilize and treat the patient if possible. These skills could include administering epinephrine,

CPR, ventilation, delivery of newborn, or administration of basic life support techniques. Skills taught in the 170-hour training to become an EMT include assessment of patients, determination of illness and injury, and recognition related health factors (UCLA, 2021).

Paramedics, similarly, to EMT, also respond to the scene of a life-threatening event to stabilize and treat immediate medical needs. Paramedic training is longer than that of the EMT at 1,200-1,800 hours. This training includes more in-depth techniques at administering medications, starting IVs, airway management, EKGs, and much more. To complete this degree and practice as a paramedic, an additional field internship in EMS is required. Both EMTs and Paramedics require certification exams (UCLA, 2021).

Interactions with Sexual Assault Victims

Regarding sexual assault, these first responders are called to meet emergency medical and emotional needs when applicable. These individuals work with dispatchers, responding officers, and others first responding to a sexual assault (West Virginia Foundation for Rape Information and Services, 2022). Part of the training to become an EMT or Paramedic is the assessment of patients, determination of illness or injury, and recognition of health factors. This may include the identification of a sexual assault occurring, responding appropriately with trauma-informed care, and seeking out appropriate services to aid that patient EMT include assessment of patients, determination of illness and injury, and recognition related health factors. One example of this may include bodily sensitivity and triggers when treating the patient for emergency medical care due to the sexual assault (UCLA, 2021). A trauma-informed response to emergency medicine may look like active listening, providing a safe space, giving options to the victim, educating on evidence collection if desired, identification of crisis centers in the area, and

informing the patient of their right to an advocate (Texas Association Against Sexual Assault, 2015).

Evaluation

Sexual Violence: A Healthcare Priority for EMS Providers developed by The Nevada Coalition to End Domestic and Sexual Violence is ninety-two-page training presentation for medical emergency first responders in the Nevada area. This presentation was completed by the Nevada Coalition to End Domestic and Sexual Violence training coordinator Judy Henderson at the 2019 National Sexual Assault Conference. This training was made public as supplemental learning material for emergency service providers via The National Sexual Assault Coalition Resource Sharing Project and National Sexual Violence Resource Center. The presentation focuses on response to sexual assault and is a cumulation of information from other statewide trainings for EMS providers including the EMS Response to Domestic Violence: A Curriculum and Resource Manual. This presentation was required viewing for conference participants and allied EMS service providers in the state of Nevada. It is keen to note that the presentation acknowledges the lack of formal resource guides or training on trauma and trauma-informed care for EMS providers outside educational requirements and urges the integration of trauma training for all EMS providers (Henderson, 2019).

Sexual Violence: A Healthcare Priority for EMS Providers developed by The Nevada Coalition to End Domestic and Sexual Violence contains thirteen slide chapters. These chapters include A Call To Action, Presentation Objectives, Terminology, Dynamics of IPV Relationships, Power and Control Wheel, Barriers for IPV Victims, Common Medial Conditions & Injuries Associated with IPV including Sexual Assault, Strangulation & Traumatic Brain

Injury, The Role of EMS, EMS Response: Recognizing IPV, SA, and Speaking with the Patient , Crime Scene Considerations & Preserving Evidence, Making Appropriate Referrals, and National Resources for Survivors & Professionals (Henderson, 2019).

Identified in the literature, the four major components of a successful trauma-informed care training program include the identification of the importance of responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of Social Work, 2022).

The first component, identification of the importance and impact of trauma-informed response was addressed in slide chapters A Call To Action, with four slides dedicated to the importance of trauma-informed care and The Role of EMS, with five slides dedicated to the impact of trauma-informed care. Second, the modification of policies to serve staff and victims was briefly mentioned in three chapters: A Call To Action, Barriers for IPV Victims, and Role of EMS. In Call To Action two slides are dedicated to a need for change in policies to protect victims, in Barriers for IPV Victims two slides are dedicated to an address on current policies that make reporting and seeking treatment more difficult for victims, and in Role of EMS two slides are dedicated to educating providers on the need for safety and self-care in the role. Third, identification of collaboration was briefly touched on throughout the presentation when describing transfer of the patient to other services. This includes two pages in the chapter Making Appropriate Referrals and some information in Crime Scene Consideration & Preserving Evidence. Finally, the five-principles of trauma-informed care were not directly addressed. These five principles are safety, choice, trustworthiness, empowerment, and collaboration (University of Buffalo School of Social Work, 2022). Of those named, safety, choice, and trustworthiness

were the only principles mentioned in related content. These principles were explored separately through chapters Barriers for IPV Victims, Crime Scene Consideration & Preserving Evidence, and EMS Response: Recognizing IPV, SA, and Speaking with the Patient (Henderson, 2019).

Recommendations

Although medical emergency first responders' priority is to treat immediate medical needs, it can be overlooked that the mental and emotional health of the patient is also a vital part of their care. Trauma is not always as visible as a wound however it makes a significant impact on the healing and wellbeing of the patient (Purkey, Patel & Phillips, 2018). Emergency service responders are often the first contact with victims after the occurrence of a crime making it pivotal to provide compassionate care. Interactions with this provider may impact the victim's perception of the system, willingness to engage, and address re-traumatization faced by many victims (Patterson & Tringali, 2014). Treating patients with a trauma-informed focus through trauma awareness and acknowledgment, creation of safety and trustworthiness, choice, and collaboration are only a few of the ways to reduce re-traumatization and improve patient experiences. Trauma-informed training was found in surveys of emergency room care workers not only to improve patient care, but to also lead to greater satisfaction among medical personnel of care given to patients further supporting the importance of mandatory trauma-informed care training among emergency medical service providers (Purkey, Patel & Phillips, 2018).

While the training presentation meets three of the four components of successful trauma-informed training, this training is offered and required only by those allied Nevada EMS providers. Currently outside classes to qualify for EMS positions, trauma specific training remains supplemental in nature (Henderson, 2019). This lack of consistency across providers and

evidence supporting the need for and importance of trauma-informed services provided by EMS suggests a recommendation that trauma-informed training become a required topic in initial and continued training, evaluations of programs and services be conducted, and collaboration with currently successful programs be completed.

Law Enforcement

About the Profession

Law enforcement is defined by the Bureau of Justice Statistics as,

"Agencies and employees responsible for enforcing laws, maintaining public order, and managing public safety. The primary duties of law enforcement include the investigation, apprehension, and detention of individuals suspected of criminal offenses. Some law enforcement agencies, particularly sheriff's offices, also have a significant role in the detention of individuals convicted of criminal offenses." (U.S. Department of Justice, 2021).

Interactions with Sexual Assault Victims

In cases of sexual assault, the primary responsibilities of law enforcement include attending to the victim, being careful not to stigmatize the victim, preserve evidence on the victim, secure and protect the crime scene, contact local advocacy centers, and apprehend offender if present. Additional responses based on victim consent and situational needs may include investigating contacts driven by victim, assessing special needs if needed for victim,

explaining the local investigation process, explanation of next steps and what to expect (New York State Coalition Against Sexual Assault, 2003).

Evaluation

The Trauma Informed Sexual Assault Investigations Training Curriculum was developed by The International Association of Chiefs of Police to act as a resource for training curriculums to educate law enforcement on the impacts of trauma and how to utilize trauma-informed care techniques in their practice. This training was supported through research and grants given by the Office on Violence Against Women, U.S Department of Justice. The International Association of Chiefs of Police is the world's largest professional association for police with more than 31,000 members in over one-hundred countries. This training is available for use by any law enforcement agency however it is not required for those outside the association. Membership to the association is not required for all chiefs of police ("Trauma Informed Sexual Assault Investigation Training Curriculum," 2021). This training was chosen for evaluation due to the lack of required training for law enforcement on a national or statewide scale on trauma-informed care (Haime, 2020).

The Trauma Informed Sexual Assault Investigations Training Curriculum includes eight modules with PowerPoints and lesson plans for instructors utilize. This includes a total of twelve hours of verbal instruction content with activities and two-hundred and thirty-three slides of PowerPoint material. The modules include Overcoming the Complexities of Sexual Violence: Understanding the Realities, How Does Culture Influence the Communities We Serve, The Impact of Trauma: A Trauma-Informed Lens and Response, Trauma-Informed First Response-First Impressions Matter, Trauma-Informed Victim Interview, Perpetrator Realties and

Investigative Strategies, Alcohol and Drug Facilitated Sexual Assault Cases, Perpetrator Realities, and Alcohol and Drug Facilitated Sexual Assault Cases ("Trauma Informed Sexual Assault Investigation Training Curriculum", 2021).

Identified in the literature, the four major components of a successful trauma-informed care training program include the identification of the importance of responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma-informed care (University of Buffalo School of Social Work, 2022). The identification of the impact and importance of trauma-informed care was included in the The Trauma Informed Sexual Assault Investigations Training curriculum chapters on The Impact of Trauma, with three slides dedicated to the topic, and Trauma-Informed First Response, with three dedicated slides. The second component, modification of policies to serve staff and victims, was briefly mentioned in How Does Culture Influence the Communities we Serve, with sixteen slides, and in The Impact of Trauma, with one slide dedicated to vicarious or secondary trauma. There were no slides or materials dedicated to the identification of professional collaboration techniques. Additionally, there were no mentions of the five-core principles of trauma-informed care ("Trauma Informed Sexual Assault Investigation Training Curriculum," 2021). These five principles are safety, choice, trustworthiness, empowerment, and collaboration (University of Buffalo School of Social Work, 2022).

Recommendations

Programs when implemented have been received as beneficial to those officers who have completed trauma-informed training. Some departments that have requested training, such as the

New Hampshire Police Department, have seen improvements in officer response and positive community responses (Haime, 2020).

Trauma training is vital for police as it helps officers access and recognize trauma rather than reacting to the immediate situation. This process allows for an officer to understand why someone is behaving in the context of trauma, deescalate the situation, and avoid re-traumatization. Experts in the field of police training however, argue that due to the diverse nature of the role of the officer, it is difficult to include comprehensive training on all skills that could be utilized and instead propose the implementation of psychological and trauma professionals as accompanying guides to those officers responding to victims (Haime, 2020). This argument would still call for the coverage of basic trauma-informed training for law enforcement as interactions between officers and victims still occur.

While the training curriculum meets two of the four components of successful trauma-informed training, this training is offered and required only by those members of The International Association of Chiefs of Police. Currently law enforcement agencies and state mandated police academies hold their own standard for training and care, which may not include training specific to trauma-informed care (Haime, 2020). This lack of consistency across providers and evidence supporting the need for and importance of trauma-informed services provided by law enforcement suggests a recommendation that trauma-informed training become a required topic in initial and continued training, evaluations of programs and services be conducted, and collaboration with currently successful programs be completed.

Conclusion

Summary

Despite its long history, our understanding of trauma due to medical and technological advances continues to develop (University of Buffalo School of Social Work, 2022). Trauma is highly prevalent in all ages of the population, and partially high among survivors of sexual assault (Coates, 2016). It involves complex psychological and biological components that affect a victim's experience, coping abilities, memory, and overall response. These unique responses may be different from those witnessed by other victims, or those who have not experienced trauma, by criminal justice professionals (Substance Abuse and Mental Health Services Administration, 2014). This can make re-traumatization and secondary trauma more likely for victims and the professionals working with them (Defining vicarious trauma and secondary traumatic stress, 2021).

Re-traumatization of victims can occur due to triggers or flashbacks causing further distress and damage (Substance Abuse and Mental Health Services Administration, 2014). Likewise, those working with trauma victims can be affected by the experiences with victims of sexual assault trauma impacting their mental and physical health, as well as impacting their level of care for victims leading to burnout Benuto, Newlands, Ruork, Hooft, & Ahrendt, 2018). Studies in the experiences of victims and criminal justice staff across professions have found that trauma-informed training improved the experiences of victims, promoted healing and wellbeing of victims, and can aid in preventing both re-traumatization and secondary trauma (Nadeem et. al, 2021).

Evaluation of literature identified key components of successful trauma-informed training. Effective components of trauma-informed care training identified included education on

responding, modification of policies to serve staff and victims, identification of professional collaboration, and training on the five core principles of trauma informed care. These five principles are safety, choice, trustworthiness, empowerment, and collaboration (University of Buffalo School of Social Work, 2022). While the implementation of trauma-informed care and its benefits are supported and spreading, criminal justice professionals and first responders to victims of crimes do not all have mandatory comprehensive programs (Courtois & Gold, 2009). The implementation of comprehensive trauma-informed training then would suggest minimization of re-traumatization, victim centered approaches, creation of a positive victim experience, minimization of barriers to justice, improved outcomes for victims, and a more confident workforce that can be more engaged and better protected from secondary trauma (Benuto et al., 2018).

This research evaluated programs across criminal justice professional that worked directly with sexual assault trauma victims to evaluate current training and make recommendations for an ideal program. In its evaluation, it was found that two of the four criminal justice professional training programs did not meet contain the components of an effective trauma-informed care training. Both SANE and Advocate training programs contained all four components identified in the literature for a successful program and additional require this training for all positions. Both Law Enforcement and Medical Emergency First Responder training programs failed to contain all four components' elements and additional did not have trauma-informed training programs that meet these criteria as a requirement for the position despite research suggesting its importance. Therefore, these research findings suggest there is necessary to require professional training in trauma-informed care across criminal justice

professionals who respond to adult survivors of sexual assault to avoid re-traumatization and create a victim-centered process.

Limitations & Future Research

When reviewing this research is important to note that there are many criminal justice professionals who may encounter victims of sexual assault. The current study limits these professions examined to first responders, SANEs, advocates, and law enforcement. The training evaluated for each profession is also only representative to the population where that training is mandatory. As previously noted, criminal justice professionals and first responders to victims of crimes do not all have mandatory comprehensive programs (Courtois & Gold, 2009). This research explains the scope of each program's reach but does not give a comprehensive evaluation for every training mandate for all members of the profession evaluated unless a national training curriculum is in effect. This study does not include supplementary training and materials that can be requested outside of traditional training.

To further the academic and practical understanding on the importance of trauma-informed care training, it would then be suggested that future research explore trauma related training effects outside the criminal justice system, compare training across states and organizations, and explore holistic training over a longer period for each profession outside mandatory initial training.

Reference List

After Sexual Assault. (2021). Retrieved from RAINN: https://www.rainn.org/after-sexual-assault

American Counseling Association. (2022). Vicarious trauma - American counseling association.

American Counseling Association. Retrieved from https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf

American Psychological Association. (2022). APA Dictionary of Psychology. American Psychological Association. Retrieved from https://dictionary.apa.org/trauma

Ashley-Gilmore, K. (2021, April 26). *Types of traumatic events*. Mountain Creative Arts Counseling. Retrieved from https://www.mountaincreativearts.com/types-of-traumatic-events/

Beal, L. (1994). Burnout, Social Support, and Coping in Crisisline Volunteers. Illinois Wesleyan University. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.860.6547&rep=rep1&type=pdf

Benuto, L., Newlands, R., Ruork, A., Hooft, S., & Ahrendt, A. (2018). Secondary traumatic stress among victim advocates: prevalence and correlates. Journal of Evidence-Informed Social Work, 15(5), 494-509. Retrieved from https://doi.org/10.1080/23761407.2018.1474825

Benuto, L., Singer, J., Cummings, C., & Ahrendt, A. (2018). The Vicarious Trauma Scale: Confirmatory factor analysis and psychometric properties with a sample of victim advocates. Health & Social Care in the Community, 26(4), 564-571. Retrieved from https://doi.org/10.1111/hsc.12554

Bruce, M. M., Kassam-Adams, N., Rogers, M., Anderson, K. M., Sluys, K. P., & Richmond, T. S. (2018). Trauma Providers' Knowledge, Views, and Practice of Trauma-Informed Care. Journal of trauma nursing: the official journal of the Society of Trauma Nurses, 25(2), 131–138. Retrieved from https://doi.org/10.1097/JTN.0000000000000356

Camacho, C., Adams, A., Wasco, S., Ahrens, C., & Sefl, T. (2009, January 30). The Significance of the Victim Advocate for Domestic Violence Victims in Municipal Court. Violence and Victims, 288-300. Retrieved from https://doi.org/10.1177/1077801208331248

"Certification and Training Requirements." *Iowa Attorney General*, Iowa Department of Justice (2022), Retrieved from https://www.iowaattorneygeneral.gov/manual/chapter-6-victim-advocate-certification-and-training-requirements/certification-and-training-requirements

Coates, C. (2016). Trauma Informed Care: New Innovations in Mental Health Care (thesis). Minds@UW, Platteville (2015). Retrieved from https://minds.wisconsin.edu/handle/1793/74216

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 3–23. Retrieved from https://doi.org/10.1037/a0015224

Choitz, V, and Wagner, S. "A Trauma-Informed Approach to Workforce." *National Fund for Workforce Solutions,* National Fund for Workforce Solutions, Apr. 2021, https://nationalfund.org/wp-content/uploads/2021/04/A-Trauma-Informed-Approach-to-Workforce.pdf

Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault Initial Review of Existing Literature (2005-2012) (2013, March 13). Retrieved from https://aasas-media-library.s3.us-west-2.amazonaws.com/AASAS/wp-content/uploads/2015/08/Clinical-Models-of-Treatment-for-Trauma-Experiences-and-Symptoms-specific-to-Sexual-Abuse-and-Sexual-Assault-2013.pdf

Curi, M. (2018, June 25). *A short history of trauma-informed care*. Iowa Watch. Retrieved from https://www.iowawatch.org/2018/06/15/a-short-history-of-trauma-informed-care/

Davies, J., Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2013). Building Cultures of Care A Guide for Sexual Assault Services Programs. The National Sexual Assault Coalition Resource Sharing Project and National Sexual Violence Resource Center. Retreived from https://www.nsvrc.org/sites/default/files/publications_nsvrc_guides_building-cultures-of-care.pdf

Gouvernement du Québec. (2016, October). Perpetrators. INSPQ- Institut national de santé publique du Québec. Retrieved from https://www.inspq.qc.ca/en/sexual-assault/understanding/perpetrators

Haime, Jordyn. "Trauma-Informed Practices Necessary for Police, Experts Say." *Concord Monitor*, Concord Monitor (2020, July 1). Retrieved from https://www.concordmonitor.com/Trauma-informed-policing-35032160

Haskell, L., & Randall, M. (2019). The impact of trauma on adult sexual assault victims. Justice Canada. Retrieved from https://justice.gc.ca/eng/rp-pr/jr/trauma/trauma_eng.pdf

Henderson, Judy. “Sexual Violence: A Healthcare Priority for EMS Providers” National Sexual Violence Resource Center, 2019. https://www.nsvrc.org/sites/default/files/2019-08/Sexual%20Violence%20EMS%20Providers.pdf

Helitzer, D., & Crandall, C. (2003, December). Impact Evaluation of a Sexual Assault Nurse Examiner (SANE) Program. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/203276.pdf

IA Code § 708.1. Assault Defined. From https://www.legis.iowa.gov/docs/code/708.1.pdf

IA Code § 709.2. Sexual Abuse. From https://www.legis.iowa.gov/docs/ico/chapter/709.pdf

IA Code § 709.3. Sexual Abuse. From https://www.legis.iowa.gov/docs/ico/chapter/709.pdf

IA Code § 709.4. Sexual Abuse. From https://www.legis.iowa.gov/docs/ico/chapter/709.pdf

Iowa rape and sexual assault laws. Findlaw. (2016, June 21). Retrieved from https://www.findlaw.com/state/iowa-law/iowa-rape-and-sexual-assault-laws.html#:~:text=Created%20by%20FindLaw's%20team%20of,or%20can't%20give%20consent.

Learn. (2022). First Responder: Job Duties, Occupational Outlook, and Education Requirements. Learn. Retrieved from https://learn.org/articles/First_Responder_Job_Duties_Occupational_Outlook_and_Education_Requirements.html

Mindlin, J., & Reeves, L. J. (2005). Confidentiality and Sexual Violence Survivors: A Toolkit for State Coalitions [Scholarly project]. In Lewis & Clark Center for Law & Public Policy on Sexual Violence. Retrieved from https://law.lclark.edu/live/files/6471-confidentiality-and-sexual-violence-survivors-a

Nadeem, T., Asad, N., Hamid, S. N., Mahr, F., Baig, K., & Pirani, S. (2021). A need for trauma informed care curriculum: Experiences from Pakistan. Asian journal of psychiatry, 63, 102791. Retrieved from https://doi.org/10.1016/j.ajp.2021.102791

Nathan, S., & Ferrara, M. (2020). An Innovative Trauma-Informed Curriculum for Sexual Assault Care. *The Journal of nursing education*, *59*(6), 336–340 (2020, May 20). Retrieved from https://doi.org/10.3928/01484834-20200520-07

Neufville, N., & Randall, A. (2014, July 30). The importance of understanding trauma-informed care and self-care for Victim Service Providers. The United States Department of Justice. Retrieved from https://www.justice.gov/archives/ovw/blog/importance-understanding-trauma-informed-care-and-self-care-victim-service-providers

New York State Coalition Against Sexual Assault. (2003, July 22). Pocket guide for police response to sexual assault. National Criminal Justice Reference Service. Retrieved from

https://www.ncjrs.gov/ovc_archives/sartkit/tools/lawenforcement/Pocket%20Guide%20for%20Police%20Response%20to%20Sexual%20Assault.pdf.pdf

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. Journal of Consulting and Clinical Psychology, 60(3), 409–418. Retrieved from https://doi.org/10.1037/0022-006X.60.3.409

Office of Justice Programs. (1999). SANE program development and Operation Guide. Office for Victims of Crime. Retrieved from https://www.ovcttac.gov/saneguide/introduction/what-is-a-sane/

Patterson, D., & Tringali, B. (2014, October 6). Understanding How Advocates Can Affect Sexual Assault Victim Engagement in the Criminal Justice Process. Journal of Interpersonal Violence, 30(12), 1987-1997. Retrieved from https://doi.org/10.1177/0886260514552273

Petrak, J., & Hedge, B. (2004). The trauma of sexual assault: Treatment, prevention, and Practice. John Wiley & Sons.

Purkey, E., Patel, R., & Phillips, S. P. (2018, March). Trauma-informed care: Better care for everyone. Canadian family physician Medecin de famille canadien, 64(3), 170–172. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851387/

Rape, Abuse & Incest National Network. (2020). The Criminal Justice System: Statistics.

RAINN. (2022). The Criminal Justice System: Statistics. Retrieved from https://www.rainn.org/statistics/criminal-justice-system

RAINN. (2022). Key terms and phrases. Retrieved from https://www.rainn.org/articles/key-terms-and-phrases

Sexual Abuse Legal Definition. (2021). Retrieved from Merriam-Webster: https://www.merriam-webster.com/legal/sexual abuse

Texas Association Against Sexual Assault. (2015). Helpful Tools for EMS Responding to Sexual Assault. Austin. Retrieved from http://taasa.org/wp-content/uploads/2016/01/EMS-Fact-Sheet-SAAPM-2015.pdf

The SAFE Alliance. (2018, October 19). Sexual assault victim advocacy. SAFE Stop Abuse for Everyone. Retrieved from https://www.safeaustin.org/our-services/face-to-face-support/sexual-assault-survivor-advocacy/

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

"Trauma Informed Approaches in Schools." *Colorado Department of Education,* Colorado Department of Education (2018, February). Retrieved from https://www.cde.state.co.us/pbis/traumainformedapproachesarticle

"Trauma Informed Sexual Assault Investigation Training Curriculum." International Association of Chiefs of Police, 2021, https://www.theiacp.org/resources/trauma-informed-sexual-assault-investigation-training-curriculum.

University of Buffalo School of Social Work. *What is trauma-informed care?* (2022, March 31). Retrieved from https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

UCLA. (2021, September 2). What's the difference between an EMT and a paramedic? Center for Pre-Hospital Care. Retrieved from https://www.cpc.mednet.ucla.edu/node/27

United States Department of Justice, Federal Bureau of Investigation. (2014). Crime in the United States (2013). Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/violent-crime/rape/rapemain_final.pdf

U.S. Department of Justice. Law enforcement. Bureau of Justice Statistics (2021, February 18). Retrieved from https://bjs.ojp.gov/topics/law-enforcement

West Virginia Foundation for Rape Information and Services. (2022). First response to sexual assault. Foundation for Rape Information and Services. Retrieved from https://www.fris.org/Resources/PDFs/Brochures/Bro-FirstRespond.pdf

Washington Coalition of Sexual Assault Programs. (2018, October 11). What is an advocate? Advocacy. Retrieved from https://www.wcsap.org/help/support/sexual-assault-services/what-advocate