

Just Trauma-Informed Patient Interviewing and Prevalence of Strangulation

Introduction [00:00:05] Now this is recording, RTI International Center for Forensic Science presents Just Science.

Voiceover [00:00:19] Welcome to Just Science, a podcast for justice professionals and anyone interested in learning more about forensic science, innovative technology, current research, and actionable strategies to improve the criminal justice system. In episode three of our 2022 Sexual Assault Awareness Month mini season, Just Science sat down with Kelly Taylor, a Sexual Assault Nurse Examiner, also known as a SANE, Sexual Assault Care Coordinator, and Forensic Healthcare Program Manager, to discuss trauma-informed support for sexual assault survivors and the prevalence of strangulation in sexual assault cases. Trauma-informed victim centered expertise and support from sexual assault nurse examiners is crucial to providing appropriate medical attention and helping a survivor heal. Without it, survivors may not fully disclose all aspects of the incident and whether strangulation occurred, leaving injuries that may go untreated. Listen along as Kelly Taylor discusses her work as a SANE and a multidisciplinary team member broadened her understanding of trauma-informed care and honed her interview best practices to support survivors of sexual assault and strangulation. This episode is funded by the National Institute of Justice's Forensic Technology Center of Excellence. Some content in this podcast may be considered sensitive and may evoke emotional responses or may not be appropriate for younger audiences. Here's your host, Tyler Raible.

Tyler Raible [00:01:27] Hello and welcome to Just Science. I'm your host, Tyler Raible, with the Forensic Technology Center of Excellence, a program of the National Institute of Justice. April is Sexual Assault Awareness Month, and all month we'll be covering emerging topics in the arena of sexual assault response reform. To help guide us in today's conversation, I'm joined by our guest Kelly Taylor, a Sexual Assault Nurse Examiner, Sexual Assault Care Coordinator, and Forensic Healthcare Program Manager. Kelly, it's great to see you. Welcome to the show.

Kelly Taylor [00:01:52] Thanks, Tyler, I'm really excited to be here.

Tyler Raible [00:01:54] We're excited to have you. So, Kelly, for our listeners at home who haven't had the pleasure of hearing you speak before, can you tell us a little bit about yourself and your role as a SANE?

Kelly Taylor [00:02:04] I'm a Forensic Healthcare Program Manager in North Carolina, and I have the privilege and honor to serve patients that present with the chief complaint of sexual assault, strangulation, domestic violence, any kind of physical assault or abuse. And the primary concern is, is medical care - medical before anything, just making sure that our patients are taken care of, that all of their crisis intervention needs are met. Resources are provided. And then as a secondary function, a forensic examiner or sexual assault nurse examiners are also able to collect forensic evidence, do injury identification, forensic photography that may then later be processed at a crime lab through a law enforcement investigation. And it really just used to be for sexual assault cases, but as our role kind of expands and becomes more well-understood in our communities, we're really kind of branching out and servicing different populations of specialized patients.

Tyler Raible [00:03:13] I know that you provide training on understanding trauma in sexual assault patients and recently were involved with a workshop with the FTCoe about a

similar topic. So can you tell us a little bit about how did you get started in this kind of understanding trauma facet of your job?

Kelly Taylor [00:03:30] Sure. So I just kind of noticed that where we were having a little bit of a gap with our patients and kind of through our multidisciplinary teams of working with law enforcement and advocacy and medical communities was that we were all kind of interviewing patients differently, and we really just kind of needed to start to train together and work together so that we had a more cohesive flow in how we were all providing warm handoffs and how we were all speaking to victims and survivors of crime. And so I really just kind of started in our local area just reaching out to my counterparts in different agencies, rape crisis centers, law enforcement, legal communities. And I said, you know, really, does anyone have an interest in all of us coming together and having a seat at the same table and learning together and growing together so our process is really cohesive, and I just had this great response from everyone. They said, yes, we need to know this information. And so I really started doing a lot of research, attending a lot of courses and just realizing that as we evolve, we know better so we do better. And so how we are interviewing victims of crime, it just needs to evolve with our amazing technologies of, you know, of our hard sciences, our DNA, all that's advancing, and we need our soft sciences to advance as well, too - how we're speaking and interviewing victims and witnesses of crimes. And then we started implementing, you know, these techniques and just this trauma-informed interviewing technique, and we just saw these huge positive results. My patients were just feeling so much more understood and accepted, and we were just noticing that there was just more of a sense of people willing to participate with the different disciplines because they didn't feel so lost or on their own or judged. And we just started getting really positive feedback from our patients. And then I kind of started putting teaching out there and partnering with different agencies and law enforcement and developed, you know, kind of a teaching course for trauma-informed interviewing from my medical perspective. And it's really just empathy and compassion and slowing down and active listening. And it's just really something that I feel that people have really latched on to and they've started to embrace it.

Tyler Raible [00:05:50] I really enjoy the counterpoint between this concept of medical facilities being sterile and then you flipping that motif and making it a, a warmer place through this, this trauma-informed approach. One thing I am interested in is, you know, when you're working with these other agencies, law enforcement, maybe even District Attorney offices on the effects of trauma on patients, is this a unique relationship? Do you see this kind of reflected in peers at different medical facilities or different organizations?

Kelly Taylor [00:06:22] Yeah, Tyler, we really do. Kind of back to your first point about hospitals can sometimes be, you know, very sterile and- and frightening, we find that to be true. You know, my background is in emergency and trauma medicine, so I've always really been a nurse in an ER or a trauma unit. And ERs can be really, really scary places. They can be very intimidating. They're very fast paced, typically can be very overcrowded. And so navigating that can be really intimidating and really frightening. And so I think it's important that health care providers, especially in emergency settings, are coming up with a plan to make this less intimidating so that people will present to us. And then we also face challenges with the pandemic and people's apprehension to present to hospitals and emergency departments. So being really cognitive of that and having a plan in place before how we're going to handle this and what does our process look like? And even in emergency departments that may not have a high volume of sexual assault, strangulation, domestic violence, and physical assault patients, I think it's really important that you get your plan in place early before you need it, you know, like part of your natural process. The

staff will feel better, and it will provide a confidence for the staff that will make those patients feel more comfortable. And then that also spills over into getting your plan in place with your other agencies, with your multidisciplinary team. You know, we shouldn't be meeting each other at two o'clock in the morning in an emergency department. We should already know each other. So I think with that warm handoff I was speaking about, I make it a point to know all of our victim advocates and our law enforcement. So therefore, when I go into an emergency department in the middle of the night and there's a patient sitting there with a victim advocate, they've already developed that rapport and you know, they're well on their way to establishing a relationship. Victim advocates, we can learn a lot from them. I feel like these things that are just becoming, you know, so groundbreaking to us with, you know, empathy and compassion and active listening, I feel like they've been doing this forever. And we should really be taking a page from their book, and I do. And so I feel like that if I already have a relationship established with that victim advocate, that transfer of trust is going to seem so much more reasonable for the patient that's sitting before us. And then in turn, it's my, you know, it's my responsibility to kind of do that warm handoff with law enforcement. Because if we're really coming from a patient-centered, victim-centered approach, it's not about us - really about that patient that's sitting before us and doing everything that we can to facilitate their comfort, their emotional safety, their physical safety. That's part of what we should be doing. And so I think the biggest thing I would stress is get your teams and your processes together before you ever need them. We found what worked for us is once a month, we do a multidisciplinary lunch. We have a guest speaker, we do a lunch and learn. And you know, what we found is that when you sit down with your colleagues, you know, maybe colleagues that you would never come across otherwise and you learn together at the same table, when you go into that emergency room at two o'clock in the morning and you're already familiar with that person, there's a trust there. There's a safety there. I think that that just automatically genuinely transports on to the person that's in need of services.

Tyler Raible [00:09:37] Kelly, as a sexual assault nurse examiner, SANE, can you tell our audience a little bit about what happens during a sexual assault medical forensic exam?

Kelly Taylor [00:09:47] When a patient presents to a hospital or an emergency department, obviously, as we already talked about before, the primary focus is going to be that medical care. And so really, we let the patients very much direct where it goes from there. We're obviously going to do whatever interventions we need to do both medical, crisis interventions, things like that. If a patient then elects to have evidence collected, at that point, you would call in your SANE nurses, your specialized team to deliver those services. Once they arrive there, we're going to get a history from all of our patients that's really going to drive our exam and determine what evidence may or may not need to be collected. And it's a long process. You know, it's really important that we, as health care providers, are doing really good expectation management with our patients and also with the services that may be at the hospital with them - behavioral health or crisis intervention, social work services - because it's really important that they understand what an entire forensic exam may entail. You know, we may have a patient that is unfamiliar with the fact that this process could take several hours, you know, four, five, six hours. And so as much as they may want to engage in that process, it may not be feasible for them at that moment in time, they may have other concerns. So it's really important having that conversation upfront and letting them know what it entails and then allowing them to make the decisions and be a partner in guiding their own care. If a patient does elect to have the evidence collected, it's- what's really done is a history driven head to toe exam that still entails medical care along the way, and I think the key is just really that open communication and the patient understanding that they still have options in this process.

Tyler Raible [00:11:40] So during the process of working with, with a survivor, of working with the patient, and you're finding out all of the circumstances that are involved with the assault, you work pretty hard to create more of a safe and caring environment. Why? What is the added value of this extra level of effort to create this safe environment for your patient?

Kelly Taylor [00:12:01] Sexual assault, strangulation, physical assault - that creates a level of vulnerability within people. And, you know, people that are already feeling vulnerable are not going to choose to make themselves more vulnerable by opening up to, in essence, strangers if they don't feel like we're invested in them. If they don't feel like we care about them, if they don't feel like we're listening to them, that's human nature. You know, you're not going to make yourself more vulnerable to people and places that you feel is not going to add value to what you're doing. So I think us being aware of this level of vulnerability is really important and providing that emotional safety, that physical safety, that comfort, that empathy, that hey, you, you are safe with me. You are not only physically safe in this building, but you are emotionally safe with me to speak with me. And just that understanding that this is hard to talk about, this is hard to express. And, you know, information is only useful if it's shared, and that's true for every discipline. If our patients aren't sharing information with us because they don't feel safe with us, you know that's on us. We need to make sure that we're providing an environment where people feel comfortable enough to share the information that we need to do whatever our job is, whether that's health care or law enforcement or advocacy. We need to just take that moment understanding that empathy goes a long way. Sitting in, in someone's pain with them goes a long way. Not always filling in the gaps of the silence, being slow and patient, and understanding that sometimes silence is OK. But we need to be grateful and appreciative that they've chosen to speak to us, and we don't always have to have the right thing to say. But I think just sitting there with someone in their- their pain and in their process, and that support is very comforting in its own way.

Tyler Raible [00:14:08] Yeah, I love that answer. This patient has gone through one of the just absolute worst experiences of their life, and if they're met with anybody who isn't warm and welcoming, it might make things worse.

Kelly Taylor [00:14:20] What I've kind of realized through working with different disciplines and educating is I actually don't think that a lot of our nonverbals or a lot of even our verbals, even the way that we're trying to be more victim centered, I actually don't even think that people are not doing well at it. I think it's just a lack of education because, you know, I've noticed certain interactions with different disciplines and our patients. It's very easy for me to step back in my own environment and kind of observe because it's an environment I'm comfortable in. I'm comfortable with patient care and sometimes observing other disciplines, it's interesting - they're not as comfortable in the emergency department, it's not their own environment. So sometimes maybe they're not as comfortable in that interaction with that patient. I kind of step back and I watch and so I'll kind of see it going down a path, and I have no problem just kind of saying, "Hey, you know, could I chat with you for a second?" And typically, when I go out and I say, "Hey, look, you know, I don't know if you were picking up on it, but I've been with this patient for several hours and I'm starting to pick up on their, you know, maybe anxiety or nonverbals. And I think that they're becoming a little bit anxious. You know, this was kind of the trigger to that when you said this." And typically, what I hear back from other disciplines is, "Oh my gosh, I had no idea - that was never my intent. Can I fix this? Tell me how to do this better." Like, there's such an eagerness to make it right. I think that it's just kind of a lack of

understanding how to communicate with people in these situations. You know, you don't want to say the wrong thing and you don't want to do the wrong thing. And so you almost become more self-conscious instead of just having kind of natural interactions with people. So I really think that as we start to educate more and we start to learn more and we start to focus on trauma-informed communications, everyone will really become more comfortable with what that really looks like. And I think the biggest key is like supporting each other in that and not being afraid to say, "Hey, can I see you for a second?" Because, you know, I think we should give each other the opportunity to make on the spot corrections. I don't think we need to embarrass each other. I think we need to look at ourselves as a team. And if I see something is not going well and I feel like in that moment in a really respectful manner that I could possibly impact that turning into a positive interaction, you know, I say go for it, which also gets back to why it's really important to have these relationships ahead of time. You know, we know we're different disciplines, but sometimes to the patients, it just kind of all looks like one, one system, one process. In a way we almost have to make ourselves as healthcare providers, law enforcement, advocates, I think we almost have to make ourselves vulnerable too to understand that we're learning and we're growing and we're in a process. But at the end of the day, if this is a patient-centered, victim-centered approach, it doesn't matter. We just have to get in there and do the right thing.

Tyler Raible [00:17:03] I really love that sentiment. I want to switch gears a little bit because there was something that cropped up a couple of times and I really want to run it down. And it's this prevalence of strangulation when it comes to sexual assault cases, and you've mentioned strangulation a couple times. Are you seeing a lot of strangulation in sexual assault cases?

Kelly Taylor [00:17:20] We are seeing an increase in strangulation cases with and without sexual assault. It's interesting because I started to see an increase, but sometimes we have to know the right questions to ask. And so I think across the board, when you look at different hospitals, you'll get kind of varying feedback about what they're seeing. But what I always find interesting is the hospitals that have strangulation protocols that have, you know, non-fatal strangulation process, policies, assessments, things like that, they're seeing a lot more of these cases because they're educated, and they are asking the right questions and they have a process in place for identification. And so I think we're starting to see a lot more of the prevalence of strangulation with sexual assault. We're also seeing that increase in strangulation with sexual assault in domestic violence as well with current or ex partners. And so I think that this is something that we're going to start to really hear a lot about as people start to educate themselves and develop their own policies and strangulation assessments. So I think the key with almost seeing that increase is knowing what to look for and not always with strangulation, not always relying on the fact that there's going to be physical injury that's very obvious when a patient presents to, you know, a clinical setting - that's not always the case. There may be more symptoms that aren't so obvious. Patients will sometimes present with a hoarse or raspy voice or, you know, coughing or constantly clearing of the throat. They may complain of things like ringing in the ears or headaches, or things that just seem like a more obscure symptom and without that physical symptom that people think that that may be present, you know, on the neck or near the neck. And so I think it's really important to start getting that strangulation education so that we're able to identify it because not all victims will actually disclose the strangulation, especially when it's in conjunction with a sexual assault. And so what I found is as part of our sexual assault documentation, there's actually a question that we do ask about external pressure to the neck. And what we're finding more and more is now that when we ask this question that patients are saying yes, that actually that did occur to me and whether they're not focused on it because they don't understand the

severe medical implications of this or because of fragmented memory or because maybe in their opinion, it's not even that big of a deal because they survived. We're noticing that sometimes we're having to ask certain questions in order to better assist and have better patient outcomes.

Tyler Raible [00:20:06] Yeah, that all makes sense. I was really struck by some of the numbers I was reading and hearing - what may have been causing victims, survivors, patients to not disclose this information?

Kelly Taylor [00:20:17] I think that strangulation has not only been misunderstood by, you know, the medical community, the legal community, law enforcement, I think it's also been unrecognized and underdiagnosed. So I think if we, as you know, first responders are just now really kind of understanding this education piece and we're finally kind of changing our terminology and our verbiage and our understanding of how serious and fatal strangulation can actually be. I think it's our job to now educate our patients because if we've been under diagnosing and under treating for years just because we're now, we're really getting this education piece and we're finally recognizing how dangerous this can truly be. It's our job to educate our advocates and our law enforcement on just how medically dangerous strangulation can be. And it's interesting since I've kind of started getting out there and really saying, you know, strangulation is not only dangerous in the immediate, but it can have for several days and weeks after and then potentially lifelong implications, the immediate response that I get back from advocacy and law enforcement and legal is we had no idea. Thank you so much for telling us. We're going to handle these situations differently now. We're going to radio for EMS at a scene or we're going to encourage the victim to seek medical attention or we're going to give the hospital a call and tell them what we're hearing or seeing or observing. So I've gotten really positive feedback with the education that I'm providing. So I think now people are really starting to take notice and then as a result, they're handling these cases differently because they're educated. I mean, if you don't know and you think that a strangulation occurred, but now it's over and everything's OK, if you don't know that there's these secondary and third order effects that can have really negative, immediate, and lifelong impacts on a patient, that may just be where the care terminate.

Tyler Raible [00:22:23] Could you tell us what are some of the short-term and long-term effects of strangulation?

Kelly Taylor [00:22:27] Any time blood or oxygen is impeded and unable to get from the heart and lungs to the brain and then circulate back throughout the body, there's concerns for the immediate. There's concerns for long-term. So it's really important to have these patients evaluated and assessed just to make sure that there's not a carotid artery dissection or that there's anything with the cervical spine or anything like that that may cause kind of that immediate, life threatening damage. It's important to understand that, though the signs may not be very obvious, that when we hear things like there was a loss of consciousness or there was loss of bowel or bladder control, that definitely signals to clinicians that this could be a very dangerous strangulation. And it's really important that we're evaluating those patients to make sure that they're going to be stabilized and that they're going to be OK, that the oxygen saturation is remaining where it should be, and that there's no immediate medical or life-threatening effects that could occur. So it's really important that we're understanding how serious this can be. You know, you do worry about patients having strokes or seizures or memory impairment, things like that. And then also, you know, being concerned about the cumulative effects of multiple strangulations. That's

another concern for just compounding these complications that may arise with patients from external pressure to the neck.

Tyler Raible [00:23:54] You'd mentioned the importance of education and training, especially with- with your team and the- the terminology that is associated with it. So is this something that you really work with your SANEs on?

Kelly Taylor [00:24:08] Yeah, Tyler. So choking from a medical standpoint is when there is something internally blocking the airway. So that's going to be inside the airway blocking airflow. And so, you know, people may think of that as when like a piece of food is caught in the throat so that that's technically what choking is as opposed to strangulation, which is going to be that external pressure on the neck, its structures, and the vessels. And so I don't think I've ever had a patient report that they've been strangled. It's, you know, typically the verbiage, the very common verbiage is choking, and that's perfectly fine. And that's acceptable. And I think as long as we clarify that for all intents and purposes, the choking is actually external pressure, I'm not going to correct my patients. I'm not going to do that. I'm just going to clarify that what they're talking about is in alignment with external pressure of strangulation, certainly never to be correcting our patients. But I think it's really important that we change our verbiage, that law enforcement and medical and advocacy and all these disciplines that deal with strangulation, that we're changing the way that we speak about it to accurately reflect what's occurring. So in our documentation and in our conversations and our education and our teaching, I think it's important that we're all using the term strangulation, which indicates external pressure and then just clarifying those details with our patients.

Tyler Raible [00:25:32] Kelly, when you're working with a victim, when you're working with a patient and you learn that strangulation is involved, are you worried about their safety at home? Do you look at this as a- a precursor to kind of more, more violence?

Kelly Taylor [00:25:44] Yes, absolutely. It can be. And so with our strangulation patients, safety concerns, so that's going to be part of our discharge safety planning. That's also going to be part of our discharge instructions. That's where we're going to have to really rely heavily on our outside resources, maybe through our advocacy, our social services, things like that just to make sure that there's protection orders in place, things like that that may address other concerns. Strangulation really is viewed as a precursor to homicide. And so it's really important that we are taking this seriously and that not only are we treating the emergent medical needs, but that we're also taking the next step to make sure that the patient is safe, to make sure that their family is safe, and to be sure that we are doing everything that we can possibly do to prevent this non-fatal strangulation from becoming a fatal strangulation.

Tyler Raible [00:26:35] Kelly, in previous conversations that we've had you've mentioned that in the future you're planning on working with a medical examiner on this issue. So can you tell us a little bit about that partnership and the work involved?

Kelly Taylor [00:26:46] Yeah, I'm excited. Medical examiner offices all across the country work with different local agencies, law enforcement, and medical as well. And so this is something I've kind of just been getting involved in and reaching out to, you know, with medical examiner cases, unfortunately, at that point, we're dealing with fatal strangulation cases. And so I think it's really important for me to learn from them to get at that preventative aspect and also to understand in a fatal strangulation case, what are we looking at? What are the signs? What are the symptoms? What's the internal damage

that's been caused? What are the injuries that sometimes we can't see when a patient is in front of us. It's a very interesting perspective to work with those practitioners because I think it gives us more insight so that we can do work on the front end so that our cases don't end up with the medical examiner. I think it's all about lessons learned and understanding so that we can do better with the opportunities that we're given with our patients when they're sitting before us.

Tyler Raible [00:27:51] It's going to be better for you to see a patient than for the ME, right?

Kelly Taylor [00:27:55] Yeah, absolutely. And that's where it's really important for us all to come to the table and learn together and train together. We can catch signs and symptoms. We can gain their medical perspective on what they're seeing in fatal strangulation so that we don't miss things in non-fatal strangulation. So taking that medical knowledge that they have and that insight that they have and then applying it to our current practice, the current tests that we're ordering and studies, and taking that research and looking at it and saying we don't want to miss this. So what tests do we need to order to meet the gold standard so that we're making sure that we're providing the absolute best care so we have better patient outcomes?

Tyler Raible [00:28:34] Unfortunately, Kelly, we're running out of time. Is there anything you'd like to share with our listeners?

Kelly Taylor [00:28:38] Yeah, Tyler. You know, there is and I kind of thought about this and I could really reiterate all the teaching points that I've brought through this. But I think really what I wanted to end on was just words of encouragement for the people that are doing this work and then also for the victims and survivors that deal with sexual assault and strangulation. And so I really kind of wanted to end on that note. You know, over the past two years, first responders have been called on on astronomical ways. As a nurse working in a pandemic, it's been my honor and my joy to help those in need to help them heal, to make their life just a little bit easier physically and emotionally if I'm able to do that. When I graduated from nursing school, I understood that I would work through crisis and sickness and disease. And so the pandemic hasn't been the first time that I've had to put on personal protective equipment or masks or anything like that. But I think where I want to give gratitude and what never ceases to amaze me is that as I am donning that protective equipment and masks in emergency rooms, it's amazing to me who's standing by my side doing the same thing, saying "We're going to show up, we're going to be there, we're going to help." You know, it's the victim advocates, the police officers, the social workers, the forensic technicians, even the lawyers that have said, I'm going to walk into this house or the hospital or this shelter so that I can stand with our victims. And so I think, you know, we've highlighted it several times throughout this recording how important relationships are, and I really just want to end with that. The relationships are so important that multidisciplinary teams are so vital to what we do so that we can make our community stronger and we can make them safer. We have to support each other and we have to develop resources that don't break. We have to start having these conversations that sometimes make us really, really uncomfortable, and we have to keep having them because it's the only way that we're going to affect real and meaningful change. And I think just on a final note, I want to say to any victim of crime, any victim of sexual assault or violence, strangulation, you know, to the families and the friends that worry about them and grieve for them, and to the victims that sometimes feel like they're lost in the system, I want them to know that there are health care workers and there are nurses in emergency departments and clinics all over this country that think about them. And there's police

officers that worry about them. There's attorneys that are going to fight for them and there's victim advocates that are going to stand with them. And I just never want them to lose hope that we will continue to educate. We will continue to have these conversations and that we will always, always have our doors open to them and our arms open to them. We will get better and we will do better. And thank you for all of my colleagues that do this alongside of me.

Tyler Raible [00:31:19] What an excellent note to end on. We covered a lot, so many incredible topics - so Kelly, thank you for taking the time out of your day and for sitting down and- and sharing your expertise with us in this, in this platform.

Kelly Taylor [00:31:29] Well, thank you, Tyler, and thank you for all the work that you guys do to provide these platforms so that it can reach so many people so that even if we don't have a physical seat at the table together, we have this virtual seat together. So thank you guys for what you do to make this education and learning process happen.

Tyler Raible [00:31:46] We're happy to do it. It's work worth doing. If you liked today's episode, be sure to like and follow Just Science on your preferred platform. For more information on today's topic and resources in the forensic field, visit ForensicCOE.org. I'm Tyler Raible, and this has been another episode of Just Science.

Voiceover [00:32:05] Next week, Just Science sits down with Dr. Rachael Goodman-Williams and Dr. Jessica Volz to discuss their research on survivors' choice for anonymous and non-reporting of sexual assault cases. Opinions or points of views expressed in this podcast represent a consensus of the authors and do not necessarily represent the official position or policies of its funding.