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Patient, victim, or survivor?: An analysis of SANE nursing curriculum bias

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## **Introduction**

Prior to the development of the Sexual Assault Nurse Examiner (SANE) program, people who experienced interpersonal violence often endured long waiting times in emergency rooms, where they were treated by medical personnel who lacked skills necessary in order to provide forensic exams and information about specialized services that the person might need (Patterson, Campbell, Townsend, 2006). The SANE nursing program began to develop in the 1970s as a solution this inadequate care (Maier, 2012; Ort, 2012). Sexual Assault Nurse Examiners (SANE) are nurses who have completed a specialized 40 hour training in order to provide certified, specialized care to people who have experienced interpersonal violence. In addition to working with people who have experienced interpersonal violence, SANEs also come into contact with law enforcement officers and interpersonal violence advocates as they collect forensic evidence and act as witnesses on behalf of the person. In addition to providing medical treatment, SANE nurses also provide immediate emotional care to people who have experienced interpersonal violence and help them navigate these complex legal, medical, and policing systems (Renzetti & Edelson, 2008; Ort, 2012; Maier, 2012; Oregon SAE/SANE Certification Commission, 2017). State-specific protocol in Oregon requires nurses to attend a 40-hour training prior to beginning a preceptorship. Recertification is required every three years in order to ensure that SANE nurse practices remain updated and effective (Oregon SAE/SANE Certification Commission, 2017). In this paper, I will be using the umbrella term of “interpersonal violence” in order to capture the wide array of violence against women, including sexual assault and domestic violence.

Since the program has developed, it has been found that SANE nurses help to reduce not only the trauma that people face from their sexual assault, but also the secondary trauma that they may experience while navigating the legal, medical, and policing systems. These systems often question, alienize, stereotype, and complicate their access to resources, further traumatizing people in relation to their experiences (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001; Maier, 2012). This revictimization is not only reported by people when discussing their experiences, but also by SANE nurses through their observations of the ways that these systems revictimize and retraumatize people who have experienced interpersonal violence (Maier, 2012).

It is apparent that SANE nurses dramatically improve people's experiences, especially when navigating complex social and legal services (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001; Maier, 2012). However, we also know that people who experience interpersonal violence sometimes have negative experiences when receiving services from SANE nurses (Fehler-Cabral, Campbell & Patterson, 2011). People have indicated that SANE nurses acting cold and distant during the exam, not providing enough explanation of what was happening during the exam, and giving no choice to people during the exam hindered their emotional healing process (Fehler-Cabral, Campbell & Patterson, 2011). Fehler-Cabral, Campbell and Patterson suggest further emphasis on emotional care in SANE training in order to better equip nurses to handle both the emotional and clinical aspects of SANE exams. A study by Patterson, Campbell, and Townsend (2006) found that SANE program goals directly affected patient care. This suggests that the certain expectations that are imposed upon SANE nurses by their programs affect the level of patient care that SANEs demonstrated (Patterson, Campbell, & Townsend, 2006). They identified 3 different goals that predicted patient care: high prosecution, community

change, and low prosecution. SANE programs that focus on prosecuting rape cases were less likely to attend to patient's emotional needs, supporting feminist ideas and values, empowering patients, and changing the community responses to rape survivors. In contrast, SANE programs that focused on community change were excellent at achieving these outcomes, while programs that put the least emphasis on prosecuting rape cases gave moderate attention to these outcomes (Patterson, Campbell, & Townsend, 2006). Given this information, we can infer that the biases of SANE programs and the SANE nurses within the program directly relate to survivors' positive or negative experiences (Patterson, Campbell, & Townsend, 2006)

While Fehler-Cabral, Campbell, and Patterson identify that gaps in training cause ineffective SANE nursing, there is no research that discusses where or why these gaps occur—“The current study suggests that survivors perceived the emotional *and* forensic care to be beneficial to their well-being. Although this balance may be difficult for nurses (Cole & Logan, 2008), SANEs should include more emotional practice (e.g., validation, compassion, choice) within their professional training as it is likely to promote recovery” (Fehler-Cabral, Campbell & Patterson, 2011, p. 3635). Patterson, Campbell, & Townsend identify that both the negative and positive program outcome bias occur in three different groups; the High Prosecution cluster, Community Change cluster, and the Low Prosecution cluster (2006). The High Prosecution cluster placed the most importance on prosecuting rape cases, so much so that they often neglected attending to patient's emotional needs, supporting feminist values, empowering patients, and changing the community response to rape. However, the Community Change cluster placed less focus on prosecuting rape cases, and instead all of their focus on achieving the other four goals. The Low Prosecution cluster valued prosecuting rape cases the least, and put

medium importance on the other four goals (Patterson, Campbell, & Townsend, 2006). This study shows that when a SANE program's goal is biased towards prosecution, they provide less services to patients. However, it does not identify how to address these biases. It is clear that both biases and gaps in SANE training negatively affect survivors experiences, but there is no research that addresses both.

### **Research Question**

This study will assess SANE program training for the Oregon Sexual Assault Task Force to identify gaps that fail to address bias, causing SANE nurses to provide less-effective care to people who have experienced interpersonal violence. This thesis will address a particular question: How does the SANE nursing curriculum address bias?

### **Methods**

My analysis of the Oregon Sexual Assault Task Force SANE training manual will be guided by Foucault's ideas that words are loaded with influences of culture and power (Grbich, 2009). Foucault describes how discourse within a certain discipline serves as an aspect of power in that they determine what kind of knowledge is and isn't available to those within the discipline— "The discursive practices within disciplines and specialisms further serve as a micro form of control, allowing meaning and myth to become the product of power relations" (Grbich, 2009, p. 147). This was significant to my analysis of the SANE training manual in that it asserts that the language that the training uses either equips SANE nurses with the tools needed to address bias, or intentionally or unintentionally dismisses conversations about bias.

My first step in my research was to conduct an in-depth literature review in order to pinpoint the existing literature on bias within the SANE curriculum. After this step, I conducted

an initial read-through of the curriculum text. This initial read through enabled me to identify key words, phrases, and language that shape the ways that nurses think about sexual assault or domestic violence and the people who experienced it. In keeping Foucault's ideas of language and power in mind, I then conducted a second read through of the text in which I made memos on notecards of the key words, phrases, and language used, paying careful attention to the subtle meanings that were relayed through them (Grbich, 2009). I read through my notecards, and began to categorize the memos into patterns that I had seen in the curriculum. I found patterns of meaning associated with the words “survivor,” “victim,” and “patient. I also categorized instances in which bias was addressed in the curriculum, and identified clear ties between the curriculum and the literature.

## **Results**

### ***The Importance of Language***

After analyzing the language used in the SANE program training handbook, I identified three key terms that were used when referring to people who had experienced sexual assault. These terms include “survivor,” “victim,” and “patient,” and specific patterns for the usage of these terms were present within the training handbook.

### ***Survivor***

I found that the term “survivor” was used when focusing on a positive aspect of the person who had experienced interpersonal violence or their experience. For example, in the sentence, “Remember that this should be survivor-led, and recognize they know best for themselves,” the term “survivor” is used because it refers to the agency that the person who experienced sexual assault has and is able to exercise in their experience. Another example is the

sentence, "...you may not feel comfortable with what the survivor chooses. Learn to sit with your fear and anxiety." Here, the person who has experienced sexual assault is referred to as a "survivor" because they are practicing agency and choice in the situation, even if their choice does not align with the opinion of the nurse. This particular sentence highlights the positive experience of agency that nurses are to help facilitate and support.

By using the term "survivor," the SANE nursing curriculum addresses both positive and negative biases that nurses might hold towards people who have experienced sexual assault or domestic violence. The word holds power in that it attaches positivity and agency to the person who has experienced sexual assault or domestic violence. The curriculum's use of language, in this instance, the word "survivor," works to counteract any negative biases that these nurses might hold about this particular group of people and their experiences. The word holds power in attaching a positive narrative to people's experiences of sexual assault or domestic violence that they may not have otherwise considered. For nurses who already hold a positive bias, "survivor" enforces their positive bias by using language that suggests agency and positivity on behalf of the person and their experience.

### ***Victim***

A sharp contrast occurs when the SANE nursing curriculum labels the person as a "victim" when referring to a negative aspect of their experience. When discussing the ways that neurology impacts the brain, "victim" is used because it is discussing how the trauma that they have experienced negatively impacts their ability to talk about their experience. In this case, trauma happened to them, and has negatively affected their brain's neurology. This negative impact labels the person as a "victim." "Victim" is also used when talking about any



strangulation or non-genital injuries the person might have experienced. Here, “victim” is fitting because trauma and violence has happened to the person without their control, and has negatively impacted their body. In the section that talks about the dynamics of sexual assault, it explains that aspects of sexual violence can include “Sexual jokes that make the victim feel uncomfortable...Criticizing the victim’s sexuality...Sexually assaulting the victim in front of the children.” These aspects highlight the person’s loss of power and control.

People are also referred to as “victims” when talking about them in relationship to the assailant. An example of this is the question, “How does ‘Frank’ target his victims?” In this case, “Frank” is targeting the person, and holds the power in the dynamic between himself and the person he is harming. The person is targeted as his prey, and is less powerful in the dynamic. For this reason, the person is a “victim.” Another example of this appears in the section that discusses characteristics of child sexual abuse. The curriculum explains that, “MOST perpetrators don’t want to ‘hurt’ their victims...want continued access.” In the case, “victim” is used because there is an aspect of control that a perpetrator takes over the child. The child has no agency in their interaction with the assailant.

There are instances in the training that exemplify the different meanings associated with “survivor” and “victim.” On page 9 of the section titled, “Sexual Assault Dynamics,” one slide reads, “One of the most important things you can say to a victim is...I believe you and it is not your fault.” The next slide says, “Survivors who experience a supportive and compassionate response are less likely to experience PTSD....” This is an example of the differences in the implications surrounding the terms “victim” and “survivor.” “Victim” is used in the first slide because it is discussing a tool for validating the negative experience that the person had to go

through. The next slide switches to “survivor” because it is talking about those who have been affirmed, which is a positive experience as a survivor of sexual assault. In the first slide, the person is being validated, and in the next, the person has already been validated.

This shift in terminology acts as a space for nurses to address their bias. This switch between using “survivor” and “victim” causes the curriculum to address both positive and negative biases that they may hold about a person who has experienced sexual assault. For example, if a nurse comes into the training believing that all people who have experienced sexual assault are completely damaged both physically and psychologically, the use of “victim” might perpetuate these beliefs. At the same time, the inclusion of “survivor” challenges this idea that people’s experiences are solely negative. In this way, the language highlights the complexity of survivor’s experiences by focusing on both positive and negative aspects of experiences. The curriculum is creating a narrative in which both positive and negative outcomes and experiences can be a part of a person’s experience.

### ***Patient***

The next important term that this training uses is “patient.” This term is used when talking about the person medically or when referring to the nurse’s relationship with the person. Some examples include “discuss with the patient the importance of completing all medications and follow-up bloodwork,” and “Collect 2 swabs from the patient’s body if forceful/prolonged contact has occurred.” These two examples show how the word is charged with medical meaning, causing it to be used specifically when referring to the person who has experienced sexual assault in a medical context. “Patient” is used in reference to both the nurse’s interaction

with the person who has experienced sexual assault, and the relationship between the person and their medical needs.

Some examples that illustrate the shifts between using “victim” and “patient” exemplify these terms’ different meanings. In “The Crime Lab: *What Evidence to Collect and Why*,” page 5 uses the documentation example, “assailant removed victim’s clothing...” “Victim” is used here because it is referring to both the person’s negative experience of sexual assault, and the person's powerlessness in the situation with the assailant. The next slide talks about protocol when working with male victims. “Victim” is used in the title because it refers to the negative experience of the person. In this same slide, the language switches to “patient” because it refers to the nurse’s protocol in collecting evidence from these men. In this way, “patient” is appropriate because it is referring to the nurse’s protocol in working within their medical position as a SANE nurse. This shift exemplifies the difference in meaning of the two terms.

The use of the term “patient” shows a power dynamic that exists between the person who has experienced sexual assault and the SANE nurse. The SANE nurse is helping the person medically, and oftentimes emotionally. For this reason, the power dynamic is not necessarily a negative one. “Patient” signals the relationship between person and nurse as they provide them with care. While “patient” signals a relationship in which the nurse provides care to the person, “victim” only highlights the negative aspects about the person’s experience. As I discussed earlier, “victim” is used when referring to the person in relationship to the assailant. This relationship is a negative one, where the assailant has power and control over the person. “Patient” also signals a relationship, but this is much more positive in that the nurse is acting as both emotional and medical support to the patient.

The literature subscribes to the language patterns that are found in the curriculum. The website for the Oregon SAE/SANE Certification Commission highlights that its goal is to ensure that nurses use a “victim-centered” approach (Oregon SAE/SANE Certification Commission, 2017). Here, “victim” is used because emphasis is placed on how nurses help to reduce the trauma that the person is experiencing through care. The Encyclopedia of Interpersonal Violence also uses the word “victim” because it describes the ways that SANE provide care and information to the person and their families after the person has been assaulted (Renzetti & Edelson, 2008). Ort’s piece also utilizes “victim” in the same way (Ort, 2012). For example, “victim” is used in the sentence “The SANE acts as a liaison between the sexual assault victim and the police and the legal system” because it is describing how SANEs help people who have experienced interpersonal violence to navigate necessary resources and systems (Ort, 2012, p. 24KK). Maier’s (2012) piece uses “victim” throughout because it focuses on the ways that medical practitioners, police, and legal professionals often re-traumatize people who experience interpersonal violence.

Campbell, Wasco, Ahrens, Sefl, and Barnes’ (2001) article uses “victim” is the primary language used in order to refer to the person who has experienced sexual assault, but it also uses the term “survivor.” For example, “victim” is used when discussing the secondary trauma and revictimization that they feel when navigating certain systems in order to illustrate the negativity of this experience. Additionally, the sentence, “These analyses revealed that approximately one third of the rape survivors we interviewed sought community assistance postassault...” the term “survivor” is used because the person took the initiative to seek help for themselves (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001, p. 1246). This use of both “victim” and “survivor” is an

example of how language is used to recognize the duality and complexity of the experience of people who experience interpersonal violence.

The article, “Sexual Assault Nurse Examiner (SANE) program goals and Patient Practices” utilizes all three terms when referring to people who have experienced sexual assault, and the usage of these terms exhibit the same patterns as the curriculum. For example, “patient” is used in the sentence, “...SANEs address their patients’ medical needs by providing evaluation and care of injuries...” because it is discussing the medical care that the nurse provides to the person who has experienced sexual assault (Patterson, Campbell, Townsend, 2006, p. 181). The SANE program goals that they assess also follow the pattern. For example, “Empowering victims/survivors” uses both terms in order to address both the lack of agency that people who experience interpersonal violence experience before interacting with SANE nurses, and the agency that they experience after this interaction.

A deviation from the language pattern found in the curriculum is found in the article written by Fehler-Cabral, Campbell, and Patterson (2011). This article primarily uses “survivor” when referring to people who have experienced interpersonal violence, and it uses “victim” and “patient” as well. However, I think that the authors have in some instances chosen to use “survivor” as the primary term when referring to people who have experienced sexual assault rather than strictly following the language pattern that I have identified. Its title “Adult Sexual Assault Survivors’ Experience with Sexual Assault Nurse Examiners (SANEs)” exhibits this choice. An in-text example of this deviation from the pattern reads “As previously mentioned, the narratives suggest that survivors felt that their sense of control and dignity were taken away during the assault.” (Fehler-Cabral, Campbell, & Patterson, 2011, p. 3630) If this article were to

follow the language pattern, “victim” would be used here instead because it is discussing a negative aspect of the experience of the person who has experienced sexual assault. However, the authors have chosen to focus on the positive aspects of the person rather than the negative.

### *Addresses bias*

There are certain parts of the curriculum that directly address bias in some capacity. At the beginning of the curriculum, there is a pre-training test. Some of the scenarios and questions address mental health. For example, scenario 5 reads, “Tammy, age 18, and Mike, age 24, are patients in an inpatient psych unit. Tammy is developmentally delayed, has a history of sexual abuse, and is admitted for severe depression. Mike is admitted for bipolar disorder...” By addressing this topic, it helps to destigmatize and normalize the situation by showing it as a common and normal factor in working with patients. There are also questions that ask whether or not a person who has mental health issues is able to give consent. A question to scenario 5 asks, “Who can give consent for Tammy’s exam?” The choices read, “ a. You do not need consent. b. Tammy. c. Robin. d. Tammy’s parents.” At the end of the curriculum, there is a post-training test that contains the same questions. I assume that there is conversation around these questions and their answers, which are clearly loaded with bias around mental health and consent. By including questions about mental health, the curriculum is adding a narrative about the different types of people that might experience interpersonal violence. Whether this narrative is good or bad depends on the types of conversations that are had in regards to the scenarios and the questions. In addressing mental health in relation to interpersonal violence and consent, the curriculum addresses a bias that someone might hold about a person who has a mental illness and experiences interpersonal violence. This conversation is a great place for facilitators to help

unravel some of the bias while providing nurses with practical knowledge for their nursing practice.

In the presentation that addresses hormones, there are several slides that address the various medical care that trans patients choose to receive and what their bodies might look like as a result of these choices. The curriculum states that there are “Many variations on the medical care people may get.” In the “Scenarios: Things to Think About” section, the curriculum says, “Don’t assume trans patients want or have had hormones or surgery.” By including trans identity and bodies in the training, the curriculum affirms trans existence, thus addressing any negative bias towards trans patients. This narrative of trans existence holds power in that it makes their existence known.

By acknowledging the variation in medical care that trans patients choose to receive, the curriculum creates space to address their biases about what a trans person looks like and the medical choices that they make for themselves. It articulates that it is wrong to make assumptions about the medical care that trans patients want or have received. These assumptions might be rooted in bias as well. In these ways, the curriculum, addresses any bias that nurses might hold, whether positive or negative. For example, if a nurse believes that all trans people choose to undergo sexual reassignment surgery or wants to undergo sexual reassignment surgery, this section of the curriculum shows that this is not always the case.

In the same scenarios section, the curriculum also instructs nurses to ask trans patients their pronouns, and to use whatever they tell you. This is another way that trans visibility works to prevent bias. By acknowledging the importance of using the pronouns that they prefer, the curriculum shows that trans people’s identities are valid. If a nurse hold a bias that is against

trans identity, this works against the bias by affirming their right to be referred to in a way that aligns with their identity.

The scenarios also discuss different ways to work with different populations. These populations include the elderly, people with disabilities, critically injured patients, people with mental health concerns, people who are homeless, people who are in prison, and populations who may have a connection to CSEC (commercial sexual exploitation of children) or human trafficking. By addressing populations with diverse needs, the curriculum equips nurses with the ability to connect more with patients by giving them the specialized care that they may need. This scenario section addresses bias in that it shows that survivors can come from all different types of backgrounds. In acknowledging these populations, the curriculum holds power by making this knowledge known to nurses.

The curriculum contains a whole section dedicated to HIV in order to provide nurses with information that they need to know on how to keep it from spreading. This part is a possible place where bias is addressed in that it gives statistics on the amount of people who have HIV, both nationally and in Oregon specifically. This information destigmatize HIV by showing how common it actually is, possibly producing a counter narrative to a bias that only certain types of people have HIV. In showing facts about how many people and what types of people have it, these possible biases are met with a counter argument.

There are parts of the curriculum that address myths that nurses might believe about interpersonal violence and people who perpetuate it.. The section titles “sexual assault dynamics” states that, “Sexual Assault is NOT ‘Sex Gone Bad.’” The phrase used in this sentence is a bias that a nurse might hold about what sexual assault is, and in this sentence, the curriculum



counteracts it. This allows nurses to have a counter-narrative to what they might believe about people who have experienced interpersonal violence and their experience. This is an example of the curriculum addressing bias in that it is specifically debunking a myth about what sexual assault is and is not. This also addresses a bias that the larger society might hold. Because SANEs work with so many different types of people, they may encounter someone who believes that sexual assault is just sex gone bad. After going through the curriculum, they can see that this is not true, and are potentially better equipped to address this bias within others.

Another example of the curriculum preparing nurses to work with biases that others might hold is the the scenario that addresses working with a person who is does not speak English and an interpreter. One of the slides touches on things to consider when working with an interpreter, and reads, “May lack specialized training on sexual assault, which may create unintended bias or inaccuracy.” Here, the curriculum addresses the bias of the interpreter rather than the bias of the nurse. This is important because it acknowledges the fact that nurses might be in situations where they have to work with individuals who hold biases that are not in alignment with the nurses, and might hinder the care of the person who has experienced sexual assault.

In the same section, the curriculum talks about what research has shown about perpetrators and their beliefs, the tactics that they use, and it even explains that they are “More similar to ‘us’ than the stereotype.” This statement addresses a possible bias that all perpetrators look or behave a certain way, or that they are easily identifiable. By stating that this is not true, nurses receive a counter narrative and are given space to consider other viewpoints. This section also explains that perpetrators who do not believe that they did anything wrong of. These beliefs

speak to the biases that perpetrators might hold about women that might lead to sexual assault. For example, the curriculum explains that research shows that perpetrators believe that “Women are seductresses.” This illuminates a bias that perpetrators often hold about women, which in this case is that they are hypersexual, and because of this, they seduce others. This bias is dangerous because by believing that women are always enticing men to have sex with them, the blame is taken off of the perpetrator and put on the women who seduced him.

The “Sexual Assault Dynamics” section addresses bias about the gender of people who have experienced sexual assault in a subtle way. One slide explains that one way to support survivors is by “Understanding it wasn’t his/her fault.” By including “his” the curriculum is articulating that men can also experience interpersonal violence. This might address bias by acknowledging that not all people who experience sexual assault are women. In this case, the simple inclusion of “him” provides a narrative that includes men’s experience of interpersonal violence.

The section of the curriculum that educates nurses on how and what to document expresses that it is important to be objective in your documentation. It states “Avoid using words that suggest judgment, such as ‘refused,’ ‘uncooperative,’ ‘noncompliant,’ etc.” This section also includes a page that nurses can reference when they need to use objective words to describe their interaction with people who have experienced interpersonal violence. By putting emphasis on objectivity, the curriculum teaches nurses how to remove their personal thoughts, feelings, and emotions from the situation at hand. This also works as good practice in removing your biases from the situation. Because biases are based in feelings and opinions, remaining objective in situations makes room for nurses to learn to remove their biases from the situation.

The “Forensic Nursing” section of the curriculum addresses what SANEs do and do not do. Among the things that SANEs do not do is “Allow their own prejudices to impact care or documentation.” Biases result in prejudice, and so in order to avoid acting on your prejudice, you must first examine your bias. By addressing prejudice, bias is indirectly addressed as well. The “Sustaining Ourselves and Our Work” section says, “You may have your own wounds or biases...What biases and assumptions surround you?” These are the most clear spaces in the curriculum in which bias is addressed. This narrative explicitly states that nurses might hold biases and that the people around them might hold biases as well. By asking these questions, the curriculum creates space for nurses to think about their own biases and the biases that they might encounter.

### ***Perpetuates bias***

While the curriculum addresses ways in which bias might show up in SANE nursing, it also perpetuates some negative biases through language choice. The section on forensic nursing states that “Patient populations cared for by forensic nurses are among the most vulnerable, disparaged, and disadvantaged in society.” While this might be true, it has the potential to reinforce existing biases about people that experience sexual assault. For example, if a nurse believes that all people who experience sexual assault lack agency, this sentence might give more power to that bias. In the “Forensic Photography” section, it instructs nurses to “Preserve patient’s modesty...provide blanket/sheet.” This sentence puts emphasis on modesty, which is subjective. While this does not necessarily perpetuate bias, it suggests using your own judgment in choosing what is modest for the patient and what is not. It has been found that people who experience sexual assault have negative experiences with SANE nurses when they feel that they

have no choice (Fehler-Cabral, Campbell, & Patterson, 2011). When a nurse chooses what is best for the patient, there is room for people who have experienced sexual assault to feel a lack of control during the exam.

## **Discussion**

Some content and information in the handbook connected directly back with the literature that I previously analyzed. The handbook reviewed Oregon certification, which clearly related back to the information that I found on the website for the Oregon SAE/SANE Certification Commission (2017). The website highlights that its goal is to ensure that nurses use a “victim-centered” approach. In referring back to the patterns found in the SANE curriculum, I suppose that “victim” is used here because emphasis is placed on reducing trauma through care.

The training gives nurses tips for working with their facility in addressing and expanding their program. I found this linked to Patterson, Campbell, and Townsend’s (2006) work in that in nurses influencing their program, they are also influencing the patient care that they will be influenced to give (2006). In the “Expert Testimony” presentation, the training states, “It is not your job to win this case- trust your prosecution.” This is also linked to Patterson, Campbell, and Townsend’s findings in that it addresses the struggle between “winning” a case and fulfilling your duties as a nurse (2006). Also linked to this article is the handbook’s urge to prioritize patients and their needs over forensic needs. We know that this is important because programs that prioritize case prosecution are more likely to provide lower quality patient care (Patterson, Campbell, and Townsend, 2006).

Maier’s (2012) findings were the most prominent and applicable in the training. The position paper at the end of the training handbook entitled “A Best Practice: Why Law

Enforcement Is Excluded from the Forensic Medical Exam” discusses law enforcement’s role and explains that their presence during the forensic medical exam is both illegal and unnecessary. Although this position paper does not state that law enforcement revictimizes the person, this paper is linked to Maier’s findings that SANE nurses find law enforcement to cause revictimization. The training discusses how SART “Increases trust in criminal justice system and service providers. This also links back to Maier’s findings on revictimization, and particularly her assertion that while SANEs help reduce revictimization, they are not the solution to ending it. In linking SART’s role with this research, we see that SART is also a valuable resource for reducing revictimization along with SANEs. The training instructs nurses to “ensure that compassionate and sensitive services and care are provided in a non-judgmental manner...” This is consistent with Maier’s findings that SANEs believe they give personalized and emotional care and treatment. The training also addresses times when law enforcement is not professional, which will help nurses to reduce revictimization by law enforcement, which is also consistent with Maier’s findings.

When reviewing my writing, I noticed that I had been unconsciously using the term “survivor” when referring to people who had experienced interpersonal violence. As an advocate for people who have experienced interpersonal violence, I have been trained to always highlight on the agency that these people hold, and to focus on the positive aspects of their experience. It is clear that I subscribe to these language patterns as well. While I do not believe that there is anything inherently wrong with using “victim” or “patient” versus “survivor” when referring to people who have experienced interpersonal violence, it is important that we understand the implications of language. Because language is power, what language we use has implications for

how the person feels about themselves and their experience (Grbich, 2009). My research is intended to begin a conversation around language and the implicit or explicit meaning that it holds, and how this meaning influences the work that we do with people who have experienced interpersonal violence. While my research focuses on the curriculum that trains nurses who work with people who experience interpersonal violence, more research needs to be conducted with other curricula in various fields that train others who work with this same population. Careful attention needs to be paid to the language in regards to its power and meaning in these trainings in order to understand what narratives that are being provided. By being aware of language and its power, we can better control and understand what messages are being conveyed to those practicing in the field and the populations that they are working with.

### **Researcher Positionality**

In my research, I have taken an intersectional feminist approach to analyzing the SANE nursing curriculum bias. Intersectional feminism focuses on the multiplicity of people's identities, and how they work together to form complex experiences of oppression and privilege (Uwujaren & Utt, 2015 ). My practice of intersectional feminism has led me to challenging one-way patterns of thinking and acknowledging the multiplicity of experience, power, and oppression. I have not looked at the world in this way, and I have had to challenge myself in order to adopt an understanding of social justice that includes and acknowledges all aspects of identity in order to work towards the liberation of all people. During my time volunteering at Portland State University's Women's Resource Center, I have continually grown in my personal use of intersectional feminism by challenging my own thinking and biases in order to move towards liberation for myself and others.

My work in intersectional feminism has led me to want to challenge and complicate the systems in which people operate in order to better them. For a little over a year, I have been an interpersonal violence advocate at the PSU Women's Resource Center. During this time, I have heard many great stories of survivors receiving trauma-informed care from SANE nurses. However, I have heard a couple of stories about survivor's experiences with SANE nurses being retraumatizing. My approach to this topic was to explore the ways in which the system in which SANE nurses operate was potentially not preparing them for working with survivors. My goal was to analyze the curriculum to see how it was both addressing and ignoring bias so that the practice could move towards an unbiased, inclusive approach. My intentions were to critique the system in order for it to grow. I believe that each person in this work, and each system in which we operate in, can be doing better at practicing intersectional feminism, and this is why we must constantly be challenging ourselves and the systems in which we are working in.

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