Post-assault care of transgender sexual violence survivors: A guide for healthcare providers, forensic nurse examiners, and medical advocates

This project was supported by Grant No. 15JOVW-22-GG-00921-MUMU awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the U.S. Department of Justice.

Who is this guide for?

While many documents are geared towards any advocate or victim service provider to support them in becoming more trans-knowledgeable in serving trans and nonbinary survivors, this guide will be most useful for forensic nurse examiners, healthcare providers who conduct forensic exams/evidence collection, medical advocates, and others who might be “in the room” where a forensic exam might occur. Additionally, this guide will provide a brief overview of some of the medical needs, beyond forensic exams, that trans/nonbinary survivors of sexual violence may have. This may be useful for medical advocates in providing long-term support as well as for healthcare staff providing care outside of exams. Any healthcare provider and advocate who is working with a trans/nonbinary survivor of sexual violence might benefit from reading this guide.

How to use this guide

This guide strives to provide introductory, intermediate, and advanced information for sexual assault nurse examiners/forensic examiners (SANE/SAFE), healthcare providers (HCP), and medical advocates. Since the needs of advocates are different from healthcare providers, different sections may be more relevant than others to each type of provider. We encourage readers to find the sections that are most applicable to their work and their clients’ needs. Short, summary, tip sheets accompany this guide and can be used as a quick reference or reminder.

About the authors

Special thanks to michael munson & Emil Rudicell of FORGE for authoring the content of this resource.

Note

Throughout this document, the terms transgender and trans will be used interchangeably. In some cases, we will refer to trans and nonbinary survivors/communities when addressing common issues, barriers, and needs that affect a broad section of the community. We will use specific identity language or descriptors when discussing unique identities that may have specific service implications, such as trans men or trans women.

This guide assumes that the reader will have some familiarity with transgender and nonbinary people. For an introduction to these communities, check out:
Serving Trans and Non-Binary Survivors of Domestic and Sexual Violence,

- https://vawnet.org/sc/serving-trans-and-non-binary-survivors-domestic-and-sexual-violence

For resources specifically for trans/nonbinary survivors:
Resources and Support for Transgender Survivors,

- https://www.nsvrc.org/blogs/resources-and-support-transgender-survivors
- https://vawnet.org/material/transgender-sexual-violence-survivors-self-help-guide-healing-and-understanding

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Basic information about trans/nonbinary (T/NB) survivors of sexual assault

Introduction to Trans/Nonbinary People

Trans and nonbinary people are a diverse population. Research indicates that 1.03% (US Census Bureau, 2024) to 1.5% (Brown, 2022) of adults identify as transgender (between 3.4 and 4.9 million). Among youth up to age 30, 5% (about 16.6 million) of youth say their gender is different from their sex assigned at birth (Brown, 2022).

Trans and nonbinary people may be of any race, ethnicity, sexual orientation, disability status, or class background. They live in rural, urban, suburban, and tribal communities. Just as with any other community, trans and nonbinary people are unique individuals. It is imperative that providers understand the broad community needs and specific types of care required for each individual as their own person.

Quick definitions

Transgender/Trans: Transgender is an adjective to describe people whose gender identity differs from the sex they were assigned at birth. People who are trans may also use other terms, in addition to (or instead of) transgender, to describe their gender more specifically. For example, trans man/woman, woman/man of trans experience, formerly trans, man/woman, etc. Being trans is not dependent on physical appearance, legal status related to gender, or medical procedures.

Quick definitions

Nonbinary: Nonbinary is an adjective used by people who experience their gender identity and/or gender expression as falling outside the stereotypical, culturally-defined binary gender categories of man and woman. Many nonbinary people also identify as transgender/trans and consider themselves part of the trans community. Others do not. Nonbinary is an umbrella term that encompasses many different ways to conceptualize one's gender. Some nonbinary people may also use words like agender, bigender, demigender, genderqueer, pangender, etc. to describe the specific way(s) in which they are nonbinary.

Being trans or nonbinary are not dependent on physical appearance, legal status related to gender, or medical procedures. It is important to ask people what they use to describe themselves.

For more information and additional definition of terms, see GLAAD's Glossary of Terms: Transgender, https://glaad.org/reference/trans-terms

Prevalence statistics

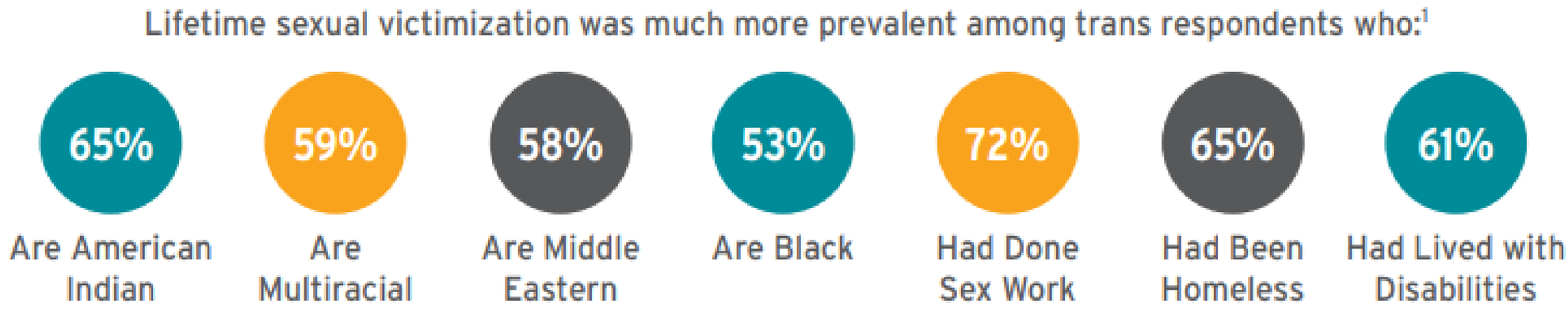
Trans and nonbinary people experience sexual violence and other forms of violence at higher rates than non-transgender people. Unfortunately, research is fairly limited. Many major surveys do not adequately include transgender and nonbinary people. For example, the National Intimate Partner and Sexual Violence Survey (NISVS) – one of the most common sources of data on sexual and domestic violence, did not have enough participants label themselves as transgender to disaggregate the data (Chen et al., 2023).

Many other surveys do not even provide the option for participants to identify as a gender other than male or female. This is why many of the statistics throughout this guide may be a decade or more old or have smaller sample sizes.

Academic and other types of research indicate that at least 50% of trans and nonbinary people experience sexual violence at some point in their lives (FORGE, 2005). Similarly, trans and nonbinary people experience intimate partner violence (IPV) – which also can include sexual violence – at a similar rate of 50% (James et al., 2016).

“Almost half of all transgender people have been sexually assaulted at some point in their lives, and these rates are even higher for trans people of color (53-65%) and those who have done sex work (72%), been homeless (65%), or have (or had) a disability (61%) (James et al., 2016).”

Research further indicates that trans people often experience multiple sexual assaults in their lifetime.



Infographic: *Sexual Violence & Transgender/ Non-Binary Communities, https://www.nsvrc.org/sites/default/files/publications/2019-02/Transgender_infographic_508_0.pdf*

Sexual violence towards trans and nonbinary people often is connected to their gender identity. Survivors often report being told they are being assaulted because of their gender or are called anti-trans or gender-specific slurs during the assault. Frequently, trans people experience more than one form of victimization in combination with sexual assault, including physical abuse, verbal harassment, anti-trans hate-motivated violence, use of a weapon, property damage, and other forms of violence. Offenders may specifically physically target "gendered" parts of the body – face, chest, genitals – during an assault.

One research study found that sexual assault increased when transgender youth were denied access to the locker rooms or bathrooms of their affirmed gender. "The 12-month prevalence of sexual assault was 26.5% among transgender boys, 27.0% among nonbinary youth assigned female at birth, 18.5% among transgender girls, and 17.6% among nonbinary youth assigned male at birth."

Youth whose restroom and locker room use were restricted were more likely**2** to experience sexual assault compared with those without restrictions (Murchison et al., 2019).

2The study found risk ratios of 1.26 (95% confidence interval [CI]: 1.02–1.52) in transgender boys, 1.42 (95% CI: 1.10–1.78) in nonbinary youth assigned female at birth, and 2.49 (95% CI: 1.11–4.28) in transgender girls. Restrictions were not associated with sexual assault among nonbinary youth assigned male at birth. This indicates the highest risk was for transgender girls, followed by nonbinary youth assigned female at birth, then transgender boys.

Reasons why SA might be higher for trans people

There are many issues that contribute to the higher rates of sexual violence towards trans/nonbinary people. This includes the social discrimination and oppression experienced by trans/nonbinary people. Oppression makes communities more vulnerable to sexual assault by decreasing access to some of the resources that create safety and by creating a cultural narrative that a group of people may be less valued or respected by others, and thus more deserving of harm or less deserving of safety.

Due to these factors and other societally constructed inequities, many trans people have limited access to meet their basic needs. Many trans people may survive without safe housing, a livable wage, or in other situations that have higher rates of violence, which may lead to higher rates of sexual victimization.

One in five transgender people have experienced homelessness in their lifetime (National Center for Transgender Equality, 2019). Homelessness places people at increased risk of being assaulted. Trans/nonbinary people face extensive barriers in access to housing, employment, healthcare, and the other resources needed for daily life. This discrimination can make it more likely that transgender people will be targeted for sexual violence and have fewer resources to access safety and support after an assault.

Trans people are also more likely to live with a disability. In the 2015 US Trans Survey, 39% of respondents reported having a disability (James et al., 2016). One study found

transgender adults have a 27 percent chance of having at least one disability at age twenty and a 39 percent chance at age fifty-five, which is nearly twice the rate of their cisgender counterparts at both ages (Smith-Johnson, 2022). Rates of sexual assault are higher for people of all genders who live with disabilities (Weiss, 2012).

Sexual assault is never the fault of the victim. Discrimination and inequality are also not the fault of the targeted group. Trans people should not be blamed for the systemic inequities that create barriers. **Trans people are not "asking for it" through any action, appearance, life circumstances, or any other reason.**

Tragically, there is a common myth that trans people are deceptive or violent, simply for being trans. This is absolutely false, yet this belief is used by perpetrators and defense attorneys to "justify" violence against transgender people.

Advocacy Quick Tip:
Think about the questions you ask and the language you use when working with survivors. Could you be implying that they deserved the assault or should have behaved differently? Think about if you would question a non-trans person's choice of clothing, occupation, or behavior in relation to their assault.

Key concepts

For those who are less familiar with trans and nonbinary people, gender affirming care, or overarching medical needs, please see Appendix A for more detailed information.

Barriers to Seeking Sexual Assault Services

Trans and nonbinary survivors face many barriers to accessing services for sexual violence. By recognizing these barriers service providers can start to address them proactively and in real time.

Past negative experiences and the threat of harm.
Many sexual assault services are accessed by making a phone call. Some advocates make assumptions about a caller's gender based on their voice. Trans/nonbinary survivors are less likely to have a voice that fits into the narrow stereotype of their gender's voice. If advocates react negatively, are more skeptical of the caller, or misgender the caller because of their voice, the survivor may not continue seeking services or may be denied services.

Similarly, based on appearance, in-person staff may make inappropriate assumptions about a survivor and direct them to the wrong services or be more skeptical of them because of the staff/volunteer's biases about gender.

It is not uncommon for trans people to be threatened by staff in ways such as:

- Calling law enforcement on the victim/survivor (presuming the person is an offender)
- Verbally threatening the person to leave or not call back
- Accusing the victim/survivor of not telling the truth and not being a victim/survivor
- Telling the trans person that they are taking away services and resources from "real" survivors

Tips for addressing past negative experiences/threats:

- Provide training to all staff on not only trans issues, but who can be a survivor
- Provide services to people of all genders – which will make it so that people don't have to "determine" someone's gender
- Offer clear, direct apologies when mistakes are made
- Have resources and vetted referrals ready if your agency is not able to provide services to specific types of survivors

Medical barriers (general)

19% of trans and nonbinary people are routinely denied medical care. Even more trans people have negative experiences with healthcare providers, including being disrespected, or being verbally, physically, or sexually assaulted by health care providers (James et al., 2016).

> *"Flat out, I don't go to medical providers really anymore. I don't send people to medical providers, when they're queer or trans or have some sort of disability or basically anything that would marginalize them as a part of their story and their lived experience. It's just not safe. It's not. Sometimes it's not helpful at all and it's more harmful."* – **Trans person in FORGE Listening Session**

Collectively, trans people have profoundly negative experiences with accessing healthcare. Denial of care can profoundly impact someone's perception of medical providers as helpful. The combined negative experiences of individuals and communities create distrust of providers and

a perception of healthcare as not a place of help but as a place of potential harm. Many trans people report that aside from accessing trans-related healthcare, they typically avoid healthcare except in emergencies.

After an assault, trans/nonbinary people may be less likely to trust medical providers or see medical resources as helpful. If survivors do seek care, they may have heightened distrust and distress due to prior negative experiences.

Ways to address prior healthcare harms:

- Acknowledge past harms.
    - “I know that many people have had negative experiences getting healthcare before. I want this to be as comfortable and safe for you as possible. I’m glad you came in today. I am here to help provide care to you. You are in control of what happens here today.”
- Take time to be welcoming.
- Ensure that all staff are trained to use gender-inclusive language and the correct names and pronouns for everyone.

Identity documents

Every state and territory have a different process for obtaining a legal name change and for changing the gender marker on identification documents. The federal government has a separate system for federal identification such as a US Passport. In some cases, people must get the change made in the state they were born, in order to update a birth certificate.

In 2023, many states pursued legislation to make it more difficult to change gender markers – on birth certificates, driver's licenses, and other forms of documentation. Pursuing name and gender changes can cost hundreds of dollars and hours of time. In many cases it involves at least one in person visit to a courthouse. Not everyone wants to pursue this process and not everyone who wants it can do it. For some, no gender options exist to accurately depict their identity. For immigrants, the process becomes even more complicated.

The result is that for many transgender people, their identification is not consistent with their identity – meaning their name and/or gender on their ID is not accurate. Incongruent identification can result in the denial of services, people being extensively questioned (or disbelieved) about their identity, forced to be outed as being transgender, or being dismissed.

Trans people have extensively reported seeking services (medical care, counseling, other supports) and having staff respond harmfully to "incongruent" documents. Staff have demanded information about the differences in appearances, accused survivors of using fake IDs, and publicly outed them at the front desk of a service provider.

If a person has health insurance, the name and gender associated with their insurance card/company may pose additional challenges. Many medical institutions primarily or exclusively use the name listed on a person's insurance as the primary name within a medical record. This is often not the

name and gender of the transgender person seeking services. Insurance companies also may deny care based on the gender marker on the insurance.

Additional name/gender complications can exist for people who have changed their identification and still need medical care for their whole body. For example, an insurance company may refuse to provide coverage for a pregnancy test if their records indicate the person is male or deny a prostate exam for a woman.

These types of concerns can influence a person's decision to change their gender marker or to seek medical care.

Remember:

- Use the name and pronouns the person shares with you – regardless of what is on their legal documentation.
- If there is a known concern about "gendered" procedures and insurance coverage, see if care can be paid for through non-insurance methods (e.g. Victims Compensation programs).
- The information on identity documents does not tell you any information about the person's body or their medical needs.

Law enforcement and the criminal legal system

The vast majority of trans people who have interacted with law enforcement have had negative experiences or have been treated with disrespect related to their gender. (For more details, see the US Trans Survey report (James et al., 2024).

9% of trans people have been physically attacked by law enforcement as a result of simply being trans (James et al., 2016).

In addition to direct experiences with law enforcement, trans/nonbinary people are often aware of the ways that others have had negative experiences. For communities of color, especially Black, Latinx and Native communities, the distrust is more elevated due to the intersections of discrimination. As just one example, 24% of Latina trans women in Los Angeles reported sexual assault at the hands of law enforcement (Woods et al., 2013).

This treatment has led to a strong distrust of the criminal legal system.

When sexual assault happens within the context of an intimate partnership and law enforcement is called to the scene, it is common that both trans women and trans men are seen as the offender versus the victim, even before any information is gathered about the situation. This is often the result of implicit or explicit bias that leads officers to presume the larger person (which could be the trans woman) or male person (the trans man) is the offender. Because of these biases, many trans people are afraid to come forward and involve law enforcement.

There are also increasing numbers of people who do not see the criminal legal system as a way to seek accountability or justice. Even people who are not worried about their personal involvement with the system, may not believe that

there is anything the system can do to help them or their communities.

Many people – trans and non-trans – believe that law enforcement must be involved in order to receive medical/forensic care after an assault. As a result of this inaccurate belief, many trans people will not seek post-assault medical care. Many survivors who know that such an exam exists, may not see the point in it if they will not be pursuing criminal charges.

Addressing law enforcement related barriers:

- Sexual assault organizations can promote information that disconnects receiving post-assault care with law enforcement involvement.
- Advocates and SANEs/health care providers can provide care to survivors before bringing up law enforcement involvement. (At the very least, advocates and providers can begin to develop a relationship and dialogue with survivors before mentioning law enforcement.)
- Advocates can be present with a survivor when law enforcement is present. This can help serve as a witness so further abuse/ harassment doesn't occur, as well as can provide support to the survivor.
- Sharing with survivors what their rights are is essential for survivors to make informed decisions about if, when, or how they would like law enforcement involvement.
- Letting survivors know that the cost of receiving medical or forensic services is not tied to reporting the crime to law enforcement.

Legal Barriers

Due to discrimination in education and employment, trans people are more likely to have “under the table” employment.

As a result, some people may be engaged in activities that are deemed illegal and avoid law enforcement for this reason. Trans/nonbinary sexual assault victims may survive through the street economy, which can include selling drugs, engaging in sex work, living on the street, or stealing food or other items necessary for survival. Individuals who are struggling to survive due to low income or other difficult conditions may possess weapons for self-defense (legally obtained or licensed, or not), may violate probation, or engage in other activities that may place them at higher risk for arrest/interaction with law enforcement.

Sex workers report extensive negative experiences with law enforcement, and many trans women report being perceived as engaging in sex work (even when they are not), leading to additional harassment or mistreatment. Sex workers also experience higher rates of sexual assault than non-sex workers.

Similarly, because many trans people do not have access to health insurance, stable housing, adult mentors, or loving family members, trans people are at higher risk for untreated substance use/abuse and mental health conditions.

Survivors living under these circumstances may be afraid they will not be eligible to receive medical/forensic services, or that they may not be treated with respect.

It’s important to remember that all survivors deserve advocacy and healthcare. All survivors should be believed about their experiences.

Remember:

- People may feel shame for how they are surviving – our job is not to add more shame or stigma. Treat all survivors with respect and compassion.
    - By treating sex work as work, rather than as criminal activity, advocates and healthcare providers are more likely to respond without stigma.
- Check with the survivor to understand any needs they may have. Those without reliable, safe access to income may be more likely to need basic healthcare, food, housing, or a place to bathe. Advocates may be able to assist with these needs.
- Avoid unnecessary engagement with law enforcement and seek consent before introducing survivors to law enforcement.

Inadequate/misleading information about the availability of services

Maybe people don’t know where to go or what to do after they have been sexually assaulted. Most people don’t know what types of services can be provided, even after they reach an advocate or sexual assault agency.

For example, it is not commonly known that medical/forensic sexual assault services are free. For trans people who are un- or under-insured, possibly living at low-income levels, cost may be a perceived deterrent to seeking care.

Trans people may not be aware that forensic nurse examiners are well-trained in being non-judgmental, accepting, welcoming, and believing people for who they are and for what happened to them. This type of medical care may be unusual or even unimaginable for many trans people who have routinely experienced discrimination and abuse within medical settings.

Tips for sharing information about services:

- Sexual assault agencies and health care facilities that provide medical/forensic exams can provide information about their services through their websites and social media. Including information about what type of care is available will allow people to make more informed choices.
- Agencies can also provide information that forensic exams and evidence collection is free.

Belief that services are for women only

The dominant paradigm – both culturally and within sexual assault service systems – is that sexual assault is a "women's issue." Even though most people will acknowledge that sexual assault can happen to men and boys, the predominant belief is that sexual harm almost exclusively happens to women and girls. Although there has been progress in acknowledging that sexual assault also happens to men (trans and non-trans), as well as to trans people of all genders, this growth has been slow and sporadic.

With this pervasive messaging that sexual assault happens only to girls and women, trans people may wonder if sexual

assault services will even acknowledge that trans people can experience victimization.

Services related to domestic violence and sexual assault have historically (and still currently) been viewed as “women’s” services. While some organizations who are trans-affirming include trans women when using the term women, there are many others that don’t include trans women under the umbrella of “woman,” or may do so as an afterthought or exception. It can be difficult to tell which use of the word “women” is intended without additional information. Trans men and nonbinary people are still left out entirely from this framework.

Asking for support is challenging for many people, and they are even less likely to do so if they believe that the services are not available to them or will not be appropriate. Many trans/nonbinary people have experienced (or know people who have experienced) being turned away from services due to their gender.

Even when sexual assault services are overtly trans-welcoming, some forensic exam offices are housed within the “women’s health” areas of hospitals or other locations that require trans people to go through gendered spaces.

Reminder:

The Violence Against Women Act nondiscrimination policy (Office of Civil Rights, 2014) requires that people of all genders be provided with equivalent services. Despite having been in existence since 2013, there is still much work to be

done to meaningfully provide equivalent services to everyone (Office of Civil Rights, 2014).

In addition to VAWA, many states and localities have nondiscrimination provisions that include sex, sexual orientation, gender identity and/or gender expression protections that could be used to challenge agencies that do not or cannot serve survivors of all genders. Increasingly, federal courts are finding that existing federal nondiscrimination laws protect sexual and gender minorities seeking public accommodations, a category that includes many services for survivors.

Similar nondiscrimination policies to those outlined in the Violence Against Women Act's nondiscrimination policies have been developed by the Family Violence Prevention and Services Act (FVPSA), Department of Education, the Office for Victims of Crime, Health and Human Services, and other federal and state agencies.

Tips to increase access:

- Work towards policy changes so that medical/forensic exam services are not housed within "women's health" areas of a facility.
- Work to dispel myths that sexual assault only happens to women and girls.
- If some services are only available to women, be clear in messaging that "women" = all women, trans, non-trans, femmes, etc.

Provider knowledge | Training

Those of us working in the field know that sexual assault forensic examiners, healthcare providers, and advocates want to provide respectful, caring, competent services to the people they serve. Trans people may not have confidence in the good intentions and care that providers offer.

It's also true that the best of intentions from providers doesn't always equal cultural sensitivity or trans-specific knowledge. Gaps in knowledge can unintentionally lead to unequal services.

Many trans/nonbinary people report being denied services and told their situations are "too complex." Others have experienced providers shifting their focus to irrelevant things rather than assisting with the problem the survivor is seeking help with.

Providers benefit from training and knowledge of intersecting identities and experiences that are not necessarily trans-specific. For example, understanding how to respond to victims with physical and/or intellectual disabilities, neurodivergent victims, people who may be intoxicated, people engaged in activity that is deemed illegal around the time of the assault, people who are incarcerated, etc., will all better prepare staff to work with trans survivors, because trans survivors may also be in any of the above populations.

Tips for affirming services

- Remember to use survivor-centered practices with all clients

- Remember to stay focused on the skills you already have to do your job well. (In other words, don't forget your skills, when you experience a population you might not be familiar working with.)
- Specialized training on working with trans communities is important.
- If you are in a situation with a trans person that you are unsure of how to handle, being compassionate, having humility, and treating people with respect will help the survivor stay to receive care.

Privacy Concerns

Trans/nonbinary survivors may also have concerns about being outed or mistreated throughout the legal or medical process. For example, filing a police report may bring up concerns about possibly losing custody of their child if information about their gender becomes public. If a survivor does want to report to law enforcement and possibly pursue litigation, they might have concerns about being fired from their job, if their gender is disclosed in court paperwork (and they had not been out on their job). There can be similar privacy concerns within medical records and who has access to this information. Youth might be worried that their parents may learn about their trans identity if they disclose to people providing post-assault care.

These and other issues surrounding privacy and disclosure may cause further harm to a trans/nonbinary survivor, through having to relive traumatic event(s) of prior privacy breaches, and the possibility of being misgendered or discriminated against for their gender.

Ways to address privacy related barriers

- Ask survivors about their privacy needs and concerns.
- Have clear reporting policies that are disclosed to survivors – what is confidential and what is reported to child protective services or police.
- Make it clear how law enforcement is involved in the process (if at all) and what services are available without law enforcement.
- Be clear about what services are available to people if they are intoxicated.
- Let young survivors know what services are available to them without the involvement of a parent or guardian (or without the involvement of Child Protective Services).
- Acknowledge past harms and injustice.
- Support survivor agency and choice.
- Offer alternatives.

Barriers related to belief systems and knowledge

Many trans people will not seek post-assault care due to commonly held beliefs that circulate within the general population and/or the trans community.

Gendered paradigms (of who is assaulted)

Our culture has reinforced the message that only girls and women are sexually assaulted. While those who work in victim services or healthcare know that people of all genders experience sexual violence, service systems are often still set up to focus on women, sometimes at the exclusion of people of other genders.

The systems that can impede trans survivors from accessing care include:

- Crisis line workers disbelieving survivors who “sound male” from connecting to an advocate (presuming the caller is a perpetrator vs. survivor)
- Front desk staff questioning a person who doesn’t present as female about why they are there (more questions than a non-trans woman seeking services)
- Sexual assault treatment centers being housed within the “women’s health” areas of hospitals or other facilities

For sexual assault organizations, understanding how sexism contributes to the high rates of sexual violence in this country and globally is important. This framework does not mean that only women and girls have been assaulted. Service providers can work to ensure that all people are aware of their services and see themselves as eligible for these services. Service providers can also seek to understand the unique dynamics that may impact people of different genders, as well as how intersecting identities such as race, class, and nationality may impact someone’s experience.

Beliefs about who is assaulted within trans community

General societal and within-trans-community assumptions about who is and isn’t assaulted can impact a survivor’s access to support.

Due, in part, to the high rates of sexual violence that both trans and non-trans women experience, there is a common belief that women will be assaulted at some point in their lives.

Some trans women hold the belief that being sexually assaulted is part of what it means to be a woman and affirms their womanhood.

Many trans women report experiencing multiple assaults in their lifetime, and some report a sense of exhaustion ("am I really going to report everything that happens?").

None of this means that the emotional impact of these assaults is any less. However, if the situation is not perceived as a medical or safety "emergency" many people won't access services. In fact, many won't even consider what happened to them as assault (or something that should/could be treated), because it happens so frequently.

It is also a common myth that men do not get assaulted. Trans men may internalize this belief. When trans men are assaulted, if they think that men do not experience assault they might:

- Experience compounded feelings of shame and stigma when assault does happen
- Be more averse to seeking post-assault care, since it would mean they have to "admit" to being assaulted
- Be less likely to talk about or have peer/support connections following assault (or before any assault happens)
- Not share what happened to them with any one
- Minimize what happened and not view it as assault
- Believe they could or should have stopped the assault from occurring

Internalized Stigma

Some people have internalized cultural beliefs or ideas about trans people and about survivors of sexual violence. These myths can make it harder for a person to seek help or feel worthy of help. Some of these beliefs include:

- This is what happens to trans people.
- It's shameful to be assaulted.
- It's embarrassing.
- It's the victim's fault.
- It's not bad enough to get help.
- It happens to everyone and just part of life.
- Other people have it worse and I don't want to take resources from them.

Ways to address belief-based barriers:

- Ensure that outreach is trans-affirming and inclusive
- Be clear about the services available, the costs (or lack of costs), and who they are for
- Work with other partners and organizations to ensure they understand services and can refer appropriately to you.
- Check your own biases and assumptions about who victims and perpetrators are and what sexual assault is. Work with colleagues and organizations to do the same.

(Trans people) Protecting the (trans) community

Trans/nonbinary people may have concerns about other people in the community knowing they were assaulted, or the implications that seeking services has on their communities. Many trans/nonbinary communities are smaller and insular. In small communities, information can spread

quickly. Many survivors describe that they do not want the perpetrator to "get in trouble," particularly in terms of law enforcement engagement. They may also be concerned about community backlash towards the perpetrator or towards themselves. Particularly in cases where the perpetrator is well regarded, the survivor may face increased harassment or scrutiny for disclosing the assault.

In addition to concern for the perpetrator, survivors may be concerned for their community's well-being. This can include assumptions or stereotypes that outsiders may make about the community, the potential of harm caused by law enforcement or incarceration, or the stress of sharing information within a small community.

These concerns can be compounded when the assault is perpetrated by another trans person. The victim may not want others in the broader community to associate trans people as being perpetrators.

Some survivors avoid LGBTQ or Trans specific services because they know the providers and staff at those services – or the perpetrator does.

Barriers Due to State-Sanctioned Hate and Hate-motivated Bias

State-Sanctioned Hate

Since 2016, there has been a dramatic rise in anti-trans legislation and policies at the local, state, and federal levels. During this same time, there has also been a sharp increase

in legislative and cultural actions that target immigrants, people of color, individuals with disabilities, people with uteruses, people of specific faiths (specifically in Muslims and Jewish communities), and many other populations. The widespread discrimination, legislation, and culturally motivated hate-focused actions have resulted in people not being able to access their basic rights. These actions have directly caused substantial physical, emotional, sexual, and spiritual harm.

The landscape is in a constant state of flux, with legislative and cultural shifts occurring almost daily. The chaos of uncertainty is often nearly as painful to bear as the actual laws and abusive behaviors.

Some of the most common legislation and policies against trans people and families include threats to accessing to public facilities, education, criminalizing healthcare, and the general participation in public life. Many anti-trans legislative initiatives have passed and have resulted in intense restrictions on transgender people's lives, especially the lives of young people. The impact of anti-trans cultural and legislation also affects the people around trans people, including family members, teachers, medical providers, and therapists. In some states, trans people or those around them have been fined for using a public restroom, providing health care, sharing a book, or having a discussion about gender-specific topics.

Many health care providers have closed their practices or moved to another state, when their original state restricts

their ability to provide care to trans and gender-diverse patients. Other health care providers are under increased stress and scrutiny due to changing laws. These laws have impacted hospitals and health care facilities, not just individual providers.

Some hospital systems have revised their policies about what types of services they offer and who can receive those services. As a result, some hospitals that house post-sexual assault care, may now have more restrictive policies and may not be welcoming to trans and nonbinary survivors.

Even the anti-trans legislation that does not pass has a negative impact on public perception and on the quality of life and emotional well-being of transgender communities.

Accompanying the anti-trans initiatives is an increase in sexual assault and other forms of violence against trans/nonbinary individuals and communities. This has included an upsurge in bullying, mis-gendering, forced clothing options, physical assault, dating and intimate partner violence, stalking, doxing, and swatting.

Although no one can easily keep up to date on legislative actions, let alone the more elusive cultural actions, providers can be aware of the substantial impacts anti-trans hate violence has on the patients/survivors they work with. State-sanctioned hate will influence the level of trust someone has, as well as their concerns around disclosure of their trans identity or history.

To learn more about this legislation and the rise in associated anti-trans discrimination and hate violence, these resources are helpful:

- **Erin in the Morning** - https://www.erininthemorning.com/
- **National Center for Transgender Equality** – https://transequality.org/
- **Equality Federation** - https://www.equalityfederation.org/
- **Movement Advancement Project** - https://www.lgbtmap.org/
- **FORGE Resources** (hate violence collections) - https://forge-forward.org/responses-to-hate/

Exam specifics

Trauma-informed, patient-centered services

Many of the needs of trans/nonbinary survivors during an exam can be met through using a trauma-informed approach to providing services.

Initial introductions

All too often, medical providers (SANEs, ED physicians, and others), are so focused on medical care and treatment that they forget the simple act of introducing themselves and creating rapport and trust with their patients.

Introduce yourself, including sharing your role and your pronouns. For example:

“Hi, my name is Cara. I use she/her pronouns. I am the medical provider who is going care for you today. I am also a forensic nurse examiner. That means my role is to both provide you with medical care and, if you would like, to work with you to collect any evidence of the assault from your body. You are in charge of this process and I am here to listen and provide the care you want and need. As we get settled here, I will make sure to explain everything and make sure you feel okay before we move on.”

Ask the survivor what name they would like to be called. For example:
“I ask everyone what name they would like me to call them. I make sure to ask everyone so that you feel respected during this process. What name would you like me to call you? What pronouns would you want me to use? If you have a different legal name that needs to be on your paperwork, we can talk about that later, but I don’t need that now.”

The EVAWI Virtual Practicum has a scenario that of a trans-masculine person. There is an excellent example of an advocate introducing themselves with name and pronouns early in the video.
Sexual Assault Medical Forensic Examination: A Virtual Practicum - https://evawintl.org/vp/

Explaining what you do and why you ask

Due to possible prior negative medical experiences and intrusive (unnecessary) questions, trans people can be more sensitive about the types of questions a provider might ask, fearing discrimination or being skeptical about why a question is being asked.

For example, trans people are often, inappropriately asked about their genitals when seeking care for a cold or broken bone; or might be asked about their transition, when it doesn't relate to the care they are seeking.

Providers who don't commonly work with trans clients may want to reflect on why they would like to ask a question prior to asking the survivor. Sometimes providers are genuinely curious or would like to know specific information, but those questions may be unrelated to the care needed by the client (and will have a high likelihood of being offensive or intrusive).

When posing questions, especially initially, it is important to normalize and contextualize questions. For example, using phrases like "We ask everyone…" and "I'm asking because…." or "your answers will guide what questions I ask down the road."

If you need to ask about someone's medication, including hormones, you could ask: "We ask everyone about their medications, since they may impact the exam, treatment, or medications we might prescribe. Can you share if you are on any medications? This can include prescription, over the

counter medications, hormones, or medications not prescribed by a provider."

Resource
FORGE's "Know and Tell Why" Victim Service Providers' Fact Sheet #4 provides additional helpful examples. https://forge-forward.org/wp-content/uploads/2020/08/FAQ-08-2012-know-tell-why.pdf

Consent at every step

SANEs are aware of the importance of asking for and receiving affirmative consent at every step of an exam. Healthcare providers who may not routinely work with survivors may not recognize the critical importance of asking for and receiving consent – even for actions they might consider minor, or unnecessary to ask about.

Share information with the client about what to expect before asking, touching, or performing any portion of the exam. Some survivors will want detailed information and others will prefer a briefer summary. Checking in with your client and listening to their desired level of detail will help guide the process of how much information share.

For example: "When you are ready, I am going to place my hand on your thigh, near your knee. I'll check in with you before I move my hand to your upper thigh, to check for abrasions. You can ask me to stop at any point. May I place my hand on your thigh?"

After receiving initial consent, it's vital to continue asking for additional consent throughout. Repeating the process of explaining, getting consent, and then proceeding will build trust and increase the ability to receive more care.

Staying focused on survivor's needs

Responding to a survivor's stated needs is essential. Some survivors may not know what options are available to them, when seeking post-assault care. By reviewing the components of what types of care can be provided, it will allow survivors to be able to determine what feels comfortable, safe, and desired.

"I wish that just healthcare providers, or even just the system itself, understood that, at the end of the day, when somebody's coming to you and saying, 'This is my problem,' know that this is the problem... It's not because I'm trans, it's not because I'm poz, it's not because I live in Detroit. It's because I have a problem." - survivor in FORGE listening session

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Some trans and nonbinary survivors may not want to undress – at all – or may want to only have some injuries treated. Some may want prophylactic care, such as emergency contraception, sexually transmitted infection treatment, or HIV post-exposure prophylaxis.

Other trans survivors may seek medical care for cuts or abrasions, while others may need safety planning with an advocate.

By understanding some of the common underlying reasons why trans people might feel uncomfortable or unsafe receiving care, it will better allow providers to stay focused on providing survivor-specific care.

Sample language:
"I hear you that you would only like me to bandage the cut on your arm and provide you with PEP. Is that correct? Let me get the supplies to take care of your arm now."

Pacing and acknowledgement

Seeking a forensic exam or post-assault care is difficult for everyone.
Acknowledge that this process can be difficult. Offer the opportunity for breaks.

For healthcare providers who do not routinely work with survivors:

- Any survivor may have...
- difficulty remembering the exact details of the sexual assault(s),
- describing the assault in a linear fashion, and
- keeping track of new information.
- Survivors might be less able to focus, take in new information, or make decisions.
- These are common responses to traumatic or stressful experiences.

Medical providers can acknowledge changes in cognition and the emotional impact of the assault by demonstrating patience and empathy.

Using patient-centered approaches that respect the unique needs and experiences will also help survivors believe their privacy and safety needs are being acknowledged.

Offering breaks or slowing the pace might be necessary.

Sample language to help provide more space and time:

- *"We've been talking for a while; let's take a short break. Do you need to move around, use the bathroom, or take some deep breaths?"*
- *"Would you like to take a break?"*
- *"Before each step of this exam, I will check with you for your consent. You can skip anything you don't want, and if you aren't sure of something, we can save it for later or try an alternative."*
- *"You can undress to the level of your comfort. Some people undress all the way, some leave on underclothes, some leave on all their clothes."*

Companions

For their safety, many trans people bring another person with them to medical settings. Their companion could be an important emotional support and safety resource. A companion might be a partner, family or origin, family of choice, a community member, a friend, or another loved one.

Because many people are assaulted by people they know, it

is important to keep in mind that the companion may be the assailant or an abusive partner or family member. Taking time to thoughtfully talk to the patient privately can help the provider assess for safety.

Companions

Many survivors of sexual assault go to an exam accompanied by another person. Staff have the important role of assessing the patient's safety and privacy while protecting their right to be accompanied during the exam. All patients should have an opportunity to meet with a medical provider or advocate in private. At this time their safety and the role of the accompanying person can be assessed. This screening resource, by **The Network/La Red**, can be a useful reminder tool about how to screen for possible relationship abuse: *Intimate Partner Abuse Screening Tool For Gay LesbianBisexualand For Gay, Lesbian, Bisexual and Transgender (GLBT) Relationships: A Project of the GLBT Domestic Violence Coalition*, https://nnedv.org/wp-content/uploads/2019/06/screening_tool_LGBTQ.pdf

If the survivor would like their companion to be with them and there is no sign that the person is the abuser or abusive, check in with the survivor about what name, pronoun(s), and other information they are comfortable with the companion knowing. The trans survivor may not use a consistent name and/or pronouns with everyone in their life – this can be especially true with youth, who may have a parent or other adult present.

Disclosing/not disclosing information about gender identity

Some patients will describe themselves as transgender or nonbinary during introductions. Other survivors may never explicitly share information about their gender identity or trans experience. Healthcare providers and advocates can provide appropriate medical care and supportive sexual assault services whether or not they know the words a person uses to describe themselves.

There are many reasons why people may or may not share information related to their gender. See Appendix A: Disclosure for more extensive details.

Providing care, with or without information about trans identity

- Consider what information is actually needed when asking questions.
    - For example, if you need to know if someone may be at risk for pregnancy, the information you need might be asking if they have a uterus.

        "Sexual assault can have many medical impacts. I ask these questions of all my patients so I can provide appropriate care. Do you have a uterus? If so, have you had any procedures or take any medications that will prevent pregnancy?"

    - For example: A patient shares they have pain in their ribcage area. You notice they have a binder on. The information you need is likely about if they are able/willing to allow the binder to be removed vs. why they are wearing a binder.

- Provide information to all people. Include options if you don't know about someone's body.

  "Would you like to discuss medications that can prevent pregnancy?"

  "We can swab the genital area if that was touched in the assault, internally or externally, if you feel comfortable with that.

- Use more general and less gendered language for everyone.

  "The next step is a swabbing of the outer genitals" instead of "the next step is a swabbing the labia."

- Share your name and pronouns. Organizations and healthcare facilities can help normalize this universal practice by printing name badges with the staff members' pronouns. This shows patients that the facility/staff is aware that pronouns are not an assumption.

- "Go with the flow." No survivor's story or body is the same. Providers often encounter things they aren't "expecting" to see or hear. Through listening, reflecting back, and making adjustments in real time, it allows for survivors to feel heard, to share more freely, and to feel acknowledged and validated by the "normalcy" of the provider response and responsiveness.

Body and gender dysphoria: Implications for exams

When a survivor lives with body or gender dysphoria – or both – there can be direct service implications within medical or forensic exam settings. (See Appendix A for more information on dysphoria.)

Survivors with dysphoria may not want or be able to allow others to examine their body or treat their injuries or may only feel comfortable with a certain provider or a certain setting for an exam. As with all survivors, respecting where, how, and when they want to be touched or examined is essential for building respect and trust.

For those with dysphoria, who agree to a forensic sexual assault exam, some extra care may be useful. This may look like

- Having an advocate be present and involved, for example:
  - holding the survivor's hands,
  - maintaining eye contact,
  - helping talk through what will happen,
  - providing distractions
- A health care provider or SANE may help by
  - Asking the survivor how they would most like things to go
    - i.e. if they want someone to talk and explain each step, or not talk, or use specific language (or not use certain words)
  - Maintaining eye contact (or intentionally not make eye contact if that is not comfortable to the patient)
  - Providing options for discussing specific body areas
    - Offer a chart that someone can point to

        - Use the words that people want for an area of the body
    - Providing options for draping
        - Some survivors may not want to remove all their clothing or may want extra draping in some areas
        - Some survivors may want to see what the examiner is doing at all times
- Checking for areas that the survivor does not want touched or examined

Reminders:

- Not all trans/nonbinary people experience gender dysphoria.
- It is our culture that generally stimulates or enhances dysphoria around bodies – be it “general” body dysphoria or gender dysphoria.

It is likely that the majority of the trans and nonbinary survivors who seek medical care following an assault will not want to pursue genital-based evidence collection, contact with law enforcement, or other traditional forensic exam components.

Trans survivors may have had prior negative healthcare experiences, discomfort or dysphoria with specific parts of their body (especially genitals), harmful experiences with law enforcement, or the knowledge that medical/legal systems are often dismissive, abusive, or violent towards trans people.

Some trans survivors may seek services following an assault to:

- Be in a physically safe place for a short time

- Be in a physically safe place for a short time
- Find support for emergency housing or safety
- Receive prophylactic medication and treatment
- Obtain referrals to additional support services of medical care
- Have medical treatment for injuries from the assault that are not genital-based.

As with all survivors seeking post-assault care, focusing on the survivor's specific needs is critical. More time, consent check-ins, and explanation about the process can be useful in building trust and ensuring the survivor receives the care they want and need.

"I use the massage therapist language, like, 'Please undress to the level of your comfort,' because I don't want people to feel like they owe me their whole body. Especially if the assault was only like the upper half or only the lower half, like you don't have to take off your bra. You don't have to take off your binder." - Forensic Nurse at FORGE Listening Session

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Tips

- Have people only undress as needed for the exam
- Provide extra blankets/covering – for example someone who usually binds their chest may be very uncomfortable being unclothed on the top half of their body but need/want that area examined. Providing extra coverage can help them feel more protected.
- If possible, support someone to get dressed as the exam progresses. For example putting a sweatshirt on after an examination of the top half of the body. Taking underwear

- off only when it is time for that portion of an exam and then being able to immediately get redressed.
- With the survivor's consent, explain each step of the exam, what will happen and its purpose. Check with the survivor at each step for consent to continue and to ensure they know they can decline any part of the exam.

Gathering Information for the Exam

Each individual has different levels of comfort talking about their body, their genitals, and harm perpetrated against them. Trans people may have added layers of difficulty and discomfort conveying information about "gendered" parts of their body (e.g. face, chest, genitals).

As with all clients, finding ways of communicating injuries may take a variety of forms – verbal, written, non-verbal, through the use of anatomical dolls or drawings.

If the survivor indicates their genitals were touched or assaulted, it can be helpful to ask what words the survivor uses to describe those body parts. Reflecting their language will help build trust and show respect.

Organ inventory

Some electronic medical records have enabled modules that include organ inventories. While not always available online, some agencies may have paper versions of organ inventories they use when gathering information about a client's medical history.

An organ inventory is quite simply a list of organs (usually reproductive organs) that allows a provider to identify which organs a client may have or not have, if they were removed or altered through surgery or not.

The benefit of an organ inventory is that a person does not need to disclose their gender identity or determine how to share specific information with you that might feel difficult to talk about. Many providers simply bring up the organ inventory on their screen (or clipboard) and go through each item one at a time, allowing the patient to indicate – verbally or through pointing – if they have specific anatomy or not.

This process can ease discussion and allow for conversations that are specific to the patients' medical needs. It can also prompt the provider to bring forward appropriate charting tools, such as gender neutral body maps, organ-specific body maps, etc.

Gender-neutral body maps
Gender-neutral body maps are a useful way to capture injuries in ways that do not presume or reinforce a person's gender. Although some injuries cannot be fully and accurately captured with gender-neutral maps, the majority of areas of the body can be documented in a non-gendered collection tool.

One of the most complete references (printable) of both gender-neutral and body-specific maps is from the State of California, Office of Emergency Services (CAL OES 2-023).

State of California
Office of Emergency Services
(www.oes.ca.gov)

FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS) ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION

CAL OES 2-923

(State of California, n.d.)

Body-specific maps

To fully document genital or anal injuries, a body-specific map will need to be used. The map that best aligns with a trans survivor's body may not be of the gender that they identify. For example, a trans woman may have genitals that include a penis. To accurately chart any abrasions, bruising, or other injuries, a body map that has an image that looks similar to her genitals should be used.

Patients can often see the paperwork or computer screen a provider is using. Prior to bringing the body map into view, explain to the patient that you want to most accurately capture their injuries. Be overt in noting that the charting

tool has no reference to their gender or how you perceive their gender.

This is another opportunity to ask the survivor the language they use for their body, so that you can reflect that language as you chart and verbally interact with the patient.

Sample language:
"I want to accurately chart your injuries. I am going to be using this body map, where I will record where you were hurt. Please know that just because this map is labeled "male" it is not how I see your gender or how I will relate to you. Please let me know if there is specific language that you use to refer to your body so I can also use that language."

Language for body parts

This guide uses a variety of terms for body parts – both clinical and common community language. Many trans/nonbinary people have terms they use for their body but may not feel very comfortable using those in medical settings. Others may not refer to certain body parts at all.

Here are some examples of language health care providers might hear. Use the language that the survivor wants, regardless of the "clinical" language.

Trans people may use words like clit, girldick, T-dick, cock, front hole, vag, bits, genitals, junk; back hole, ass, butt; breasts, chest, or breast tissue. People may also use language that correlates with their affirmed gender,

regardless of the shape of their bodies. For example, a transman may have a body part that is clinically considered a clitoris. The man may refer to that as his penis. A transwoman may have a body part clinically considered a penis and she calls that body part her clitoris.

In addition, health care providers can use language that is not gendered such as pregnant person or person with a prostate. Avoid terms like female-bodied or male-bodied, as there is no one way for a body to be shaped based on gender. More examples can be found in this style guide. *The Radical Copyeditor's Style Guide for Writing About Transgender People*, "https://radicalcopyeditor.com/2017/09/12/update-to-transgender-style-guide-bodies-and-anatomy

Survivor safety considerations and evidence collection

Trans people may use clothes, prosthetics, make-up, accessories, wigs, or other objects to increase their safety and/or affirm their gender. These items can be very important to trans and nonbinary people, and in some cases are expensive or difficult to replace.

When clothes, wigs, binders, packers, or other objects are involved in the assault, medical providers should be thoughtful about how to collect evidence from these items. While it is standard in some locations to collect all clothing that could contain evidence, examiners may want to use other methods to collect evidence from these devices. This can include swabbing materials, combing evidence out of awig, taking photographs of objects or other evidence

collection methods.

Note: Some trans people will not feel comfortable removing items like binders in front of any other person. In these cases, if there is evidence to collect, the patient might be able to self-swab. Keep in mind what is legally required for evidence collection.

Some of the accessories and prosthetics that trans people might use include:

- Wigs
- Clothing or tape for tucking/gaffing (items that help flatten and smoot external genitals through tape or garments)
- Binders (items that help flatten the chest area)
- Breastforms or hip pads (to add curvature)
- Packers/packies (items that create a bulge in the genital area and are sometimes used as stand-to-urinate devices)
- Specific clothing (to accentuate affirmed gender)

Programs should stock items for survivors that will fit a wide range of body sizes and genders. Remember that trans people may often be outside of “standard” sizes for their gender, for example wearing smaller/shorter men’s clothing, or larger/taller women’s clothing. Supplying people with wigs, hats, scarfs or other head coverings as well as providing the option of make-up, shaving accessories, or other grooming supplies for survivors before they leave the exam, can be beneficial not only to a trans/nonbinary person’s comfort but to their safety.

Safety

Most non-trans individuals will not be impacted if they need to be in public without e.g. make-up, or in situation-specific clothing, etc. For many trans people, clothing, accessories and prosthetics are essential in order to move through the world without experiencing anti-trans violence. When trans people are perceived by others as being trans, this can dramatically heighten their risk of physical, sexual, and verbal assaults. Many transgender people dress in specific ways as a safety strategy. Providing appropriate clothing and accessories can be the difference between safety and danger.

Before the exam

Medical considerations for trans-affirming exams

As a reminder, trans/nonbinary people may use a variety of medical interventions to affirm their gender. This can include hormones or surgeries, as well as the use of prosthetics, accessories, binders, tucking/gaffing devices, or other body modifications – which may create exam-specific considerations. (See Appendix A: Key Concepts for more detailed information.)

Not every trans person has the desire or capacity to medically transition from one gender to another. There is no "right" way to be trans, and no "final" or "complete" transition for those who take transition-related actions.

Lower income, limited access to health care/insurance, social

stigma, and many other reasons may also impact the actions people may take to alter their body with hormones and surgery. Unfortunately, many procedures and medications are inaccessible to trans people, so not everyone will be able to access the resources they need.

Trans and nonbinary people may use hormones, or not; may have surgery/surgeries, or not. For more information about hormones and surgery, please see the University of San Francisco (UCSF), Prevention Science Department of Medicine's Center of Excellence for Transgender Health (UCSF, n.d.).

It is common for people to have both breasts and a penis, or a flat chest and a vagina. It is normal for people to have hairy or smooth skin. Health care providers and advocates can provide affirming care by treating all bodies and their various configurations with respect.

Targeted Violence: Trans-specific targeting by offender

Many trans people report that sexual assaults are in part related to their gender identity or expression (FORGE, 2005). Offenders may specifically target "gendered" parts of a person's body during an assault – such as their face, chest, or genitals.

Some offenders will use anti-trans slurs, engage in extreme physical violence, graffiti property or write on/cut on their bodies, or other additional forms of anti-trans-focused violence.

Anti-trans assaulters will often blame the victim for the attack by stating it's their fault for being trans. Some perpetrators will tell their trans victims that they are making them a "real man" or "real woman" by having sexual contact with them.

These messages can have a huge emotional impact on trans survivors, in addition to the harm caused by the sexual assault itself.

Documenting trans-specific targeting is vital if the survivor plans to pursue criminal or legal action. Even though most attorneys don't escalate cases to include a hate-crimes enhancement, medical charting of hate-motivated behaviors may influence the legal outcome and enhance possible penalties.

Types of assaults: Trans-specific additional layers of physical and emotional pain

Sexual assault has nothing to do with the types of consensual sexual interactions a person might typically engage in. Physical and emotional pain from an assault has no bearing on if a person would otherwise consent to a specific type of sexual behavior.

Some trans people have areas of their bodies they are uncomfortable having anyone touch, for any reason. These areas might heighten their feelings of dysphoria or might be physically or emotionally painful to have touched (or looked at).

For people who have added layers of physical or emotional sensitivities, some forms of assault may be particularly painful. It may also mean that treatment or discussion about treatment or examination may also be more difficult – physically or emotionally.

For example, some trans men, trans-masculine people, or nonbinary people who were assigned female at birth, may not engage in any contact (consensual) with their vagina/front hole. The reasons may be due to gender dysphoria about that part of their body, increased pain due to lack of use or from testosterone-enhanced atrophy, or any number of reasons. Assault on this part of their body may cause extreme physical pain, as well as added layers of emotional pain beyond “just” being sexually assaulted.

Another example might be a trans woman who views her external (not-surgically altered) genitals as so emotionally uncomfortable that she doesn’t look at them in the mirror, or touch her genitals even during urination, etc. If an assault involves the offender touching her genitals, especially if she experiences an erection, the unwanted physiological response can be confusing, upsetting, and may undermine her feelings of womanhood

Reminder:

It’s critical to keep in mind that every person may have unique relationships to each part of their body. Some people will engage in consensual sex using their genitals, whether or not they have had surgery or want surgery in the future.

Some people will never or rarely engage in these types of sexual activity. How someone has consensual sex, what they think of their body, and what words they use for their body do not make them more or less of a man, a woman, transgender, or nonbinary.

Conducting Exams

When moving from interview and dialogue to a physical exam, providers should continue to use trauma-informed practices. This includes being sure to:

- Always ask for consent at each stage of the exam
- Use neutral language about bodies or reflect the language of the survivor

All humans have unique bodies. Transgender people may have had medical or surgical procedures that changed their bodies. A critical aspect of providing appropriate medical care is to ensure that the health care provider's reaction to an individual's body is neutral rather than stigmatizing.

Unfortunately, many trans people report that health care providers have responded to their bodies with visible shock or surprise.

Many SAFEs are practiced in responding with neutral body language and facial expressions, as they frequently see unsettling injuries, current or prior scars, medical assistive devices, or other bodily features that may not be anticipated. Maintaining this same demeanor even if surprised by the

shape or structure of someone's body is an important way to show respect.

Head and Face

For all people, injuries to the head or face can be upsetting. Assaults frequently involve harm to the head or throat (as a result of strangulation, or other types of injury). Facial injuries can make public an assault that happened, creating additional privacy and safety concerns for survivors after they leave medical care.

Faces are very visible to others, and they are one of the primary ways that many people express themselves – both in appearance and in communication/facial expressions. Head injuries can be scary, due to the possibility of excessive bleeding, loss of consciousness, concussions, or traumatic brain injury.

For trans people, facial injuries can be especially concerning. Faces are often perceived to be gendered, so trans people may take a lot of care in how their face appears to others. This could be through the use of hormones, makeup, jewelry, facial hair or lack thereof, silicone injections, facial surgeries, control of body hair (shaving, electrolysis), wigs, hair style, hair coverings, or hats. The ability to present one's face and head in a particular way can be crucial to a trans person's safety.

Implications for exams:

<u>Wigs, head coverings, jewelry and other removable objects:</u>

Some trans women and femmes will be very hesitant or

resistant to leave items like wigs that might contain evidence. Wigs can be a primary way for a person to present as female, aligning their gender identity with expression, and providing safety in the world.

Consider evidence collection through cutting a small amount of hair from the wig or using a swab or other type of collection method. Provide the option of having the person keep their wig on throughout this collection process, if desired.

Electrolysis

Electrolysis is common, especially for trans women and femmes. You may notice facial redness or bumps if there has been a recent electrolysis treatment.

Silicone (facial area)

Lips and cheeks are common locations for silicone injections. Silicone may be dislodged if the area it is in is injured.

If dislodged, it can cause disfigurement – which can pose immediate and long term appearance-related safety risks, as well as challenges for making alterations to return the appearance to its original form. Dislodged silicone can also pose serious short- and long-term health risks.

When possible, a consult with a plastic surgeon is advised.

Injected silicone use is common, especially within populations of trans women. Between 16.7% (Wilson et al., 2014) and 50% of trans women have had a silicone injected (Zevin & Deutsch, 2016). Silicone filler injections can provide an immediate body shape change that can help relieve gender dysphoria. Silicone is often pursued when other options for changing body shape are not available or affordable.

Common areas where silicone is injected include, lips, cheeks, breasts, and hips, particularly for trans women/trans-feminine people. Trans men/trans-masculine people are more likely to use silicone to enhance their genital size and shape, as well as to fill in the chest area if surgery results in a concave chest.

Silicone can be dislodged fairly easily, resulting in both “disfigurement” (unwanted aesthetic placement) and increasing long-term health consequences. Silicone injections carry substantial short and long-term health risks, including infection, inflammation, auto-immune conditions, organ systems failure, and even death.

<u>Facial injuries:</u>

When providing care instructions for facial injuries, take into consideration if the survivor may be shaving or covering the area with make-up. It may not be emotionally or physically safe for a trans woman/trans-feminine person to be out in the world without make-up. Providing information on how to care for the injury and continue to engage in gender-

affirming practices is important. This may need to be a case where harm reduction approaches are practiced, since it might be medically advised to, for example, keep the injured area clean and uncovered to physically heal faster (no makeup or shaving), but this may not be practical or safe for the survivor.

Chest Area

Some trans-masculine, trans-feminine, and other trans folks feel uncomfortable undressing or having anyone see their chest. This awareness will help providers find creative ways of providing care if injury or evidence collection is needed in this area.

Ask the survivor what language they use for this area of their body. Reflecting the client's language is ideal. When in doubt, using more gender-neutral language like "chest" can be more universally inclusive than words like "breasts."

Binding:

Some trans/nonbinary people bind. This means that they use something to flatten the chest area. Binders that are made specifically to flatten the chest are the safest to use, but due to their cost, many individuals find other ways to bind.

Binders are items that help flatten the chest area.

Types of binders:

- Binders/items specifically designed to flatten the chest (half or full length, t-shirt, vest, Velcro or zipper)
- Compression vests
- Athletic compression shirts
- Tight t-shirts (single or multiple)
- Tight or multiple sports bras or tank tops
- Waist compression, “trimmers,” abdominal support
- Back support wraps
- Elastic bandages wrapped around the chest
- Tape (directly on skin or over garments)
- Other “home made” devices

People who bind may have bruising on the chest, back, shoulders, armpits, or belly from the tightness or friction of the binding device. They may also have pinpricks or scratches if they use safety pins to secure the binding, or if the binder has hook or Velcro closure.

Offenders may cut off or cause harm to the chest area or binder. This may or may not be related to anti-trans intentions. If the chest was targeted in the assault, this should be documented on body maps and in narrative text.

Resource

If you can support survivors in replacing their clothes, including binders, this website has a long list of buying options of different types of binders.

A Binding Guide for All Genders and Gender Expressions, https://translifeline.org/binding-guide/

Implications for exams:

The chest tissue may have marks or scars from binding. Determine which injuries are new and which are not (e.g. from long-term binder use or from the assault).

If possible, do not damage, destroy, or collect a binder for evidence without providing a replacement (prior to leaving the medical office). Binders are expensive.

Survivors may be reluctant to show their chest area, if it is not affirming to their gender. They may also be hesitant to reveal places with injuries from binding or other self-inflicted injuries. Being objective and compassionate about what you see is critical.

Ensure people are able to leave the exam with their chest covered in a way that feels right – and safe – for them. Not having an effective binder for those who need one, can pose serious safety risks.

Tip

People bind out of necessity. Trans people are frequently told they are causing harm to their bodies through behaviors such as binding. If you are concerned about physical damage that a binder might be causing your patient, there are gentle, harm-reduction-oriented approaches to having a discussion. However, when a survivor is receiving post-assault care is not the time to bring up these concerns.

Top Surgery (chest reduction)

There are many types of “top surgery” – surgical reconstruction of the chest to create a reduced chest size or a flatter chest. This is most commonly performed on trans

men/trans masculine individuals, as well as nonbinary people who find a flatter chest to be more affirming.

A person who has had top surgery may have a variety of types of scars, ranging from almost unnoticeable, to scars that span the length of the chest and possibly around to the back.

As with any scar, medical staff and advocates should not react in surprise or disgust or ask questions that are unrelated to the services the survivor is seeking.

Top surgery itself will have few implications for post-assault care, unless the surgery is very recent and scars have reopened.

Remember that offenders may target the chest area of trans people, which could include physical assault of the chest. In addition to the physical implications, anti-trans damage to the chest may be emotionally significant and may require providers to be exceptionally sensitive when discussing or examining this area.

Types and components of top surgery:

- Double incision mastectomy
- Keyhole or periareolar incision/removal
- Fishmouth incision
- Full and partial tissue removal
- Maintaining nipples through grafts
- Nipple preserving techniques

- Removing nipples
- Liposuction to reduce chest size/volume, without recontouring
- Liposuction techniques to masculinize chest-adjacent areas (e.g. under arms, flanks, back/sides)

Breast augmentation surgery

Breast augmentation is a common surgical procedure to enhance existing breast tissue or create breasts from a flat chest. There are many forms of breast augmentation, which may include minimal or substantial scarring. There is a range of size and composition of implants.

For trans women and trans-feminine individuals, this may be a first or only surgery they pursue.

<u>Implications for exams:</u>
Although uncommon, implants might be dislodged or damaged if there is substantial physical assault to the chest area.

Some people may also have non-surgically injected silicone in addition to having had medical breast augmentation surgery. See silicone section for more information.

Body/chest hair

Since not everyone wants top surgery or can afford it, it is not uncommon to see a trans-masculine person who has breast tissue and body hair covering their chest.

Similarly, some trans-feminine people have body hair before starting on estrogen or spironolactone (or other feminizing medications). It is not uncommon to see breasts and body hair covering their chests, too.

This will have no exam implications, medically, but is something to be aware of and not be surprised by.

Some trans people may feel shame or stigma related to the shape of their chests and if they do/don't have body hair.

Electrolysis

The removal of body and facial hair is common, especially for trans women and femmes. If a person is having electrolysis on their chest, there can be redness and raised skin/bumps.

Electrolysis is also common for people who are preparing for some types of trans-affirming surgery, such as phalloplasty. The forearm and thigh are common areas for hair removal for these surgeries.

Silicone (chest area)

Silicone may be present in surgically placed breast implants or from silicone injections.

It is unlikely for there to be damage to breast augmentation/implants that are placed by a surgeon. Some people may have encased liquid silicone, which is less common than it used to be. Most implants are soft silicone or other materials that are not subject to leaking and are difficult to damage.

Individuals who cannot afford or do not want to have augmentation surgery may inject silicone into their chest area to create breasts. Injected silicone can be easily dislodged if struck or the area is handled roughly. Injected silicone breasts are often uneven or may be placed on the chest asymmetrically.

Dislodged injected silicone can cause undesired appearance ("disfigurement") and serious health implications. (See head/face section for more details about silicone.)

When possible, a consultation with a plastic surgeon is advised.

Genital Area

Every person's genitals are different. This is true for trans and non-trans people.

Sexual violence can involve genitals in many different ways, including penetration or being forced to penetrate someone else, manual or oral contact (active or receptive/receiving), other forms of touch, or verbal comments about a person's genitals.

When proceeding to this area of the exam, it is good practice to ask – or ask again – what language the survivor uses to talk about their genitals.

Genitals can be affected by hormones and surgeries. Trans and nonbinary people have many different genital configurations, sizes, and shapes. Many trans people may be

hesitant, untrusting, or concerned about genital exams due to prior negative medical experiences, stigma, shame, or dysphoria.

Make sure to believe everyone about their experiences, take time to listen and approach survivors in ways that encourage sharing.

Hormones – changes in body and exam process

Not every trans person is able to access hormone therapy through a licensed medical professional. This is due largely to the prohibitive costs of healthcare in the United States and the numerous state regulations that make it harder to access this necessary care. People who access hormones through other means – unlicensed providers, sharing with friends, etc. – may or may not be receiving reliable dosages, and may not have consistent access to medications.

There are several different types of hormones that trans/nonbinary people may take. The decision of which hormones and which doses are best for a person is a discussion that should happen with their primary medical provider/clinic based on the person's unique goals with taking the medication, their health status, and on their body's response to it. The information below is a quick overview of the most common gender-affirming medications.

Taking hormones typically results in a "second puberty." During the early months or years of using hormones, a person may experience many of the body changes and mood changes commonly associated with puberty.

Testosterone

Testosterone is administered via intramuscular injection, topical gel, compounded cream, patches, or implantable long-acting pellets. People assigned female at birth – both trans men and nonbinary people – may choose to take testosterone.

People who cannot access testosterone through a medical provider may access prescription testosterone through friends, which can lead to irregular and inconsistent dosages. Others may use steroids, either store-bought or unregulated steroids. Some use supplements to boost testosterone production.

Common effects of testosterone include:

- Facial and body hair growth
- Enlarged clitoris
- Acne
- Hair loss
- Vaginal atrophy
- Decreased vaginal elasticity and increased tissue fragility
- Changes in weight/body fat distribution
- Cessation of bleeding/menstruation

Some people assigned female at birth, who are or are not on testosterone, may use an estrogen cream to help with vaginal dryness and to increase tissue elasticity. Estrogen creams do not diminish the effectiveness of testosterone.

If a patient needs emergency contraceptives, there is no contraindication or loss of efficacy when also taking

testosterone.

Implications for exams:

- Some people may not want any contact with their genitals.
- Vaginal tissue is often more fragile and less elastic. As a result, if this area was penetrated or touched during the assault, it may have more substantial tissue damage and pain.
- Examination of the vaginal area may require the use of a smaller speculum. Speculum exams may not be possible due to pain or dysphoria.
- When possible, find ways of collecting evidence that does not involve the use of a speculum.
- Self-collection/self-swabbing can be a viable option for collecting evidence.
- Pregnancy is still possible if the person has a uterus, even if they are on testosterone.

Estrogen, Progesterone, Spironolactone

Most of these medications are taken by people who are trans women, trans feminine, or nonbinary who are assigned male at birth. As with testosterone, people who cannot access these medications through a medical provider, may access prescriptions through friends, which can lead to irregular and inconsistent dosages.

Estrogen is administered by pill, injection, or topical application (commonly a transdermal patch or compounded cream or gel).

There are substantial health risks for those who smoke and use estrogens, including blood clots, pulmonary embolisms, strokes, and heart attacks. There is some evidence that risks are higher when using oral delivery routes vs. transdermal patches. When possible, people should try to reduce or stop smoking before beginning estrogen therapy.

Progesterone is most often delivered orally but is also available via injection. Many physicians are no longer including progesterone in combination with estrogen since it does not have substantial feminizing benefits. For those who are unable to take estrogen, progesterone and/or spironolactone may be viable options.

Spironolactone is one of the most common anti-androgens available. It has multiple uses; and other anti-androgens are available. If a person has an orchiectomy (removal of the testes), this medication is often no longer needed.

Alternatives. People who cannot obtain these medications through a medical professional may use prescription medications from a friend or use unregulated medications obtained by other means. Some people use high doses of birth control, which might be more easily obtained through friends.

<u>Common effects of estrogen, anti-androgens, or progesterone.</u>

- Changes in skin tone and texture – less oily, possibly drier and thinner
- Breast growth

- Weight redistribution, resulting in more traditionally “feminine” curves (hips and thighs)
- Decrease in muscle mass and strength
- Thinning of body hair, and slower hair growth
- Reduction in sweating
- Sometimes changes in genital size and sexual function/lower libido
- NO changes in voice pitch or quality
- NO changes in facial hair growth

Implications for exams:

- Changes in skin texture can affect bruising and how easily the skin can be cut/damaged
- The chest/breast area may be more sensitive to pain in early states of estrogen use, and if that area is harmed in the assault
- The skin of external genitals may also be more sensitive

Self-reporting of medications:

Some trans people will not list hormones when asked about the medications they are on. This happens for any number of reasons, including, but not limited to:

- They do not want to provide information that might disclose their identity
- They do not want to disclose the medication, especially if it is acquired or used in an off-label manner
- They genuinely forget. Many people who have been on hormones for a long time may have become so used to taking it that it doesn’t occur to them to list as a medication.

- They don’t think of it due to the trauma or stress of the situation

Surgery (genital) – changes in body and exam process

There are many types of gender-affirming surgeries. The Cleveland Clinic has a useful summary of many types of surgeries trans people might pursue.
Gender Affirmation Surgery, https://my.clevelandclinic.org/health/treatments/21526-gender-affirmation-confirmation-or-sex-reassignment-surgery

Trans/nonbinary people may have had facial surgery, chest surgery, or genital surgery (often called bottom surgery). (See Appendix A: Key Concepts – Gender affirming actions for more details) Each type of surgery can result in different possible scarring or tissue changes.

There is a wide range of surgical procedures and outcomes for those who do have surgery. Types of genital/reproductive surgery:

- Orchiectomy
- Vaginoplasty
- Zero Depth Vaginoplasty
- Vulvoplasty
- Labiaplasty
- Hysterectomy/Oopherectomy
- Phalloplasty
- Metaoidioplasty
- Testicular implants

- Urethral extension
- Vaginectomy

Gender-affirming surgeries are expensive and not easily available to many people. They may not be covered by insurance, there are not many providers, and the time for recovery may not be something that everyone can manage. Not everyone wants surgery, even if it is affordable and available.

Reminders about genital surgery:

- Genital surgery is not the goal for every trans/nonbinary person.
- Some people are happy with the genitals they were born with.
- Some people feel a disconnect or mis-alignment with their genitals.
- Not everyone who wants/needs to change their genitals through hormones or surgery is able to – mostly due to lack of access to affordable healthcare.

Many trans/nonbinary people who have had surgery may not list gender-affirming surgeries when asked about previous surgeries. This is for a number of reasons, including, but not limited to:

- Fear of harassment or harm from disclosure
- Not considering this type of surgery as a medical procedure that qualifies as surgery
- Not thinking about it – many trans affirming medical procedures feel different than other types of medical

procedures. When asked about surgery many people's minds go to things like emergency surgery.

- The stress or trauma of just being sexually assaulted can impact someone's ability to remember information or to process information

Trans women/femmes and vaginal exams (if needed/appropriate)

Surgically constructed vagina

Surgically constructed vaginas are less resilient/elastic than non-surgically created vaginas. The tissue is not as elastic and generally the vaginal canal is less deep. This leads to an increased likelihood of tearing and damage during an assault (if there is vaginal penetration). The skin may be more fragile if the survivor uses estrogen. The vaginal walls are likely to be thinner and more easily perforated – increasing the risk of injury and contracting sexually transmitted infections.

An increasing number of trans women, trans-feminine people, and nonbinary assigned male at birth or AMAB individuals are opting for

zero-depth vaginoplasty (also known as limited- or minimal-depth vaginoplasty, or vulvoplasty). For these patients, there will be no vaginal canal or opening. Some may have a "dimple" indentation where the vagina would typically be located. The vulva, labia, clitoris, urethra, will all be constructed to appear similar to many non-trans women's genitals.

Further, injuries to the vaginal area can cause added

emotional harm to the survivor.

Due to the small number of surgeons who provide gender-affirming surgeries, it is unlikely that the original surgeon will be nearby or available for consultation if there are vaginal injuries requiring surgical interventions.

Implications for exams:

- Some people who have vaginoplasty may or may not have had labiaplasty. There are no overt exam implications related to if a person has had labiaplasty, but providers should be aware of this physical configuration.
- For those who have had zero-depth vaginoplasty, there may have been attempts to penetrate. If so, there may be more extensive physical damage.
- When there has been damage to genitals that have been surgically constructed, survivors may have concerns about how they will pay for any needed medical intervention and if the assault has damaged the money they spent on surgery.
- Speculum-based exams on a person who has had vaginoplasty may be more difficult, painful, or not possible at all, due to non-elasticity. Similarly, if a person doesn't dilate regularly, or have consensual penetrative sex regularly, the vaginal canal could be extremely narrow.
- Consider using swabs or other modes of evidence collection if speculum insertion is not possible.
    - Self-swabbing/-collecting is an option that may be more physically and emotionally comfortable for some patients. (See self-collection section.)

General tips for trans women and genital/vaginal exams

- If speculum exams are necessary, use the smallest speculum possible.
- If possible, use swabs for evidence collection instead of a speculum and swab.
- Check in with the survivor about their pain or comfort levels.
    - For example: “I can stop at any time. All you have to do is say stop or no. If it hurts, you can tell me or make any noise you want. I will check with you if you’d like me to continue. I will also do my best to adjust what I am doing to make it less uncomfortable.”
- Advocates can play an essential role in making genital exams less painful emotionally and physically.
- Advocate for insurance or crime victims comp to cover any reconstructive surgery if this area is damaged during the assault.
- Connect with local surgeons and consulting physicians ahead of time to determine who is most familiar with trans-affirming surgeries – this may be gynecology, urology, or plastic surgeons.

Trans men/masculine and exams (if needed/appropriate)

Lower surgery (phallus-focused) and exams implications

Trans men and masculine people may have had genital surgeries. (See the surgery section under genital exams or Appendix A for more information.)

For those who have had metaoidioplasty, phalloplasty, testicular implants, there will likely be minimal exam

implications. A provider may notice surgical scars from phalloplasty graft sites (on the forearm, thigh, or abdomen). The tissue of phalloplasty will look different from native penile tissue, since the skin is sourced from non-native genital skin. The urethra may or may not be extended through the metaoidioplasty or the phalloplasty. If not extended, the urethra will be located beneath the constructed genitals, in their original location. Some people may choose metaoidioplasty or phalloplasty with or without testicular implants.

Testicular implants are placed in the labia majora. Frequently, the skin is stretched with tissue expanders in order to accommodate implants. In general, the visual appearance will be testicles placed “higher” than average and might be closer together. If the urethra will either remain in the original position or be routed through the metaoidioplasty or phalloplasty.

People may opt for only testicular implants without other genital surgery(ies) or extension-oriented surgeries without testicular implants.

Some people will retain their vagina, uterus, ovaries, while others will have surgery to remove those organs.

There are few exam implications related to these surgical procedures. The visual appearance of these surgeries may be new to the provider, so not acting surprised is the primary task of the provider.

Implications for exams:

- It would be rare, but some testicular implants may be dislodged if they were struck or targeted during an assault.
- If the patient still has a uterus and ovaries, and if there was vaginal penetration by a penis, a discussion about pregnancy is needed. (See pregnancy section.)
- Some patients who have had phalloplasty may have a prosthetic erectile device. These can be easily damaged, including breaking through the skin (erosion), or damaging the bladder or rectum. In most cases, if there is damage, the prosthetic will need to be surgically removed.
- Urethral strictures are common with both phalloplasty and metaoidioplasty surgeries that have had urethral extensions. This may not pose any direct exam risks, but some patients may be more prone to urinary tract infections, or damage to the genitals that increases the likelihood of a stricture.
- Some patients may feel stigma or shame around their graft sites (forearm, thigh, belly), since they are usually quite prominent. Some people prefer to keep those areas covered due to the intensity of the scarring.
- If the survivor has had gender-affirming surgery, they may need additional consultations if there is damage to the area that has had surgery. SANEs can develop partnerships with plastic surgeons, urologists, and other specialists to be on-call to assist with more severe injuries.

Lower surgery (reproductive organ-focused) and exams implications

Some trans men/masculine individuals and nonbinary people assigned female at birth may have a hysterectomy, oophorectomy, and/or vaginectomy. These surgeries may be for gender affirmation or for non-trans-related medical conditions.

Most healthcare providers are aware of the implications and ramifications of hysterectomies and oophorectomies or ovary removal surgery. The biggest exam implication for post-assault exams in trans masculine people who have had these surgeries is the lack of need for emergency contraception or pregnancy testing.

Providers may be less familiar with vaginectomies (the "removal" or closure of the vagina). Prior to this surgery, all reproductive organs must be removed, so someone with a vaginectomy will obviously not be able to become pregnant. This type of surgery poses minimal exam implications, other than a provider not being accustomed to seeing this genital configuration.

Implications for exams:

- As with anyone who has their ovaries removed, there is a decrease in estrogen levels. This may cause the lining of the vagina to thin and become less elastic. If this person is also on testosterone, vaginal atrophy might be significant.

- With some vaginectomies, there is only partial closure. If there is still a slight vaginal opening, penetration might still be possible. Due to limited depth (and likely minimal width), there could be extensive physical damage if the assault was penetrative.
- Some trans people who have had a complete hysterectomy may have the belief that no one will ever need to examine that part of their body again. Seeking post-assault care, when this part of their body might be examined, may bring up intense emotions and a sense of defeat.

Vaginal exams

People who take testosterone may have more fragile, less elastic, or drier vaginal tissue. This can result in increased injury during the assault (or during an exam) and pain when anything is inserted in the vagina. [Remember, not all trans men/masculine people take testosterone.]

As noted throughout the guide, many trans men/masculine people may not be comfortable physically or emotionally with others examining this part of their body. Due to the physical changes of the vaginal area – either from testosterone, reduced estrogen levels, or lack of consensual contact – exams might be extremely painful.

Speculum-based exams may not be physically possible with some trans men/trans-masculine individuals. Internal or external swabbing might be viable options to collect evidence.

Implications for exams:

- If speculums are needed, use the smallest possible size.
- Consider swabbing or other forms of evidence collection if speculum exams are not feasible.
- Stirrup positions may be associated with “female” exams. Work with the patient to find a position that will still allow the provider adequate access and be more emotionally comfortable to the patient. (For example, feet flat on the exam table, with knees bent.)
- If a patient has had phalloplasty, metaoidioplasty, and/or testicular implants, they may still have a vagina. Access may be more difficult due to the other genitals above the vaginal opening.
- If the patient has had a vaginectomy – it may be partial or more complete. For these patients, a vaginal exam won’t be possible. However, the offender may have attempted to penetrate; there could be external damage to the area.
- If a vaginal, speculum, exam is required, it might be necessary to offer medication to the patient, including anti-anxiety drugs, pain medication, or even twilight anesthesia.

Self-swabbing/collection

Some trans/nonbinary people may be more comfortable collecting samples rather than having someone else see or touch them. When possible, offer the option for survivors to self-swab, with the provider’s guidance and oversight.

Carefully describe the process to survivors, using the body language that they prefer. The SANE may use gestures to show what the process is like or point to a gender-neutral

body map to demonstrate specific areas of the body. Be sure to communicate clearly, provide simple, direct instructions, and check for understanding.

Implications for exam:

- Self-swabbing or self-evidence collection may not be legally allowable in some areas. Be familiar with local and state laws and policies, as well as the healthcare institution's policies and practices.
- The healthcare provider will need to remain in the exam room during self-collection to maintain evidence integrity.

Self-swab procedure guide

Hologic has created simple, visual and text-based instruction sheets for collection of swab specimens by patients. This PDF includes guides – for both clinicians and patients – on multiple forms of swabbing. These products may not be what is needed for collection, but the guides are useful to help illustrate how a patient can collect. Aptima® Multitest Swab Specimen Collection Kit: Clinician Collection Procedure Guide, https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Lab_Services/Hologic%20Collection%20Devices.pdf

(General) Tips for working with trans men/masculine individuals and genital exams:

- If speculum exams are necessary, use the smallest speculum possible.
- If possible to only use swabs for evidence collection, do so.

- Check in with the survivor about their pain or comfort levels.
    - For example: “I can stop at any time. All you have to do is say stop or no. If it hurts, you can tell me or make any noise you want. I will check with you if you’d like me to continue. I will also do my best to adjust what I am doing to make it less uncomfortable.”
- Advocates can play an essential role in making genital exams less painful emotionally and physically.

Pregnancy concerns and prevention (if needed/appropriate)

People who have a uterus and ovaries may be able to get pregnant, even if they do not regularly menstruate/bleed. Testosterone generally stops menstruation after several months of use but is not a guaranteed pregnancy prevention medication.

If a survivor has not had other procedures (e.g. hysterectomy, oophorectomy) or medications (e.g. birth control) that prevent pregnancy, and the sexual assault was such that semen may have entered the survivor’s vagina or vaginal opening, the SANE or medical advocate should discuss pregnancy prevention options.

This discussion of pregnancy can be potentially very traumatizing for the survivor. Many trans men believe that pregnancy is not possible if they are on testosterone. They may not believe a provider who brings up the subject of pregnancy, since there is such an in-community belief that pregnancy cannot happen. (Even some health care providers

believe that pregnancy is not possible.)

Since this is such a potentially sensitive subject, it can be useful to build trust and establish positive rapport with the survivor before broaching this subject.

> *One way you can start this conversation could be:*
>
> *"Based on how you've described the assault, it is possible that you could become pregnant, even if you have not menstruated/bled in a long time. We can provide pregnancy prevention options. Would you like me to share more information about those with you?"*

Emergency contraceptive medications are not contraindicated with testosterone (Miriam, 2023). Emergency contraceptive medications may induce bleeding. It can be helpful to discuss this with the survivor as part of emotionally planning for that, since bleeding may be a potent trigger (both related to the assault, as well as to their gender).

> *One way to bring up this topic is by saying:*
>
> *"This medication works by preventing ovulation. For some people this may result in bleeding, like when someone has their period. This may mean that you experience some bleeding. Usually, bleeding is fairly light. How do you feel about that?"*

SANEs may need to provide education on what emergency contraception is – it is a one-time dose of hormones and does not counter the effects of testosterone. It's not the same as going on birth control. However, do not assume the survivor has a lack of knowledge or extensive knowledge on this issue.

All survivors have the right to choose for themselves what pregnancy prevention options they want, including none. Some trans men, nonbinary people, and trans masculine people do want to become pregnant at some point in their lives. They may have questions about how the assault and/or any medications they take could impact their ability to get and stay pregnant in the future. As with any other survivor, it is important to not make assumptions about their desires related to pregnancy and childbirth. It is also important to know that trans/nonbinary survivors may already be pregnant.

Emergency contraception

When prescribing emergency contraception, refer to it as emergency contraception or levonorgestrel vs. "Plan B" – which has overt implications that their initial plan would have been to use another form of contraception. With an assault, there was no "Plan A" or "B." Although at the time of this publication, the medication (levonorgestrel) in "Plan B: One Step" (using the brand name here, not the concept of a back up plan), this may not be easily available at many pharmacies, even though it is an over-the-counter medication. In some locations, emergency contraception is kept behind the counter at pharmacies, so interaction with a

pharmacist is still necessary, which may pose access challenges.

There are some prescribing considerations related to the levonorgestrel (Plan B) and ulipristal (Ella), in terms of their effectiveness due to body size and other factors. Take the patient's full medical history into consideration, as well as their body size, before prescribing one of these medications.

When possible, provide the emergency contraception to the survivor at the time of the exam rather than sending them elsewhere for it.

Prophylactics/Medications

Many trans/nonbinary survivors may have limited access to follow-up and continuous healthcare. For this reason, SANEs should assist as much as possible with providing medications at the survivor's initial visit and help to decrease barriers to any needed follow-up care. The cost of prescription medication can be prohibitive for many people. Others may not feel comfortable going to a pharmacy. Accessing a pharmacy can be difficult for some people if they are concerned needing to provide identification (which may not match the gender they are living in) or picking up a medication that is "gendered" (and the pharmacist questioning the person and medication).

Providers can also be aware when prescribing medications that are
dosed differently based on "sex." Rather than rely on the sex listed on a person's identification, consider why the

medication is dosed differently. Is it about weight? Does it interact with testosterone or estrogen? This can help create accurate prescriptions.

Genital creams for yeast

When prescribing genital creams, use the drug name or the term genital cream. For example, if writing a prescription for possible ‘vaginal’ yeast infection, writing the script for Clotrimazole vs. Clotrimazol Vaginal Cream will make it easier and more possible that the patient will not experience difficulties acquiring this medication at the pharmacy.

Providers need to consult with prescribing requirements, but a possible prescription direction could read: “Apply to the affected area x times per day” (vs. naming a specific body part).

Other genital creams or suppositories

For people who have experienced physical trauma to their vagina, they may benefit from an estrogen-based cream. Like when prescribing a yeast medication, it is important for the prescription text to be general enough to not cause inadvertent disclosure of someone’s trans identity/history, but specific enough for the prescription directions to be understandable. Both trans people with surgically constructed vaginas and individuals who have always had a vagina may benefit from the soothing effects from estrogen creams/suppositories.

Providers can remind trans men/trans-masculine people that estrogen creams or suppositories will not counteract the

effects of testosterone, if they are using androgen-based therapies. Trans man/masculine people may prefer creams to suppositories due to possible dysphoria of inserting a suppository into their vagina.

Other medications for genital pain

As discussed throughout this guide, trans people may have especially fragile genital skin that is easily damaged. Topical pain medications can be helpful in these cases. Although some trans people may not want to apply medications to their genitals – not wanting to physically touch their genitals – some may benefit from a reduction in the physical pain. When prescribing, use specific enough language, but not gendered language. For example, “apply to the affected area” versus apply to the labia.

Sexually transmitted infections

Due to the increased likelihood of genital tears resulting from hormones or surgery, there can be increased risks of sexually transmitted infections. As with other non-trans patients, proactive treatment options should be discussed.

HIV

Although HIV can be a risk for any person who has been sexually assaulted, some portions of the trans community may be at LOWER risk of contracting HIV.

PrEP (Pre-Exposure Prophylaxis) has been marketed heavily towards men who have sex with men (typically cisgender men) and to trans women who have sex with non-trans men. Trans women may have more information about PrEP and

PEP (Post-Exposure Prophylaxis) and may be more likely to already be on PrEP or have a primary care physician who will prescribe PEP after a possible exposure.

Trans men, trans-masculine individuals, and nonbinary people of all gender vectors may have less information about Pre- or Post-exposure medications and options.

Tips for providing and discussing medications:

- Provide medications at visit whenever possible, so trans survivors won't need to access a pharmacy, where they may experience discrimination, misgendering, or added trauma.
- Provide medication coupons for prescriptions that must be filled at pharmacies.
- Use gender neutral language on prescription instructions when possible (e.g. "apply to the affected area").
- In addition to providing in-person referrals to health care providers for follow up, also offer referrals to telehealth providers who can work with patients by phone, including prescribing medication refills.
- For survivors in abusive relationships, it may not be safe to have medications in their home or to use their insurance to get medications. SANEs or medical advocates can safety plan with survivors to help increase their access to care.
- Provide at home testing kits/self-testing if safe to do so. Home test kits might be available for pregnancy, STIs, and HIV. Home testing may reduce the barrier of needing transportation or safety concerns of being in public settings to get to appointments.

Other physical exam trans-specific considerations

There are a number of other considerations that SANEs will want to be aware of that could impact caring for trans/nonbinary survivors.

Trans/nonbinary people are more likely than their non-trans peers to engage in non-suicidal self-injury, such as cutting (dickey et al., 2015). Genital and chest areas may be two places that trans/nonbinary people may cut, as well as more traditional locations such as arms and thighs.

Due to binding or tucking/gaffing, trans/nonbinary people may develop a rash, abrasions, or yeast infection around chest or genital areas. They may also have bruising from binding, taping, or tucking/gaffing. Some people develop hernias in the testicles as result of tucking.

Implications for exams:

- Ask if the scar/injury is recent or older or a component of the crime. This lets you document without judging.
- When possible, provide medical care for non-assault related injuries or rashes.
- Remain non-judgmental and objective when documenting scars, injuries, and resulting medical conditions.

Charting

Effective charting is important for forensic exams and to provide trans-affirming care. This section will cover some of the common considerations for charting.

This guide does not address legal ramifications for charting, so providers are encouraged to consult with their healthcare facility, local laws/policies, as well as guides and resources produced by the International Association of Forensic Nurses, and the EVAWI Virtual Practicum.

“My everyday practice is making sure that that electronic medical record monitor is faced towards the patient, so that that is very much a, ‘This is a together thing.’ And in non urgent situations I tend to do this more often, but I would say definitely in urgent or sensitive conversations, it's important to again mention to the patient, that if you see something in my documentation that you don't feel comfortable being there, I can take it out or whatnot.”
- HCP from FORGE Listening Session

Documentation

Trans/nonbinary people report that a major concern with healthcare providers is not having their names and pronouns respected. Unfortunately, many medical databases are set up based upon legal names. (See comment box on the nuances and parameters of the use of “legal” name.) It is critical that providers create effective processes to document and refer to patient’s affirming names and pronouns.

“Legal” names
There is no one document or set of documents that determine someone’s “legal” name or gender. A person many legal/legally binding documents that may have

different names and genders. For example, Passports and birth certificates are both legal documents, as is a driver's license. Since federal documents, like passports, are somewhat easier to change name and gender, this document might be the most accurately reflective of a person's gender. In some states, changing the gender on a birth certificate is either not allowed, or requires extensive hoops to jump through (such as genital surgery) before the gender marker is changed. Similarly, different states have varying rules for updating driver's licenses or other state identification cards. All three of these documents in this example are legal documents and contain a person's legal name and gender.

Use care when referring to "legal" name/gender with a client. Instead, be specific about which document or what information you need to know. For example, "What name is on your driver's license?" or "What name would you like me to use in documenting what happened to you? This charting information might be seen by law enforcement or legal systems if you decide to press charges.?" Or "What name and gender are on your health insurance card? We want to make sure your insurance doesn't deny your care because of a discrepancy on what is on your card."

Intake forms

When using intake forms, consider creating spaces for both affirmed name and legal name. The affirmed name should be the primary name seen by staff so that it will be the name used with the patient and during interactions with/about the patient. Having a blank space for gender and pronouns

allows for self-disclosure and identification. Providers using health insurance may need another space to document the name and gender listed on insurance information.

Medical/body diagram charting

Survivors will often see what a provider is writing and/or the charts used to document. When documenting an exam, start by using gender neutral body maps, whenever possible. If documenting injuries to genitals, more detailed body maps will be needed. Proactively share with the patient – if they would like you to explain the process or to help build their trust in the process – that you are using a specific body map so you can accurately record their injuries. Convey to the patient that even if the form you are using has "female" or "male" written on it, that this is not how you view them and will not change how you interact with them.

For example, if the body map being used includes a label of "Genital Examination – Females" and has accompanying diagrams of genitals that include labia, vulva, urethra, vagina, etc., you can verbally re-frame this documentation sheet to the patient by not referring to it as a "female" form.

Below is an example from the State of California Office of Emergency Services

FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION
CAL OES 2-923
(www.oes.ca.gov)
https://www.ccfmtc.org/wp-content/uploads/2-923-Form1.pdf

J. GENITAL EXAMINATION - FEMALES

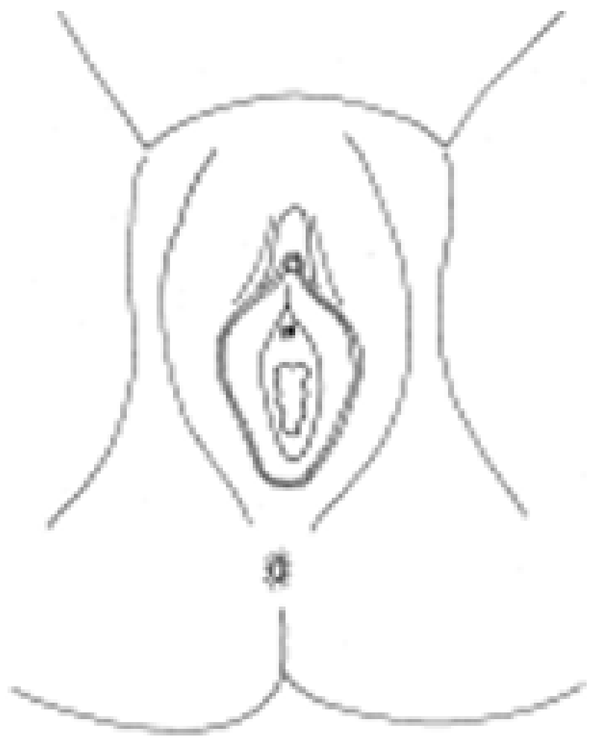
Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings:

- ☐ No Findings
- ☐ Inner thighs
- ☐ Perineum
- ☐ Labia majora
- ☐ Labia minora
- ☐ Clitoris/surrounding area
- ☐ Periurethral tissue/urethral meatus
- ☐ Perihymenal tissue (vestibule)
- ☐ Hymen
- ☐ Fossa navicularis
- ☐ Posterior fourchette

Patient Identification

Diagram G



Sexual Assault Nurse Examiners (SANEs) who are trained in documenting sexual assaults, will fully understand the implications of the levels of details documented, as well as the language used in diagrams and narrative content.

Keep in mind that many trans people have bodies that may require the use of multiple body maps to accurately capture all of their body.

Note, too, that no body maps (to date) have variations that include, for example, images of metoidioplasty, or zero-depth

vaginoplasty, or phalloplasty with no urethral extension. When working with trans people with these types of bodily configurations, it's critical to accurately document with the recording paperwork approved by your agency or legal system(s). It also may mean adding additional comments on the charts and in the accompanying narrative.

Consult with the patient about name, pronoun, body part language that they would ideally like used in the charting. They may or may not have more than one name/pronoun they use and may be concerned with this information being disclosed in legal settings or in other public records. This can pose safety dangers for clients, if language is not consistent with their safety needs.

If clients do want affirmed language used in charting, there are simple ways of including both legally valid language and words that affirm a person's gender identity and body.

For example, in narrative text:

Name:

> *"Diamond Jones, legally known as David Jones, was seen at....." Text can continue with language such as, "This documentation will use the patients affirmed name of Diamond throughout but is legally recognized as the same person as that of David Jones."*

Pronouns: Pronouns can be added when listing the patient's name and is a good practice to include with both trans and non-trans patients. Quite simply:

> *"Diamond Jones (she/her/hers), legally known as David Jones, was seen at ... She arrived following a sexual assault ..."*

Body parts:

Some descriptions of bodies will be the same for trans and non-trans individuals. Being descriptive is a well-skilled, familiar job of SANEs, so this process will be easily translatable for trans clients who may have bodily configurations that vary from many non-trans patients.

For example, if there is a need to describe a person's genitals who has had metaoidioplasty, a provider may need to indicate on the body map diagram the outward shape of the genitals. Depending on the shape and size, it may be difficult to determine if the diagram marked "female" or "male" would be most easily modified to represent the person's body. Narrative descriptions might include:

> *"The patient's external genitals include a small phallus, with surgically inserted testicular implants. The urethra is beneath the testicles. There are circular abrasions on the right testicle, that are 1" in diameter. A small ½" cut is at the tip of the phallus. The area surrounding the urethral and vaginal opening are bruised, red, and swollen."*

In addition to a description like the above, if the patient uses "front hole" vs. vagina, the provider may want to reflect that language in the narrative, with an initial explanation of word choice.

Medical record systems

Medical record systems can create privacy and safety concerns. A patient may have limited ability to control what information is in their medical records, if they had been a prior patient at a facility and/or if their health insurance or identity documents contain a specific name/gender that may not be their lived identity.

Fortunately, more and more electronic medical records are including fields for “name of use,” as well as for pronouns.

If the patient has not been to a facility before, and may not have gone through intake at registration, the healthcare provider may have the ability to ask the survivor what information they would like listed in the medical record.

Systems generally dictate what is allowable and may be outside of the patient’s or provider’s control. If there are options, check with survivors about what information they want listed in their electronic medical record and be clear about who the information will be available to. Survivors may have concerns about their trans/nonbinary identity being shared or about their experience of assault being shared.

Exit Paperwork

After the exam

Once an exam is completed, medications or prescriptions are provided, and resources are secured for the survivor, help the survivor to leave the facility in a way that feels safe to them. This may include helping the survivor access clothing,

grooming products, or make up to dress in a safe and gender-affirming manner (as they determine) prior to leaving the facility. It may also include safety planning or connecting them with follow-up support.

Discuss if it is safe to write down information. Many survivors have difficulty remembering information after an assault and will likely need instructions repeated. Written information can be beneficial, if safe to keep with the survivor. Be as specific and clear as possible when providing information, since the survivor is likely unfamiliar with the information you are sharing, the victim service system, and the types of resources available to them.

Crime victim compensation and role of medical advocates/forensic nurses

Crime victim compensation procedures vary by state. Medical advocates may be involved in completing paperwork or advocating for a survivor's access to compensation. A police report must be filed and/or law enforcement contacted to be eligible to apply for crime victim compensation. Due to substantial negative experiences trans people have had with law enforcement, some trans/nonbinary people will not feel like this is a safe option for them to pursue. The survivor should not be charged for the forensic rape exam, this is prohibited in the Violence Against Women Act.

See local state boards here: National Association of Crime Victim Compensation Boards, https://nacvcb.org/

If applying, compensation may cover common crime-related costs, such as:

- Medical and mental health care
- Lost wages
- Replacement costs for damaged items
- Replacement of stolen property
- Replacement of locks or installation of security equipment

Trans survivors across the country have experienced challenges in receiving crime victim compensation for specific items/services. Common denials have included:

- Access to compensation for medical care related to hormones, reconstructive surgery (to repair injuries during the assault that targeted previously surgically constructed parts of the body)
- Prosthetics (binders, wigs, etc.)
- Lack of coverage of lost wages, if the survivor doesn't have a tax-paying job (i.e. if the survivor works for cash, or in an unregulated industry)
- Full denial of the compensation if the survivor was perceived to be committing a crime while the assault happened (e.g. those who work in the sex industry, or who might be living in non-rented/-owned property)
- Other costs that are typically covered for non-trans individuals that are commonly denied for trans and nonbinary survivors.

Discuss with the survivor what name needs to be on the paperwork and if they have a safe place to have mail sent to that name. To learn more about safer mailing addresses and

confidentiality, consult Victim Connect Resource Center's Address Confidentiality, https://victimconnect.org/learn/address-confidentiality/. For Pennsylvania residents, consult with Office of Victim Advocate and the Address Confidentiality Program (ACP). https://www.pa.gov/en/agencies/ova/address-confidentiality.html

If a survivor is uncomfortable or unwilling to involve law enforcement (if this is required to apply for compensation), help the survivor find other ways to get their needs met. For example, some states have limited discretionary funds for survivors to cover medical or other expenses. Nearly all states have victim service organizations that have grant funds which include emergency funds for survivors. States that have LGBT anti-violence projects (National Coalition of Anti-Violence Programs, n.d.), are also good resources that frequently have access to emergency funds and/or leads for trans-safe housing.

LGBT Anti-Violence Programs
Trans survivors may feel more comfortable accessing support services through an LGBT-focused organization. The National Coalition of Anti-Violence Programs (AVPs) is a collection of 40 organizations across the country. Most AVPs are connected to trans-welcoming shelters, alternative housing options, awareness of mental health providers that are trans-affirming and trauma-aware, support groups that might be LGBT-specific or -welcoming, etc.
www.avp.org/ncavp

In many places if a person is “actively engaged in a crime” when a crime is committed against them, they may not be eligible for compensation. This restriction can exclude people assaulted while engaged in sex work. Many states, however, will process claims regardless of these types of circumstances.

Partnering with other local programs with experience in crime victim compensation can help with framing or documenting to increase the likelihood of compensation.

Follow-ups

Adequate institutional preparation is essential for providing meaningful follow-up resources. Agencies that take time to learn their community, gather culturally specific referrals, and develop relationships with other providers and organizations will best serve their clients.

Trans clients may or may not have existing relationships with trans-affirming healthcare providers. When possible, have a list of providers who are trans-aware and can provider follow-up medical services to trans clients without creating additional barriers of bias. One way to increase the likelihood that a trans client will pursue follow-up care is to share information about the referred provider.

Some programs have created gendered exit folders to make things “simpler” for staff. If your agency regularly has pre-filled folders – for example a “men’s” folder and a “women’s” folder – consider taking the extra time to individually tailor each folder to the client. Many folders will still contain the

same information for any survivor and can be prepared ahead of time. Including specific resources for each client is best practice. Remember to discuss any privacy and safety concerns the survivor has about information they may leave with.

If survivors are unhoused, or if survivors were assaulted by an intimate partner or family member, they may not be able to bring any printed materials “home” with them. Consider providing needed information on an easily accessible website with a short (easily remembered) URL for clients to access when it is safe for them to do so.

Specific Considerations: Trans-youth

This section is a brief summary of some key points to keep in mind when working with trans/nonbinary youth. The National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric is an excellent guide for working with pediatric patients and does have some trans-specific content (Littel, 2016).

People may share their trans/nonbinary identity with others at any age. There is no one “right” age when people start to understand their gender or gender identity or communicate it to others. Some trans/nonbinary people know from a very young age that the sex that they were assigned at birth does not align with their affirmed gender identity. Others may not start this process of discovery until they are older. Some

people may be very firm in their gender identity at early ages, while others may take time to understand their gender.

Younger people are more likely to identify under a nonbinary umbrella, not aligning themselves with male or female. It is likely that young people will more likely than older trans/nonbinary people use pronouns other than he/him/his, or she/her/hers.

Pronouns

Common pronouns outside of the binary that you may hear young (and older) people using include:

they	them	theirs
ae	aer	aers
e/ey	em	eirs
fae	faer	faers
per	per	pers
ve	ver	vis
xe	xem	xyrs
ze/zie	hir	hirs

What this means for SANEs, Office of Violence Against Women and medical advocates is that young people could be at any “stage” in relationship to their gender. They may be able to express their gender; they may be having feelings of discomfort or dysphoria but not have words for it; they may be taking actions to express themselves with or without language for what that means.

Gender-affirming care: medications and surgery(ies).

- Gender-affirming care for most youth means that youth are treated with respect, their name and pronouns are honored and used.
- Some youth may be on puberty blockers (with parental consent).
- Some older youth may be taking affirming hormones (testosterone, estrogen, progesterone, spironolactone).
- The age at which young people can consent to healthcare varies by state and by the type of healthcare. How involved the parents/guardians are in the young person's medical decisions will vary based on laws, age, and the relationship between youth and parent.
- Medications for emergency contraception, STI or HIV treatment/prophylaxis are generally not contraindicated with youth who are on puberty blockers or hormones.
- It is very unlikely that trans/nonbinary people under 18 years old will have had gender-affirming surgeries. However, it is becoming slightly more common for older teens to be able to access some forms of gender affirming care, when they are able to make mature, informed decisions, and have parents/guardians who also support this decision.

In general, minors are less likely to know the names and doses of medication than adults, but trans kids may be slightly more likely to remember this information due to the amount of advocacy they have to do for themselves.

Puberty blockers are typically used for a short period of time (months to a few years) while a child decides what next

steps to pursue, if any. Children with a uterus on puberty blockers may have menstruated in the past but are not currently or may never have had a period. Remember that during the first few years of menstruation, cycles are often irregular for most people.

Some of the major considerations for working with transgender/nonbinary young people include:

- Parental/Guardian involvement
- Access to healthcare and emotional support
- Legal considerations including: mandatory reporting, parental notification, laws about sexual assault, laws regulating access to other types of healthcare, and more

Parents and Guardians

The level of support and affirmation that parents and guardians provide can vary dramatically. Some guardians are affirming of their child's gender, understand that sexual violence is never the survivor's fault, and support the decision-making capacity of their child. Some guardians do some of these things and not others. Some guardians do none of these things. For the young person's safety, it is critical to identify what information they want shared with parents or guardians and how they want adults involved.

When possible, finding time to meet with the youth privately to discuss their safety (from the adult who is with them, or who lives with them) is critical. It is also important to determine what information about their gender or other aspects of their life that they are comfortable being shared with the parent or guardian.

All work with young people should be age appropriate. The needs, communication skills, and experiences of people may vary greatly. However, SANEs and advocates can always use empowerment-based communication to support the young person's agency.

The impact of cultural bans on sexual health education
With recent cultural shifts in educational opportunities at schools, many young people may not be receiving sexual health education at school or might be learning from their peers – which may or may not be accurate information. Youth are industrious and have access to peers and the internet, so they may actually have more information from those sources than through traditional sex- and body-based education in the classroom.

Keep in mind:

- Be aware of who the perpetrator might be. Most young people are assaulted by someone they know, which includes adults such as parents, family members, or other trusted adults in their life (Alaggia et al., 2019).
    - The identity of the perpetrator may impact the reactions of the parents/guardians and how safe the young person feels disclosing information, consenting, or assenting to care.
- Young people, particularly trans/nonbinary young people, have an increased likelihood of delayed disclosure of assault. This may mean that a forensic exam to collect evidence is no longer possible. However, SANEs or other providers can still provide care for any injuries, provide treatment for STIs, and provide

information, support, safety planning, and education as needed.

- Trans/nonbinary youth are at increased risk of being homeless or in the foster system (National Network for Youth, n.d.). This can increase the challenges that they face in seeking follow-up medical care, accessing medications, or receiving support services.

Considerations:

- What is the role of the parents/caretakers?
    - Does the minor feel they have to comply with the exam because their parent/guardian wants it?
        - No one should be forced to have an exam, medical procedure, or be touched without their overt consent and assent.
        - Advocates can help interface between the youth, adult(s), and SAFE/health care providers, to support the youth's decisions about their own bodies.
- Are they trans-affirming? Are they supportive of the survivor?
- Is there a difference between the adult and the young person's perception of if the activity was consensual?
- Can you find the time/ability to talk with the young person alone to find out their wishes and hear their story without others being present?
- What legal requirements do you have to meet based on the age and assault?
    - This may include parental notification, mandatory reporting, police involvement, age of consent, etc. Each jurisdiction and case will be different.

Safety plan

Safety planning should include:

- Who the youth would like to have access to information about their gender, name, and pronouns.
- Who can know about the assault.
- Who can be in the room during any conversations or exams. (There may be legal requirements that need to be followed, but having the discussion with the youth is essential. Additional support can be included if the youth would like an advocate or other supportive individuals present.)
- What concerns the minor has about any reporting steps that have to happen.
    - Youth may be concerned that abusive situations occurring at home may escalate if mandatory reporting results in a Child Protective Services home visit, for example.
- Where the minor can get ongoing medical and emotional support, especially if the adults are not willing or able to follow through with after-assault, longer term care.
- If the assault happened at home and the youth is returned to the home environment, help them find ways of staying as safe as possible while living with an abusive person(s).
- If the assault happened at school or in an environment that the youth will still be required to be part of, help them find ways of staying safer in those environments.

Tips

Always involve the minor in the process. This includes all steps of an exam as well as any reporting steps that must be

taken. Let the young person know as soon as possible what may be required of you. Engage them in the process – for example if mandatory reporting is necessary, consider making the phone call together, discussing if there is anyone else they want to tell so they have emotional support, and sharing as much information as you can about the process.

Specific Considerations: Trans-youth

Trans people are also incarcerated at disproportionate rates and sexual assault is extremely prevalent in jails and prisons.

Note: Trans people are not more likely to commit crimes than non-trans people. However, many trans people are arrested for being profiled ("walking while trans") or due to survival behaviors (including being unhoused, sex work, or theft for food and basic resources). Trans people are also likely to be detained in facilities that do not align with their gender identity, which may pose additional risks for physical and sexual violence.

Health care providers should plan ahead to prepare to provide forensic exams and post-assault healthcare to survivors who are incarcerated or in judicial custody.

Different municipalities and levels of detention will dictate specific ramifications about how post-assault care can be delivered. For example, if the correctional facility staff or law enforcement need to be in the room during exams, or if the patient needs to be restrained/cuffed.

Resources specific to detained survivors:

PREA (Prison Rape Elimination Act) guidelines will help healthcare facilities and advocates learn more about the rights of detainees who have been incarcerated, as well as the care that all incarcerated individuals are entitled to. The act includes many trans-specific sections that provide guidance for detention facility staff, as well as for healthcare providers and advocates. Visit the Prison Rape Elimination Act for more details, rights, and regulations. https://www.prearesourcecenter.org/about/prison-rape-elimination-act

Just Detention International has multiple resources on their website specific to transgender people in detention, including written and audio survivor stories, newsletter briefs, and webinars.

- Not Alone: How to Help Transgender Survivors in Detention (Part 1)

https://justdetention.org/webinar/not-alone-how-to-help-transgender-survivors-in-detention-part-1/

- Not Alone: How to Help Transgender Survivors in Detention (Part 2)

https://justdetention.org/webinar/not-alone-how-to-help-transgender-survivors-in-detention-part-2/

EVAWI (End Violence Against Women International) provides additional resources on serving sexual assault victims who are in detention. Although their *Virtual Practicum* content on people in detention is not trans-specific, it offers guidance on

how to better serve incarcerated sexual assault survivors.

- The free Sexual Assault Medical Forensic Examination: A Virtual Practicum, including both a trans-masculine patient and a separate scenario with a non-trans incarcerated patient can be found at: https://evawintl.org/vp/

- Another resource from EVAWI is a community dialogue/webinar with presenters from Just Detention International, titled “How Can We Do This Better?” Caring for Incarcerated Survivors. This is not trans-specific but will provide basic context for working with incarcerated survivors. https://evawintl.org/courses/how-can-we-do-this-better-caring-for-incarcerated-survivors/

For general resources on transgender people in detention, including those who experience abuse, violence and assault, consult the National Center for Transgender Equality’s issue section, Police, Jails & Prisons, https://transequality.org/issues/police-jails-prisons

Communities where there are no SANEs or well-trained providers

Trans and nonbinary people live in all communities, including rural and Tribal areas. Rural areas may have fewer options for service providers or formal SART programs. Less densely populated areas may also have fewer financial resources or institutions that provide services like medical advocacy, forensic exams, or trans-specific care.

Healthcare providers – both those working in the emergency department, or in a clinical setting – can benefit from accessing TeleSAFE which offers best practice support in providing post-assault care and evidence collection.

RESOURCE

IAFN's TeleSAFE website offers an extensive set of recorded videos, webinars, resources, and contact information. Providers can access these resources here: https://www.forensicnurses.org/page/TeleSAFE/

For provides who may not have the time/access to TeleSAFE or other trained SANE/SAFE staff, advocates or other staff may take on a role of coaching members on how to create a trans-affirming space for survivors. Often, advocates have received more training on transgender issues than health care providers and may be useful in guiding the exam process to be more trans-affirming.

Some trans and nonbinary survivors may not feel comfortable accessing care with an unknown provider, so may opt to travel to their gender-affirming provider. This might result in exceeding the time window for collecting evidence and/or seeing a provider who is not skilled in forensic exams.

For longer-term development of sexual assault response services, communities that do not have a SANE program, a SART, or available sexual assault advocates may benefit from resources focused on building SANE programs and effective collaboration, such as: the Office for Victims of Crime

Training and Technical Assistance Center's SANE *Program Development and Operation Guide,* https://www.ovcttac.gov/saneguide/building-a-sustainable-sane-program/creating-programs-in-unique-community-settings/

In addition to building a sexual assault program that includes forensic exams and medical advocacy, organizations will want to consider how to include trans-affirming services from the start of their program.

Those working in communities with fewer SANE resources or fewer trans-affirming resources may want to consider the following:

- Plan ahead to identify trans-affirming resources. Gather information about what information is collected by various agencies to prepare trans/nonbinary survivors when providing referrals.
- Identify healthcare resources in surrounding areas, which may include extending to larger urban communities.
- Become familiar with local laws that might be applicable, such as restrictions on trans healthcare (and treating trans patients at all). Knowledge about if law enforcement involvement is necessary in order to have an exam paid for or medical care provided at no cost can be very important to many trans survivors.
- Develop policies for advocates to accompany survivors to out of area healthcare and other support resources, for example hospitals in neighboring counties.
- Provide training to all members of a SART together on trans-affirming services. Bring up trans/nonbinary needs

during team meetings.

- Identify alternative options for exams, such as IAFN's TeleSAFE, when possible. https://forensicnurses.org/page/Telesafe

Additional Resources

Caring for the Sexually Assaulted Patient When There is No SANE in Sight: A Training for ALL Healthcare Providers, https://www.forensicnurses.org/page/NoSANEInSight/
The International Association of Forensic Nurses has a website section devoted to communities where there is no SANEs in the geographic area. There are multiple resources on this webpage and providers can earn CEU credits.

EVAWI Virtual Practicum
The Virtual Practicum is free and offers many scenarios and helpful resources for both skilled providers, as well as those who have limited experiences in working with sexual assault survivors. This resource is excellent for providers in communities without a formal SANE program. Although it will not provide immediate answers if a provider has a patient in their office who needs care, it is an excellent resource for professional development and longer-term learning. It does include a transgender scenario, as well as a set of videos on law enforcement interviews with a transgender woman.
https://evawintl.org/vp

Role of medical advocates

Supporting survivors

The role of medical advocates (and other types of advocates or allied staff members) is to focus on supporting survivors. This includes normalizing their experiences, providing emotional support, sharing information, offering referrals and resources, providing other forms of assistance post-assault, and accompanying them through medical services if the survivor pursues care. Medical advocates will likely benefit from reviewing all previous sections of this guide.

Keep in mind that trans survivors may prioritize other services over medical exams and evidence collection. Body discomfort, lack of trust in medical providers and other reasons may create hesitancy to be examined, receive medical care, disrobe, or fully engage in a forensic or medical exam. Advocates can support survivors by being an early point of contact, building a trusting relationship, and sharing information with survivors so they can make an informed choice about what medical components they wish to pursue or not.

Advocates can help slow down the pace of medical intervention, interviews, and forensic evidence collection, allowing survivors more time to fully understand their options, gain the trust of medical providers, and determine their safest course of action.

Advocates can also play a critical role in interfacing between

the survivor and medical providers, other staff, or between the survivor and other individual who may have accompanied the survivor to the facility.

Advocates may engage with survivors about what role the survivor would like them to take around trans issues, post-assault care, and their healthcare needs. After discussion with a trans survivor, the survivor may request that the advocate proactively share specific information with other staff – such as their affirmed name and pronouns, concerns about their body and an exam, or any other information that might be easier for the trans/nonbinary survivor to have an advocate disclose to others.

With prior agreement with the survivor, advocates can take the role of making any language corrections if staff misgenders a patient or uses non-affirming language or behavior.

During the discussion, interview, and exams, medical advocates may support survivors by:

- Helping the survivor navigate the exam. This could look like asking:
    - “Do you want to be able to see what is happening with a mirror?”
    - “Would you like me (or the examiner) to describe what is happening?”
-
- Offering support or distraction. Survivors may need to have their attention on something other than the exam to feel comfortable with the exam. An advocate might ask:

    - “Do you want me to hold your hand?”
    - “Do you want distractions?”
        - These could be talking about pets or food, watching a TV show or movie on a phone, looking at social media humorous pictures together, or discussing something else.

- Assisting the examiner with trans-affirming care. If the provider is not familiar with trans-affirming care, the advocate may offer suggestions – if that is desired by the survivor.

- Assisting everyone involved with trauma-informed care. This may look like
    - Encouraging the examiner to slow down or take a break.
    - Asking the survivor what they want to happen next.
    - Providing information about the process and what happens next.
    - Validating the survivor’s experiences.
    - Helping the survivor find ways to be comfortable – such as only partially undressing or having extra drapes in a certain area.

- Safety planning
    - See the safety planning section for specific information and resources.

Medical advocates may also be supporting survivors in accessing healthcare outside of forensic exams. This can include:

- Listening to their concerns about accessing healthcare. Acknowledging their feelings including fear, dismay, anger, and distrust.
- Be present to their needs. Take the time to listen to what they are looking for.
- Accompany survivors to medical appointments. Discuss ahead of time the support they might want from an advocate or other people.

Advocates can encourage their sexual assault program to provide additional practical supports to trans survivors including:

- Clothing. (Although this is a commonly provided resource, some trans people fall outside of “traditional” sizes – for example many trans women may need larger sized shoes or clothing. For safety reasons, people may need traditionally feminine or masculine clothing, in order to present as their affirmed gender in public in order to minimize discrimination and violence.)
- Gender-affirming items – wigs, binders, packers, breast forms, etc. These items are both for gender affirmation, but more critically, will increase the survivor’s safety when in public spaces.
- Transportation assistance. (Keep in mind that for some trans people, public transportation is not safe due to harassment, stalking, or other harms. Transportation assistance may need to include ride share services or other creative options.)
- Food. (Again, this may be a commonly provided resource. Many trans people live at or below poverty lines, so may not have access to any food, or may not be housed or

have access to a kitchen to prepare food.)
- Housing. (While most sexual assault programs are familiar with connecting survivors to housing resources, many shelters and housing resources do not house trans people or may be hostile environments. Know which housing options are trans-inclusive and trans-welcoming.)

Sexual assault programs can create a trans-affirming environment by celebrating body diversity. This includes having pictures of people of various sizes and genders, providing information to all staff on body diversity and trans-affirming care, and taking care to create an environment that welcomes and respects all different kinds of bodies.

Connection to resources

Sexual assault programs provide survivors with a number of resources and referrals. To support trans/nonbinary survivors, it can be beneficial to know additional information about the referrals provided to survivors:

- What agencies are trans-affirming and competent in your area?
    - If local resources are not trans-affirming, are there online resources that may provide similar supports/services?
- What is the process for intakes at the agency?
    - Do survivors need ID or insurance? (If you don't know, call to find out before referring a trans survivor.)
- What services are provided?
    - Are those services available to people of all genders?
- Are services gender-specific?

- If so, how does the organization define gender? Is it based on self-identification, legal paperwork, or something else? What are their policies for serving trans/nonbinary people?

Sexual assault programs can build connections with trans-affirming organizations and providers before they need to provide these referrals.

Prepare to navigate the specific laws and regulations in their area – including gendered laws, mandatory reporting, and more.

Most sexual assault programs are funded through the Department of Justice, Office on Violence Against Women, Office for Victims of Crime, VOCA, or through Health and Human Services (such as FVPSA). If organizations receive funding through these streams, there are very specific nondiscrimination provisions that require agencies to serve people of all genders in equal or equitable ways. A useful reference is the U.S. Department of Justice, Office for Justice Programs, Office for Civil Rights Frequently Asked Questions: Nondiscrimination Grant Conditions in the Violence Against Women Reauthorization Act of 2013. https://www.justice.gov/archives/ovw/file/29386/download

This document is what many other DOJ and other federal agencies have modeled their non-discrimination policies after.

Sexual assault programs should also:

- Prepare to navigate the specific laws and regulations in their area – including gendered laws, mandatory reporting, and more.
    - For example, most sexual assault programs are funded through the Department of Justice, Office on Violence Against Women, Office for Victims of Crime, VOCA, or through Health and Human Services (such as FVPSA). If organizations receive funding through these streams, there are very specific nondiscrimination provisions that require agencies to serve people of all genders in equal or equitable ways. A useful reference is the U.S. Department of Justice, Office for Justice Programs, Office for Civil Rights Frequently Asked Questions: Nondiscrimination Grant Conditions in the Violence Against Women Reauthorization Act of 2013. https://www.justice.gov/archives/ovw/file/29386/download

This document is what many other DOJ and other federal agencies have modeled their non-discrimination policies after.

- Train advocates to make calls for survivors or assist survivors in making calls to other agencies (whichever the survivor prefers)
    - Advocates can call ahead to assess trans-competency at an organization or to help make an appointment and navigate a resource.
    - Advocates can also sit with survivors while the survivor calls or pass the phone to the survivor during the call. This may mean being on speakerphone together (when in private place) so that the advocate

and survivor can both hear everything discussed.
    - If initial referrals/resources are not a good fit or are not trans-affirming, help the survivor find other resources.

Intervening with other providers

Another major role of medical advocates and sexual assault programs is to help other providers support the needs of survivors. This may mean providing education or intervention with other providers.

For trans/nonbinary survivors this layer of advocacy can be especially important as the more providers they have to deal with the more likely they are to encounter professionals who are not adept at trans-affirming care.

I needed somebody to walk with me into the hospital and say, 'I want to hold you while we're in here. So that way, when they misgender you, I want to sit there and say, 'She,' and replace the 'he.''

– Survivor from FORGE Listening Sessions

Advocates may do things like:

- Ensuring survivors and other providers are gendered correctly.
- Help providers hear the main concerns of a survivor.
- Intervene when someone is misgendered.
- Help redirect the conversation if inappropriate questions are asked.

- Help the provider use correct body maps and language during physical exams or documentation.
- Help the survivor have agency throughout the process. This may include reminding the provider to slow down, asking for consent, suggesting that the exam can go in a different order or skip sections, and helping to build trust between the survivor and provider.

Advocates and agencies may also look at how systems and organizations can better support trans/nonbinary survivors by:

- Assessing and training all staff that could interact with survivors/patients, such as front desk staff, emergency department healthcare providers, law enforcement, and others involved in survivor care.
- Helping agencies improve their paperwork and policies, such as the intake process.
- Providing training on the needs of trans survivors.
- Helping establish processes for survivors to have support during procedures.
- Assessing referrals and resources

Safety planning

A core role for many advocates is to help with safety planning. Medical advocates are generally already prepared to assist with safety planning related both to sexual violence and to medical concerns. When working with trans/nonbinary survivors, advocates should continue to use empowerment-based advocacy, working together with the survivor to identify their safety concerns and strategies that work for them. Advocates may find it beneficial to be aware

of some concerns that are more common in trans/nonbinary communities.

Trans survivors need basic safety planning but also safety planning around the potential transphobia of that law enforcement officer, which is very common and can be really violent. So every step of safety planning involves this extra hurdle of safety planning around transphobia which I think is so categorically different from the experiences of cisgender survivors.

– Provider at FORGE Listening Session

Physical Safety

- Survivors may need assistance to dress in a way that makes them feel safest. Trans/nonbinary people are often targeted because of their transgender identity (or how others perceive them/their gender), thus clothing and appearance can be a major safety concern for some.
- Trans/nonbinary people often have fewer economic resources, meaning they are more likely to be engaged in sex work or street-based economies, and are less likely to have their own home and transportation.
    - If a survivor's employment is sex work, they may routinely see the person who assaulted them, if the assault happened on the job.
    - If the survivor relies on public transportation (vs. having a car), this may limit their options for traveling different routes. If they walk or need to be on the street to get from one place to another, they may experience street harassment or violence.

    - People who live with multiple people may not have control over safety or privacy at home. They may not be able to restrict access to their offender.

Relocation

- Access to gender-affirming items should be considered. Both in terms of what the survivor may need from their home – medications, clothing, other supplies and options in terms of relocating.
    - Survivors may not be able to move easily without disrupting their medical or mental health care and other support networks.
- Common ideas such as changing routes and routines may not be as possible when options are limited.
    - For example, if there is only one trans-affirming 12-step recovery meeting, the survivor has the choice to stop attending a needed support or to continue even though the abuser knows the time/location.
- Housing options for trans/nonbinary people are often limited.
    - SA/DV programs often have gender-segregated housing with few options for trans/nonbinary survivors.
    - Homeless shelters are not a safe alternative to SA/DV-based housing and in most cases are also gender-segregated.

Emotional safety

- Due to smallness of trans/nonbinary communities (even in large cities), it may be more likely that others in the person's social network/community will know about the assault.

- It may be more difficult for the survivor to avoid the perpetrator, especially if the offender is also part of the trans or LGBTQ+ community.
- The survivor may need support around trauma responses, self-blame, and other emotional needs after an assault.

<u>Privacy</u>

- The survivor may have concerns about privacy and how their information will be shared, both by agencies they must interact with and by the assaulter.
- If pursuing legal action, their prior name, gender, or other information may become public and could have an impact on their personal safety, their employment, their ability to retain their children or housing.

<u>Legal Options</u>

- Survivors may have concerns about mistreatment and outing within the legal system.
- Restraining orders (PPOs/Injunctions) may not be an option for everyone. In some places this is due to the relationship between the survivor and assaulter or may because of how the survivor would be treated by the court.
    - Orders of protection also require the use of a person's legal name, which may cause safety concerns if the person needs to show the PPO to anyone to enforce the protection.
    - The name on the order of protection may also be a risk if the offender, who also receives this notice, was previously unaware of the victim's name/gender.
- Most survivors will know the perpetrator. This can impact

their decisions on what options to pursue in the legal system.

- Programs designed to support survivors such as confidential address programs or services that redirect mail may be difficult for trans/nonbinary people to access. This could be due to lack of housing, concerns about which name would be on the paperwork, and how to safely get access to any legal follow-up paperwork. Survivors may be concerned about what name is on any mail they receive, depending on who else may see their mail.

Tech safety

- In addition to concerns about how the abuser may use technology to continue to cause harm, trans/nonbinary survivors may be concerned about how their information will be available in general – including in court documents and who will have access to health information.
- Trans/nonbinary people have experienced higher rates of online harassment, including doxing and swatting and threats of sexual violence. Survivors may have already faced this or be targeted if others find out about the assault.
- Many trans survivors use technology as a primary way of connecting with other supportive peers and where they receive the most affirmation and validation. It may be difficult to restrict or change their online access, if this has been a source of support for them.

Other types of violence

Many trans/nonbinary people have experienced multiple

forms of violence in their lifetime. In addition to the sexual assault, advocates may need to assist with safety around:

- Hate-motivated violence
- Neighborhood violence
- Street-based harassment
- Workplace harms
- School bullying or lack of equal access at school

Advocates can learn more about safety planning with trans/nonbinary survivors:

- FORGE safety planning guide: https://forge-forward.org/resource/safety-planning-tool/
- Stalking and Harassment of Trans People guide – https://forge-forward.org/resource/stalking-and-harassment-of-trans-people/
- Disasters safety planning guide webinar: https://youtu.be/EGeJzv4nUPI?si=udXDftPpeni0EXJP
- Safety planning blog: https://trans-survivors.com/2023/07/18/safety-planning-for-disasters-and-intimate-partner-violence/
- SPARC (Stalking, Prevention, Awareness, and Resource Center) Stalking guide for advocates (includes safety planning content): https://forge-forward.org/resource/supporting-lgbtq-stalking-victims-a-guide-for-victim-advocates-sparc/

Building Capacity

Advocates and sexual assault programs have a role to play in building the capacity of all those who engage with survivors to provide trans-affirming services.

This may look like:

- Developing relationships with individual SAFEs to determine how to offer feedback or ideas.
    - Advocate may know more about trans individuals than the medical provider. Consider how to navigate that knowledge difference, which may need to be sensitively navigated around power imbalances, how a provider takes feedback from others, and what will be most supportive of the survivor.
- Assisting in creating or finding training resources for SAFEs and other providers. This guide and the resources listed can be a useful start in sharing resources.
    - FORGE also provides training to providers. Reach out to FORGE for training or technical assistance can offer tailored educational opportunities.
- Training primary care providers to know more about sexual assault. Many trans/nonbinary people who have a primary care provider are more likely to go to that person for care rather than a sexual assault program. Primary care providers or LGBTQ+-specific clinics are often not trained in sexual assault response.
    - Survivors who do come to sexual assault programs may want support in navigating conversations about assaults with their other medical or mental health providers.
- Assisting with screening when people come in with someone else.
    - A survivor may be accompanied by a perpetrator to a medical visit. Youth, in particular, may arrive with a parent or guardian. When necessary, remind health care providers about the need for screening for abuse by the companion.

- It is also common for trans/nonbinary survivors to bring in a supportive companion. In fact, many people will recommend this to trans people as the companion can help advocate for the survivor. Advocates may have to help ensure that safe/supportive companions are allowed in the room.

Advocates are tasked with a wide variety of responsibilities, all of which can be tailored to the needs of trans/nonbinary people.

Concrete actions providers can take to improve medical/forensic services to T/NB survivors

- Ask and use the correct name and pronouns for everyone
- Welcome any non-offending support person into the room if the survivor requests
- Reflect and mirror language used by the survivor for their bodies, identities, and experiences
- Check for clarification when needed
- Use less gendered language until a preference is known. For example – genitals instead of penis or vagina; chest instead of breasts
- Check in about survivor safety with charting/documentation for what words to use
- Provide options at every step – give information so that survivors can make informed decisions
- Ask for consent at every step
- Support and affirm survivor choice at every step
- Offer trans-affirming follow-up resources – know who provides trans-knowledgeable services and who is

trauma-informed, etc.
- Ensure materials have included trans people (for example, posters, brochures, website)
- Partner with trans-affirming and trans-led organizations
    - Cross-train, share resources, develop materials, collaborate, work together to collect supplies
    - Hire and train trans/nonbinary people
    - Be creative in advocacy. Work together to problem solve.

Frequently Asked Questions

"I've never worked with a trans person before – I don't want to mess up"

You likely have worked with a trans survivor before but didn't know it!

Many of the skills needed to support trans/nonbinary people are the skills that best support non-trans people as well – listening, being respectful, taking time to provide support that meets their needs. If you can slow down and remember the basics, chances are you will serve all of your clients well.

It's okay if you make a mistake when working with your first known trans survivor. If you make a mistake, acknowledge it, correct yourself (or accept correction from others), and move on after apologizing.

"I feel awkward about pronouns; what can I do?"

It can feel awkward to share your pronouns or invite others

to share theirs.

Fortunately, this practice is becoming more and more common. It also gets easier with practice. Try practicing with colleagues or other supportive people in your life so the process of sharing and asking about pronouns becomes second nature.

You may want to bring your discomfort up with a supervisor or at a staff meeting. Others may also be experiencing feelings of awkwardness or might not be sure how to share/ask about pronouns. Sharing as a team and creating organization-wide policies can help normalize the process.

Keep in mind that your role is to help your client! When clients are addressed with the correct name and pronouns, they feel respected and will be more easily able to receive the services they deserve. So, even if you feel awkward, do it for your client!

“I don’t want to offend someone by asking questions.”
A core part of your job is asking questions and listening openly to answers. Some guidelines that might help you determine if a question is appropriate to ask or not include:

- Is the question you are asking relevant to the care the person is receiving? Or the services they wish to obtain?
- Would you ask this question to someone you knew was non-trans?
- Is your question based on curiosity for your own personal interest, or does the question support the care you are

providing to the client?

If you are in doubt about asking a question, consider pausing and allowing yourself to think about its appropriateness/offensiveness. Sometimes, just having a few moments to reflect will help you determine if you should proceed with the question or not.

“I feel badly that my hospital won’t do x, y, z, and it likely is offensive to trans/nonbinary survivors, how can I let them know I’m safe?”

We all have to work within systems and structures. Sometimes change can take a long time and might be riddled with administrative hurdles that can feel insurmountable.

When a survivor is in crisis, they MAY or may not notice some of the systemic problems you have identified. They might be acutely focused on what just happened to them and how they can find safety and services. For these clients, not addressing the systemic issues can be the best path forward.

For those clients who might have noticed or said something about these barriers, you can openly share that you, too, are uncomfortable with these aspects of the system.

Acknowledging that you are aware and that you would like to see change too, can help the client know that you are trans-aware and will do what you can to make their experience affirming and welcoming.

You can let your clients know you are safe through many

ways that your hospital or agency will not oppose, such as:

- Introducing yourself with your name and pronouns (and asking for theirs)
- Wearing a pronoun button or label on your nametag
- Choosing clothing or accessories that contain trans/LGBTQ affirming messages (e.g. rainbow-colored socks, Jibbitz shoe charms in your Crocs, earrings with trans/queer symbolism, etc.)
- Placing trans or LGBT static cling flags on doors or in common areas (which you can have in your office – and can take down when you leave if not allowable by the agency)
- Asking questions in ways that affirm human complexity (not just about gender, but acknowledging intersectional identities)
- Referencing or sharing resources that are known to be within the LGBTQ+ community and/or that are trans-affirming (and stating so)
- Saying overtly trans-affirming statements that signal your support and acceptance

What are some signs and systemic issues that people may see that send a non-trans-affirming messages?

- Medical record systems that only allow for two binary gender options.
- Medical records systems or forms that do not ask about name of use or pronouns.
- Sexual assault services are located in an area that requires people walk through a “women’s department” type of sign.

- Gendered bathrooms as the only option.
- Posters or signage that may be overtly trans-phobic, including signs indicating specific religious or political beliefs.

Resources

Additional Training Resources

The following organizations provide training, information, and resources related to transgender/nonbinary communities, victims services, and more.

- National LGBTQIA+ Health Education Center: https://www.lgbtqiahealtheducation.org/
- American Bar Association Commission on Domestic and Sexual Violence: https://www.americanbar.org/groups/domestic_violence/
- National LGBTQ Institute on Intimate Partner Violence: https://lgbtqipvinstitute.org/
- Just Detention International: https://justdetention.org/
- National Coalition of Anti-Violence Projects: www.avp.org/ncavp
- National Center for Transgender Equality - https://transequality.org/
- Movement Advancement Project - https://www.lgbtmap.org/

Forensic Exam Resources

National Protocols

- *A National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric*, https://www.safeta.org/wp-content/uploads/2021/12/national_pediatric_protocol_.pdf
- *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents* (2nd edition), https://www.safeta.org/wp-content/uploads/2021/12/SAFE_PROTOCOL_2012-508.pdf
- *A National Protocol for Intimate Partner Violence Medical Forensic Examinations* (PDF), https://www.safeta.org/wp-content/uploads/2023/05/IPVMFEProtocol.pdf
- *A National Protocol for Intimate Partner Violence Medical Forensic Examinations* (interactive format), https://www.safeta.org/national-ipv-protocol/

Forensic Exam Trainings

- End Violence Against Women International's *Sexual Assault Medical Forensic Examination (SAMFE): Virtual Practicum*, https://evawintl.org/vp/
  - The practicum contains one scenario with a trans man who was sexually assaulted. The practicum also has a director's cut and other supplemental information and external resources.
- IAFN (International Association of Forensic Nurses) has an online learning center for members. There are two vignettes available to members, including:
  - A vaginal exam with a trans woman

    - A self-swap collection of evidence with a genderqueer person
- *National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach*, https://www.safeta.org/wp-content/uploads/2021/12/National_Best_Practices_for_.pdf
- *National Training Standards for Sexual Assault Medical Forensic Examiners*, https://www.safeta.org/wp-content/uploads/2021/12/training_sexualassaultforens.pdf

Charting Considerations

Organ inventories

State of California, Office of Emergency Services, *Forensic Medical Report: Acute (<72 Hours) Adult/Adolescent Sexual Assault Examinations (CAL OES 2-923)*, https://www.ccfmtc.org/wp-content/uploads/2-923-Form1.pdf

Self-swab procedure guide

Hologic has created simple, visual and text-based instruction sheets for collection of swab specimens by patients. This PDF includes guides – for both clinicians and patients – on multiple forms of swabbing. These products may not be what is needed for collection, but the guides are useful to help illustrate how a patient can collect. *Aptima® Multitest Swab Specimen Collection Kit: Clinician Collection Procedure Guide*, https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Lab_Services/Hologic%20Collection%20Devices.pdf

Connecting with SANE programs

SANE program listings (Search for SANE programs across the country)
https://myonline.forensicnurses.org/rolodex/searchOrganizationDirectory

IAFN's TeleSAFE website offers an extensive set of recorded videos, webinars, resources, and contact information. Providers can access these resources here:
https://www.forensicnurses.org/page/TeleSAFE/

For longer-term development of sexual assault response services, communities that do not have a SANE program, a SART, or available sexual assault advocates may benefit from resources focused on building SANE programs and effective collaboration, such as the Office for Victims of Crimes's *SANE Program Development and Operation Guide,*
https://www.ovcttac.gov/saneguide/building-a-sustainable-sane-program/creating-programs-in-unique-community-settings/

The International Association of Forensic Nurses has a website section devoted to communities where there is no SANEs in the geographic area.
Caring for the Sexually Assaulted Patient When There is No SANE in Sight: A Training for ALL Healthcare Providers,
https://www.forensicnurses.org/page/NoSANEInSight/

Transgender Topics

GLAAD's *Glossary of Terms: Transgender*,
(https://glaad.org/reference/trans-terms

For resources specifically for trans/nonbinary survivors: Resources and Support for Transgender Survivors, https://www.nsvrc.org/blogs/resources-and-support-transgender-survivors

Transgender Sexual Violence Survivors: A Self Help Guide to Healing and Understanding, https://vawnet.org/material/transgender-sexual-violence-survivors-self-help-guide-healing-and-understanding

Serving Trans and Non-Binary Survivors of Domestic and Sexual Violence, *https://vawnet.org/sc/serving-trans-and-non-binary-survivors-domestic-and-sexual-violence*

FORGE webinars

- There are many 101/basic webinars to improve overall trans knowledge and the intersections of victimization and trans identities
- Several webinars include forensic-exam-specific content
- Many webinars focus on intersectional identities and concepts.
- All webinars are archived and available on FORGE's website and YouTube channel.

Research on Trauma experiences

Lacombe-Duncan, A., Jadwin-Cakmak, L., Trammell, R., Burks, C., Rivera, B., Reyes, L., Abad, J., Ward, L., Harris, H., Harper, G. W., & Gamarel, K. E. (2022). "...Everybody else is more privileged. Then it's us...": A qualitative study exploring community responses to social determinants of health inequities and intersectional exclusion among trans women

of color in Detroit, Michigan. *Sexuality Research and Social Policy, 19*(4), 1419–1439. https://doi.org/10.1007/s13178-021-00642-2

Arayasirikul, S., Turner, C. M., Hernandez, C. J., Trujillo, D., Fisher, M. R., & Wilson. E. C. (2022). Transphobic adverse childhood experiences as a determinant of mental and sexual health for young trans women in the San Francisco Bay Area. *Transgender Health, 7*(6), 552–555. https://doi.org/10.1089/trgh.2021.0062

White Hughto, J. M., Reisner, S. L., & Pachankis, J.E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine,147,* 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010

Garcia, J., & Crosby, R. A. (2019.) Social determinants of discrimination and access to health care among transgender women in Oregon. *Transgender Health, 5*(4), 225–233. https://doi.org/10.1089/trgh.2019.0090

Tordoff, D. M., Martin, A., Fernandez, A., Gross, B., Caracciolo, B., Minalga, B., Perry, N. L., Lentini, S., Heberling, W.B., Barry, M., Slaughter, F., Moreno, C., Buskin, S., Golden. M. R., & Glick, S. N. (2022). *2021 Pride Survey Report: Social determinants of health and barriers to health care for LGBTQ+ people in Washington State.* https://www.dianatordoff.com/wp-content/uploads/2022/08/Pride-Survey-Report_FINAL.pdf

IPV/SA Resources

This screening resource, by The Network/La Red, can be a useful reminder tool about how to screen for possible relationship abuse: *Intimate Partner Abuse Screening Tool for Gay, Lesbian, Bisexual, and Transgender (GLBT) Relationships: A Project of the GLBT Domestic Violence Coalition,* https://nnedv.org/wp-content/uploads/2019/06/screening_tool_LGBTQ.pdf

Victims Services

Crime victim compensation. See local state boards here: National Association of Crime Victim Compensation Board, https://nacvcb.org/

To learn more about safer mailing addresses and confidentiality, consult Victim Connect Resource Center's *Address Confidentiality.* https://victimconnect.org/learn/address-confidentiality/

Prison Rape Elimination Act https://www.prearesourcecenter.org/about/prison-rape-elimination-act

Safety planning

- FORGE's *Safety Planning Tool,* https://forge-forward.org/resource/safety-planning-tool/
- *Stalking & Harassment of Trans People,* https://forge-forward.org/wp-content/uploads/2024/05/Stalking-harassment-trans-people.pdf
- Disasters safety planning guide webinar: *Weathering the*

Storm: Safety Planning for Natural Disasters with Trans/Nonbinary Survivors, https://youtu.be/EGeJzv4nUPI?si=udXDftPpeni0EXJP

- Safety planning blog: *Safety Planning for Disasters and Intimate Partner Violence*, https://trans-survivors.com/2023/07/18/safety-planning-for-disasters-and-intimate-partner-violence/
- SPARC (Stalking, Prevention, Awareness, and Resource Center) stalking guide for advocates (includes safety planning content): *Supporting LGBTQ+ Stalking Victims: A Guide for Victim Advocates (SPARC),* https://forge-forward.org/resource/supporting-lgbtq-stalking-victims-a-guide-for-victim-advocates-sparc/

Youth Resources

General Information

Adopting a Trauma Informed Approach for LGBT Youth, https://www.mass.gov/doc/adopting-a-trauma-informed-approach-for-lgbtq-youth-part-2/download

The Idaho Coalition Against Domestic and Sexual Violence: Teen Resources https://idahocoalition.org/teen-dating-violence/

For more on childhood trauma (not LGBTQ+ specific) check out: The National Child Traumatic Stress Network, https://www.nctsn.org/
Help Children by Changing Minds, https://changingmindsnow.org/
Recognizing and Treating Child Traumatic Stress, https://www.samhsa.gov/child-trauma/recognizing-and-treating-child-traumatic-stress

For more general information on child sexual assault and abuse check out: NSVRC SAAM blog *April is also Child Abuse Prevention* Month, https://www.nsvrc.org/blogs/saam/april-also-child-abuse-prevention-month

5 Keys to Healthy Relationships, https://www.nsvrc.org/publications/nsvrc-publications-sexual-assault-awareness-month-infographic/5-keys-healthy

Our Whole Lives: Healthy Sexuality Program, https://www.uua.org/re/owl

Service Providers, direct services

For more resources on working with teenagers and their caregivers check out:

Tip Sheet on Teen Survivors and Parents/Guardians, https://resourcesharingproject.org/wp-content/uploads/2021/11/Tip20Sheet20on20Teen20Survivors20and20Parents20and20Guardians20.pdf

Surviving and Thriving: Supporting Teens After Sexual Abuse, https://resourcesharingproject.org/resources/surviving-thriving-supporting-teens-after-sexual-abuse/

Serving Teen Survivors: A Manual for Advocates, https://www.nsvrc.org/sites/default/files/publications/2018-12/Serving%20Teen%20Survivors%20A%20Manual%20for%20Advocates.pdf

Tech Safety: Teens and Technology, https://www.techsafety.org/survivor-toolkit/teens-and-technology

A National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric, https://www.justice.gov/ovw/file/846856/dl

Grounding and Anxiety Management with Young Children Series (Part 1 of 3, with links to Parts 2 and 3) https://www.wcsap.org/resources/publications/tips-guides/youth-advocacy-therapy-tips/fingerholds

Th Advocates Guide: Working with Parents of Children Who Have Been Abused, https://nsvrc.org/sites/default/files/publications_nsvrc_guides_the-advocates-guide-working-with-parents-of-children-who-have-been-sexually-assaulted.pdf

Service Providers, collaborations and approach

Working with Young Survivors: Issue Briefs and Tipsheets (Note - Break the Cycle closed, so these do not get updated) https://www.breakthecycle.org/working-young-survivors/

Rural Collaborations to Prevent and Respond to Teen Dating Violence, https://idahocoalition.org/wp-content/uploads/2023/09/Rural-Collaborations-to-Prevent-and-Respond-to-Teen-Dating-Violence-2023.pdf

The Homeless and Runaway Youth and Relationship Violence Toolkit: Guidance and Materials for Advocates and Practitioners, https://rhytoolkit.org/toolkit/RHYtoolkit-NRCDV.pdf

Learn more with this resource on creating safer spaces: *Creating Safer Spaces for LGBTQ Youth: A Toolkit for Education, Healthcare, and Community-Based Organizations*, http://www.advocatesforyouth.org/wp-content/uploads/2020/11/Creating-Safer-Spaces-Toolkit-Nov-13.pdf

For Young People

Healing from Abusive Relationships for Teens & Young Adults, https://idahocoalition.org/wp-content/uploads/2021/01/ICA-20-091-Healing-from-Abuse-Teens-YA.pdf

Healing from Sexual Assault for Teens & Young Adults, https://idahocoalition.org/wp-content/uploads/2021/01/ICA-20-092-Healing-from-Sexual-Assault-Teens-YA.pdf

That's Not Cool: A project examining healthy and unhealthy relationships
https://thatsnotcool.com/

Love is Respect's *Safety Online,* https://www.loveisrespect.org/personal-safety/online-safety-while-dating/

Love is Respect's *Healthy Relationships*, https://www.loveisrespect.org/everyone-deserves-a-healthy-relationship/

Parents and Caregivers

Keeping Teens Safe On Social Media: What Parents Should Know To Protect Their Kids, https://www.apa.org/topics/social-media-internet/social-media-parent-tips

Resources For Parents And Caregivers – Connected Parents, Connected Kids, https://www.futureswithoutviolence.org/resources-for-parents-and-caregivers-CPCK

Conversations with Kids: Why It Is Important To Listen When Children Talk, https://www.wcsap.org/resources/publications/tips-guides/youth-advocacy-therapy-tips/conversations-kids

Safe Secure Kids: Provides information to increase parent/guardian and child connections: https://www.safesecurekids.org/

Family Support: Resources for Families of Transgender & Gender Diverse Children, https://www.lgbtmap.org/policy-and-issue-analysis/advancing-acceptance-for-parents

LGBTQ Youth & Family Resources To Decrease Mental Health Risks & Promote Well-Being, https://lgbtqfamilyacceptance.org/

Resources for parents of foster children:
https://www.childwelfare.gov/

Appendix A: Key Concepts

Gender affirming care

Gender-affirming care "encompasses a range of social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth." This includes social supports, counseling, and medical care (Boyle, 2022).

Gender-affirming care frequently refers to types of care related to supporting care specifically around someone's gender identity. However, gender-affirming care can and does extend to providing respectful, trans-aware, sensitive, and responsive care when a client needs general medical or behavioral healthcare services.

While some may consider gender-affirming care as related to hormones and surgery, for example, true gender-affirming care encompasses everything from addressing a client with their correct name and pronouns, having electronic medical records and forms that have space for people of all genders, an understanding of the barriers frequently faced by trans people, and the ability to work compassionately and respectfully with clients.

Meeting overall medical needs

Trans people report significant barriers in accessing basic

healthcare. Combined with the lower wages, less stable housing, lack of health insurance, widespread discrimination, as well as complex trauma histories, this can lead to trans people having higher overall unmet medical needs.

Many trans people delay addressing routine medical concerns due to these barriers. Some may have chronic or acute untreated medical conditions, including not receiving preventative screening or treating acute medical concerns.

When trans people do seek medical care, in addition to possibly being faced with trans-related discrimination or denial of care, some health care providers engage in shaming behaviors for not receiving routine medical care. Some providers will inappropriately focus on “trans issues” or body parts vs. the presenting issue the client is seeking care for.

> The vast majority of trans people who have sought care for minor concerns, such as a cold or a rash, have been asked about their genitals, if they have had surgery, and/or what it is like to have sex as a trans person. Of course, these questions are totally unrelated to the care they are seeking, offensive, and a major deterrent from seeking health care in the future.

Service providers need to be aware that survivors may be facing additional medical needs that are unrelated to the assault or were exacerbated by the assault. Providers may need to help survivors to connect with primary care or longer-term healthcare solutions in order to address these needs.

In addition to experiencing a wide array of health disparities and poor health outcomes, transgender people report higher rates of disability than non-transgender people. One study noted, “After confounders are controlled for, transgender adults have a 27 percent chance of having at least one disability at age twenty and a 39 percent chance at age fifty-five, which is nearly twice the rate of their cisgender counterparts at both ages (Smith-Johnson, 2022).”

Additionally, studies have indicated that transgender and nonbinary people are between 3-6% more likely to be Autistic (Warrier & Baron-Cohen, 2020). Note that Autism is not considered a disability by all Autistic people.

Further neurodivergent people and people with disabilities are sexually assaulted at higher rates. Knowing this, medical advocates, forensic nurses, and others who work with survivors should take time to learn about serving these communities.

Quick tips in working with people who are neurodivergent

- Take time to understand what someone is telling you and to check that they are understanding what you communicate.
- Do not make assumptions about why someone is communicating in a certain way.
    - Example: To help affirm and normalize your acceptance of communication styles, a provider could say: “Thank you for pulling out your notepad to jot down your ideas and help explain things more clearly.”
- Plan ahead for strategies to communicate with people

who are nonverbal.
    - Example: “I know this is difficult to be here. Some people like to have something to have in their hands while we talk. We have a basket of fidget spinners and other sensory objects. Would you like anything from it?”
    - Note: All of the above tips are relevant to all survivors. Trauma, brain injuries, developmental disabilities, exhaustion, and more can impact someone’s communication style.

Gender-Affirming Actions and “Transitioning”

Trans/nonbinary people may pursue a variety of actions as part of affirming their gender. Some trans/nonbinary people may not take any overt actions, while others may take many steps to affirm and live in their gender.

Some trans people may refer to specific actions as part of their “transition.” Others may not consider their actions (or non-actions) to be related to transitioning at all.

Keep in mind that some trans and nonbinary people move from one gender to another through social, legal, or medical steps, while others may not have a goal of transition. Some trans and nonbinary people may not take any social, legal, or medical actions to affirm and live within their gender.

Just like there is no one right way to be a cisgender (non-trans) woman or cisgender (non-trans) man, there is no one correct way to be trans or nonbinary. Every person (trans and non-trans) takes specific steps (consciously or not) to

affirm their gender.

Several decades ago, the medical community (and society) expected that trans people move from one socially defined gender to another. This is no longer true. The plurality of people within the trans/nonbinary population identify as nonbinary or a gender other than male or female. With this shift and expansion to acknowledging multiple genders has also come a shift in embracing multiple avenues for affirming a person's gender.

Similarly, many young people have accepting and affirming parents, adults, and friends. This acknowledgement has enabled some youth the option of living in their affirmed gender at earlier ages (mostly related to socially living in their true gender).

Regardless of if or when a person makes decisions around their social, legal or medical status, none of these decisions invalidate a person's identity or make them "less" trans.

Some of the common actions people might take include:

- Telling people or "socially transitioning".
    - This can include "coming out" or "inviting in" – sharing with others the person's gender, affirmed name and pronouns, and that they are trans, nonbinary, or of trans experience. Some people are out as trans in only some aspects of their life. Some people present as different genders in different situations for safety (and some do this because their gender is fluid and changes overtime).

    - People may change their name or pronouns with their friends/family/others.
    - Social “transitioning” can also include how people present and interact in the world. For example, someone may begin to play on a men’s sports team instead of the women’s team. People may make a variety of changes based on their lives and gender.
- Dressing/grooming in affirming ways.
    - This can include wearing clothing that is affirming, changing one’s hairstyle, using make-up, using prosthetics (e.g. breast or hip pads), packing (an item to create a penis-like bulge), binding (flattening of the chest), or tucking/gaffing (flattening and smoothing external genitals through tape or garments).
    - People may have a consistent form of dress/grooming or may present in different ways at different times.
- Accessing gender-affirming hormones.
    - Hormonal options include puberty blockers, testosterone, estrogen, progesterone, and spironolactone.
    - The amount and type of hormones people may use may change over the life course – either due to physical changes/needs, desired results from hormones, and/or because hormones may or may not be affordable.
    - People may receive hormones through a licensed provider or through other means (such as peers, non-licensed providers, or possibly providers in another country).
    - Hormones are more readily accessible in recent years due to more insurance companies providing coverage.

    - (Insurance coverage is not relevant if a person is un/underemployed.)
    - Hormones are also more available in recent years due to tele-health options that blossomed during the COVID pandemic. People who live in rural communities or don't have ready access to healthcare providers who feel comfortable/competent to prescribe, are now able to access effective and safe care through tele-health.
- Accessing gender-affirming surgery.
    - Many people are unable to afford gender-affirming surgery, even if surgery would help affirm their gender.
    - For those who have healthcare, an increasing number of insurance companies are offering gender-affirming care, including coverage of surgery.
    - There is no "one surgery" for trans people. There are numerous options, and some types of surgery may be more affirming to some individuals than others.
    - Surgical options can include:
        - Chest surgeries
            - Breast augmentation
            - Chest reduction/removal (typically called "top surgery")
            - Nipple removal or repositioning
            - Liposuction to redistribute fat/contour the chest
        - Genital surgeries
            - Orchiectomy
            - Vaginoplasty
            - Zero-depth vaginoplasty

- Vulvoplasty
- Labiaplasty
- Hysterectomy
- Metoidioplasty
- Phalloplasty
- Testicular implants
- Urethral extension
- Vaginectomy
- Liposuction or other modes to reshape tissue

- Facial or other forms of plastic surgery
  - Chondrolaryngoplasty (Tracheal shave)
  - Rhinoplasty (nose)
  - Blepharoplasty (eyelid)
  - Rhytidectomy (facelift, browlift)
  - Genioplasty (chin augmentation or reduction)
  - Otoplasty (ear repositioning)
  - Facial feminization (which can include any common facial plastic surgery, but might focus more on making changes to dominant features so as to appear in ways that are more traditionally perceived as feminine)
    - This may include forehead or brow recontouring, cheek augmentation, lip lift/augmentation, jaw angle reduction, hairline lowering or hair transplantation.
  - Liposuction and fat transfer
- Changing name or gender.
  - People may change their name or gender informally (socially) without a legal or court-ordered name change.
  - There are numerous documents that contain a

person's legal name and/or gender. It is difficult to change many of these documents without a legal name change.
    - Laws on changing names and gender markers vary by state.
    - Typically, the process of a court-ordered name or gender change is expensive. Changing gender markers often requires extensive verification and is not available to all people who want it.
    - In some states, not all documents can be changed or amended (for example, birth certificates).
    - For most people (trans or non-trans), it is difficult to change every document that contains a person's name. It is common for people to have some documents in a prior name, even if they attempt to change all documents.
    - The National Center for Transgender Equality has an ID documents resource (https://transequality.org/documents) that provides detailed information on how people can change their name/gender. The two sections include:
        - State/territory name change – providing information on general state laws, driver's license, and birth certificate changes for each state.
        - Federal identification and records, including how to change name and gender on passports; Social Security records, selective service, U.S. Immigration documents, military/veteran records, and consular birth certificates.
    - Some communities in urban areas offer support with name change clinics, that both provide the "how to"

as well as financial support.

- Seeking other adaptive practical support – such as voice training, changing physical mannerisms.
    - People may work on changing the pitch of their voice, changing their physical mannerisms, or taking other steps to change the way others might perceive their gender or how they feel affirmed in their bodies. There are some people that provide coaching in these areas.

Resource

The National Center for Transgender Equality has an ID documents resource (https://transequality.org/documents) that provides detailed information on how people can change their name/gender. The two sections include:

- State/territory name change – providing information on general state laws, drivers license, and birth certificate changes for each state.
- Federal identification and records, including how to change name and gender on passports; Social Security records, selective service, U.S. Immigration documents, military/veteran records, and consular birth certificates.

When working with trans/nonbinary people, it is important to realize that people may have taken no action in one area or taken a lot of actions; they may have plans to take further actions in the future or may not. They may be happy with how their gender is now or hope to do more to affirm their gender in the future. They may not be able to afford everything they want to do or be safe to take the desired actions.

Remember:
A person's gender identity – and how we treat/respect them – is not based on their social, legal or medical actions. Their gender is what they share with you, what they state it to be.

(see conducting exam section, page 47, for more details on how medical care may impact forensic exams)

Body and gender dysphoria

Body dysphoria is common for survivors of all genders. Body dysphoria is a state of feeling discomfort or misalignment within one's own body.

American culture reinforces stereotypical "standards" that many young people and adults believe they must conform to. "Standards" related to appearance, body size, shape, body proportions, skin color, age, and much more dictate the lives of nearly every person in the country, whether they are conscious of it or not. Most of these "standards" revolve around gendered expectations about appearance.

Trans and nonbinary people often live with body dysphoria, because they were raised in American culture and exposed to the same messages as non-trans people. Trans people may also experience gender dysphoria – a discomfort or feeling of misalignment between their body or the gender others perceive them as and their affirmed gender or view of their body.

NOTE: Gender dysphoria is a psychiatric diagnosis (Nokoff, 2022), often necessary for insurance coverage of gender-affirming medical care. Within trans communities this term is often associated with pathologization and the history of psychological and medical communities deeming being transgender as something “wrong” that needs to be “fixed.” This is often unwelcome and seen as harmful. Many trans communities assert that gender variation is natural and should not be stigmatized.

Trans and nonbinary people are sometimes more acutely aware of these culturally dictated “gender norms.” Some may learn to conform to binary gender norms, while others may chart a path outside of the system of only two genders.

Trans people may feel discomfort or dysphoria about or in their bodies. Some trans people do not feel dysphoria or might be dysphoric about only some aspects of their body, or only at specific times or places. Every person’s experience is valid and is not an indicator of “how trans they are.”

Trans and nonbinary people may be especially aware of or dysphoric about parts of the body that are typically considered gendered, such as their face, facial or body hair, hands, chest, or genitals.

Additionally, survivors of sexual violence may have added layers of feelings about their bodies, including being seen or touched by others. This might be connected to areas of the body that were assaulted or areas the person associates with the assault.

The consequences of this dysphoria or keen awareness may result in a person not wanting to disrobe or not wanting anyone to see or touch those parts of their body. There might be a heightened sense of shame or stigma – or not.

Advocates and health care providers can be cognizant of the possibility that trans/nonbinary survivors may be experiencing dysphoria or have experienced it in the past. Through this awareness they can approach medical care and evidence collection with compassion and thoughtfulness.

Quick Overview:

- Not all trans people want or use hormones. Not everyone who wants them can get them.
- Not all trans people want or have surgery. Not everyone who wants surgery(s) can get them.
- Not everyone feels uncomfortable with their body.
- Some trans people use different language than non-trans people for their bodies. Some do not.

Disclosure (or non-disclosure) implications for care

Disclosure is the process of sharing information about someone's trans/nonbinary experience with another person. Disclosure is not always necessary for someone to receive appropriate medical care, get supportive sexual assault services or other types of advocacy. Some trans/nonbinary survivors will disclose their gender identity/history, and some will not.

Reminder:
If someone is seeking post-assault care for a broken bone in their arm, they may not discuss their gender with anyone at the healthcare facility, with law enforcement, or with an advocate. Their gender is irrelevant to the care they are seeking.

Survivors may make disclosure decisions based on any of these factors (and others):

- People want to have control over what is shared about their life. Control over their own narrative is even more important for survivors, since control has already been taken away from them. So having control over their own narrative and sharing their stories and histories in a way that feels empowering, if at all, may be a central early component to their healing.
- Everyone has the right to privacy. Trans/nonbinary people have the right to determine whether or not they disclose their identity. Many health care providers are used to asking everyone their sex (a question that may disclose someone's trans status). It can be helpful to consider whether that information is actually necessary in order to provide care.
- Survivors are juggling a lot of emotions and concerns post assault. They can be struggling to prioritize what is most important to share with a provider, or what is most urgent to receive the care they need. Sharing information about their trans identity may be quite low on their priority list.
- Sharing information about one's gender takes energy and effort. Survivors do not always have the capacity to

engage in this process. A survivor may be focused on what feels most important to them – this could include a specific injury, an allergy, or other medical information that feels more relevant. They may also be more focused on the assault or on the next steps.

Disclosure may take on many forms; it is not limited to verbal communication.

- Someone may have already disclosed *for them* – either with that person's consent or not, with or without their knowledge.
- Sometimes paperwork does the disclosure of some information that a person might make inferences about. For example, health insurance cards, drivers license, intake forms, or prior medical records.
- A staff person addressing someone with a pronoun other than the one you might have expected or what the person told you – may prompt you to question what you knew about a person. This difference in pronouns may make you question whether someone is trans/nonbinary or not (ultimately semi-disclosing).
- Someone may offer that they use a name or pronoun that is different than their identification. While this doesn't tell you whether they are transgender, it does let you know how to respectfully engage with them.
- Someone may share about what body parts they do or do not have.
- Someone's body may disclose for them. For example, a healthcare provider may have an assumption that a person is a certain gender based on their outward appearance. Through the process of providing care, the provider may find the person has a different physical

anatomy than the provider had initially expected.

If someone does not disclose they are trans or of trans experience, there might be fewer ways for advocates or others to support the survivor in navigating possible barriers or challenges related to their transness. Although some people will not disclose information under any circumstance, providers can create an environment that makes it easier to share information.

Tips for responding to disclosures/lack of disclosure

- Assume good intentions. A person may not share information for any number of reasons. By assuming that they have a good reason, you are more likely to continue to treat the person compassionately and enhance a trusting relationship.
- Be mindful of facial expressions and body language. By not acting surprised or showing a reaction to new information, trans survivors will feel more comfortable sharing, since your response is accepting.
- Embrace the wide range of shapes and sizes of bodies. By being open and welcoming to all shapes and sizes of bodies, medical advocates and health care providers can not only create a more positive environment for trans/nonbinary people but for people with all types of bodies that are different from mainstream assumptions of "normal."
    - Whenever possible, healthcare facilities should have ample space in exam rooms, accommodating exam tables, bathroom space, and room for support individuals and accessibility devices within the exam

space. This relates to better serving trans people because 1) trans people have higher rates of disabilities, and may need greater space for physical accessibility, 2) may have accompanying support people who will also be in the room, and 3) larger, more open spaces, help reduce traumatic responses of possibly feeling 'trapped.'

- Ask for the information you need.
    - For example, if you need to know if someone may be at risk for pregnancy, the information you need might be asking if they have a uterus.
        - "Sexual assault can have many medical impacts. I ask these questions of all my patients so I can provide appropriate care. Do you have a uterus? If so, have you had any procedures or take any medications that will prevent pregnancy?"
    - For example: A patient shares they have pain in their ribcage area. You notice they have a binder on. The information you need is likely about if they are able/willing to allow the binder to be removed vs. why they are wearing a binder.
- Provide information to all people. Include options if you don't know about someone's body. (For example, would you like to discuss these types of medications)
- Use more general and less gendered language for everyone – "the next step is a swabbing of the outer genitals" instead of "the next step is a swabbing the labia."
- Share your name and pronouns. Organizations and healthcare facilities can help normalize this universal practice by printing name badges with the staff members'

pronouns. This shows patients that the facility/staff is aware that pronouns are not an assumption.

- “Go with the flow.” No survivor’s story or body is the same. Providers often encounter things they aren’t “expecting” to see or hear. Through listening, reflecting back, and making adjustments in real time, it allows for survivors to feel heard, to share more freely, and to feel acknowledged and validated by the “normalcy” of the provider's response and responsiveness.

References

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2019). Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). Trauma, Violence, & Abuse, 20(2), 260–283. https://doi.org/10.1177/1524838017697312

Boyle, P. (2022, April 12). What Is gender-affirming care? Your questions answered. Association of American Medical Colleges. https://www.aamc.org/news/what-gender-affirming-care-your-questions-answered

Brown, A. (2022, June 7). About 5% of young adults in the U.S. say their gender is different from their sex assigned at birth. Pew Research Center. https://www.pewresearch.org/short-reads/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/

Chen, J., Khatiwada, S., Chen, M. S., Smith, S. G., Leemis, R. W., Friar, N. F., Basile, K. C., & Kresnow, M. (2023). The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Victimization by Sexual Identity. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. nisvsreportonsexualidentity.pdf (cdc.gov)

dickey, l. m., Reisner, S. L., & Juntunen, C. L. (2015). Non-suicidal self-injury in a large online sample of transgender adults. Professional Psychology: Research and Practice, 46(1), 3–11. https://doi.org/10.1037/a0038803

University of California San Fransisco. (n.d.). Center of Excellence for Transgender Health {Website]. UCSF, Department of Medicine, Prevention Science. https://prevention.ucsf.edu/transhealth

FORGE. (2005). Sexual Violence in the Transgender Community Survey (Unpublished data); Kenagy, G. P. (2005). The health and social service needs of transgender people in Philadelphia. International Journal of Transgenderism 8(2/3), 49–56. https://doi.org/10.1300/J485v08n02_05;

Kenagy, G. P., & Bostwick, W. B. (2005). Health and social service needs of transgender people in Chicago. International Journal of Transgenderism 8(2/3), 57–66. https://doi.org/10.1300/J485v08n02_06

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

James, S. J., Herman, J. L., Durso, L. E., & Heng-Lehtinen, R. (2024). Early insights: A report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality. https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf

University of California San Fransisco. (n.d.). Center of Excellence for Transgender Health {Website]. UCSF, Department of Medicine, Prevention Science. https://prevention.ucsf.edu/transhealth

FORGE. (2005). Sexual Violence in the Transgender Community Survey (Unpublished data); Kenagy, G. P. (2005). The health and social service needs of transgender people in Philadelphia. International Journal of Transgenderism 8(2/3), 49–56. https://doi.org/10.1300/J485v08n02_05;

Kenagy, G. P., & Bostwick, W. B. (2005). Health and social service needs of transgender people in Chicago. International Journal of Transgenderism 8(2/3), 57–66. https://doi.org/10.1300/J485v08n02_06

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

James, S. J., Herman, J. L., Durso, L. E., & Heng-Lehtinen, R. (2024). Early insights: A report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality. https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf

Littel, K. (2016). A national protocol for sexual abuse medical forensic examinations: Pediatric (NCJ 249871). U.S. Department of Justice, Office on Violence Against Women. https://nij.ojp.gov/library/publications/national-protocol-sexual-abuse-medical-forensic-examinations-pediatric

Miriam. (2023, January 20). Can trans men take the morning-after pill? Ask the Experts. Planned Parenthood. https://www.plannedparenthood.org/blog/can-trans-men-take-the-morning-after-pill#:~:text=Emergency%20contraception%20won

Murchison, G. R., Agénor, M., Reisner, S. L., & Watson, R. J. (2019). School restroom and locker room restrictions and sexual assault risk among transgender youth. Pediatrics, 143(6), e20182902. https://doi.org/10.1542/peds.2018-2902

National Center for Transgender Equality. (2019). Housing & homelessness. National Center for Transgender Equality. https://transequality.org/issues/housing-homelessness

National Coalition of Anti-Violence Programs. (n.d.). National Coalition of Anti-Violence Programs [Webpage]. NYC Anti-Violence Project. https://avp.org/ncavp/

National Network for Youth. (n.d.). LGBTQ+ youth homelessness. https://nn4youth.org/lgbtq-homeless-youth/

Nokoff, N. J. (2022, January 19). *DSM-5 criteria for gender dysphoria.* National Institute of Health, National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK577212/table/pedia t_transgender.T.dsm5_criteria_for_g/

Office of Civil Rights. (2014, April 9). *Frequently asked questions: Nondiscrimination grant condition in the Violence Against Women Reauthorization Act of 2013*. U.S. Department of Justice. https://www.justice.gov/archives/ovw/file/29386/download

Smith-Johnson, M. (2022). Transgender adults have higher rates of disability than their cisgender counterparts. *Health Affairs, 41*(10), 1470–1476. https://doi.org/10.1377/hlthaff.2022.00500

State of California, Office of Emergency Services. (2001). *Forensic medial report: Acute (<72 hours) adult/adolescent sexual assault examination.* www.ccfmtc.org/wp-content/uploads/2-923-Form1.pdf

US Census Bureau. (2024). *Household Pulse Survey*. USA Facts. https://usafacts.org/articles/what-percentage-of-the-us-population-is-transgender/

Warrier, V., & Baron-Cohen, S. (2020, August 7). Transgender and gender diverse people up to six times more likely to be autistic – new study. *The Conversation*. https://theconversation.com/transgender-and-gender-diverse-people-up-to-six-times-more-likely-to-be-autistic-new-study-144085

Weiss, T. C. (2012, November 20). People with *disabilities and sexual assault*. Disabled World. https://www.disabled-world.com/disability/sexuality/assaults.php#ixzz2SXMEQWra

Wilson, E., Rapues, J., Jin, H., & Raymond, H. F. (2014). The use and correlates of illicit silicone or "fillers" in a population-based sample of transwomen, San Francisco, 2013*. The Journal of Sexual Medicine, 11*(7), 1717–1724. https://doi.org/10.1111/jsm.12558

Woods, J. B., Galvan, F. H., Bazargan, M., Herman, J. L., & Chen, Y. (2013). Latina transgender women's interaction with law enforcement in Los Angeles County. *Policing: A Journal of Policy and Practice, 7*(4), 379–391. https://doi.org/10.1093/police/pat025

Zevin, B., & Deutsch, M. B. (2016). *Free silicone and other filler use*. University of California San Francisco Gender Affirming Health Program. https://transcare.ucsf.edu/guidelines/silicone-filler