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Mental Illness as a Vulnerability for Sexual Assault: A Retrospective Study of 7,455 Sexual Assault Forensic Medical Examinations

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Background: Persons with severe mental illness (MI) are at a high risk of becoming victims of sexual assault (SA). Vulnerability for SA with any type of MI is unknown. This study aimed to identify the prevalence of preexisting MI and other significant factors in patients reporting preexisting MI at the time of their SA medical forensic examinations (SAMFEs).

Method: A retrospective SAMFE chart review of patients ($N = 7,455$) from 2010 to 2020 was conducted. Sexual assault nurse examiners completed SAMFEs. Inclusion criteria included (a) aged 14 years and older, (b) completed SAMFE with SA kit evidence collection, and (c) reported to law enforcement (restricted cases not included). Descriptive statistics and chi-square analyses were completed.

Findings: It was found that 46.7% of study participants reported preexisting MI and/or current use of psychotropic medications, more than double the MI prevalence rates in the general population. MI in patients seen for SAMFE was associated with prior history of SA, medical health problems, and physical or mental impairment. In addition, patients with MI reported more violent SAs with increased anogenital and nonanogenital injuries.

Discussion: The high prevalence rate of any MI in patients seen for SAMFE indicates MI in varying severity is a significant vulnerability for SA. The association of preexisting MI with a history of SA, health problems, and physical or mental impairment expands understanding of associated MI factors. These findings support the development of interventions by healthcare providers and stakeholders to address SA vulnerabilities in individuals with MI.

KEY WORDS:

Evaluation; mental health; mental illness; sexual assault; sexual assault medical forensic examination; vulnerabilities

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This article is not registered with Prospero because it is not a systematic review or protocol. A search of PROSPERO found no related reviews or protocols.

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Sexual violence is highly prevalent in our communities and a major public health problem. The U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2019) reported the rate of rape or sexual assault (SA) increased from 1.4 victimizations per 1,000 persons in 2017 to 2.7 per 1,000 in 2018. Unfortunately, these available statistics do not reveal actual SA prevalence as it is the most underreported crime in the United States, with only 25% or less reported to police in 2018 (Morgan & Oudekerk, 2019).

The findings are even more troubling as SA has been shown to result in serious long-term mental and physical health consequences, as well as substantial social and public health costs (Angelone et al., 2018; Carey et al., 2018; Dworkin et al., 2017; Sachs-Ericsson et al., 2014; Santaularia et al., 2014; Valentine et al., 2019). Black et al. (2011) reported that 81% of women and 35% of men reported significant short-term or long-term impacts, such as posttraumatic stress disorder (PTSD), depression, and anxiety. The negative individual consequences after SA are broad and include psychological dysfunction, PTSD, suicidality, mental illness (MI) onset, and increased vulnerability to future SA (Combs et al., 2014; Dworkin et al., 2017). It is postulated that preexisting MI can inhibit a person's capacity to perceive threatening situations (Dworkin et al., 2017) and make one more susceptible to SA. The relationship between SA and MI appears to be bidirectional, with SA contributing to the development of MI and MI increasing vulnerability for SA (Grubaugh et al., 2011).

According to the National Institute of Mental Health (NIMH, 2018), one in five adults in the United States experiences MI per year. Severity varies from mild to severe MI (SMI). The NIMH defined SMI as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. In the United States, SMI prevalence is 4.5% (Substance Abuse and Mental Health Services Administration, 2018). Individuals with SMI are at a higher risk for becoming victims of violence (Khalifeh & Dean, 2010; Khalifeh et al., 2015; Latalova et al., 2014), with sixfold higher odds of sexual violence (Khalifeh et al., 2016).

Although prior studies have documented the relationship between preexisting SMI and SA, few studies have explored the relationship between preexisting MI of any severity and vulnerability for SA. The purpose of this retrospective, exploratory study was to identify the prevalence of preexisting MI in patients receiving SA medical forensic examinations (SAMFEs) and evaluate associated patient and assault variables.

Design/Methods

This study is novel by exploring whether any degree of preexisting MI is a vulnerability for SA. Retrospective chart reviews were conducted of patients ($N = 7,455$) receiving a

SAMFE (2010–2020) in eight of the most populous counties (representing 84% of the population) in a U.S. western state. Inclusion criteria were age of 14 years or older, a completed SAMFE with SA kit (SAK) evidence collection, and reported to law enforcement. Most of the SAMFEs were completed by SA nurse examiners (SANEs). Military and restricted cases were excluded. Institutional review board approvals and Memoranda of Understanding were obtained from participating agencies.

Variables from SAMFE forms were coded into SPSS 25 statistical software (IBM, 2017) by the research team: a PhD-prepared SANE-A (certified adult/adolescent SANE), two Doctorate of Nursing Practice certified psychiatric nurse specialists, and three graduate and eight undergraduate research assistants.

Demographic information included age, gender, race, and housing status. SANEs documented physical and mental impairments based on assessment and patients' verbalized medical histories. Physical impairments included mobility, sight, and hearing disabilities. Mental impairments included dementia, psychosis, cognitive impairments, and developmental disabilities. Prior histories of SA under the age of 14 years and over the age of 14 years were questions asked in the SAMFEs by SANEs in the largest county and all sites after 2018.

Assault factors included suspect relationship, assault location, suspect actions, suspected drug-facilitated assault, multiple suspects, and the number of assaultive or penetrative acts. Assault factors were analyzed to identify differences in assault characteristics between patients with MI and patients without MI.

The SAMFE form did not prompt the SANE to query directly about MI; however, patients were asked about current medical conditions. If patients self-disclosed MI, researchers coded the information into MI disorder categories: anxiety, attention-deficit/hyperactivity disorder (ADHD)/attention deficit disorder (ADD), bipolar disorder, depression, drug and alcohol, personality disorders, PTSD, psychosis, and others (such as eating disorder).

Patients were not directly asked about current psychotropic medication use during the SAMFE but asked about current medications. Self-disclosed psychotropic medications were used to identify patients who did not self-disclose MI; however, the use of psychotropic medication indicated current MI treatment. Because many patients with MI are treated with psychotropic medications, the use of psychotropics was an indicator of currently treated MI but not diagnostic.

Medications were analyzed for psychotropics and classified according to the most common MI use: addiction, anti-anxiety, ADD/ADHD, antidepressant, atypical and typical antipsychotics, bipolar disorder, and sleep aids. Because many psychotropics are also utilized for medical treatment (e.g., headaches, pain, and seizure conditions), medications were analyzed by two psychiatric nurse specialists. If any medical conditions were reported in which psychotropic

medications could be used as treatment (e.g., antidepressants or antiseizure medications for pain), the psychotropic medication was not included under psychotropic medication use. Medications misspelled in the SAMFE forms were searched online for the correct spelling. For inclusion, the drug name had to appear in the Internet search, and two investigators had to concur (see Table 1 for psychotropics examples). Over-the-counter medications (e.g., melatonin, St. John's wort) were not included. When combined, self-disclosed MI and psychotropics yielded an MI prevalence of 47%.

Physical nonanogenital and anogenital injuries were obtained from SANE documentation in the SAMFE patient charts. For nonanogenital injuries, the location on the patient body (head, neck, chest/back, abdomen, extremities), type (abrasion, avulsion, bite mark, bruise, burn, conjunctival hemorrhage, discolored mark, ecchymosis, bone fracture, incision, laceration, missing or broken teeth, petechiae, puncture wound, redness/erythema, and swelling), and the number of injuries were included in the data set. Tenderness without visible evidence was not included as an injury. For anogenital injuries, the location for both female and male genitalia, type (abrasion, avulsion, bruise, ecchymosis, incision, laceration, petechiae, puncture wound, redness/erythema, and swelling), and the number of injuries were included in the data set. Areas of tenderness or redness alone were not counted as injuries for anogenital injuries.

Data Analysis

Descriptive statistics, frequencies, and measures of central tendency as appropriate for categorical and continuous variables were analyzed for included variables. Associations between variables and the variable of self-disclosed MI were evaluated with chi-square analysis. Independent samples *t* tests were conducted for continuous variables. Ten percent of cases were recoded to assess interrater reliability with Cohen's kappa coefficient.

Missing Data

To determine the best approach to handling missing data, the percentage of cases with missing data was evaluated.

The number of cases with missing data on variables of interest ranged from 4 to 64 cases, 0.05%–0.86%. Further exploration on missing data found the cases with missing data were missing completely at random, indicating that the SANE forgot to document a variable. As the percentage of cases with varied missing data was very low in this large study size, these cases remained in the data analysis.

Results

Results are presented in the following categories: demographics, patient factors, assault factors, self-reported pre-existing MI, and self-reported psychotropic medication use by type. Cohen's kappa was 0.9555, indicating high interrater reliability.

Demographics

The age range was 14–94 years with a mean age of 27.55 years; 95% were female, and 5% were male. The SAMFE form did not designate transgender and intersex patients until 2018. Because of low numbers of transgender ($n = 35$) and intersex ($n = 9$) patients, these cases were not included in the data analysis. Patients with MI were more likely to be White compared with those without MI (83.4% vs. 76.7%; $p = 0.000$). Patients with MI were more likely not to have a permanent address (25.6% vs. 19.2%; $p = 0.031$).

Patient Factors

Patients with MI were more likely to have a prior history of SA compared with patients without MI, both before the age of 14 years (58.5% vs. 41.5%) and at the age of 14 years and above (60% vs. 40%; $\chi^2, p = 0.000$). In addition, they reported more current medical problems (57.2% vs. 42.8%; $p = 0.000$) and chronic medical problems (50.6% vs. 31.8%; $p = 0.000$) than persons without MI. Patients with self-reported MI also had more physical and mental impairments than patients without MI (13.5% vs. 6%; $p = 0.000$). Documented physical and mental impairments included visual impairment, hearing impairment, cognitive impairment, developmental delay, physical mobility

TABLE 1. Examples of Psychotropic Generic Medications by Category

Medication category	Examples
Addiction	Acamprosate, buprenorphine, methadone, Nicotrol
Antianxiety	Alprazolam, buspirone, clonidine, clonazepam, diazepam, lorazepam
ADD/ADHD	Atomoxetine, amphetamine, methylphenidate, guanfacine
Antidepressant	Bupropion, citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine
Antipsychotic: atypical	Aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone
Typical	Chlorpromazine, haloperidol, pimozide
Bipolar	Lithium, lamotrigine, valproic acid
Sleep	Temazepam, trazodone, zaleplon, zolpidem

ADD = attention deficit disorder; ADHD = attention-deficit/hyperactivity disorder.

TABLE 2. Patient Variables Associated With Mental Illness, N = 3,485 of 7,455

Variable	n	χ^2	df	p < 0.05	
Chronic medical condition	1,762	269.644	1	<0.001	
Current medical problem	1,940	255.014	1	<0.001	
Prior history of SA over the age of 14 years	1,213	177.504	1	<0.001	
Race	White	2,865	159.458	1	<0.001
	Minority	573			
Prior history of SA under the age of 14 years	1,125	128.886	1	<0.001	
Physical/mental impairment	470	122.404	1	<0.001	
Permanent address ^a	979	15.163	1	<0.001	

Note. χ^2 = chi-square; df = degrees of freedom; SA = sexual assault. p < 0.05 = asymptotic variance (two-sided t test).
^aPermanent address variable was not collected until 2018, n of valid cases = 2,679.

impairment, and severe psychosis with delusions/hallucinations/mania/paranoia (see Table 2 for χ^2 results on variables associated with MI).

Assault Factors

Patients with MI had differing percentages of suspect relationships than patients without MI, $\chi^2(df = 6, N = 7,455) = 12.995, p = 0.000$, with higher rates of rape by acquaintances (58.6% vs. 57.7%) and others, for example, family member, boss, and teacher (6.4% vs. 5.7%), and lower rates of rape by spouses or partners (5.8% vs. 7.8%). Patients with MI also reported statistically significant differences in locations of SA compared with patients without MI, $\chi^2(df = 4, N = 7,455) = 29.246, p = 0.000$, with more reporting locations as outside (10.3% vs. 8%) and other location, for example, motel and business (16.4% vs. 13.6%). The only suspect action with a statistically significant difference was greater use of weapons during the assault for patients with MI than patients without MI, $\chi^2(df = 2, N = 7,455) = 7.208, p = 0.000$ (10.8% vs. 9.1%). Patients with MI reported a higher number of assaultive or penetrative acts ($M = 2.49, SD = 1.509$) than patients without MI ($M = 2.39, SD = 1.559$), $t(7144) = -2.636, p = 0.008$, and a higher number of documented physical injuries ($M = 6.62, SD = 10.620$) compared with patients without MI ($M = 5.68, SD = 9.369$), $t(6932) = -4.011, p = 0.000$. In addition, patients with MI had more documented anogenital injuries ($M = 1.57, SD = 3.001$) compared with patients without MI ($M = 1.43, SD = 2.558$), $t(6639) = -2.055, p = 0.040$. No statistical differences were found in suspected drug-facilitated assaults or multiple suspect assaults.

Preexisting MI

As shown in Table 3, 42.8% ($n = 3,192$) of patients seen for a SAMFE self-disclosed MI when asked about current medical conditions; 41.6% self-disclosed use of psychotropic medications ($n = 3,108$). When combined, self-disclosed MI and psychotropics yielded an MI prevalence of 46.7% ($n = 3,485$). Combining self-disclosed MI and self-disclosed

use of psychotropic medications provided the most accurate prevalence rate of MI. Some patients openly disclosed MI, whereas others did not report MI when asked about current health problems but reported prescriptions for psychotropic medications. The most frequently reported conditions were depression (26.1%) and anxiety (23.3%). Other MI prevalence rates included the following: bipolar disorder (9.4%), PTSD (7.6%), ADHD/ADD (5.7%), psychotic disorders (2.7%), personality disorders (2.3%), drug and alcohol disorders (1.6%), and eating disorders (0.7%). The NIMH (2018) statistics were utilized for data comparison of preexisting MI prevalence (see Table 3).

Psychotropic Medication Use by Type

Over 42% of patients self-disclosed taking at least one psychotropic medication. Self-disclosure of antidepressant medications was the most common psychotropic medication (55.4%) in patients who self-disclosed psychotropic

TABLE 3. Types of Mental Illness (MI) Compared With National Institute of Mental Health (NIMH) Prevalence Rates

MI disorder categories	Study, N = 7,455	NIMH (2018)
Depression	26.1% ($n = 1947$)	7.1%
Anxiety	23.3% ($n = 1738$)	19.1%
Bipolar	9.4% ($n = 702$)	2.8%
Posttraumatic stress	7.6% ($n = 563$)	3.6%
Attention deficit	5.7% ($n = 423$)	4.4%
Psychotic	2.7% ($n = 203$)	0.64%
Personality	2.3% ($n = 169$)	9.1%
Drug and alcohol	1.6% ($n = 119$)	1.4%
Eating	0.7% ($n = 53$)	2.7%

Note. Numbers are not mutually exclusive to one patient as some patients disclosed more than one mental disorder.
 Categories of mental illness disorders organized by the American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Disorders not listed: dissociative identity, oppositional defiant, and seasonal affective as numbers were smaller and no comparison data were available.

TABLE 4. Psychotropic Medication Use in Patients Seen for SAMFE Who Disclosed Mental Illness, N = 3,108

	n	%
Antidepressants	1,930	55.4
Antianxiety	937	26.9
Antipsychotics		
Atypical	746	21.4
Typical	42	1.2
Mood stabilizers	641	18.4
Sleep aids	613	17.6
Psychostimulants	432	12.4
Addiction	111	3.2
Other ^a	244	7.0
Polypharmacy, <3 psychotropic medications	965	27.7

Note. Prevalence of medication use is >100% as some patients disclosed more than one type of medication. SAMFE = sexual assault medical forensic examination.
^aOther category includes common medications used to treat anxiety and post-traumatic stress disorder symptoms (e.g., prazosin, hydroxyzine, clonidine, propranolol) as well as antipsychotic medications for extrapyramidal symptoms (e.g., benztropine, trihexyphenidyl, propranolol).

medication use (see Table 4). Polypharmacy, defined as three or more psychotropic medications, had a high rate (27.7%).

Discussion

This study aimed to identify the prevalence of preexisting MI and associated significant factors in patients at the time of their SAMFEs. Females were predominantly represented, which aligns with the increased SA prevalence rate for women. Recent statistics indicate that one in five women and one in 14 men will experience rape or sexual violence in their lifetime (Smith et al., 2018). In the United States, 10% of victims who report SA are male (Department of Justice, 2013). Males were underrepresented in this study as approximately 5% of the victims were male. Although SA among the lesbian, gay, bisexual, and transgender population is significantly higher than that among their cisgender counterparts (Dank et al., 2014), their reporting numbers in this study were low. This is an area that deserves further exploration.

Homelessness, often associated with MI, was higher (25.6%) than those without MI (19.2%). Persons who are homeless are disproportionately impacted by personal crime, including SA (Heerde & Hemphill, 2016), and less likely to seek care (Santa Maria et al., 2020). Homelessness appears to be a significant vulnerability for SA, especially in those with MI.

Considering this study's young mean age of 27.55 years, the high rates of preexisting and chronic medical problems among those with MI are highly concerning. The large percentage of patients reporting a prior history of SA under the age of 14 years (58.5%) and over the age of 14

years (60%) underscores the need to provide appropriate, adequate, and possibly long periods of mental health treatment for those who have experienced SA. The finding of prior history of SA as highly associated with MI and medical problems supports the results from the Adverse Childhood Experiences study (Felitti et al., 1998), which identified associations between childhood trauma and physical and mental illnesses. Prior history of SA has been associated with future chronic medical conditions (Dube et al., 2005).

Patients with MI reported some significant differences in assault factors compared with patients without MI. Patients with MI had higher rates of rapes by acquaintances and other known individuals (family members, bosses, teachers), indicating these assailants may have assaulted victims they knew had increased vulnerabilities related to MI. Patients with MI reported more violent rapes, higher weapon use, more assaultive or penetrative acts, and more physical and anogenital injuries. These findings heighten concerns about the violence experienced by victims with MI and resulting physical and mental health impacts.

Other studies reporting MI prevalence in patients seen for SAMFE used different methodologies of assessing patients for MI. Discrepancies in prevalence findings between this study and other studies (Christ et al., 2018; Culatta et al., 2020; Brown et al., 2013; de Waal et al., 2017; Manning et al., 2019) may be related to whether patients were directly asked about having an MI. In a study of 180 individuals, Manning et al. (2019) reported an MI prevalence rate of 69% when patients were directly asked about MI. Because patients were not directly asked if they had MI in our study, MI may have been underreported because of stigma (Bharadwaj et al., 2017). Stigma about MI and lack of recognition of MI as a medical condition may have resulted in patients not disclosing MI when not explicitly asked (Bathje & Pryor, 2011; Schomerus et al., 2012). The number of patients who self-disclosed MI or used psychotropics was almost 2.5 times higher than MI in the general population (NIMH, 2018), which strongly indicates that persons with preexisting MI are more vulnerable to SA. The high rate of polypharmacy of psychotropic medications warrants further study.

Another possible explanation for the high rates of self-reported MI in our study is that persons with diagnosed MI might be more likely to seek medical care after SA. Previous receipt of mental health care was associated with over 4 times greater likelihood of persons to use mental health care after SA in one study (Price et al., 2014). Therefore, it could be possible that persons treated for MI are more accustomed to seeking health care. Another consideration is that persons with MI may lack informal social supports that persons without MI utilize after traumatic events and thus are more likely to seek formal support. Yet, these explanations likely do not account for the substantially higher rates of MI found in this study.

All types of MI disorders had significantly higher prevalence rates in the study sample than U.S. prevalence rates.

Depression prevalence was over 3 times higher (NIMH, 2018). Krahé and Berger (2017) found depression to be a risk factor for both a first SA and SA revictimization. Higher prevalence rates were found for ADD/ADHD, anxiety, bipolar disorder, PTSD, and psychotic disorders. Personality disorders are generally not viewed as a medical condition and are not treated with medications, which could explain the lower reporting rates. MI disorders are characterized by changes in emotions, thinking, and behaviors. These deviations could impact a victim's presentation and judgment, which could contribute to increased vulnerability for SA.

Analyzing prescribed psychotropic medication classes provided another view into current psychiatric illnesses being treated in patients seen for SAMFE. Classes of psychotropic medications are mostly aligned with self-reported MI of depression, anxiety, bipolar disorder, psychotic disorders, and ADD/ADHD. It should be noted there are no specific medications to treat PTSD, personality disorders, and eating disorders. Over 41% of patients self-disclosed taking at least one psychotropic medication. Unfortunately, there are very limited data available on national psychotropic medication use for comparison. Overall, antidepressant medication use (28.5%) was more than double the reported 12% rate from Moore and Mattison's (2017) analysis of U.S. 2013 Medical Expenditure Panel Survey data, which is the percentage of the U.S. population using antidepressants but does not specify a depression diagnosis. Among those who self-disclosed psychotropic medication use, antidepressant medications were most prominent (55.6%). Anti-anxiety medications (26.9%) were the second most commonly used psychotropic medication, more than 3 times the national rate of 8.3% (Moore & Mattison, 2017). Notably, the combined class of antipsychotics (typical: 1.2%, atypical: 21.4%) yielded a rate of 22.6% in patients who self-disclosed psychotropic medications. The rate of antipsychotic medication use in this study (11.5%) was more than 7 times the national rate of 1.6% (Moore & Mattison, 2017). Atypical antipsychotics are often first-line treatment options for psychotic illnesses like schizophrenia and bipolar disorder and adjunct treatment for depression.

Strengths and Limitations

The major strength of this study is the large sample size over a 10-year period from several sites representing urban and rural areas. As a retrospective chart review, no other sources of information were available to verify patients' disclosure of medications or diagnoses. Data collected from SAMFE forms were dependent on patients' self-disclosures of MI and psychotropic medications and SANEs' documentation. Patients were not directly asked about MI but asked a question about medical conditions, so the response was dependent on patients' understanding of their mental health. If patients did not provide information about current medications or diagnoses, our methodology excluded these patients.

Our data may not reflect the entire prevalence of MI in this population as some patients may not have reported MI or specific psychotropic medication use. In addition, patients presenting for SAMFEs do not represent all persons who are sexually assaulted. Because of low numbers of transgender and intersex patients, this patient population was not represented in our data. The findings from this study may not be generalizable to other populations with higher rates of minorities.

Clinical Implications for Forensic Nursing Practice

"The constructed theory for forensic nursing care" (Valentine et al., 2020) provides a framework for exploring the clinical implications of this study. The constructed theory of forensic nursing care assumes forensic nurses provide specialized care to diverse populations impacted by violence and trauma and practice as part of an interdisciplinary team. The theory propositions state that forensic nursing informs, impacts, and improves patient health outcomes, forensic evidence outcomes, and criminal justice system outcomes, with patient health outcomes as the primary focus.

The concept of caring is integral to all nursing, including forensic nursing, and is both an ethic and an action (Valentine et al., 2020). An aspect of caring critical to forensic nursing is providing trauma-informed care, recognizing SA is a traumatic event requiring strategies to mitigate further trauma (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The six principles of trauma-informed care (SAMHSA, 2014) include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and consideration of cultural, historical, and gender issues. The application of these principles during a SAMFE may be even more important when caring for patients with MI (Downing et al., 2019) as they are more likely to have a prior trauma history.

Another essential concept within forensic nursing is social justice (Valentine et al., 2020), which implies patients' rights are respected, regardless of their characteristics or vulnerabilities. All professional disciplines who interact with SA victims should develop targeted prevention strategies to reduce sexual violence of persons with MI while working to reduce sexual violence in our communities. These concepts are integral to providing holistic, patient-centered, trauma-informed care to patients after SA.

Regardless of MI history, all persons are at risk for MI after SA. Forensic nurses and survivor advocates should provide mental health resources to patients after SAMFE. Patients should be evaluated for suicidal ideation and self-harm. Any endorsement of past or current suicidal thoughts should be discussed with the attending healthcare provider to assess suicide risk before the patient is discharged. If

available, a psychological consultation should be arranged to evaluate for safety and discuss follow-up care.

Despite high MI and substance use disorder rates after SA, follow-up for mental health concerns after SAMFE is low (Price et al., 2014). Therefore, the SAMFE might be the only opportunity for a healthcare provider to identify the risk for adverse mental health outcomes and emphasize the importance of follow-up care and counseling. The presence of a survivor advocate during the SAMFE might decrease barriers to seeking follow-up support as advocates can reduce patient distress and improve interactions with healthcare personnel and law enforcement (Campbell, 2006).

Educating the interdisciplinary team of professionals who respond after SA (e.g., SANEs, hospital staff, advocates, law enforcement, prosecutors) about the connection between MI and SA can decrease bias and stigma and promote understanding of how to better engage persons with MI. Positive interactions with interdisciplinary team members may promote mental health and engagement of victims in the legal process.

Conclusion

The findings from this study indicate preexisting MI is a substantial vulnerability for SA. Patients seen for SAMFE self-disclosed MI and/or use of psychotropic medications at more than twice the prevalence rate in the general population. Educating stakeholders (e.g., interdisciplinary team members, law enforcement, prosecutors, mental health providers) of the increased vulnerability of persons with MI for SA can inform prevention strategies for persons with MI.

Understanding the association between MI and SA is critical for SANEs to provide trauma-informed care to diminish negative sequelae after SA and promote positive health outcomes. Some patients might not disclose MI because of fear of stigma or self-stigma. However, knowing about a patient's history of preexisting MI can alert the SANE to the need to consider additional coping strategies during the SAMFE and ensure appropriate follow-up referrals are in place.

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