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Attitudes of emergency nurses toward victims of sexual assault

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Attitudes of emergency nurses toward victims of sexual assault

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San Jose State University, 1992

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ATTITUDES OF EMERGENCY NURSES TOWARD
VICTIMS OF SEXUAL ASSAULT

A Thesis

Presented to

The Faculty of the Department of Nursing

San Jose State University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science

By

Anita Ruiz-Contreras

December, 1992

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ABSTRACT

EMERGENCY NURSE ATTITUDES TOWARD VICTIMS OF SEXUAL ASSAULT

by Anita Ruiz-Contreras

This descriptive study examines the attitudes of registered nurses ($N=26$) toward victims of sexual assault. The nurses worked in the emergency department of a large publicly funded hospital. The focus was on whether or not the nurses held strong beliefs in myths and misconceptions that surround sexual assault. The instrument was modified from a previous study (Cochrane, 1986) of emergency nurses' attitudes.

The study showed that the majority of the nurses in the sample did not believe in myths and misconceptions about rape. The nurses strongly identified rape as a crisis event in the life of a sexual assault victim. These findings suggest that nurses are aware of rape myths and misconceptions. However, it was also clear that nurses do not want to care for victims of rape. The reason for this is unclear. It may be that the nurses find it difficult to communicate therapeutically with the victim of a sexual assault. Areas of future research could include the development of a tool to examine why nurses tend not to work with these victims.

Inservice training in the area of sexual assault victim care needs to have an emphasis on nurse-patient communication. Crisis counseling techniques need to be developed that specifically deal with adult female victims of sexual assault.

ACKNOWLEDGEMENTS

I would like to dedicate this thesis to my late father, John L. Ruiz who taught me to fly high. I would like to express my sincere appreciation to a number of people: To Susan Murphy for getting me through when it did not seem possible, to Frances Munet-Vilaro for her job as second reader, to Sharon Hogan for years of understanding that graduate students also have lives to live, to my mother, Dorothy and sister, Rose who saved both my life and my sanity, to Rosie, for making me see the promise of a better future, to my friends at Valley, in ACLN, and in TEC who believed in me, and to my husband, the victim in my quest for knowledge, may he someday understand that I do and have always appreciated the wonderful things he does for me. I love you, Peter. Thanks for the memories.

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Chapter 1

INTRODUCTION

Background

Sexual Assault is considered one of the fastest growing crimes in the United States (Bassuk & Apsler, 1983; Valley Rape Crisis Center, 1988). It is estimated that one in 10 females and one in three males will be sexually assaulted in their lifetime (Valley Rape Crisis Center, p. 1). In 1989, there were an estimated 94,504 forcible rapes reported in the United States (FBI, 1989). In comparison to 1988, the 1989 forcible rape volume increased 2% nationwide. It is estimated that a forcible rape occurs in the United States every 6 minutes.

Rape must be viewed as more than a sexual act (Green, 1988). Green says of rape that, "it is a profound and violent insult to the body and psyche" (p. i). Sexual assault is a crime where one person uses sex to degrade, humiliate, and control another person (Foley & Davies, 1983). It is this author's experience that nurses confuse sex and rape. There is a misconception that women who have had sex should not be as upset about being raped as a woman who was a virgin at the time of her attack. Many think sexual assault is merely rough sex. Some believe the virgin who has been raped has just had a bad "first sexual experience." Rapists use sex as

a weapon, not to sexually gratify themselves or their victims. In this society, there is not a recognition of sexual assault as a violent, life threatening event. Nevertheless, rape is often the most significantly disturbing event of the victim's life.

Sexual assault has been called the most under-reported crime in the United States (Green, 1988). Studies have shown that less than 10% of all sexual assaults are reported to the police (U.S. Congress, 1990). Historically, victims have feared reporting the sexual assault for a number of reasons: (a) fear of not being believed, (b) feelings of guilt that they in some way contributed to the attack, and (c) uncertainty as to whether what occurred would be considered rape (such as in the case of acquaintance rape). These fears or beliefs are long held misconceptions that surround sexual assault. Fears experienced by the victim may be reinforced by the individuals whom the sexual assault victim encounters after the attack. These individuals include friends, family, police, and health care workers.

Problem Area

Sexual assault victims often seek medical care as one of the first steps in coping with the reality of the assault. Medical attention after a sexual assault is necessary to treat injuries, prevent venereal disease, and prevent unwanted pregnancy. The California State Medical Protocol for the

Examination and Treatment of Sexual Assault Victims (Office of Criminal Justice Planning [OCJP], 1987) states that immediate, comprehensive medical care is critical to alleviate the emotional as well as the physical trauma of a sexual assault victim.

Medical personnel have not always reacted therapeutically to the sexual assault victim (Green, 1988). Gilmore and Evans (1980) state "that nurses, from all specialties, are raised on the same myths and misconceptions as the general public" (p. 50). "The prevailing attitudes in society are not on the side of the victim" (Burgess & Holmstrom, 1979, p. 127). Nurses may have an aversion to caring for victims of sexual assault. The nurse may feel unprepared or uncomfortable about talking with the victim. In classes given by this author, a common request is to discuss what the health care worker should say to the victim. Nurses find it difficult to identify with the sexual assault victim. Even nurses who have been assaulted in the past view their own assault differently than that of their patients. The nurse may see her experience as a "real rape" but not be so sure about her patient's story. The nurse may also distance herself to feel less vulnerable and identify less with the victim.

In the emergency department, nurses are given the responsibility of initiating the care of the sexual assault victim. The emergency nurse is the

first to hear the patient describe the assault. In a follow-up study of rape victims, it was found that those victims who reported a positive hospital experience had a more rapid emotional recovery than those that reported a negative experience (Burgess & Holmstrom, 1979). Based on these findings, the importance of the emergency nurse in the care of the sexual assault victim is clear: the emergency nurse can either assist in the victim's recovery or extend her crisis state.

Purpose

Based on clinical practice, this author has observed that many emergency nurses use a framework built on myths and misconceptions when working with sexual assault victims. The most common question which nurses ask of this author is, "Out of the numbers of rape victims you see, how many are really raped?" This question indicates that these nurses believe that women "cry rape." Research has demonstrated that "crying rape" is a myth (Dean & deBruyn-Kops, 1982) and that women do not report sexual assault as a way to seek vengeance against a jilted lover.

In order to provide optimum care for the victim of a sexual assault, nurses must examine their attitudes. Identifying the assumptions, misconceptions, and myths underlying one's attitude toward rape is the first step toward understanding that these beliefs may affect the quality of care

a nurse delivers to victims of sexual assault.

The purpose of this study was to examine the attitudes of nurses working in the emergency department of a large urban public hospital toward victims of sexual assault. The major question was, "What are the attitudes of emergency nurses toward victims of sexual assault?" Using the rape attitude scale (Cochrane, 1986), specific research questions included:

1. How does the victim's age affect the attitude of the emergency nurse?
2. How does the location of the assault affect the attitude of the emergency nurse?
3. How does the time of assault affect the attitude of the emergency nurse?
4. Does perceived carelessness on the part of the victim affect the attitude of the emergency nurse?
5. Does the victim's acquaintance with the rapist affect the attitude of the emergency nurse?
6. Does the victim's appearance affect the attitude of the emergency nurse?
7. What are the nurses' responses to general questions regarding a victim of sexual assault?

The findings of this study would provide information that could be shared and discussed during inservice training or staff meetings designed to prepare nurses to be more therapeutic with rape victims. Also, a discussion on myths and misconceptions about sexual assault, using the results of this study, could be included in emergency nurse orientation programs.

Definition of Terms

The definitions that apply to this study include the following:

1. Emergency nurse is a registered nurse who is employed in the emergency department of a large, urban, publicly funded hospital.
2. Sexual assault is a life threatening, life changing event in which the individual's mind, body, and soul are invaded and injury has occurred. For the purpose of this study, rape is described as a pseudosexual act that is more concerned with status, aggression, control, and dominance than with sensual pleasure or sexual satisfaction (Koss & Harvey, 1987).
3. Rape is taken from the Latin word, "rapere" which means "to seize and carry off by force" (American Heritage Dictionary, 1985). The terms rape and sexual assault were used interchangeably in this study.
4. Sexual assault victim is an adult (over 12 years old) female individual who states that she has been sexually assaulted (OCJP, 1987).

5. Attitudes are beliefs, feelings, and opinions held by individuals specifically regarding sexual assault victims as defined by the instrument used (Cochrane, 1986).

Summary

The victim's initial health care encounter after a sexual assault has a significant impact on her eventual recovery (Green, 1988). As stated, health care workers have been exposed to the same rape myths and misconceptions as the general public (Heinrich, 1987). An examination of emergency nurse attitudes toward sexual assault victims may assist in improving the quality of care delivered to this patient population.

The following chapter discusses in more depth the background for this study. A review of pertinent literature on the historical perspective of rape myths and misconceptions is included. The conceptual framework that guided this study is also discussed.

Chapter 2

LITERATURE REVIEW

History

This chapter begins with a historical look at the myths and misconceptions that shape society's attitudes regarding sexual assault. The conceptual framework follows with a discussion of Rape Trauma Syndrome (Burgess & Holmstrom, 1974) and how it relates to this study.

Warner (1980) states that "rape is as old as human existence." Women throughout history have received little recognition and have had limited rights under the law. Herodotus (500 BC), known as the Father of History, stated that "the abduction of young women was not a lawful act, but it made no sense to make a fuss about it. The only sensible thing to do is to not take notice. For it is obvious that no young woman would be abducted if she did not allow herself to be" (p. 1). The statements of Herodotus foster the myth that women want to be raped or at least are in control of whether or not they are raped.

Throughout time virginity has been a highly valued commodity. Virgins were thought to have mystical or spiritual qualities. It was seen as a mortal sin to rape a virgin. Death was the punishment.

Rape was the oldest means by which man took a wife (Warner, 1980).

When marriage became a tribal function, rape became a crime. Once married, the woman became the property of her husband. Women were viewed as pieces of property to be bought and sold. If a married woman was raped, society did not see her as the victim of a sexual assault. It was the woman's father or husband who was thought to have been violated by the rapist.

The Babylonians considered rape a sin. If the rapist was married, he was put to death. If he was unmarried, he was made to marry the woman and pay her father more money than would normally be expected from the groom. To complete his punishment, the rapist was forbidden from divorcing his victim. By committing rape, the unmarried man had devalued the father's property (the victim). The woman not only suffered the trauma of the rape but also was forced to live out her life with the rapist (Warner, 1980).

In early English law, social position determined punishment. It was impossible to charge a king or bishop with rape, but an accused slave was castrated. The female victim of lower social status had little chance of seeing her rapist brought to justice. In addition to social position, two other factors were given major consideration in the determination of guilt. The first was the location where the event occurred. It was believed that a

woman could not be raped within city limits because others nearby would hear her scream. If a woman reported being raped in the country, she was believed because no one would have been there to hear her scream. The second factor was the amount of resistance exerted by the woman. If a woman did not fight back or have visible injuries, she was thought to be lying.

Burgess and Holmstrom (1988) state that myths support and promote rape. Rapists may not fear prosecution because they do not see what they have done as wrong (Amir, 1971). Weis and Borges (1975) argue that the mythology of rape allows the man to engage in this forbidden behavior (rape) and then to rationalize it after the event.

Myths

Even today societal attitudes toward sexual assault reflect a widespread belief in myths and misconceptions. This author's clinical experience indicates that nurses hold opinions about rape that are based on myths and misconceptions. Furthermore, these opinions of nurses may cause serious emotional sequelae in the rape survivor. Groth (1979) states that rape is difficult to understand and charged with emotions. This section of the study will concentrate on refuting some of the most common rape myths and misconceptions.

Rape is thought to be a crime of sexual gratification. In a classic study of over 600 sex offenders, Amir (1971) was one of the first to describe rape as a crime of power and control. Groth (1979) interviewed over 500 sexual "aggressors" and found that sexual desire was not a factor in why they raped. These aggressors included individuals convicted of rape and individuals who had committed rape but were never caught. Power and anger were described as motivating factors.

Women are still believed to fantasize about being swept off their feet and raped (Dean & deBruyn-Kops, 1982). What this myth does not take into account is that when someone fantasizes, he or she pick the person and the circumstances. Women may fantasize about having sex but not about being raped. This myth confuses sex and rape.

Men are thought to be overcome with lust due to a provocative woman or an immediate need to satisfy a primal urge. In numerous studies it has been shown that sexual assault occurs in all age groups and to all types of people. This author has cared for sexual assault victims that have ranged from 1 month to 93 years. Sexual assaults are not usually committed impulsively. Amir (1971) found that over 70% are planned in advance. It has been said that rape exists because men must satisfy their urges somewhere. Groth (1979) found that one third of sexual aggressors he

studied were married with active sex lives, and the majority of the non-married population were sexually active. These research findings provide evidence that rape is not committed due to sexual gratification.

The common view of rape is that it is usually perpetuated by strangers. This myth has been extremely damaging in court proceedings of acquaintance rapes. The victim is accused by the defense attorney of crying rape. She is thought to have falsely accused a boyfriend in order to seek revenge for some wrong doing. Amir (1971) was the first to document that over 50% of rapes are committed by individuals that the victim knows. The rapist may befriend the woman as part of his plan to stage the rape. A large publicly funded hospital, seeing over 400 victims per year, reports that over 50% of rape survivors report knowing their attacker (Santa Clara Valley Medical Center [SCVMC], 1991).

Another popular myth is that rape occurs at night and in dark, out-of-the-way places. Amir (1971) found that a significant number of assaults occurred in either the victim's or the rapist's residence. One sexual assault treatment center reports that 59% of survivors stated that they were assaulted in a home or building (SCVMC, 1991). It is disturbing to note that women cannot assume they are safe because they are in their own home. In statistics from the same center, 30% of the survivors reported

being raped during daytime hours, 50% during nighttime, and 20% were unsure. The rapist's plan may include the element of danger by taking someone in broad daylight. This author recently cared for a 60 year old survivor that was assaulted in her home at 8:00 in the morning.

Another myth is that nice girls don't get raped. This author has cared for many survivors who believe this myth. They begin to doubt their own character because of the assault. As previously discussed, most rapists develop a plan. That plan is carried out according to the rapist's criteria and may have nothing to do with the victim. Rapists look for someone they can overpower, someone they can dominate regardless of the qualities of the victim.

A broad historical definition for a nice girl would include that the girl be a virgin. When examining rape victims, this author has found the question of the victim's loss of virginity to be paramount on the victim's mind and the minds of the victim's family. Rape is not intercourse and to be raped was not a decision the victim made. The fact that one has been sexually assaulted does not change one's character or how one should be viewed by others.

Common questions asked by family members of survivors include, "Why didn't you fight back?" or "Why did you fight back?" Rapists are

unpredictable (Dean & deBruyn-Kops, 1982). Most use verbal threats and intimidation to gain submission from the victim. In the previously mentioned sexual assault treatment center, 1991 statistics showed non-genital trauma in 50% of the survivors examined. As a counseling tool this author uses the term "survivor" when describing the victim. A survivor has lived through a life threatening event. Whether survival was accomplished through fighting back or not fighting back, the victim is alive now.

This list of myths and misconceptions is not meant to be exhaustive. This section provides evidence that rape myths still exist, and that they only serve to do emotional damage to victims and their families.

Attitude Studies

The literature on attitudes about sexual assault is voluminous. Studies have been conducted examining the attitudes of health care workers, law enforcement officers, judges, juries, and social service personnel. Few studies have examined the attitudes of emergency nurses toward victims of sexual assault. This section will review the pertinent studies that used nurses as the study population.

Alexander (1980) used vignettes to examine the attitudes of nurses (N=312) toward rape victims. Two vignettes of sexual assault victims were used. One showed a married woman in a print dress who had been

brutally raped by a stranger. The other was a divorced woman in shorts and a halter top who received minor scratches after being raped by an acquaintance. The respondents in this study did not view one patient differently than the other. Alexander's results indicated that nurses' perceptions of rape victims are not duly harsh. The author suggested that sensitivity training is misdirected and that nurses' attitudes are supportive of rape victims. Nevertheless, Alexander did find that nurses who had more experience working with rape victims tended to blame victims more often than nurses with little experience.

Damrosch (1981) studied nursing students' perceptions of carelessness on the part of the victim. Six different vignettes were used to establish the appropriateness of the failure to lock a car door as a type of carelessness that could be demonstrated by almost anyone. Damrosch (1985) replicated the 1981 study to include the perceived extent of the victim's carelessness. This study also used nursing students as the study population. In both studies, the women who were raped after leaving their car door unlocked were viewed more negatively than those women who had locked their doors. Damrosch (1987) again replicated the study. The third study included nurses (N=80) attending a workshop. Of the nurses attending, 42% listed emergency nursing as their specialty. The findings of the third

study supported the previous studies: the victim who was sexually assaulted and whose car door was unlocked was seen as careless.

The Damrosch studies (1981, 1985, 1987) indicate that misconceptions are used to blame victims for the assault. It may be careless for someone not to lock one's car door. However, the fact that the door was unlocked does not justify a sexual assault.

Cochrane (1986) developed a questionnaire to measure and describe the attitudes of emergency nurses. The questionnaire included a demographic section and a 61-item rape attitude scale. The initial rape attitude scale looked at 12 different factor categories:

1. Age.
2. Marital status.
3. Acquaintance with the offender.
4. Carelessness.
5. Time of assault.
6. Place of assault.
7. Nurses response to rape.
8. Appearance of the victim.
9. Morality.
10. Liberalism.

11. Religiosity.

12. Conservatism

In Cochrane's (1986) study the factors of age, marital status, and acquaintance with the rapist influenced the nurses' negative responses. Cochrane concluded that nurses are directed toward caring for physiological trauma rather than psychological trauma, and that nurses prefer not to care for, and try to avoid, rape victims.

Alexander (1980) looked at the "nice girl" myth using what would be seen as a respectable and non-respectable victim. Damrosch (1987) validated that rape victims are blamed for their assaults even though the carelessness described (unlocked door) could happen to anyone. However, Cochrane's (1986) study included the only broad based look at a variety of rape myths and misconceptions.

This author's study is based on the work done by Cochrane (1986) which suggests that attitudes toward rape victims are based on a wide spectrum of assumptions, misconceptions, and myths.

Conceptual Framework

The conceptual framework used for this study is based on the work of Ann W. Burgess and Lynda L. Holmstrom (1974) on Rape Trauma Syndrome. In a landmark study of 94 rape victims, Burgess and

Holmstrom (1974) first identified Rape Trauma Syndrome. Rape trauma syndrome is a cluster of symptoms experienced by victims of sexual assault. These symptoms include somatic, behavioral, and psychological reactions.

Each victim is viewed as normal, a person who previously was able to manage her lifestyle. This view invalidates any consideration of past sexual history as a legitimate factor in the nurse's view of the patient. It also assumes that the victim's life, whatever that may be, is normal. This means that a wide range of lifestyles are not judged but accepted as normal for the woman. Prostitutes who normally charge for sexual favors can be raped. A woman who enjoys one night stands can be raped. These are life style choices that are normal in the lives of these women.

In this framework rape is defined, in part, as a life threatening event. Rape is viewed as a crisis that has disrupted the woman's life. By looking at the victim as one who has gone through a life threatening event, the nurse is able to emotionally support the victim as he or she would the victim of any physical assault. Attitudes that rely on myths interpret rape solely in sexual terms rather than in violent terms (Burgess & Holmstrom, 1974). However, in Rape Trauma Syndrome the nurse cannot make the assumption that the rape was not severe because the victim was not seriously physically injured. The framework of Rape Trauma Syndrome

includes the long term reorganization that a victim goes through when recovering from the assault. This period of reorganization may take weeks or years.

Burgess and Holmstrom (1979) discuss the impact the nurse's attitude can have on the long term recovery of the sexual assault victim. "The hospital experience can either aid the victims or contribute to their further distress" (p. 105). An understanding of Rape Trauma Syndrome can help the nurse to understand the victim's responses and adjust counseling techniques to those responses. The nurse can allow the victim time to compose herself if the history taking session is too emotionally draining. The nurse examiner should be able to pause during the examination to further explain the process.

The public perceives rape victims as having some fault or blame in the event. "Attitudes that blame the victim only serve to thwart therapeutic relationships before they have a chance to develop" (Burgess & Holmstrom, 1979, p. 127). Rape Trauma Syndrome stresses the initiation of therapeutic contact by the nurse. It takes into account that this event has changed not only the victim's life, but the lives of her significant others. Hilberman (1976) discusses the personal and social crisis of sexual assault. The victim's significant others may hold strong beliefs in myths and

misconceptions that would prove harmful to the victim's emotional recovery. Nurses are able to present relevant information to sexual assault victims and their families in order to refute rape myths (Foley & Davies, 1983). "Knowledgeable nurses separate rape myths from rape facts and assess their impact on victims, families, and society" (p. 17).

An understanding of Rape Trauma Syndrome and how it relates to nursing care can serve to improve the quality of care delivered to this patient population. In Chapter 3 the methodology for this study will be discussed.

Chapter 3

METHODOLOGY

This chapter will discuss the methodology used in this study. The instrument will be addressed at length. Research design, the sample/setting, data collection, and analysis procedure will also be discussed.

Research Design

A descriptive design was used to examine the attitudes of emergency nurses toward victims of sexual assault, using a rape attitude scale. This study was based on previous work by Dorothy Cochrane (1986) who developed the rape attitude scale and also studied the attitudes of emergency nurses toward victims of sexual assault.

Human Subjects Approval

Approval for this study was received by the San Jose State University Human Subjects Institutional Review Board (see Appendix A). In order to receive permission from the hospital, a written application and oral presentation was required. The hospital was concerned with the confidentiality of the respondents answers. After an explanation of the code number procedure, permission to conduct the study was granted (see Appendix B).

The consent letter (see Appendix C) was composed using San Jose State University Human Subjects Institutional Review Board requirements and requirements from the Research and Human Subjects Review Committee at the

hospital where the study was conducted. The letter informed the subjects of the purpose of the study and the confidentiality of their participation. The consent letter stated that, by completing and returning the questionnaire, the consent of the subject was implied.

Instrument

The instrument for this study came from Cochrane's (1986) study. Cochrane (1986) had developed a tool to examine the attitudes of emergency nurses. Permission to use the instrument was requested from Cochrane (see Appendix D). A letter of approval was received (see Appendix E).

Cochrane's tool included a 10-item demographic questionnaire and a 61 item rape attitude scale. Cochrane's rape attitude scale looked at 12 different categories dealing with nurses' attitudes toward rape victims. The 12 categories included:

1. Age.
2. Marital status.
3. Acquaintance with the offender.
4. Carelessness.
5. Time of assault.
6. Place of assault.
7. Appearance of victim.
8. Morality.

9. Liberalism.
10. Religiosity.
11. Conservatism.
12. Nurses's response to rape.

The 61-items rape attitude scale asked nurses to respond on a 5 point Likert scale, with 1 = strongly disagree and 5 = strongly agree. Some items required a "disagree" response to indicate a positive attitude toward rape victims and some items required "agree" responses.

Cochrane piloted the rape attitude scale using 15 emergency nurses who had provided care to victims of rape. The responses were subjected to factor analysis and varimax rotation. A study was then conducted using 101 emergency nurses from three different hospitals. Matched re-test respondents totaled 63. Cochrane (1986) reported that the reliability of the rape attitude scale was established by using matched-pair responses. Correlation coefficients supported the tool's reliability. She further stated that the validity of the factor scores were justified by squared multiple correlations. An alpha reliability coefficient (.83) provided a measure of internal consistency of the questionnaire (p. 80).

The instrument was modified for this study thereby altering the reliability of the instrument. This researcher was concerned with the length of the instrument and the effect the length could have on the number completed questionnaires returned. This researcher selected seven categories which included 36 items. The

categories selected examined the nurses responses to items that dealt with myths and misconceptions surrounding sexual assault. The modified tool included a 13-item demographic questionnaire (see Appendix F) and a 36-item rape attitude scale (see Appendix G). Categories that dealt with age, acquaintance with the offender, carelessness, time of assault, location of assault, appearance, and nurse's response to a victim were chosen for this study. Table 1 displays the items associated with each category.

Subjects/Setting

Questionnaires were given to all 64 registered nurses employed in the emergency department of a large urban publicly funded teaching hospital. The hospital is designated by the county as a treatment center for sexual assault. Since 1987, registered nurses working as independent contractors examine and treat all sexual assault victims in a clinic area separate from the hospital's emergency department. The nurse based program is called SART (Sexual Assault Response Team). The SART Nurse Examiners are not employees of the hospital. The emergency nurses recruited for this study care for sexual assault victims who have serious physical injuries that require emergency treatment but they do not assist in the medical/legal sexual assault examination. Many of the nurses worked in the facility before the establishment of SART and others work or have worked in other hospitals where the emergency staff nurses have primary responsibility for the rape victim.

Table 1

Rape Attitude Scale Items According to Categories

Category	Number	Item
Age	1	Rapists usually select attractive young women to assault.
	3	An assault of a 16 year old woman is more damaging than it would be for a 40 year old woman.
	6	An assault of an 80 year old woman is more damaging than it would be for a 30 year old woman.
	13	Sexual assault of a 50 year old woman is more damaging than it would be to a 20 year old woman.
	21	Anyone, regardless of age, is a potential victim of rape.
	22	The young victim (14-22) requires more support than the older victim.
	24	The age of the victim will affect the degree of empathy the nurse has for the victim.
Acquaintance with the offender	8	The rapist is usually a stranger.
	15	More women get raped by a male they know (an acquaintance), than a total stranger.
	16	Nurses tend to be more empathetic to the rape victim, if the rapist was a stranger than if he was an acquaintance.
	26	Nurses tend to be less supportive and sensitive to the victim who is raped by an acquaintance, than a "stranger".
Carelessness	10	Most rapes can be prevented by using safety precautions

Table 1 (Continued)

Rape Attitude Scale Items According to Categories

Category	Number	Item
		(locking car doors, using dead-bolt locks on doors).
	11	In most cases, when a woman is raped, she is "asking for it."
	27	In most cases, the victim's carelessness contributes to the assault.
Time of assault	4	The majority of rape attacks occur at night.
	14	Sexual assaults usually take place between 8 p.m. and 2 a.m.
	28	Assaults usually take place on summer weekends.
Location of assault	7	Most rapes occur in secluded locations (alleys, dark parking lots).
	12	Most rapes occur in the victim's home.
	18	Most rapes occur when women are out alone at night.
Appearance of the victim	2	Women ask for rape by using bad judgement, acting seductively, or wearing seductive clothing.
	5	Most women provoke an assault by their dress and behavior.
	9	Victims who are seductively dressed are responsible for provoking the rape.
	17	Do you agree that a rape victim's appearance (in terms

Table 1 (Continued)

Rape Attitude Scale Items According to Categories

Category	Number	Item
		dress) encourages the rape in any way?
Nurses' response to the victim	19	When admitted to the emergency department, rape victims are usually anxious and frightened.
	20	Most emergency nurses tend not to want to work with rape victims.
	23	Avoidance of rape victims by nurses is a commonly observed behavior in the emergency department.
	25	Most sexual assault victims view the emergency department staff as providers of medical care and emotional support.
	29	Most rapists have abnormal, unsatisfied sex drives.
	30	A rape victim should have immediate attention as well as emotional support.
	31	Rape constitutes a crisis situation for most victims.
	32	The most humiliating and private crime a woman can experience is rape.
	33	Sexual perversion is a common element of the rapist attack.
	34	Most rapes are treated in a personal manner in the emergency department.
	35	Rape victims blame themselves and feel guilty about the attack.

- 36 Immediate nursing care of a rape victim is directed toward reducing the rape victim's feelings of distress.
-

Data Collection

The nurses were initially informed of the study during a staff meeting. A packet that consisted of the consent letter and questionnaires was distributed. The packets were placed in each registered nurse's mail box. The mail boxes with individual combination locks were kept in a locked room. Respondent's consent was implied if a completed questionnaire was returned. Twenty six nurses completed and returned the questionnaire. Each questionnaire was identified with a code number. Completed questionnaires were returned to the mail box of the researcher which was located in the same area. Confidentiality of all information was maintained. This researcher kept the code number master in a locked drawer in a separate office. Two reminder notices were placed in each subject's mail box at approximately 6 week intervals (see Appendix H). After a 3 month period the study was concluded with 26 respondents. This number represented 41% of the subjects recruited.

Data Analysis Procedures

Because of the small sample size, frequencies were calculated for each of the subscale categories and for the demographic items. Chapter four discusses the findings of this study.

Chapter 4

FINDINGS

This chapter discusses the findings of this study. The purpose of this study was to examine the attitudes of emergency nurses toward victims of sexual assault. The rape attitude scale findings will be interpreted using the seven selected categories.

Description of Sample

The final sample size totaled 26 (41%) returned questionnaires. Almost all of the respondents were female (96%). Nearly half were in the age range of 31-40 years (46%) and 16 (62%) had over 9 years of nursing experience. Fifty percent of the respondents had under 6 years of emergency nursing experience and 50% had over 6 years. Married respondents comprised 42% (11) of the sample with fairly equal numbers of diploma, associate degree, and baccalaureate prepared nurses. Master's prepared nurses comprised only 8% (2) of the sample.

Most (96%) of the nurses had cared for victims of sexual assault. Eighteen (72%) had cared for between 1 and 20 sexual assault victims. Half of the respondents were aware of the California Medical Protocol for the care and Treatment of Victims of Sexual Assault. Only 5 nurses (19%) reported ever having used the protocol. Interestingly, 15 (58%) reported knowing someone who had been sexually assaulted. The characteristics of the sample show that the majority of the respondents were experienced emergency nurses with varied

educational backgrounds who had cared for victims of sexual assault.

Overall the attitudes of the emergency nurses sampled showed a disbelief in the myths and misconceptions surrounding sexual assault. The findings of the rape attitude scale will be reported based on the seven factor categories:

Age

Seven questions were asked regarding the age of the victim and how age affects the attitude of the nurse. The overall responses by the nurses to seven items on age indicated that age was not a determinant in their attitude about rape. Only 2 of the 7 questions regarding age as a determinant were in the "strongly agree" or "strongly disagree" category. The respondents "strongly disagreed" (54%) that assault on a 16 year old is more damaging than it would be for a forty year old. Forty-six percent of the nurses in the sample were 31-40 years old and it is possible that nurses personally identified with these questions more than some of the other questions. The respondents also "strongly agreed" (58%) that anyone, regardless of age, is a potential victim of rape. Over a third of the respondents ($n=9$) agreed that the age of the victim affects the degree of empathy the nurse has for the victim.

Acquaintance with the Offender

Four items examined the effect of the victim's acquaintance with the offender. The overall responses indicated that the nurses view acquaintance rape as a bigger problem than rape by a stranger. Eighty-one percent disagreed with the

statement that the rapist is usually a stranger. Recent media attention to "date rape" may have influenced the responses. Responses to the question "nurses are more empathetic to a woman who was raped by a stranger" were equally divided between those subjects that agreed (39%) and those that disagreed (39%).

Carelessness

Carelessness on the part of the victim was discussed in three items. The overall responses to the three items showed that the respondents did not believe that rape victims contribute to their assault by being careless. Ninety-six percent responded "strongly disagree" or "disagree" to the statement, "In most cases when a woman is raped she is asking for it." Damrosch (1985) documented that nurses perceive carelessness on the part of victims who are raped after leaving their car door unlocked. Although the subjects in this study disagreed (46%) that locked doors can prevent most rapes, 5 nurses (19%) responded that carelessness contributes to the assault.

Time and Location

The myth regarding time (3 items) and location (3 items) is that sexual assault occurs at 2 a.m. in a dark alley. As discussed in Chapter 2, this myth is not supported by research. However, responses to questions regarding time of assault showed a large number of undecided replies. Forty-seven percent ($n = 12$) of the sample was undecided when responding to the statement "sexual assaults usually take place between 8 p.m. and 2 a.m." To the same statement, 8 (31%) disagreed

with the late night hours and 23% agreed that rape occurs at night. The statement asking if sexual assault occurs more on summer weekends received 2 (12%) in the strongly agree and 15 (58%) in the agree category. Eighteen respondents (69%) responded to questions regarding location which showed an understanding that all rapes do not occur in dark alleys. When asked about sexual assaults in the victim's home, 10 (39%) agreed that most rapes occur in the victim's home and an equal number (39%) were undecided.

Appearance of the Victim

Four questions asked the nurses to respond to questions dealing with the appearance of the sexual assault victim. Overall 41% of the respondents felt that appearance is not a determinant of sexual assault or a reason to blame the victim. There was a wider variance in responses to the four items on appearance with more answering "strongly disagree" than "disagree" responses. Although the majority did feel strongly that appearance does not incite rape, 19% (5) felt that the rape victim's dress encourages rape.

Nurses' Response to the Victim

The largest category, consisting of 12 items, dealt with the emergency nurses' responses to the rape victim. No one disagreed or was undecided when responding to the following statements: (a) that a rape victim should have immediate attention as well as emotional support, (b) that rape constitutes a crisis situation for most victims, and (c) that the most humiliating event a woman can

experience is rape.

Almost all of the respondents (92%) felt that rape victims blame themselves and feel guilty about the attack. The nurses may have responded from experiences they had with rape victims. This researcher has found that many rape victims feel guilty because of their own beliefs in myths and misconceptions.

Three items in the Nurses' Response category dealt more specifically with whether or not nurses want to work with rape victims. When asked if most emergency nurses tend not to want to work with rape victims, 13 (50%) agreed and 7 (27%) were undecided. When asked if nurses avoid rape victims, 12 (46%) agreed and 5 (19%) were undecided. Although 12 (46%) disagreed that rape victims are treated in an impersonal manner, 7 (27%) were undecided and 7 (27%) agreed.

Summary

The findings of this study suggest a much more positive attitude toward rape victims than previously expected by this researcher. That is, the majority of the respondents did not show strong beliefs in myths and misconceptions surrounding sexual assault. The following chapter will discuss the implications of these findings. The limitations of this study and recommendations for further study will be discussed.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This concluding chapter will discuss the major findings of this study.

Limitations to this study and recommendations for further research will be discussed.

Conclusions

The majority of the nurses responded to the rape attitude scale with support for rape victims and the crisis they experience. The largely 31-40 year old age group of married, female, experienced emergency nurses did not feel that age, acquaintance with the rapist, time or location of assault, or appearance of the victim should affect the attitude of the nurse. Victims were not perceived as careless or contributing to the assault.

Two items specifically asked whether nurses are empathetic toward victims of assault and three items asked if nurses tended not to want to care for victims of assault. In this study responses to these items showed that some (33%) nurses are not always empathetic and that nurses (48%) did not want to care for victims of sexual assault. A reason for these responses may be a perceived lack of preparation on the part of the nurse respondents. If the nurse understands that the victim has been through a life threatening event, then the nurse should be able to therapeutically interact with the patient. In nursing school, nurses are taught to listen and facilitate the feelings of their patients. Nurses may not have

been taught about communicating with rape victims. This study shows that nurses understand the difference between rape myths and rape realities but does the nurse know how to apply this information to his or her practice.

Limitations

The major limitation of this study is the inability to generalize this information due to the small sample size ($n=26$). The findings are not necessarily applicable to the original sample population ($N=65$) or to other nursing populations. The study findings are limited, in that data from the responses can be analyzed to examine the question of emergency nurse attitudes toward victims of sexual assault, but it is not clear whether those responses truly indicate attitudes or merely responses to a questionnaire. Because the modified tool was not tested, its reliability and validity is uncertain.

The agency chosen for study has had a sexual assault response team for 5 years. The nurses' responses could have been affected by the existence of a program that identifies rape victims as a patient population requiring specialized care.

Recommendations

Further study is needed to examine the attitudes of emergency nurses toward victims of sexual assault. Studies of larger scope, possibly using the Emergency Nurses Association (ENA), could be conducted. ENA is a professional nursing organization with over 20,000 members nationwide. In California alone, the ENA

membership is over 2,000 nurses. Findings from a study with a sample population of 2,000 emergency nurses could be generalized to the larger group. In such a study the demographic questionnaire could determine whether the agency which employs the nurse has a specialized treatment program for sexual assault. One of the research questions could address the differences between nurses employed at hospitals with specialized treatment programs and nurses employed at hospitals without specialized program.

This researcher would like to see research in the area of victim guilt. Almost all of the respondents believed that the victim feels guilty. Why do victims blame themselves? Is it a belief in myths and misconceptions? This area requires further exploration. The results may have importance in changing counseling techniques for victims of sexual assault.

The number of undecided responses (27%) to the statement that rapes occur on summer weekends bring up a long held belief by this researcher. During the last 14 years, this researcher has noticed a pattern that has more to do with sporting events than summer weekends. It is this researcher's assumption that reported rapes decrease during such events as the baseball World Series and the football Super Bowl. Future study could look at the incidence of reported rape during major sporting events. The benefit to science from such a study is unknown.

Further study is needed to determine why nurses tend to not want to care

for victims of sexual assault. It is unclear whether myths and misconceptions play a major role or if there are other unknown variables, such as feelings of inadequacy in communicating with victims.

Inservice training should focus on the patient/nurse relationship. Nurses need concrete information regarding sexual assault victims and how to therapeutically communicate with these patients.

Summary

The findings of this study did not support this researcher's assumptions that emergency nurses hold strong beliefs in myths and misconceptions surrounding sexual assault. The findings in this study showed that the subjects do not believe in myths and misconceptions. Cochrane (1986) found that age, marital status, and acquaintance with the rapists were determinants in the nurses' attitudes. Cochrane (1986) reported that nurses try to avoid caring for victims of sexual assault. Nevertheless, the study has shed new light on the need for nursing education regarding the victim of sexual assault. Education should be directed toward ensuring that the emergency nurse is both comfortable and confident in his or her care of the sexual assault victim. The emphasis should change from examination of the nurses' attitudes to identifying how refuting myths and misconceptions can aid in the nurse/patient relationship.

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APPENDIX A
Human Subjects Institutional Review Board
Letter of Approval

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Anita Ruiz-Contreras, Nursing
357 South 15th Street
San Jose, CA 95112

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: June 24, 1991

The Human Subjects Institutional Review Board has reviewed and approved your request for exemption from Human Subjects Review for the proposed study entitled:

"Attitudes of Emergency Nurses Toward Victims of Sexual Assault"

You may proceed with this study without further review by the Human Subjects Institutional Review Board.

I do caution you that Federal and State statutes and University policy require investigators conducting research under exempt categories to be knowledgeable of and comply with Federal and State regulations for the protection of human subjects in research. This includes providing necessary information to enable people to make an informed decision regarding participation in your study. Further, whenever people participate in your research as human subjects, they should be appropriately protected from risk. This includes the protection of the confidentiality of all data that may be collected from the subjects. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised when people participate in your research as human subjects, each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.

CC: Sharon L. Hogan, RN, MS

APPENDIX B

Research and Human Subjects Review Committee Letter of Approval

January 27, 1992

Anita Ruiz-Contreras, R.N.
357 South 15th Street
San Jose, CA 95112

RE: Project entitled "Emergency Nurse Attitudes Toward Sexual Assault Victims"

Dear Mrs. Ruiz-Contreras:

On January 24, 1992, the Research and Human Subjects Review Committee of Santa Clara Valley Medical Center approved your request to conduct the above referenced project subject to modification of the submitted subject's consent form as follows:

In the last paragraph following the fourth sentence include the following statement: "It is the policy of Santa Clara Valley Medical Center not to provide reimbursement for medical care or any form of compensation in the event of any injury that occurs as a result of your participation in this study."

For the Committee's records, a copy of the revised version of the consent must be submitted by February 14, 1992.

Please be advised that this approval does not constitute a commitment of SCVMC space, funds, or employee time and services. All related matters must be discussed with hospital administration and resolved prior to commencing this project by contacting Mr. Edward Petrillo at 408/299-5333.

In accordance with Federal regulations and Committee policy, no changes may be made in the protocol or approved version of the subject's consent form without the knowledge and prior approval of the Committee. All problems having to do with subject safety must be reported to the Committee within five (5) working days.

The approval number assigned to this project is 1/24/92-01. It would be helpful if in future correspondence concerning this project, you would refer to this number.

Anita Ruiz-Contreras, R.N.
Page 2
January 27, 1992

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In compliance with Federal regulations, all research projects require continuing review at intervals appropriate to the degree of risk but not less than once per year. If the project is to continue beyond the expiration date of January 22, 1993, it must be renewed in accordance with the Committee's renewal instructions. As a courtesy reminder, a renewal application will be mailed to you approximately two months prior to the expiration date. If the project is terminated/completed prior to the expiration date, you should immediately notify the Committee in writing.

Should you have any questions, please contact the Administrator of the Committee, Carole Guthrie, at 408/299-6276.

Sincerely,

Elisabeth A. Mailhot, M.D., Chair
Research and Human Subjects Review Committee

EAM/cg

cc: Mr. Edward Petrillo

APPENDIX C
Subject Consent Letter

School of the Applied Arts and Sciences • Department of Nursing
One Washington Square • San José, California 95192-0057 • 408/924-3130 • FAX: 408/924-3135

Dear Registered Nurse:

I am conducting a study titled, "Attitudes of Emergency Nurse's Toward Victims of Sexual Assault". It will examine the way in which misconceptions about rape affect an emergency nurse's attitude toward victims of sexual assault. The results of this study should help to increase our awareness of how these attitudes affect patient care. Attached is a questionnaire, please complete it and return it to me before April 15, 1992. It should take approximately 15 minutes to complete.

Your participation in this study is voluntary and you are under no obligation to participate. You are free to withdraw your consent and discontinue participation in the study at any time without prejudice. I cannot and do not guarantee or promise that you will receive any benefit from this study. All data from you will be kept anonymous and used as aggregate data. All records will be kept in a locked file. There are no monetary benefits for completing the questionnaire. You give your consent by completing the questionnaire and returning it to me in the enclosed envelope.

I would be happy to answer any questions you have about this study. I can be reached at 408-287-2960. Should you have other concerns and wish to speak with my advisor, please contact Sharon Hogan, RN, MS, SJSU Department of Nursing at 408-924-3157. For questions or complaints about research subject's rights, contact Serena Stanford, PhD. (Associate Academic Vice President for Graduate Studies and Research) at 408-924-2480. It is the policy of Santa Clara Valley Medical Center not to provide reimbursement for medical care or any form of compensation in the event of any injury that occurs as a result of your participation in this study. Thank you in advance for contributing to this study.

Sincerely,

Anita Ruiz-Contreras, RN
357 S. 15th Street
San Jose, CA 95112
Graduate Student, Department of Nursing

APPENDIX D

Request For Permission to Use Instrument

TO: AARN Newsletter Editor
Alberta Association of Registered Nurses

DATE: Feb. 3, 1989

FROM: Anita Ruiz-Contreras, RN *GR*
357 S. 15th St.
San Jose, CA 95112
W-408-299-5325
H-408-287-2960

RE: Request for assistance/information

The purpose of this letter is to request information on a study reported in your newsletter. The article, "Emergency Nurses' Attitudes Toward The Rape Victim" was written by Dorothy A. Cochrane, RN and printed in the July/August, 1987 newsletter.

I am a graduate student at San Jose State University. I would like to replicate the study described in the article. I would like permission to review the tool and examine the conceptual framework used. Could you assist me by sending my request to Ms. Cochrane?

Thank you for your attention to this matter.

APPENDIX E

Letter of Approval From Dorothy Cochrane

April 21, 1989

Anita Ruiz-Contreras, R.N.
Graduate Student
357 S. 15th Street
San Jose, California
95112

Dear Ms. Ruiz-Contreras:

Thank you for your letter of February 3, 1989. Unfortunately, I just received your letter this past week and as a result may seem somewhat slow in responding. However, I am pleased that you wish to utilize my tool for your thesis study and grant permission for use in your graduate work.

During the literature search I found no tool which had been tested for reliability and validity and as a result devised my own. In reference to the conceptual framework, I used Rappaport's crisis theory as a base and expanded the framework for use in the study using parameters of how the patient arrives to the ER department and what factors may influence the treatment of the victim.

I have enclosed the chapters of my thesis which are relevant to the conceptual framework, questionnaire development and the tool itself. If you should need anymore information please do not hesitate to contact me.

BEST WISHES!

Sincerely,

Dorothy A. Cochrane

Dorothy A. Cochrane R.N., M.N.
Clinical Nurse Specialist
48 Amherst Crescent
St. Albert, Alberta, Canada
T8N 2P8
W-403-492-8063
H-403-458-6768

APPENDIX F
Demographic Scale

Demographic Data

Subject Number _____

Please fill out the following:

1. Age (Please circle one)
 - a. 20-25.9
 - b. 26-30.9
 - c. 31-35.9
 - d. 36-40.9
 - d. 41-45.9
 - e. 46-50.9
 - f. 51-55.9
 - g. 56 and over
2. Sex (Please circle one) M F
3. Marital status (Please circle one)
 - a. Married
 - b. Single
 - c. Separated
 - d. Divorced
 - e. Widowed
4. Level of nursing education attained (Please circle one)
 - a. Diploma
 - b. Associate Degree in Nursing (ADN)
 - c. Basic Bachelor of Science in Nursing (BSN)
 - d. Post-graduate Bachelor of Science in Nursing
 - e. Master's Degree in Nursing
 - f. Other (Please specify) _____
5. Number of years worked since completion of RN. (Please circle one)
 - a. 0 - 3
 - b. 3.1-6
 - c. 6.1-9
 - d. 9.1-12
 - e. 12.1-15
 - f. over 15
6. How many years have you worked in an emergency department: (Please circle one)
 - a. less than one
 - b. 1 - 2 years
 - c. 2.1-4 years
 - d. 4.1-6 years
 - e. 6.1-8 years
 - f. 8.1-10 years
 - g. 10.1-12 years
 - h. over 12 years

7. Have you provided nursing care for a victim of sexual assault?

(Please circle one) YES NO

- a. If yes, how many? (Please circle one)

1. 1- 10	4. 30-40
2. 10-20	5. 40-50
3. 20-30	6. over 50

8. Do you know of someone close (relative, friend, or yourself) who has been a victim of rape?

(Please circle one) YES NO

9. Are you aware of the California State Medical Protocol for the Examination and Treatment of Sexual Assault Victims?

(Please circle one) YES NO

- a. If yes, have you used it in caring for a victim of sexual assault?

(Please circle one) YES NO

- b. If yes, how recently? (Please circle one)

1. 1991	4. 1988
2. 1990	5. 1987
3. 1989	6. 1986 or earlier

10. Are you a Sexual Assault Response Team Nurse?

(Please circle one) YES NO

APPENDIX G
Rape Attitude Scale

PLEASE NOTE

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

57-61,

University Microfilms International

APPENDIX H
Reminder Notices

TO: SCVMC Emergency Nurse

DATE: June 20, 1992

FROM: Anita Ruiz-Contreras, RN
Graduate Student, San Jose State University

RE: Questionnaire

In the Spring I distributed a questionnaire examining the attitudes of Emergency Nurses toward victims of sexual assault. My thanks to the many that returned the questionnaire to my file. If you were not able to complete the questionnaire, please consider doing it now.

It is imperative that I receive a return sample representative of our department. There are extra questionnaires and manilla folders in my file (under R). Once completed, please return the questionnaire to that file. Please know that all information is confidential.

I thank you in advance for your participation in this study. I look forward to completing my MSN this December.

TO: SCVMC Emergency Nurse

DATE: July 26, 1992

FROM: Anita Ruiz-Contreras, RN
Graduate Student, San Jose State University

RE: Questionnaire

In the Spring I distributed a questionnaire examining the attitudes of Emergency Nurses toward victims of sexual assault. My thanks to the many that returned the questionnaire to my file. If you were not able to complete the questionnaire, please consider doing it now.

It is imperative that I receive a return sample representative of our department. There are extra questionnaires and manilla folders in my file (under R). Once completed, please return the questionnaire to that file. Please know that all information is confidential.

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