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EMERGENCY NURSES' ATTITUDES TOWARD THE RAPE VICTIM

by

DOROTHY A. COCHRANE

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

SPRING, 1986

ISBN 0-315-30120-1

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: DOROTHY A. COCHRANE

TITLE OF THESIS: EMERGENCY NURSES' ATTITUDES TOWARD THE RAPE VICTIM

DEGREE FOR WHICH THESIS WAS PRESENTED: MASTER OF NURSING

YEAR THIS DEGREE GRANTED: 1986

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled EMERGENCY NURSES' ATTITUDES TOWARD THE RAPE VICTIM submitted by DOROTHY A. COCHRANE in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

Supervisor

Date: April 10, 1986

DEDICATION

To my Father for his wit and humor.

To my Mother for her wisdom, faith and strength.

To my Sisters for their encouragement and support.

To my Brother for the memories that I hold dear.

To my Husband for his patience, love and understanding.

And most of all to my children, Kimberley, Crystal and Garett who grew with me in spite of my research.

ABSTRACT

This study was designed to measure and describe the attitudes of nurses working in emergency rooms toward rape victims. A measuring instrument developed by the researcher, consisting of two parts, a biographic questionnaire and a rape attitude scale, were used for data collection. The biographic data sheet was comprised of the following variables: age; sex; education; years worked since completion of R.N.; months worked in an Emergency Department; provision of nursing care to a victim of rape; specified departmental rape protocol; being a victim or a friend of someone raped and having attended educational workshops on rape. A 61 item scale reflecting the different ways in which people view rape, and some potential responses of nurses to rape victims, was developed and comprised the second section of the tool. The instrument was piloted by 15 emergency nurses prior to its administration in the main study.

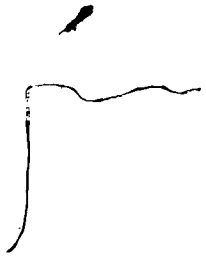
Test re-test data collected from emergency nurses from three general hospitals, known to provide medical treatment for rape victims, were analyzed. There were 101 respondents in the initial test and 63 matched respondents in the re-test. The following data analyses were used in this study: factor analysis, Pearson's product moment correlations, factor score estimation using the regression method, one-way multivariate analyses and content analysis. The attitude scale was subjected to Cronbach's alpha and resulted in a reliability coefficient of 0.83. Seven factor categories identifying the dimensions of attitudes held by emergency nurses toward rape victims were determined. Analyses of the data on the matched

responses from the test re-test resulted in item correlations ranging from .42 to .79 thereby supporting the instrument's reliability and the internal consistency of the test items.

Responses related to the care of rape victims showed that emergency room nurses identified rape as a crisis situation. Emphasis of care, however, appeared to be directed to the management of physiological trauma rather than psychological parameters. In addition, attribution of blame for the assault towards the rape victim was influenced by dress appearance and perceived carelessness of the victim. Responses in the delivery of nursing care showed that the respondents perceived that nurses prefer not to care for rape victims and try to avoid them when they are admitted to the emergency department. The victim's age, marital status and acquaintance with the offender also influenced nurses' responses toward the rape victim.

Analysis of the biographic characteristics of the respondents indicated that the majority were in the 26-35 year old group. The majority of respondents had provided nursing care for a rape victim and were aware of specific rape protocols used in the emergency department where they worked. There was an overall difference in the mean vectors of age as well as specific differences between specific groups on the factor categories. As well, those respondents who reported that they were non-attenders at a religious institution tended not to view religion as being integral in their lives and did not view the rapist as being as much of a social deviant as did the religious attenders. There was also a significant difference between emergency nurses from hospital 1 as compared to hospitals 2 and 3. However, the differences could not be explained from the data. No

significant differences in attitudes towards rape were found in relation to the respondents' educational level, years of general nursing, experience or months worked in an emergency department, or attendance at an educational program (workshop, inservice) on rape.



The Road Not Taken
Robert Frost

Two roads diverged into a yellow wood,
And sorry I could not travel both
And be one traveller, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I -
I took the one less travelled by,
And that has made all the difference.

ACKNOWLEDGEMENTS

I wish to thank Dr. Peggy-Anne Field, my thesis Chairman for her guidance and support in conducting my research. Her unrelenting pursuit for a "job well done" was exhibited by her patience and encouragement throughout the thesis production. I also wish to sincerely thank Dr. July Golec for her guidance and support in the completion of this study.

A special thank you is extended to Dr. Steve Hunka who guided and assisted me with the statistical analyses. I will always be grateful for his generosity in terms of patience, time, support and expertise.

Further I would like to express my appreciation to the emergency nurses for taking the time to answer the questionnaires. Also, to the many colleagues and friends who gave unselfishly of their caring, support and time, I would like to express my sincerest thanks. Their tireless encouragement and belief that this thesis would get done gave me the added incentive to complete the task at hand.

Also I would like to acknowledge the expertise of Donna Nicol at Donnic Word Processing for the typing of the entire thesis, and to her I express my sincerest thanks.

Finally, I thank the Alberta Foundation of Nursing Research and the Alberta Association of Registered Nurses for their financial support of my research.

TABLE OF CONTENTS

CHAPTER

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

STATEMENT OF THE PROBLEM AND ITS SIGNIFICANCE

Introduction

Rape is one of the most frequently unreported violent crimes in our society today. Statistics on sexual assault still lack adequate documentation, leaving experts to speculate on the number of rape cases committed but not reported to police (Kinnon, 1981). As an example, Braen (1976) estimates that only one of five rapes is ever reported. He further states that in the United States a forcible rape occurs, on average, every two minutes. In Canada experts estimate that only one rape in ten is ever reported (Lefort, 1977). Most often the victim of a rape attack is an adult female in her mid-twenties, but statistics show that the span of female sexual assault has involved those from 5 months to 91 years of age.

Traditionally, society has assumed a passive role with respect to the dilemma of rape victims. Accounts of further victimization of the victim have been the major complaint of advocates for the rights of victims and over the past decade changes have been initiated to enlighten public attitudes. These changes have come in the form of feminist anti-rape movements, development of rape crisis centers for victims of rape and police sponsored media programs. Despite these efforts, attitudes toward sexual assault are not easily changed because of commonly held beliefs and assumptions about violence, women and sexuality. Myths, inaccurate information and public stereotyping, at all levels of society, obscure the issue and further victimize the

victims of rape. These presumptuous notions and judgemental attitudes regarding the attribution of responsibility have been reported as reasons that some rape victims do not report the assault.

Statistics derived from police reports must be used with discretion to estimate the incidence of rape since the police must decide whether the complaint is founded, that is whether rape was actually committed. If the complaint warrants investigation, the victim of the alleged rape is taken to a health service agency, most often a hospital emergency department, to be medically examined and treated. Corroborating medical evidence is then procured to establish a basis for subsequent legal proceedings.

Nurses who work in hospital emergency departments are in an optimal position to provide the rape victim with a supportive environment based upon physiological and psychological needs. However, health care providers are not immune to the influence of cultural myths and misconceptions of sexual assault. Personal biases of professional people may be reinforced by the beliefs of society at large and such biases may result in the provision of inadequate treatment to rape victims.

Prevailing attitudes toward rape victims reported in the literature include the following: a woman who is raped had it coming to her; she must have done something to provoke the attack; she is out to get revenge or else cries rape because she is caught in an embarassing situation (Calhoun, Selby and Warring, 1976; Selby, Calhoun and Brock, 1977; Seligman, Brickman and Koulack, 1977; Feild, 1978). Burgess and Holmstrom (1974) studied 146 rape victims and

reported that the reception the victim receives in the hospital could be a vital force in either aiding the victim or contributing to her future distress. Suggestions that the quality of care offered may be dependent upon the attitudinal set of the health care provider have also been made (Alexander, 1980).

Researchers have advocated that nurses who come into contact with rape victims display a non-judgemental attitude toward the rape victim (Burgess and Holmstrom, 1974; Savage and Kearney, 1978; Alexander, 1980; Foley and Davies, 1983). However, minimal research has been conducted on the prevailing attitudes of nurses who care for rape victims. The need for further research is also supported by other health professionals (psychologists, sociologists and mental health professionals who deal with rape victims), (Cann, Calhoun and Selby, 1979; Feild, 1978; King and Rotter, 1978; Hegelman and Meikle, 1980; Resick and Jackson, 1981).

Given the importance of professional attitudes toward the rape victim and the lack of information on the prevailing attitudes of nurses who care for these individuals, it would seem important to examine this issue. Therefore the basic purpose of this study was to identify the nature of the attitudes emergency department nurses have toward rape victims.

Problem Statement

This study addressed the following questions:

a) What attitudes are held by emergency room nurses towards rape victims?

b) What are the nursing implications for improving emergency care for rape victims?

Purpose of the Study

The purpose of this study was twofold. The first purpose was to develop an instrument to measure attitudes held by emergency room nurses toward rape victims. The second purpose was to use the developed instrument to identify the prevailing attitudes held by emergency room nurses who may care for rape victims. An understanding of nurses' responses to victims of rape helped identify areas where education of the care giver was needed. The ultimate goal of this study was to improve the nursing care provided for rape victims.

Need for the Study

Although it has been suggested that the attitudes of nurses toward rape influence their behaviour when providing care for rape victims, a search of the literature showed that little data had been collected that identified nurses' actual responses to the rape victim. No appropriate instruments, which had been tested for validity and reliability, were identified during the literature search. This study was therefore designed to: a) develop a valid and reliable tool for measuring attitudes and b) identify emergency nurses' attitudes to rape victims utilizing the validated tool.

CHAPTER II

REVIEW OF RELATED LITERATURE RESEARCH

Introduction

In general, the descriptive literature in the field focused on anecdotes by rape victims, their feelings and attitudes towards the assault and care received from police, physicians and rape crisis counsellors, crisis counselling and the long-term psychological effects of rape on the victim.

The research literature included exploratory studies of the attitudes of health professionals (crisis counsellors, physicians, mental health workers) towards the rape victim and comparative studies of attributions of responsibility for the rape's occurrence between health workers, lay persons, university students and rapists.

The literature surveyed on the topic of rape is replete with accounts of the victim's perceptions and attitudes as she moves from the police reporting stage to the medical treatment stage into the long term effects of the rape trauma stage (Fox and Scherl, 1972; Burgess and Holmstrom, 1974; Feldman-Summers, Gordon and Meagher, 1979; Janoff-Bulman, 1979; Kilpatrick, Veronen and Resick, 1979; Libow and Doty, 1979; Resick, Calhoun, Atkeson and Ellis, 1981; Atkeson, Calhoun, Resick and Ellis, 1982). Apart from these reports, little attention has been directed toward the attitudes of health care professionals, and in particular to nurses in emergency departments, who deal with the treatment of the rape victim.

For purposes of clarity, this literature review is divided into

two sections. In the first section the influence cultural myths have on an individual's attitude toward rape and rape victims, attribution of victim blame and attitudes of health care providers (physicians, nurses, counsellors, and mental health workers) are explored. The second section will focus on literature regarding the personal and situational factors related to victims and findings of studies related to the care givers.

Cultural Myths

Researchers have reported that lay people and professionals who interact with rape victims and assailants are subject to the prevailing myths about rape (Feild, 1978; Burt, 1980; Burt and Albin, 1981; Deitz and Byrnes, 1981; Kanekar and Kolsawalla, 1981). Others have analyzed how rape myths have found their way into law (Smith Keating, Hester and Mitchell, 1976).

Pepitone-Rockwell (1978) researched the myths regarding rape and concluded that "the myths which help to maintain the stigmatization process serve to depict the victim as responsible and not innocent and that the myths are simply that--myths" (p. 524). He uses the term myth to depict situations wherein the victim is seen as responsible for provoking the rape and therefore got what she deserved, that only 'bad' girls get raped or that rape only occurs outside the victim's home. The same kind of social reproach is applied to women who shop unchaperoned, or who speak to someone without being introduced. He reports that although these commonly held misconceptions are part of an individual's socialization experiences they only serve to cast prejudicial blame onto the victim and therefore should be refuted for

what they are, myths.

Burt (1978) and Feild (1978) studied several groups in the population including police, social service workers and rapists. They found that the amount of credence these different groups gave to rape myths influenced their perception of 'how much' the victim's own actions were responsible for the assault. More recently, Burt (1980) studied the importance of prejudicial, stereotyped, or false beliefs (such as 'women ask for it' or 'only bad girls get raped') in creating a climate hostile to rape victims. Results of the study indicated that the higher the sex role stereotyping, sexual beliefs, and acceptance of violence; the greater was a respondent's acceptance of rape myths. Hardgrove (1976) reported that "many people in our culture still believe some of the myths about rape: that the victim usually provokes the rape, secretly wants it, and enjoys it; that the rapist is a sex-starved, deviant individual and that rape is usually a spontaneous, impulsive act" (p. 246). It can be shown that these are myths and in reality any woman is a potential rape victim.

Attribution of Victim Blame

Sociological research which has examined rape victims has generally concentrated on the tabulation of demographic information (Amir, 1967, 1971; MacDonald, 1971; Schultz, 1973) whereas medically-based research has examined aspects of immediate care for rape victims (Halleck, 1962; Nayman and Lanza, 1971; Burgess and Holmstrom, 1973, 1974, 1975, 1976; Foley and Davies, 1983). Research conducted by psychiatrists revealed that "many psychiatrists felt that rape was not a psychiatric issue and that psychiatrists had little to

offer the rape victim" (Notman and Nadelson, 1976, p. 417). They went on to report that many psychiatrists shared the view that because the rape victim was acting out through unconscious fantasies she had provoked the attack and as a result was not a 'true victim.'

Systematic examination of victim characteristics has revealed certain factors differentially influence the attribution of victim responsibility, including victim 'respectability' (Jones and Aronson, 1973; Kaplan, 1977; Kanekar and Kolsawalla, 1980, 1981), past sexual experience (Calhoun et al., 1976; Cann, Calhoun and Selby, 1979), prior acquaintance with the rapist (Calhoun et al., 1976; Smith et al., 1976), and physical attractiveness (Jolor, 1978; Unger, 1981; Thornton, Ryckman and Robbins, 1982).

These studies showed that rape victims are often blamed for having attracted the rapist and are treated as if they were the offender by the police, medical personnel, the courts, and, not infrequently by well meaning family and friends.

Attitudes of Health Professionals

Feild (1978) reports that while attitudes to rape have been regarded as important, little data has been collected on attitudes toward rape victims. It has been proposed that attitudinal sets ('she asked for it', 'she was too careless' . . .); have themselves influenced the reporting of rape by rape victims (Schwendinger and Schwendinger, 1974); the treatment of rape victims by the judicial system (Bohmer, 1974); by juries (Brownmiller, 1975); and by attorneys (Burgess and Holmstrom, 1975); the processing and investigation of rape complaints by police (Galton, 1976; Keefe and O'Reilly, 1976;

Chappell et al., 1977); and the physical and psychological care administered by medical personnel to rape victims (Burgess and Holmstrom, 1974, 1976; Braen, 1976; LeBourdais, 1976; Moynihan and Duncan, 1981).

From the medical perspective, the physical aspects of care given to rape victims and the procedures utilized for medical-legal purposes are most often discussed (Plant and Wood, 1977; Pepitone-Rockwell, 1978; Talbert et al., 1980). Other researchers discuss the rape victim's experiences within the framework of crisis counselling (Williams and Williams, 1973; Burgess and Holmstrom, 1974, 1975; Hankoff, Mischorr, Tomlinson and Joyce, 1974; Best and Kilpatrick, 1977; Talbert et al., 1980). The concerns discussed in these reports established the extent of interactions the victim had with professional health workers within the health care systems. Other research has established that rape and other forms of sexual assault are crisis events for most victims and have a traumatic and often enduring effect on the victim (Burgess and Holmstrom, 1975, 1976; Kilpatrick et al., 1979; Ruch, Chandler and Harter, 1980; Resick et al., 1981).

Resick and Jackson (1981) hypothesized that "the attitudes of mental health professionals toward the causes of rape could greatly influence the quality of care victims receive" (p. 482). Their study examined the attribution of responsibility (blame) in rape among 38 psychologists from one state. A 20-item questionnaire which reflected different ways people account for rape was developed, in which participants were asked to rate the extent of their agreement with

each item on a 6-point scale. The questionnaires were mailed to respondents. The study did not report on questionnaire development nor on the reliability or validity of the data gathering instrument. There was a significant gender difference for the psychologists on the societal blame factor, which included the following items, the prevalence of rape is directly related to our societal values, there is a strong connection between the current morality and the crime of rape, there is a strong relationship between women being regarded as sex objects by our society and the crime of rape. Another study (King et al., 1978) explored the perceptions of the rape incident for both physicians and volunteer counsellors (both in the emergency department). Their findings revealed crisis counsellors are more likely than physicians to be sympathetically attuned to the emotional and interpersonal difficulties encountered by rape victims. Generalizability was limited in this study because of the small sample size of the two groups.

Other researchers, investigating the care the rape victim receives in hospital, advocated the need for changes in the policies governing the rape protocol and encouraged additional research in reporting what hospital services exist for rape victims (Emergency Medicine, 1975; Cohen, Chappell and Geis, 1976; DiVasto et al., 1980).

A review of medical literature by Donadio and White (1974) showed that the subject matter relating to rape is focused almost exclusively on the particulars of the medical-legal examination, while in the nursing literature information is almost non-existent. The nursing care given to women who have been raped and the attitudes of

nurses toward the woman who has been raped have generated very little critical thinking or research.

One of the best known studies which addressed the roles of professional groups in the provision of immediate care to the rape victim was that conducted by Burgess and Holmstrom in 1974. Their research involved systematic interviews of 146 victims of sexual assault who entered the emergency ward of Boston City Hospital, over a one year period. Victims were categorized into three groups: rape trauma, accessory to sex, and sex stress situations. They found that for most rape victims, the rape represented a crisis, and had either psychological or social consequences for the victim. They term the crisis as a rape trauma syndrome, consisting of an acute stage, where the primary response is fear, followed by a reorganization stage, characterized by insomnia, phobias, sexual dysfunctions and major changes in life-style. In another study, (Burgess and Holmstrom, 1973) it was found that often the prevailing attitudes in society are not on the side of the victim, leading people to interpret rape solely in sexual terms rather than violence terms. The researchers caution that "any attitude which blames the victim will serve only to abort any therapeutic relationship before it has a chance to develop. The nurse should be non-judgemental" (p. 1745). Although these researchers suggest that the nurse who provides the immediate care for the victim be aware of her own prejudices, the absence of research in this area makes it difficult to infer what the prevailing attitudes held by nurses are toward the rape victim. Guidelines for nurses providing care to the victim are stated by the authors with

recommendations for further study in this area.

Bellack and Woodward (1977) surveyed 88 emergency department head nurses in Virginia and reported that 46% of their respondents felt that physicians do not want to care for rape victims, 41% believed that police officers were sympathetic to rape victims and 9.7% of the respondents felt that nurses were essential to the care of rape victims.

A questionnaire consisting of 35 items addressing the treatment of rape victims was mailed to city emergency departments which were reported to have the highest number of rapes in the previous years. Bellack reports that the instrument was not tested for reliability or validity (J. Bellack, personal communication, April 11, 1984). Responses from the survey indicated that for the majority of rape victims, treatment and legal regimes were inconsistent, lacking or at times unknown by the emergency care giver. Several respondents stated that the rape victim is indeed a low priority unless they present as a surgical emergency (stabbing, severely beaten, etc.). As well, respondents indicated that the procedure for gathering evidence was perceived as an "ordeal", while one respondent felt that victims of rape removed the nurse from caring for other emergency patients. Although the researchers, did not address the area of attitudes of emergency nurses specifically, they did state that "treatment by unsympathetic emergency department personnel can reinforce the victim's feelings of demoralization and that it is imperative that emergency nurses possess the skills and attitudes necessary to provide comprehensive, supportive and sympathetic care for rape victims"

(p. 3).

Allgaier (1979) contends that with the incidence of reported rape on the rise, hospital personnel and in particular those health workers who participate in the care and treatment of the rape victim, develop a sensitive professional protocol for the treatment of rape victims. He states that the "hospital emergency room can play a major role in furthering this process by providing sympathetic care and competent evidence collection so that rape victims feel more inclined to report the crime and pursue prosecution of the real criminals" (p. 69).

Summary

In reviewing the literature it has been shown that reported rape is growing as a public health problem in society, as evidenced by the increase in rape reportings and perhaps by a change in society's attitude towards the nature of the crime. Research and related literature on the topic of rape have mainly focused on the victim and the act of rape itself, leaving gaps in the existing knowledge concerning the attitudes of health professionals, particularly those of emergency nurses. It is evident from the evaluation of the research findings included in the literature review that further research is warranted to fill this void.

Theoretical Framework

Burgess and Holmstrom (1974) have validated, through extensive research, that rape is a crisis requiring intervention. Caplan (1964), an authority in crisis theory, defines crisis in terms of the psychological disequilibrium experienced and the method of

problem-solving the person uses. Caplan refers to an initial upset, followed by a period of disorganization, as being one in which many abortive attempts at a solution are made to restore equilibrium.

Aguilera and Messick (1978) identified four factors of disequilibrium in a crisis state. These are: a) perception of the event, b) response to the event, c) available emotional support, and d) coping mechanisms used in solving the event. A crisis occurs when the individual is unable to solve a problem by his/her usual problem-solving methods. As a result the individual's thinking capacity is overwhelmed by the emotional reponse which means that the ability to reason becomes ineffective. Rapoport (1970) identified three interrelated factors which can produce a state of crisis. These include: a) "a hazardous event which poses some threat, b) a threat to the instinctual needs which is symbolically linked to earlier threats that resulted in vulnerability or conflict, or c) an inability to respond with adequate coping mechanisms" (1972, p. 25). As a result the individual experiences anxiety, a sense of helplessness, guilt or shame, anger and ambivalence.

There are two types of crises: developmental and situational (Foley and Davies, 1983). Developmental crises occur as a normal process of growth and development marked by periods of great psychological, physical and social change. Examples include birth, puberty, marriage and retirement. Situational crises are identified by their unexpected occurrence and are viewed as a threat by the individual. The element of unpreparedness increases the individual's crisis reaction resulting in disequilibrium and loss of control.

Examples of such crises include death, car accidents, murder, rape and disasters (such as war, floods).

Individuals who are in the most life-threatening situational crisis, such as cardiac arrest, convulsion or motor vehicle trauma are the first-line recipients of care within the medical priority system of an emergency department. Immediate care of these patients may mean their life. The rape victim may be asked to wait for treatment but it does not mean that the victim's experience is not a crisis. It is indeed a crisis, but as it is not an issue of life and death, the victim will not be a priority for the receipt of medical care.

Crisis theory is a systematic approach which can be used by professionals to understand and aid people in times of emotional crises (Lindemann, 1944). It is based on the holistic concept of personality, meaning personality is seen as evolving through experience. The threat may be real or symbolic, depending upon the meaning of the event to the person or persons involved. As previously noted in the literature review, for most rape victims rape represents a crisis, which if left unresolved, can lead to psychological or social consequences for the victim.

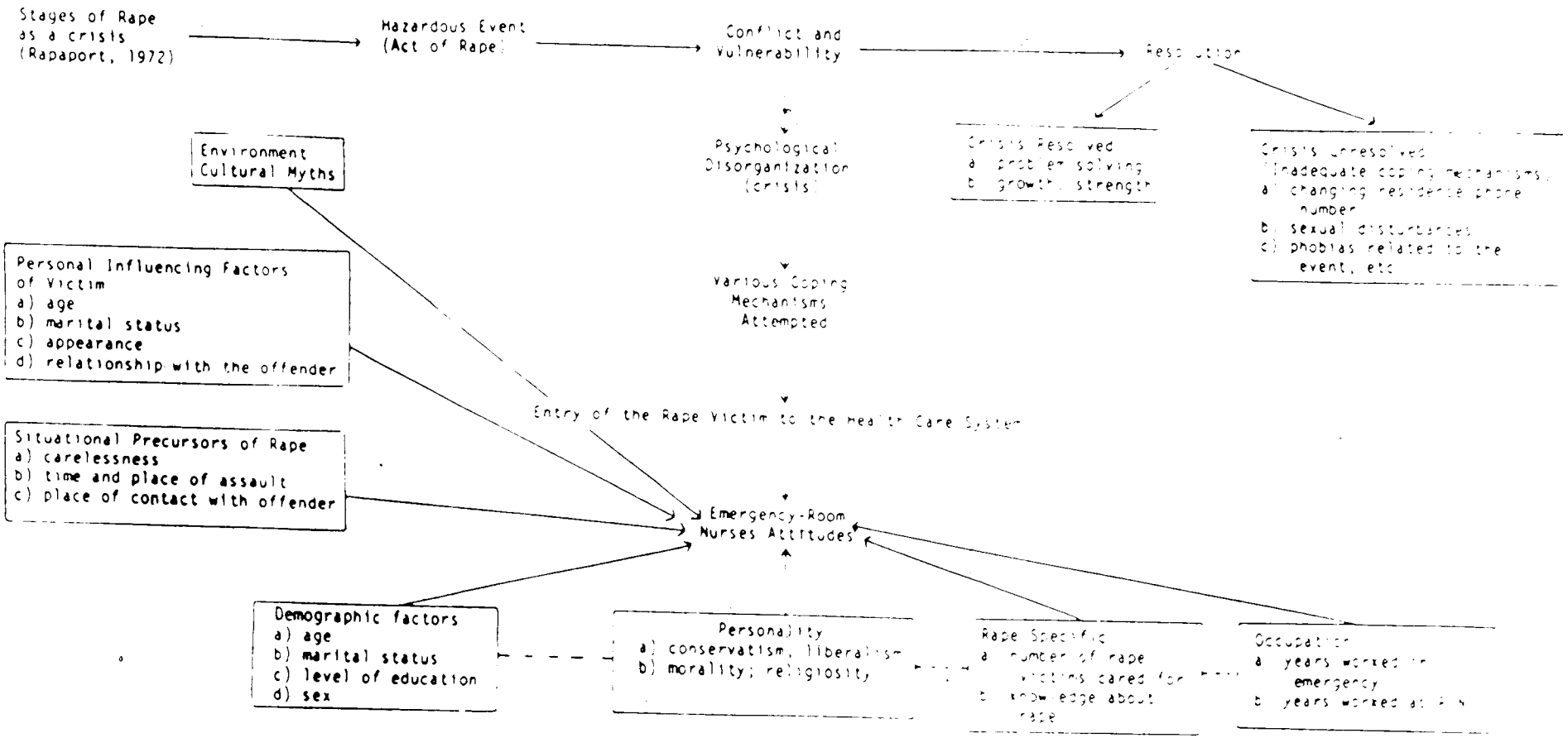
"Crisis theory provides nurses with an understanding of how a crisis state develops in a rape victim's response to the assault (Foley and Davies, 1983, p. 233). It is the theoretical construct that underlies the treatment of a rape victim. Crisis intervention means entering into the life situation of people under stress to help them mobilize existing resources in order to handle such situations. It has the two fold objectives of helping the person return to a

precrisis state and promoting individual strength and growth as a result of the crisis (Foley and Davies, 1983). Nurses can use this theoretic base in crisis resolution for developing effective helping relationships with rape victims. Crisis theory indicates that resolution will have significance for the future mental health of the victim.

A schematic representation of rape as a crisis situation beginning from the time of the reported assault, to the entry into the health care system, concluding with potential discharge outcomes for the victim is provided (see figure 1). Rapoport's three factors, the occurrence of a hazardous event, a threat resulting in conflict and vulnerability and the inability to respond with adequate coping mechanisms form the framework for examining rape as a crisis.

Note that in Figure 1, if a person perceives her situation realistically (e.g. reports the assault and agrees to medical treatment) and has adequate situational support (e.g. crisis intervention counselling, family support) and adequate coping mechanisms (e.g. ways of reducing tension by expressing anger, frustration, etc.) she will be able to mobilize existing resources to resolve the crisis. On the other hand, if one or more factors are missing, the crisis will not be resolved and the individual may develop severe psychological and physiological reactions. The nurses' response to the victim may be a pivotal factor in either enabling the victim to mobilize resources or in adding to the stress of the crisis situation. The variables within the framework will now be discussed.

Figure 1: Rape: A Crisis



The Act of Rape

Many fallacious notions and myths, (such as 'she asked for it,' 'she was too careless' . . .), held by individuals regarding rape have been identified by researchers studying the event. Researchers studying the act of rape have found that rape is generally an act of violence rather than a sexual overture (Allgaier, 1979; Braen, 1976, 1982; Burgess and Holmstrom, 1973, 1974, 1975; Kess 1980; Malamuth et al., 1980). Rape is often premeditated (Amir, 1971; Hardgrove, 1976; Pepitone-Rockwell, 1978; Rabkin, 1979). Rape is usually committed by a 'stranger' rather than an acquaintance (Bennett, 1977; Bray, 1980; Burgess and Holmstrom, 1976; Kilpatrick et al., 1979; Metzger, 1976; Resick et al., 1981), and rape frequently involves use of a weapon making it a life threatening experience (Groth and Burgess, 1977; Groth, Burgess and Holmstrom, 1977; Hursch, 1977; Kilpatrick et al., 1979; Pepitone-Rockwell, 1978).

The result of the disturbing and violent nature of the act of rape often predisposes a rape victim to the development of a crisis state. It is at this time that the decision is made to call police and/or seek appropriate medical treatment. Most often the emergency department is utilized for treatment because of its reputation as having professional people available over a 24-hour period.

Rape as a Crisis Situation

Rape is a forced sexual aggression which constitutes a crisis situation for most women. Rapoport (1970) identified three interrelated factors which can produce a state of crisis. These included: "a) a hazardous event, which poses some threat, b) a threat

to the instinctual needs which is symbolically linked to earlier threats that resulted in vulnerability or conflict, or c) an inability to respond with adequate coping mechanism" (p. 25).

Rape, as a crisis easily fits into Rapoport's three criteria. First, rape is a direct threat to a woman's physical and mental well-being. The victim suffers both psychological as well as the physical trauma of the attack. Secondly, rape constitutes a threat to a woman's sexual autonomy. Williams and Williams (1973) state that "this phenomena might bring to the surface unresolved conflicts and feelings about sexuality which a woman previously repressed" (p. 395). Finally, the occurrence of rape might be an event which is entirely new to a woman's previous life experiences. Research studies have indicated that in a small percentage of cases the woman has been raped on more than one occasion.

Entry of the Rape Victim to the Health Care System

As the person enters the health care system, mainly through the emergency department, several nursing actions are implemented simultaneously. The nature of the presenting complaint is considered the most important and is often relayed to the charge nurse of the department upon arrival. She triages the patient to a respective area after having established the urgency or the non-urgency of the complaint. Frequently, in the case of an alleged rape, the individual has been accompanied to the emergency room by police officers. This in itself draws needless attention and curiosity to the victim from other patients as well as staff members. The patient is then accompanied by a nurse into the gynecological examining room where she

awaits the arrival of the physician. The nurse remains with the patient throughout her entire stay, mainly to provide primary nursing care which ensures the continuity of care deemed essential for subsequent legal proceedings. The emphasis here is that the outward appearance of the victim may not always be representative of the inner turmoil that may be evolving; a common element of crisis situations.

Staff Attitudes to Rape Victims

Based on the research findings cited in the literature review the following attitudes of staff to rape victims were identified:

a) Belief of staff in rape myths may affect their attitudes and behaviors towards the victim (Allgaier, 1979; Bellack and Woodward, 1977; Burgess and Holmstrom, 1973, 1974; LeBourdais, 1976; Lefort, 1977).

b) Ambivalence and biases expressed by staff (e.g. "The woman is just faking") serves to destroy the patient-nurse relationship (Burgess and Holmstrom, 1974, p. 97).

c) Nurses who believe in rape myths will have difficulty in accepting the patient (Foley and Davies, 1983).

Given these findings it is probable that the victim is robbed of the emotional support she thought she might find within the health care system and is burdened with the task of convincing everyone of her innocence.

Foley and Davies (1983) when exploring nurses' responses to rape suggested that they fell into one of four categories: (1) denial of rape facts in which nurses who believe rape myths make comments such as "She was not really raped" or "This is not a legitimate rape;" (2)

cognitive dissonance whereby there is value clarification regarding myth and fact; (3) anxiety in which the nurse identifies with the victim and no longer assumes that rape can happen only to someone else, she too is vulnerable and (4) anger, which can be directed at either the rapist, society, the victim or self. Although these responses may be apparent, these authors state that many victims are still doubly victimized: first, once by the rape and again by care providers in the health care system (p. 67).

Rape Procedure Protocol

Researchers have investigated the medical-legal aspects involving the collection of evidence and generally found that because of the lack of a specified rape treatment protocol, evidence obtained was often inadequate and at times bungled (Allgaier, 1979; Bellack and Woodward, 1977; Burgess and Laszlo, 1977; Bushnell, Burke, Arnsdorf, and Steele, 1980; Lefort, 1977; Moynihan and Coughlin, 1978). Noel (1979) studied 48 emergency room nurses' knowledge pertaining to a specified protocol for the immediate care of rape victims and found that nurses working in a low rape incident emergency had higher scores related to the psychological aspects of care than did those working in high rape incident emergencies. She attributed the difference to low incidence hospitals being located in smaller communities thereby having less organizational complexity and lower numbers of people using emergency, leaving more time for individualized care for the rape victim. As a result of these studies many hospitals have implemented specified rape treatment protocols in addition to inservice education for emergency room nurses.

Personal Influencing Factors

Age and Marital Status

Research exploring the demographic characteristics of the victim has also revealed the biases professional and lay people alike have toward the victim in terms of age, marital status, appearance, acquaintance with the offender, carelessness, time and place of the assault. Studies concerning age of the victim generally agree that any female is a potential victim of rape, with the span of recorded victims being from 5 months to 91 years of age (Foley and Davies, 1983, Hicks, 1980) and the high-risk group identified as being single women between the ages of 17 and 34 (Foley and Davies, 1983; Notman et al., 1976). Statistics indicate that the majority of victims are unmarried at the time of assault and this is understandable in view of the high-risk age group. Research relating to divorced or separated women indicates that they are viewed as being more sexually approachable and available and therefore are more likely to have their credibility questioned and attributed more blame for having provoked the assault (Notman et al., 1976; Selby et al., 1977).

Appearance

Investigators have researched the victim's appearance in terms of her causal role in the crime. They found that the non-attractive victim was blamed more than an attractive victim because she was perceived as having provoked the assault in terms of acting more seductively than the attractive victim (Selby et al., 1977; Tieger, 1981). Also, studies regarding sexual provocativeness in terms of

dress showed that the provocative victim was held more responsible for the assault than the unprovocative victim (Kanekar and Kolsawalla, 1980, 1981; Smith et al., 1976). Alexander (1980) used vignettes with a sample of 500 nurses, to determine whether attitudes would be influenced by the type of crime (i.e. rape versus beating), and found no significant differences across the crimes in the average amount of responsibility assigned to victims. However, when the victim was described as disrespectful (wearing halter tops, divorced, did not struggle with their assailant, knew their assailant, incurred minor lacerations), she was blamed more than the respectable victim (wearing print dress, married, struggled with assailant, suffered a fractured jaw, did not know their assailant).

Acquaintance with the Rapist

Researchers generally agree that victim acquaintedness with the rapist often yields greater responsibility attributed to the victim than when the rapist is a stranger (Bolt and Caswell, 1981; Calhoun et al., 1976; Damrosch, 1981; Smith et al., 1976), but more often than not the majority of rapes are committed by complete strangers. Amir (1971) found that the offender was a complete stranger to the victim in 42% of 646 cases; while Kilpatrick et al. (1979) reported on a sample of 40 cases, of whom half stated their assailant was unknown to them, while 18.5% of assailants were acquainted with the victims. Resick et al. (1981) studied 93 victims and found that 57% were strangers to the victim while 28% were acquainted with the victim. Foley and Davies (1983) stated that "rapists known to the victim include same-age mates; friends; dates; boyfriends; incestuous

offenders such as fathers, uncles, brothers, cousins; and men from all paths of life" (p. 14).

Situational Precursors of Rape

Carelessness

Researchers have also investigated the degree of responsibility the victim is assigned in relation to her assault in terms of carelessness (walking alone at night, frequenting bars, hitchhiking, etc.). Resick and Jackson (1981) found that these types of situational precursors (hitchhiking/poor lighting) influenced the amount of blame attributed to the victim (usually to a greater degree). Likewise those who accepted rides from men in bars (DiVasto et al., 1980) and those who either answered an advertisement for companionship, accompanied a man to his apartment, engaged in sexual foreplay, agreed to engage in sexual intercourse and then changed one's mind and had been drinking an alcoholic beverage with a man in a bar were viewed as responsible for having been raped (Kaplan, 1977). Damrosch (1981) used vignettes with a sample of 116 graduating baccalaureate nursing students in which the victim either locked or failed to lock her car door (carelessness manipulation) and in which the rape occurred at 10 p.m. or 12 midnight. She found that the victim who did not lock her door was rated more negatively in terms of being more responsible for the rape compared to the victim who locked her door.

Time and Place of Assault

Statistics tabulated on time and place of rape incidents

generally show that reported rapes are more common on weekends, in the summer and during the hours from 8 p.m. to 2 a.m. (Brodsky, 1976; Foley and Davies, 1983; Price, 1975; Rabkin, 1979). Additionally, place of assault depends on the situation (victim accepted a ride home, offender agreed to drive victim to another party or see an apartment, etc.). Foley and Davies (1983) reported that most rapes occur in lower socioeconomic neighborhoods and in the victim's or the offender's home. Resick et al. (1981), studied 94 rape victims and found that 37% were assaulted in their own homes, 16% at the offender's residence and 5.3% in secluded locations and/or in the offender's car. Amir (1971) reports that over half of the rapes, in a study of 646 victims, occurred in the victim's home. In a longitudinal study of 43 rape victims, Kilpatrick et al. (1979), reported 34.9% of these rapes occurred in the victim's home, with 23.3% representing forced entry, often while the victim was sleeping; another 7% occurred in the offender's home. The remaining 39.5% of the assaults occurred in cars with 18.6% of victims having accepted a ride, while 20.9% were forced into the offender's car.

Potential Discharge Outcomes for the Victim

Various researchers have studied the victim's response to rape with Burgess and Holmstrom (1974) being the most comprehensive and well-known study done in this area. They term the suffering a victim undergoes during the rape, immediately following the rape, and over a considerable time period after the rape, the rape trauma syndrome. In view of the potential outcomes of the victim they found that in the acute phase (period after the attack and medical treatment) the

individual experienced sleep, eating and emotional disturbances). The long term process, referred to as the reorganizational phase, represents the disruption in the life style of the victim during the first days and weeks following the incident, and well into weeks and months thereafter. Common responses of victims included moving and changing residence either across the city or out of the state, changing the phone number to an unlisted number, staying home from work or changing jobs, sexual disturbances and phobias (i.e. fear of crowds, being alone, etc.) as they related to the characteristics of the assault.

Other investigators of aftercare victims have found that the victim's family and others may believe that 'she asked for it', and since they believe this myth, withdraw support and in turn become openly critical of the victim (Burgess and Holmstrom, 1979; Pepitone-Rockwell, 1978), with divorce or separation occurring if the husband or partner is unable to deal with the feelings that arise (Foley and Davies, 1983; Hardgrove, 1976; Moynihan and Coughlin, 1978).

Operational Definitions

Rape: The Law Reform Commission of Canada (1978) addressed the matter of the legal definition of rape (Sec. 143-5 of the Criminal Code): "A male person commits rape when he has sexual intercourse with a female person who is not his wife (a) without her consent or (b) with her consent if the consent (i) is extorted by threats or fear of bodily harm, (ii) is obtained by impersonating her husband or (iii) is obtained by false or fradulent representations as to the nature or

quality of the act."

For this study the legal definition of rape will be used to develop an operational definition.

Rape is the event, as described by verbal reports from the victim, whereby there has been vaginal, oral, and/or anal penile penetration, without consent and where agreement exists from a medical-legal examination and laboratory studies that this has occurred.

Attitudes: Those beliefs and feelings determined by the respondents recorded responses on Likert-type scales of the Rape Attitude Scale. The terms "beliefs" and "feelings" are defined in Webster's Dictionary (1983) as follows:

a) Beliefs are made up of the information we accept about an object, concept or event--whether or not that information is correct; they are factual components of attitudes.

b) Feelings are emotional states or reactions.

CHAPTER III

METHODOLOGY

Design of the Study

The study was designed to measure and describe the attitudes of nurses working in emergency rooms toward rape victims. Rape victims were not included in this study.

A measuring instrument developed by the researcher, consisting of two parts, a biographic questionnaire and a rape attitude scale, were used for data collection. The first part, the biographic questionnaire, focused on the respondent's age, gender, level of education, years of experience within an emergency department, and the estimated number of rape victims cared for by each nurse. A 61 item scale which reflected the different ways in which people view rape, and some potential responses of nurses to rape victims, was developed and comprised the second section of the measuring instrument (see Appendix A). Subjects were asked to rate their responses to the statements on a 5-point Likert-type rating scale.

Development of the Instrument

Based on a comprehensive review of the literature, a framework was developed that identified the personal and situational factors found to influence people's attitudes toward rape. These factors were used to develop the Rape Attitude Scale in which the variables, age; marital status; appearance; acquaintance with the rapist; carelessness; time and place of assault, were used to develop 61

statements that would be useful for characterizing people's attitudes toward the rape victim. Each statement described an aspect of the variable being measured. A 5-point Likert-type scale (Strongly Disagree to Strongly Agree) was constructed for the subjects to rate their responses to each statement.

The general categories of attitudes, for which items were written, stemmed from the review of the literature. Although reported research findings on the factor of age show that any female, regardless of age is a potential victim of rape, the context of this study was limited to defining victims as 18 years of age and over. Another factor, that of marital status, was included because it was reported that the majority of victims were unmarried at the time of the assault. The research also showed that there is a greater attribution of blame if the victim is divorced or separated. Appearance of the victim in terms of the degree of attractiveness, and sexual provocativeness in terms of dress, were also shown to reflect more responsibility onto the victim for the assault. A review of the literature of victim acquaintedness with the rapist indicated that greater responsibility of blame is attributed to the victim who knows her assailant than when the rapist is a stranger. Studies have also been done which have assigned a greater degree of responsibility for victims who were considered to be careless (hitchhiking, frequenting bars, walking out alone at night, etc.). Time and place of assault were shown to be situation dependent (offender agreed to drive victim to a party or take her home, etc.).

A sampling of the construct domain, consisting of statements

reflecting the personality traits of liberalism; conservatism; religiosity and morality, was also used to develop statements in the scale. Definition of terms were guided by Websters Collegiate Dictionary (1983) as follows:

a) Liberalism - opinions favoring progress or reform.

b) Conservatism - devotion to the existing order of things; opposition to change.

c) Religiosity - the beliefs, emotions, attitudes, behaviors, etc., contributing to a person's relationship with powers or principles of the universe; especially with a deity or deities.

d) Morality - principles of wrong and right conduct.

These additional categories were chosen on a speculative basis but guided by the sparse research literature. Statements representing each category were constructed and were included in the scale. The purpose of this inclusion was to determine if nurses who scored highly on one or more of these traits, differed from other respondents in their responses to the rape related statements of the scale.

Vignette Trials

Prior to the development of the rating scale, trials of three vignettes (short form descriptions of rape situations) were developed and pretested on eight post graduate obstetrical nurses for question clarity and structure. A comment section followed each scale which allowed respondents to express their opinions in regard to question validity and content. Response results and comments were subjected to qualitative analysis and proved useful in the development of the final tool; the Rape Attitude Scale, a 5-point Likert type scale.

Pilot Test

The biographic questionnaire and attitude scale were pretested for content and construct validity through administration to 15 volunteer emergency room nurses not participating in the main study. As part of this process a comment section was provided after each scale item which allowed subjects to express their reasons for having chosen their responses. The purpose of collecting the comments was to support the content validity of each item, and reduce possible ambiguities in each statement. The comment section was deleted from the attitude scale prior to being used in the main study.

An initial indication of the construct and factorial validity of the scale items was established by an examination of the correlations among items and a factor analysis of the responses from the pilot study. The main purpose of this analysis was to ensure that the items selected for each construct were likely to be reasonable and reflected the measures of that construct. The main reason that no significant deletions of items were made was that correlations among variables (61) were constrained by the number of respondents (n=15).

Reliability of the instrument was estimated by test re-test on a sub-group in the main study, and on a small sample in the pilot group. Based on the pilot study findings the tool was revised by rewording a few scale items before administration in the main study.

Examination of the Validity of the Instrument

Validity of Attitude Measurement Scales

Face validity of the tool was assessed by eight post-RN

obstetrical nurses. The validators were asked to evaluate each scale for clarity, understanding and completeness. Based on their recommendations, modifications were made to wording and sentence structure. Content and face validity were determined using another pilot group of 15 emergency nurses, not included in the main study. This was done to ensure that the constructs sampled and their associated items could be meaningfully rated with regard to content and were representative of items regarding the rape victim. A comment section was provided after each of the 61 scale items in which the respondents were given opportunity to express their comments regarding disagreement/agreement, clarity, etc. of the statement. Qualitative analyses of the responses were done and resulted in minor revisions to the scales. Factor analysis on the pilot data did not result in any major revisions to the tool because of the small number of respondents (15) compared to the number of variables (61), and therefore the variables were linearly dependent.

Construct validity in part was established by factor analysis of the responses in the initial test of the main study. Kerlinger (1973) states that, "factor analysis is perhaps the most powerful method of construct validation. It is a method for reducing a large number of measures to a smaller number called factors by discovering which measures "go together" (which measures measure the same thing) and the relations between the clusters of measures that go together." ". . . what measures measure the same thing and to what extent they measure what they measure" (p. 468). Factorial validity was established (see Table 4.8) and internal consistency of the instrument was achieved in

the various factor categories (see Table 3.1). Following factor analyses on data collected from the test re-test 9 statements, which had loaded extremely low, were excluded and refactoring of the remaining 52 variables was done (see Appendix A).

Data Gathering Instrument

The rape scale was revised following the pilot study and is included in Appendix A. Each questionnaire contained two sections: Biographic Data Sheet and Rape Attitude Scale.

The Biographic Data Sheet was comprised of the following variables: age; sex; education; years worked since completion of R.N.; months worked in an Emergency Department; provision of nursing care to a victim of rape; specified departmental rape protocol; being a victim or a friend of someone raped and having had attended educational workshops on rape.

The Rape Attitude Scale was designed to measure those factors which were considered to be related to attitudes toward rape and included items on the age of the victim; appearance of the victim; marital status of the victim; acquaintance with the rapist; carelessness; and time and place of assault. Using these areas as a guide 61 scale items were developed which were believed to be important in assessing emergency room nurses' attitudes towards the rape victim (see Table 3.1). The Emergency nurses rated each statement on a 5-point Likert type scale using the continuum Strongly Disagree to Strongly Agree.

Hypothesized Factors of Rape Attitude Scale

The 61 statements were subdivided into the factor categories of

Table 3.1

Hypothesized Factor Categories of Emergency Room Nurses' Attitudes Toward the Rape Victim

Factor Category	Item Number	Statement
Age	1	Rapist usually selects an attractive young (19-35 years) woman to assault.
	8	An assault of an 18 year old woman is more damaging than it would be to a 40 year old woman.
	14	An assault on an 80 year old woman is more damaging than it would be to a 30 year old woman.
	22	An assault on a 50 year old woman is more damaging than it would be to a 20 year old woman.
	32	Any female, regardless of age, is a potential victim for rape.
	37	The young adult victim (18-25) requires more support than an older victim.
	39	Age of the victim will affect the degree of empathy the nurse has for the victim.
Marital Status	2	Divorced women are generally viewed as being more sexually approachable and available.
	3	An assault on a married woman is more damaging (because she is married) than an assault on a woman who is divorced or who is single.
	25	Single and divorced women are more likely to get raped, than married women.
	33	In emergency, more sensitivity, and support is needed by the single victim, than by the married or divorced victim.

Table 3.1 (continued)

Factor Category	Item Number	Statement
Acquaintance with offender	5	More women get raped by a male they know (an acquaintance), than a total 'stranger.'
	11	Nurses tend to be less supportive and sensitive to the victim who is raped by an acquaintance, than a 'stranger.'
	15	The rapist is usually a stranger.
	26	Nurses tend to be more empathetic to the rape victim, if the rapist was a stranger than if he were an acquaintance.
Carelessness	6	In most rape cases the victim's carelessness contributes to the assault.
	17	Most rapes can be prevented by using safety precautions (e.g. locking car doors, putting the chain on an apartment door).
	18	In most cases when a woman is raped, she was 'asking for it.'
	34	Women can avoid being raped by staying out of dangerous situations (e.g. hitch-hiking).
Time of assault	9	The majority of rape attacks occur during week days.
	23	Assaults usually take place between 8 p.m. and 2 a.m.
	31	Assaults usually take place on summer weekends.
Place of assault	13	Most rapes occur in secluded locations (alleys, out of town).
	19	Most rapes occur in the victim's home.

Table 3.1 (continued)

Factor Category	Item Number	Statement
	29	Rapes occur when women are alone at night.
Nurse's Response to Rape	7	Most rapists have abnormal, unsatisfied sex drives.
	17	A rape victim should have immediate attention as well as emotional support.
	20	Rape constitutes a crisis situation for most victims.
	21	Sexual perversion is a common element of the rapist attack.
	24	Most rape victims are treated in an impersonal manner in the emergency department.
	28	When admitted to emergency, rape victims are usually anxious and frightened.
	30	Nurses tend not to want to care for rape victims.
	35	Rape victims blame themselves and feel guilty about the attack.
	36	Immediate nursing care of a rape victim is directed towards reducing the rape victim's feelings of distress.
	38	Avoidance of rape victims by nurses is a commonly observed behaviour in the emergency department.
	40	Most rape victims view the hospital emergency staff as providers of medical care and emotional support.
	60	Rape is the most humiliating and 'private' crime a woman can experience.

Table 3.1 (continued)

Factor Category	Item Number	Statement
Appearance of Victim	4	Women provoke their own rape by using bad judgement, acting seductively, etc.
	10	Most women provoke an assault by their dress and behaviour.
	16	Victims who are 'seductively' dressed are responsible for provoking the rape.
	27	Do you agree that a rape victim's appearance (in terms of dress) encourages the rape in any way?
Morality	47	A woman who has sexual relations with a man for money should go to jail.
	49	Having sexual relations before marraige is acceptable.
	54	Taking advantage of a person sexually is morally corrupt.
	57	Today, having sex relations outside the marriage partnership is all right (if both parties agree).
	61	For serious crimes involving an assault, capital punishment is justifiable.
Liberalism	41	If prostitution were legalized sex offences, such as rape, would decrease.
	50	A change in moral values is a necessary component of life.
	59	Censorship of pornographic materials (books or movies) is a violation of free speech.
Religiosity	43	People would be better off if religion had a greater influence in their daily lives.

Table 3.1 (continued)

Factor Category	Item Number	Statement
	51	I find that my ideas on religion have a considerable influence on my views in other areas.
	56	To lead a good life is necessary to have some kind of religious belief.
Conservatism	37	It is impossible to rape a woman against her will.
	44	One should avoid trouble at all costs.
	45	The accusation of rape is most often used by the woman seeking revenge.
	46	In order for society to operate smoothly there must be respect for rules and regulations.
	48	Today people are prying into matters that should remain private and personal.
	52	Women caught in embarrassing situations often 'cry rape' as a defense.
	53	Planned parenthood should be operated by a volunteer agency.
	55	If there is no evidence of a struggle in a rape case, then the victim must have consented.
	58	Sex crimes, such as rape, deserve more than prison sentences; such criminals ought to be publicly whipped.

age; marital status; acquaintance with the rapist; carelessness; time and place of assault; nurse's response to rape; morality; liberalism; conservatism and religiosity (see Table 3.1). The responses to these 61 statements were subjected to a principal axis factor analysis and a Varimax rotation.

The Sample

This study examined emergency nursing staff from three general hospitals in one Western province, which were known to provide medical services for rape victims. The pilot group of emergency room nurses (n=15) in one of the three participating hospitals were not included in the main study. The total number of respondents participating in the initial testing of the questionnaire of the main study totalled 101.

Data Collection

The data were collected from the respondents by use of a questionnaire. Self-addressed envelopes were enclosed with each questionnaire, along with a codeword and instructions to return the questionnaires as soon as they were completed. Coding of the questionnaires with a codeword, that only the respondent would be able to identify, insured anonymity of the respondents and confidentiality of their responses. The responses were then transferred to computer coding sheets and then to computer cards.

The questionnaires were hand delivered to the three emergency departments and then distributed by the Unit Supervisors. Prior to participation in the study, written consent forms were distributed and stored in a separate envelope by each Unit Supervisor. A one month

time period for return of completed questionnaires was allotted and respondents were instructed to keep their codeword for the second phase of the main study. Repeat administration of the questionnaires on the sub-sample was done one month after the collection of the initial data.

The number of respondents combined from all three hospitals totalled 101 on the initial testing and 75 on repeat administration. However, of the repeat questionnaires returned, 12 were discarded. Seven of these were discarded because the codeword was not written down and therefore could not be matched with the earlier administration of the questionnaire. The remainder were only partially completed. Therefore 63 responses formed the final usable repeat sample. Table 3.2 indicates the percentages of questionnaires returned by the respondents on both the initial and repeat testings in all three hospitals.

Treatment of Data

Statistical Methods

Data compiled from the questionnaires were analyzed by the following statistical methods.

1. Factor Analysis and Factor Score Estimates: Principal axis factor analysis, using the squared multiple correlations as the initial communality estimates, and a Varimax rotation were used. Estimation of factor scores using the regression method, for each subject on each factor considered meaningful, was carried out.

Table 3.2

Percentages of Returned Questionnaires

	Questionnaires				
	Distributed	Returned			
		Test 1		Test 2	
Subjects	Total No.	N	%	N	%
Hospital 1	59	38	64.4	30	78.9
Hospital 2	44	33	75	18	54.5
Hospital 3	43	30	69.7	15	50
	146	101		63	

2. Pearson Product Moment Correlations: Alpha coefficient to estimate internal consistency reliability of scales.

3. Pearson Correlation: Correlations between subjects' responses in the test re-test.

4. One-Way Multivariate Analysis of Variance and Covariance: The one-way MANOVA was used to determine if differences existed between the mean factor score estimates among various groups identified by the respondents' biographical data. Wilks Lambda and an approximate F test were used in each MANOVA to determine the degree of significance.

Summary

This study was designed to measure and describe the attitudes of emergency room nurses' towards the rape victim. A biographic questionnaire and an attitude scale developed by the researcher were used to collect data on the biographical characteristics of the respondent and their responses to 61 scale items believed to be important in assessing attitudes towards the rape victim. The scale was tested for reliability using Cronbach's alpha and the correlations between testing occasions. Factorial validity was established using factor analysis. Three groups of emergency room nurses were used in the study; excluding the 15 who had participated in the pilot study.

Data analysis included the use of factor analysis, Pearson's product moment correlations, factor score estimation using the regression method and one-way multivariate analyses.

CHAPTER IV

RESULTS AND DISCUSSION

The material presented in this chapter is divided into three main sections, the first of which contains the results of factor analyses of the final instrument, the Rape Attitude Scale, with explanation of the factor categories that developed. The second section, contains a description of the emergency room nurses who participated in the study. The third section is comprised of reports of emergency room nurses' attitudes to rape victims as indicated by their responses on the Rape Attitude Scale. The correlations between the responses on the test and re-test are also included and discussed.

Factor Analysis of Hypothesized Factor Categories in Emergency Nurses' Responses on 61 Items of Rape Attitude Scale

Hypothesized factor categories were drawn from data obtained during the literature search (see Table 3.1). From these factors 61 statements that would be useful for characterizing people's attitudes toward the rape victim were developed. It should be noted that the hypothesized factors of morality, liberalism, religiosity and conservatism were included because of their importance in the development of an attitudinal set.

The 101 responses on the initial testing of the attitude scale were subjected to factor analysis and Varimax rotation to define specific factor categories. It was found that nine items loaded extremely low in terms of loadings and communalities, thereby

contributing minimally to the overall definition of the factor space and as a result these were deleted from the questionnaire. The remaining 52 items thus formed the final instrument and were re-factored using principal axes with Varimax rotation. A clearer definition of the hypothesized factor categories resulted.

Factor Analysis of Emergency Nurses' Responses on 52 Items of Rape Attitude Scale

Factor 1: Carelessness and Appearance of the Rape Victim

The first factor related primarily to the degree of carelessness exhibited by and the appearance (in terms of dress) of the rape victim. Items loading highly on this factor related to the attribution of blame towards the rape victim in terms of appearance and the victim's behaviour (see Table 4.1).

Factor 2: Age and Marital Status of the Rape Victim

The second factor focused on the variables of age and marital status of the rape victim. The four items that loaded highly related to comparative age statements in terms of 'damage' to the individual and degree of support given by the emergency room nurse. Three items focused on the amount of support granted to victims because of their marital status. Items 8, 33, and 37 suggest more support for the young, unmarried victim in terms of age and marital status but there are no clear definitions. Note in items 14 and 22 the loadings are also high and may be due to the influence of the victim's physical stamina coupled with age. Again no clear definition can be made. A statement concerning the incidence of assaults in relation to summer

Table 4.1

Factor One: Carelessness and Appearance of the Rape Victim: Varimax Rotation

Item No.	Statements	Communalities	Loadings
10	Most women provoke an assault by their dress and behaviour.	0.621	0.718
4	Women provoke their own rape by using bad judgement, acting seductively, etc.	0.620	0.692
6	In most rape cases the victim's carelessness contributes to the assault.	0.457	0.659
18	In most cases when a woman is raped, she was asking for it.	0.627	0.618
16	Victims who are 'seductively' dressed are responsible for provoking the rape.	0.640	0.566
17	Most rapes can be prevented by using safety precautions (e.g. locking car doors, putting the chain on an apartment door).	0.365	0.546
34	Woman can avoid being raped by staying out of dangerous situations (e.g. hitch-hiking).	0.306	0.456
27	Do you agree that a rape victim's appearance (in terms of dress) encourages the rape in any way?	0.437	0.450

hours also loaded and may be related to the accessibility of victims (see Table 4.2).

Factor 3: Rape as a Crisis Situation

The third factor identified rape as a crisis state requiring appropriate medical and psychological intervention and support. The supportive aspect of nursing care and medical care was viewed as being related to the overall management of the crisis. Additionally, the act of rape was viewed as a heinous crime in which one individual violated the rights of another (see Table 4.3).

Factor 4: Degree of Personaliziation with the Offender

The fourth factor related to the rapist-victim relationship. The loadings indicated that the sex offender is more likely to be perceived as a stranger and that age may also be related to the degree of personalization. A conservative overtone suggested by items 44 and 47 which also load on this factor suggest that a more conservative attitude is related to the concept of the attacker being a stranger rather than someone familiar. Item number 45 (see Table 4.4) loaded quite high in this factor. It is speculated that this statement may have suggested an acquaintance relationship between the rapist and victim whereby retribution by the female could be procured easily by the report of a feigned assault.

Factor 5: Emergency Room Nurses' Responses Towards Rape Victims

Factor 5 primarily focused on emergency nurses' behavioural responses in the delivery of nursing care to the rape victim. The loadings indicated a perception of avoidance behaviour or option not to care for the rape victim. Furthermore, the degree of empathy for

Table 4.2

Factor Two: Age and Marital Status of the Rape Victim: Varimax Rotation

Item No.	Statements	Communalities	Loadings
14	An assault on an 80 year old woman is more damaging than it would be to a 30 year old woman.	0.619	0.766
37	The young adult victim (18-25) requires more support than an older victim.	0.573	0.676
22	An assault on a 50 year old woman is more damaging than it would be to a 20 year old woman.	0.432	0.629
8	An assault on an 18 year old woman is more damaging than it would be to a 40 year old woman.	0.416	0.601
33	In emergency, more sensitivity and support is needed by the single victim, than by the married or divorced victim.	0.491	0.481
31	Assaults usually take place on summer weekends.	0.337	0.431
25	Single and divorced women are more likely to get raped, than married women.	0.310	0.417
3	An assault on a married woman is more damaging (because she is married) than an assault on a woman who is divorced or who is single.	0.357	0.406

Table 4.3

Factor Three: Rape as a Crisis Situation

Item No.	Statements	Communalities	Loadings
54	Taking advantage of a person sexually is morally corrupt.	0.385	0.558
12	A rape victim should have immediate medical attention as well as emotional support.	0.411	0.549
60	Rape is the most humiliating and 'private' crime a woman can experience.	0.323	0.512
20	Rape constitutes a crisis situation for most victims.	0.264	0.480
28	When admitted to emergency, rape victims are usually anxious and frightened.	0.243	0.430
36	Immediate nursing care of a rape victim is directed towards reducing the rape victim's feelings of distress.	0.307	0.339

Table 4.4

Factor Four: Degree of Personalization with the Offender

Item No.	Statements	Communalities	Loadings
15	The rapist is usually a stranger.	0.528	0.605
5	More women get raped by a male they know (an acquaintance), than a total 'stranger.'	0.360	-0.593
45	The accusation of rape is most often used by the woman seeking revenge.	0.375	0.534
32	Any female, regardless of age, is a potential victim for rape.	0.466	-0.465
44	One should avoid trouble at all costs.	0.391	0.445
47	A woman who has sexual relations with a man for money should go to jail.	0.337	0.434

victims assaulted by a stranger was higher as compared to those victims who had been assaulted by an acquaintance. Age in terms of the degree of empathy displayed by respondents was revealed as important; however, it is speculated that this statement would have loaded higher if sexually assaulted children had been included in the study. The respondents were informed that the focus of the study was on the adult female rape victim, 18 years of age and over, and therefore may have expected that the adult victim was better able to cope with the assault than a child. Additionally, the respondents could have also expected that their degree of empathy shown to the adult victim would be relatively even across the sub-groups of the adult population by virtue of the victim being an adult (see Table 4.5).

Factor 6: Religious Belief with a Moral Conservative Overtone

Factor 6 predominantly focused on the degree religious beliefs influenced the respondents' general view of ~~their~~ lives. The high loadings suggested that religion is considered important by a majority of the respondents and that premarital sex is not viewed as acceptable (see Table 4.6). The fact that these items loaded on a separate factor suggest they are not related to the items defining other factors.

Factor 7: Psychological Profile of the Rapist

Factor 7 focused on the psychological profile of the rapist in which respondents viewed the rapist as being socially deviant, having an abnormal sex drive, and committing their attacks in the victim's home. Responses to a statement which concerned punishment of the sex

Table 4.5

Factor Five: Emergency Nurses' Responses Towards Rape Victims

Item No.	Statements	Communalities	Loadings
38	Avoidance of rape victims by nurses is a commonly observed behaviour in the emergency department.	0.552	0.703
11	Nurses tend to be less supportive and sensitive to the victim who is raped by an acquaintance, than a stranger.	0.621	0.653
26	Nurses tend to be more empathic to the rape victim, if the rapist was a stranger than if he were an acquaintance.	0.433	0.614
30	Nurses tend not to want to care for rape victims.	0.510	0.648
24	Most rape victims are treated in an impersonal manner in the emergency department.	0.421	0.476
39	Age of the victim will affect the degree of empathy the nurse has for the victim.	0.422	0.471

Table 4.6

Factor Six: Religious Belief With a Moral Conservative Overtone

Item No.	Statements	Communalities	Loadings
43	People would be better off if religion had a greater influence in their daily lives.	0.561	0.657
51	I find that my ideas on religion have a considerable influence on my views in other areas.	0.456	0.613
49	Having sexual relations before marriage is acceptable.	0.394	-0.534
56	To lead a good life it is necessary to have some kind of religious belief.	0.380	0.480

offender by prison sentence or public whipping, had a low loading which may possibly reflect the fact that public whipping is not a normal practice in Canadian society, rather than the severity of punishment (see Table 4.7).

Validity of the Seven Factors

Factor scores for each of the 101 respondents were calculated and the squared multiple correlations of the estimated scores with the true factor scores were found. The squared multiple correlations in Table 4.8 indicate that reasonably good estimates of factor scores were possible, and provided the justification to use the factor scores for further comparisons (Harmon, 1968).

Examination of the Reliability of the Instrument

Reliability of Attitude Measurement Scales

The Rape Attitude Scale was administered a second time to the same respondents after a one month time lapse. The 101 responses for 51 items from the initial testing of the attitude scale were correlated and an alpha reliability coefficient calculated. The alpha coefficient provided a measure of internal consistency of the attitude scale. Cronbach's alpha reliability coefficient was calculated to be 0.8261. In addition, correlations were calculated between the responses to each scale between the test and re-test administration.

Mean Differences on Attitude Dimensions for Selected Groups of Nurses

Age of the Respondents

A total of 101 female registered nurses who were employed in an

Table 4.7

Factor Seven: Psychological Profiles of the Rapist

Item No.	Statements	Communalities	Loadings
7	Most rapists have abnormal, unsatisfied sex drives.	0.661	0.721
21	Sexual perversion is a common element of the rapist attack.	0.475	0.607
19	Most rapes occur in the victim's home.	0.374	0.404
58	Sex crimes, such as rape, deserve more than prison sentences; such criminals ought to be publicly whipped.	0.301	0.333

Table 4.8

Squared Multiple Correlations of the Seven Factors

Factor	Description	SMC *
1	Carelessness and appearance of the rape victim.	0.8538
2	Age and marital status of the rape victim.	0.8357
3	Rape as a crisis situation.	0.8278
4	Degree of personalization with the offender.	0.8013
5	Emergency nurses' responses towards the rape victim.	0.8346
6	Religious belief with a moral conservative overtone.	0.777
7	Psychological profile of the rapist.	0.797

* SMC: Squared multiple correlation

emergency department participated in the study. Of these nurses 17% were between the ages of 20-25, (Group 1); 27% between 26-30, (Group 2), 27% between 31-35 (Group 3); 15% between 36-41, (Group 4); 8% between 41-45, (Group 5) and 5% were 46 years or older, (Group 6), (see Table 4.9). Respondents were fairly well distributed among the first four age categories with the majority being in the 26-35 year old group. Groups 5 and 6 were combined together and a one-way MANOVA was done on the factor scores to determine whether differences existed between groups. The mean vectors by age across the seven factors were calculated and plotted (see Figure 2).

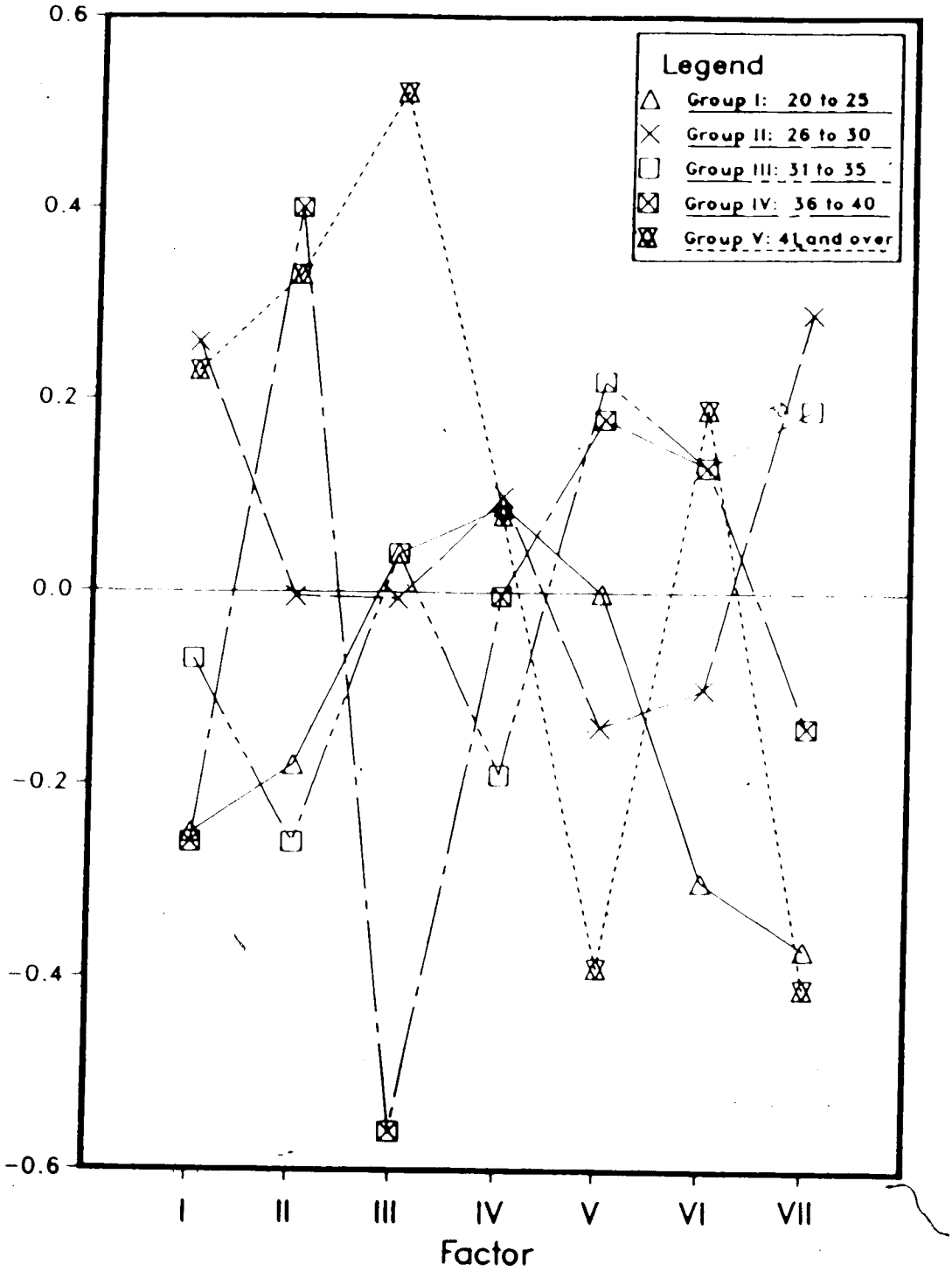
In summary, the mean vectors of the five age groups reflected differences as well as similarities across the seven factor categories. Most interesting to note was the difference between Group 1 (20-25 years old) and Group 5 (41 and over) in the first six factors (see Figure 2). A MANOVA performed on the age groups across the seven factor categories used the factor scores as variables and indicated a significant difference among groups [$F=1.64$, $df(28,325.9)$, $p \leq .02$]. The compared group mean vectors of Group 4 (36-40 years old) versus Group 5 (41 years and over) contributed to the overall significant difference of the age category [$F=2.36$, $df(7,90)$, $p \leq .02$]. In addition to an overall difference in the mean vectors by age there were also specific differences between Groups 1-2; 2-3; 1-4; 1-5; and 4-2 on Factor One; Groups 3-4; 3-5 on Factor Two; Groups 2-4; 3-5; and 4-5 on Factor Three and Groups 3-5 on Factor Four; Groups 3-5; 4-5 on Factor Five and Groups 1-2; 1-3; 2-5; 3-5 on Factor Seven. The confidence intervals suggested significance at $p \leq .10$ for the various

Table 4.9

Distribution of Emergency Room Nurses by Age Category

Age Category	Code	Absolute Frequency	Relative Frequency (Percent)
20-25.9	1	17	16.8
26-30.9	2	28	27.7
31-35.9	3	28	27.7
36-41.9	4	15	14.9
41-45.9	5	8	7.9
46 and over	6	5	5.0
Total		101	100.0

Figure 2: Mean Vectors of Age Groups on the Seven Factor Categories



FACTOR:
- I Carelessness and appearance of the rape victim.
- II Age and marital status of the rape victim.
- III Rape as a crisis situation.
- IV Degree of personalization with the offender.
- V Emergency room nurses responses towards the rape victim.
- VI Religious belief with a moral conservative overtone.
- VII Psychological profile of the rapist.

groups on the seven factor categories. There were no confidence intervals suggesting significant differences for any of the groups on Factor Six.

Marital Status of the Respondents

Sixty four percent of the respondents were married, 29% single and only 7% either separated (2%) or divorced (5%) (see Table 4.10). Because of the small proportions in the third and fourth categories, they were omitted in the one-way MANOVA, which left the largest categories of married and single respondents. No significant differences were found among the group vectors of factor scores in this category [$F=1.02$, $df(7,86)$, $p \geq .43$].

Regular Attendance at a Religious Institution

Of the total respondents, 64% did not attend a religious institution regularly, whereas 36% stated they did. A MANOVA was performed and yielded a significant difference on the mean vector of factor scores [$F=4.39$, $df(7,93)$, $p \leq 0.0003$]. It is noted that Group 2 (non-attenders) tend not to view religion as an integral part of their daily lives and that this group perceives the rapist as not being as deviant as Group 1 (attenders) (see Figure 3).

Level of Education

The largest proportion of respondents were graduates of an R.N. diploma program and comprised 86% of the total number. There were 2% who had a Basic Bachelor of Science Degree in Nursing, 8% with a Post-graduate Bachelor of Science in Nursing, 1% with a Master's Degree in Nursing and 3% with post-graduate degrees other than nursing (see Table 4.11). A MANOVA was performed and resulted in no

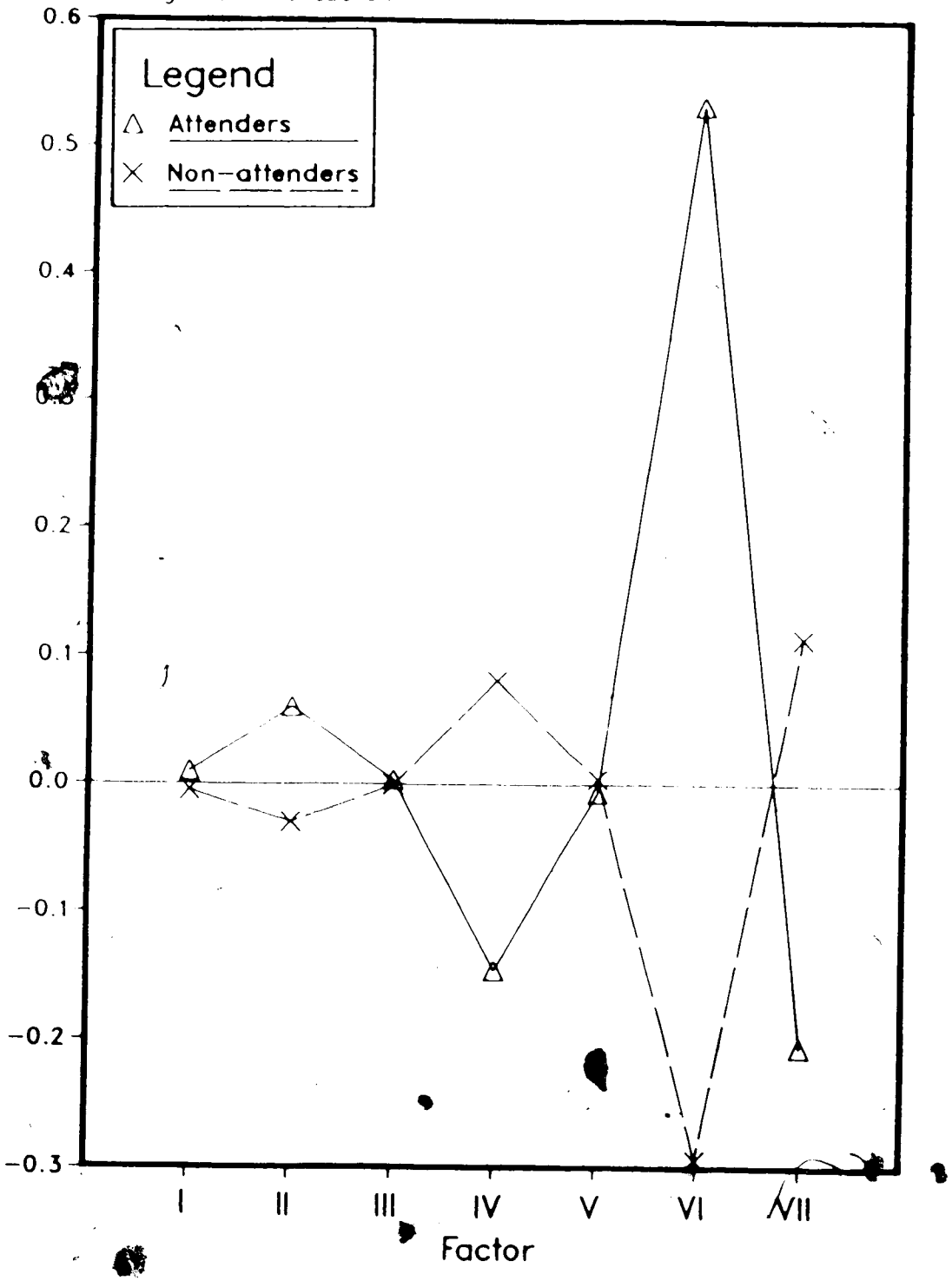
Table 4.10

Distribution of Emergency Room Nurses by Marital Status

Marital Status	Code	Absolute Frequency	Relative Frequency (Percent)
Married	1	65	64.4
Single	2	29	28.7
Separated*	3	2	2.0
Divorced*	4	5	5.0
Total		101	100.0

* Categories deleted prior to one-way multivariate analysis.

Figure 3: Factor Score Means of Non-attenders and Attenders at a Religious Institution



FACTOR:
- I Carelessness and appearance of the rape victim.
- II Age and marital status of the rape victim.
- III Rape as a crisis situation.
- IV Degree of personalization with the offender.
- V Emergency room nurses responses towards the rape victim.
- VI Religious belief with a moral conservative overtone.
- VII Psychological profile of the rapist.

Table 4.11

Distribution of Emergency Room Nurses by Level of Education

Level of Education	Code	Absolute Frequency	Relative Frequency (Percent)
R.N. Diploma	1	87	86.1
Basic Bachelor of Science in Nursing	2	2	2.0
Post-graduate Bachelor of Science in Nursing	3	8	7.9
Master's Degree in Nursing	4	1	1.0
Other	5	3	3.0
Total		101	100.0

significant difference between groups on the 7 dimensions descriptive of attitude towards rape, i.e., there did not appear to be any difference in attitude with different levels of education. However, because the educated groups were small they were disproportionate in relation to the diploma group and this may have contributed to the finding.

Years of Nursing Experience

In the distribution of years of nursing experience, 21% had less than five years of nursing experience, 32% had five to ten years, 25% had ten to fifteen years, 14% had fifteen to twenty years and 8% had more than 20 years (see Table 4.12). A one-way multivariate analysis of variance resulted in no significant difference between the mean factor scores for the group of respondents [F=1.51, df(21,761.9), $p \geq .07$].

Months Worked in an Emergency Department

Of the total nursing personnel sample, 11% had less than six months of emergency room nursing experience, 12% had six months to 36 months, 26% had 37 months to 60 months, 13% had 61 months to 84 months, 14% had 85 months to 108 months and 24% had more than 120 months (see Table 4.13). The majority of respondents arose from the last four groups and accounted for 77% of the overall representation. The results of a one-way multivariate analysis were not significant across any of the groups (F=1.16, df(35,376.8), $p \geq .26$).

Educational Program on Rape

Respondents were asked to indicate whether they had or had not attended an educational program (inservice, workshop) on rape (see Table 4.14). The results indicated that 42% had and 58% had not

Table 4.12

Distribution of Emergency Room Nurses by Years of Nursing Experience

Length of Service Category	Code	Absolute Frequency	Relative Frequency (Percent)
0 - 5	1	21	20.8
5.1-10	2	33	32.7
10.1-15	3	25	24.8
15.1-20	4	14	13.9
Over 20	5	8	7.9
Total		101	100.0

Table 4.13

Distribution of Emergency Room Nurses by Months Worked in an Emergency Department

Months Worked	Code	Absolute Frequency	Relative Frequency (Percent)
0 - 6	1	11	10.9
7 - 12	2	2	2.0
13 - 24	3	5	5.0
25 - 36	4	5	5.0
37 - 60	5	27	26.7
61 - 84	6	13	12.9
85 - 108	7	14	13.9
Over 120	8	24	23.8
Total		101	100.0

Table 4.14

Distribution of Emergency Room Nurses by Attendance at Educational Program on Rape

Attended Program	Code	Absolute Frequency	Relative Frequency (Percent)
Yes	1	42	41.6
No	2	59	58.4
Total		101	100.0

attended such a program. Results of a one-way multivariate analysis of variance indicated no significant difference between these two groups on the 7 dimensions of the attitude scale [F=.82, df(7,93), p ≥ .57].

Variation by Hospital

A one-way multivariate analysis performed on the grouped subjects from each of the three participant hospitals resulted in a significant difference in the mean vector for hospital 1 (p = 0.05) when compared with the average mean vector based on hospitals 2 and 3. However, the overall test of differences of mean vectors was not significant [F 1.43, df(14,184), p ≥ .14]. This result is noted because the exploration of differences might be a fruitful area for further research.

Having Been a Victim of Rape or Knowing of Someone Close as Having Been a Victim of Rape

Of the total sample, 2% had themselves been victims of rape, while 98% had not. Furthermore, 13% of the respondents knew of someone close (a friend, relative) who had been a victim of rape, while 87% did not.

Provision of Nursing Care for a Rape Victim

Of the total number of nurse respondents, 87% had at one point in time in their emergency room nursing experience provided care for a rape victim, while 14% had not. The nursing care provided for the rape victim ranged anywhere from one case up to 30 cases per individual.

Specified Rape Protocol

An overwhelming majority of respondents, 98%, were aware of a specified rape protocol regime, whereas 2% responded that they did not have one.

Results of Pearson-Product Moment Correlations of Test Re-test

A Pearson product-moment correlation was done on the matched responses from the test and re-test attitude scales. The total number of respondents in the re-test was 63. The main reason for doing the correlation analyses was to examine the data for any major differences between the first and second test responses. As previously mentioned in Chapter III, the test re-test results provided a check on the reliability of the instrument. The results of the test re-test correlations are shown in Table 4.15.

In summary, the correlations between the test and re-test remained reasonably high except those denoted by an asterik. Correlations of individual items between plus or minus .25 are not significant (Gullikson, 1950). The overall reliability of the scale items falls outside the 95% confidence interval. The means and standard deviations for the test re-test scores remained constant. Although a one month time period had elapsed between the test and re-test it can be seen that the respondents had not changed their responses significantly (Table 4.15). This stability of the means and standard deviations supports the test-retest reliability, and indirectly the internal consistency of the test items of the attitude scale.

Table 4.15

Pearson Product Moment Correlations of Test Re-Test
(N=63)

Item No.	Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
1. Rapist usually selects an attractive young (19-35 years) woman to assault.	2.11	1.05	2.17	1.01	.707
2. Divorced women are generally viewed as being more sexually approachable and available.	2.52	1.12	2.51	1.14	.486
3. An assault on a married woman is more damaging (because she is married) than an assault on a woman who is divorced or who is single.	1.71	0.84	1.63	0.71	.691
4. Women provoke their own rape by using bad judgement, acting seductively, etc.	2.17	1.09	2.19	0.95	.697
5. More women get raped by a male they know (an acquaintance), than a total 'stranger.'	3.60	0.77	3.65	0.81	.335*
6. In most rape cases the victim's carelessness contributes to the assault.	2.73	1.07	2.65	1.01	.631
7. Most rapists have abnormal, unsatisfied sex drives.	3.04	1.17	2.84	1.07	.674

Table 4.15 (continued)

Item No.	Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
8. An assault on an 18 year old woman is more damaging than it would be to a 40 year old woman.	1.93	0.95	1.84	0.76	.422
10. Most women provoke an assault by their dress and behaviour.	2.09	1.04	2.12	0.91	.713
11. Nurses tend to be less supportive and sensitive to the victim who is raped by an acquaintance, than a 'stranger.'	2.39	1.06	2.56	1.12	.746
12. A rape victim should have immediate medical attention as well as emotional support.	4.57	0.58	4.53	0.56	.656
13. Most rapes occur in secluded locations (alleys, out of town).	2.96	0.98	2.92	0.99	.678
14. An assault on an 80 year old woman is more damaging than it would be to a 30 year old woman.	2.19	0.94	2.00	0.81	.434
15. The rapist is usually a stranger.	2.47	0.87	2.39	0.80	.630
16. Victims who are 'seductively' dressed are responsible for provoking the rape.	2.11	0.99	2.00	0.92	.759

Table 4.15 (continued)

Item No.	Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
17. Most rapes can be prevented by using safety precaustions (e.g., locking car doors, putting the chain on an apartment door).	3.04	0.99	3.01	1.01	.563
18. In most cases when a woman is raped, she was 'asking for it.'	1.60	0.68	1.69	0.76	.459
19. Most rapes occur in the victim's home.	2.79	0.73	2.79	0.75	.576
20. Rape constitutes a crisis situation for most victims.	4.70	0.55	4.63	0.64	.312*
21. Sexual perversion is a common element of the rapist attack.	3.38	0.96	3.26	0.94	.640
22. An assault on a 50 year old woman is more damaging than it would be to a 20 year old woman.	1.92	0.67	1.78	0.67	.414
24. Most rape victims are treated in an impersonal manner in the emergency department.	2.71	1.01	2.60	1.03	.635
25. Single and divorced women are more likely to get raped, than married women.	2.20	0.99	2.22	0.91	.594
26. Nurses tend to be more empathetic to the rape victim, if the rapist was a stranger than if he were an acquaintance.	2.60	1.07	2.60	1.09	.622

Table 4.15 (continued)

Item No.		Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
27.	Do you agree that a rape victim's appearance (in terms of dress) encourages the rape in anyway?	2.60	1.07	2.60	1.04	.634
28.	When admitted to emergency, rape victims are usually anxious and frightened.	4.34	0.66	4.20	0.59	.45[illegible]
29.	Rapes occur when women are out alone at night.	3.04	1.09	3.20	0.97	.586
30.	Nurses tend not to want to care for rape victims.	3.15	1.01	3.06	1.11	.5[illegible]
31.	Assaults usually take place on summer weekends.	2.49	0.92	2.52	0.83	.5[illegible]
32.	Any female, regardless of age, is a potential victim of rape.	4.52	0.66	4.46	0.50	.4[illegible]
33.	In emergency, more sensitivity and support is needed by the single victim, than by the married or divorced victim.	1.65	0.67	1.82	0.76	.[illegible]*
34.	Women can avoid being raped by staying out of dangerous situations (e.g. hitch-hiking).	3.88	0.87	3.79	0.77	.501
35.	Rape victims blame themselves and feel guilty about the attack.	3.63	0.78	3.66	0.75	.27[illegible]*

Table 4.15 (continued)

Item No.		Pre-Test $\bar{X}$	Pre-Test S.D.	Post-Test $\bar{X}$	Post-Test S.D.	Correlation Test-retest
36.	Immediate nursing care of a rape victim is directed towards reducing the rape victim's feelings of distress.	3.50	0.98	3.66	0.83	.831
37.	The young adult victim (18-25) requires more support than an older victim.	1.87	0.62	1.84	0.64	.690
38.	Avoidance of rape victims by nurses is a commonly observed behaviour in the emergency department.	2.96	1.08	3.12	1.03	.657
39.	Age of the victim will affect the degree of empathy the nurse has for the victim.	2.57	1.13	2.55	1.06	.607
40.	Most rape victims view the hospital emergency staff as providers of medical and emotional support.	3.58	0.76	3.66	0.71	.444
41.	If prostitution were legalized sex offences, such as rape, would decrease.	2.33	0.77	2.25	0.83	.653
43.	People would be better off if religion had a greater influence in the daily lives.	2.92	1.15	3.03	1.00	.791
44.	One should avoid trouble at all costs.	2.99	1.03	2.99	1.00	.500

Table 4.15 (continuec)

Item No.	Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
45. The accusation of rape is most often used by the woman seeking revenge.	2.06	0.77	2.26	0.73	.636
46. In order for society to operate smoothly there must be respect for rules and regulations.	4.23	0.45	4.19	0.49	.515
47. A woman who has sexual relations with a man for money should go to jail.	2.19	0.83	2.39	0.86	.622
49. Having sexual relations before marriage is acceptable.	3.58	1.00	3.60	0.93	.685
51. I find that my ideas on religion have a considerable influence on my views in other areas.	3.31	1.08	3.36	0.98	.699
54. Taking advantage of a person sexually is morally corrupt.	4.23	0.74	4.22	0.81	.436
56. To lead a good life it is necessary to have some kind of religious belief.	2.77	1.16	2.71	0.99	.685
57. Today, having sex relations outside the marriage partnership is all right (if both parties agree).	3.61	1.12	2.84	1.22	.361*
58. Sex crimes, such as rape, deserve more than prison sentences; such criminals ought to be publicly whipped.	2.82	1.04	2.87	0.93	.772

Table 4.15 (continued

Item No.	Pre-Test $\bar{x}$	Pre-Test S.D.	Post-Test $\bar{x}$	Post-Test S.D.	Correlation Test-retest
60. Rape is the most humiliating and 'private' crime a woman can experience.	4.31	0.81	4.15	0.82	.619
61. For serious crimes involving an assault, capital punishment is justifiable.	2.92	1.01	2.93	0.94	.595

* Scale items 9, 23, 42, 48, 50, 52, 53, 55, 59 deleted.

Summary of the Findings

In summary, seven factors were clearly identified following factor analyses of the 101 responses in the main test. They were: Factor 1: Carelessness and appearance of the rape victim; Factor 2: Age and marital status of the rape victim; Factor 3: Rape as a crisis situation; Factor 4: Degree of personalization with the offender; Factor 5: Emergency room nurses responses towards rape victims; Factor 6: Religious belief with a moral conservative overtone; and Factor 7: Psychological profile of the rapist. In addition, squared multiple correlations of the factor scores were calculated and resulted in sufficiently high values to suggest that these factors which were previously listed were valid and well estimated. A Pearson-product moment correlation analysis performed on the matched pairs of responses from the test re-test resulted, with five exceptions, in correlations of .414 to .791 thereby supporting the instrument's reliability and internal consistency of the test items. The overall reliability of the scale was found to be outside the 95% confidence interval.

The attitudes towards rape by groups defined by the biographic characteristics of the emergency room nurses were analyzed by use of the one-way multivariate analysis program. Respondents were fairly well distributed with the majority being in the 26-35 year old group. In addition to an overall difference in the mean vectors by age there were also specific differences between the specific groups on the factor categories.

A significant difference between mean vectors for those who

attended a religious institution regularly and those who did not was also evident ($p=0.0003$). Group 2 respondents (non attenders) tend not to view religion as being integral in their daily lives and view the rapist as more of a deviant in society than do Group 1 (attenders) who hold opposite views.

Of the total number of respondents 87 had at one point provided nursing care to a victim of rape and individual caseloads ranged from one to 30, rape victims attended by the nurse. In addition, 2% of the respondents had themselves been a victim of rape and 18% responded that they knew of someone close (a friend, relative) who had been a victim. A majority (98%) of respondents were aware that their department had a specific rape protocol regime in their emergency department while 2% did not.

An analysis was also performed on the three groups of subjects from the participant hospitals involved to ascertain whether or not differences in the responses were germaine to a particular hospital. Although a significant difference resulted in the mean vector for hospital 1 in relation to hospital 2 ($p=0.05$), the overall test of differences of mean vectors were not significant.

No significant differences in attitude towards rape were found in terms of the respondent's marital status; level of education; years of nursing experience; months worked in an emergency department; or having attended an educational program (inservice workshop) on rape.

CHAPTER V

SUMMARY AND CONCLUSIONS

In this study, the investigator examined the literature on emergency room nurses' attitudes towards the rape victim and found that no reliable nor valid instrument for measuring such attitudes had been developed. The purpose of this thesis was to determine the components of the attitude towards rape, and develop and test a rape attitude scale. Having established the scales' factorial validity and reliability, the investigator then examined the attitudes of participating emergency room nurses.

The instrument consisted of two parts, a biographical data questionnaire and a rape attitude scale. The biographic questionnaire focused on the respondent's age, gender, marital status, regular attendance at a religious institution, level of education, years of work experience since graduation, months worked in an emergency department, knowledge of a specific rape protocol in the employing agency, knowledge of someone close who had been a victim of rape or having been a victim themself, attendance at an educational program on rape, and the estimated number of rape victims cared for by each nurse. Sixty one statements which reflected the different ways in which people could view the act of rape, and its concomitant and predisposing conditions, were developed and comprised the second Part of the instrument, the Rape Attitude Scale. Subjects were asked to respond to each statement on a 5-point Likert-type rating scale, using the descriptors strongly agree to strongly disagree, with each scale item.

The tool was pre-tested using 15 nurses in a hospital emergency departments known to provide care for the rape victim, and the responses were subjected to factor analysis and Varimax rotation. Because of the small number of respondents (n=15), correlations among the variables were constrained, and therefore no deletions of items were made from the attitude scale. The scale was then administered to 101 emergency room nurses in three major hospitals. There were 63 respondents on the re-test.

Factor analysis and Varimax rotation were performed on the initial test of the scale (n=101) and nine statements were deleted to form the final instrument. The nine deleted items had low loadings and communalities and did not contribute to the overall definition of the major factors of the attitude scale. The responses, with the nine scale items deleted, were then subjected to a second factor analysis which resulted in clearer identification of factor categories.

Specifically, the following seven factor categories were identified:

1. Factor 1: Carelessness and appearance of the rape victim.
2. Factor 2: Age and marital status of the rape victim.
3. Factor 3: Rape as a crisis situation.
4. Factor 4: Degree of personalization (acquaintance) with the offender.
5. Factor 5: Emergency room nurses' responses towards rape victims.
6. Factor 6: Religious belief with a moral conservative overtone.
7. Factor 7: Psychological profile of the rapist.

Validity of the factor scores was established by squared multiple correlations for which acceptable estimates of factor scores resulted. This provided the justification to use the factor scores for further comparisons.

Reliability of the attitude scale was established by using matched-pair responses from the test re-test, and for which correlation coefficients were calculated for each of the 52 statements. Estimates of the correlation coefficients resulted in $r \geq 0.40$, thereby supporting the tool's reliability. A Cronbach alpha reliability coefficient of 0.83 was also calculated. The alpha reliability coefficient provided a measure of internal consistency of the questionnaire. On the basis of the scales established reliability and validity further analyses of the responses, namely one-way multivariate analyses of variance were undertaken to determine differences among groups identified by biographical characteristics.

Discussion of Results

Initially two questions were asked.

1. What attitudes are held by emergency room nurses towards rape victims? and
2. What are the nursing implications for improving emergency care for rape victims?

From the analyses of the data, some interesting results emerged in relation to attitudes held by emergency room nurses toward the rape victim. The dimensions of attitudes towards rape victims as they related to findings of the literature review and the differences on

factor scores by the various groups will be discussed. For sake of clarity the discussion will be divided into sub-categories.

Dimensions of Attitudes Towards Rape Victims

Statements representative of the personal influencing factors of the rape victim (age, marital status, appearance, relationship with the offender) and the situational precursors of rape (carelessness, time and place of assault, place of contact with offender) were derived from the literature to form the attitudinal scale items. Analysis performed on the responses (n=101) resulted in the identification of seven factor categories. A description of each factor category forms part of Chapter IV. The implications of the responses for each category will be presented in this section and compared to findings from the literature.

Factor 1: Carelessness and appearance of the rape victim. This factor related primarily to the degree of carelessness and appearance (in terms of dress) of the rape victim. The high item loadings strongly suggest that the respondents did attribute blame towards the rape victim in relation to their appearance and behaviour (Table 4.1). Items which suggested that the woman's dress provoked assault and that bad judgement was a factor in rape, loaded strongly. Item 18: "In most cases when a woman is raped, she was asking for it," also loaded on this factor. These findings reflect the prevailing attitudes toward the victim of rape that were identified in the literature: a woman who is raped had it coming to her; she must have done something to provoke the attack; women ask for it; the rape

victim is attributed more carelessness and responsibility for the rape (Burt, 1980; Calhoun et al., 1976; Damrosch, 1981). The nurses in study reflected the general beliefs individuals have that support the myths about rape. This in turn may affect their perception of the rape victim and has implications for the victim's potential treatment in the emergency room.

Factor 2: Age and marital status of the rape victim. The items that related to the degree of support provided for the rape victim by the emergency nurse, and the victim's age in terms of 'damage' to the individual, resulted in high loadings (see Table 4.2). These results suggested that the age of the victim does not influence the nurse's responses, and that nurses believe that 'damage' to the individual is influenced by the marital status of the victim. These findings are supported by the literature in that, attitudes of health professionals could greatly influence the quality of care victims receive in both the physical and psychological realms (Bellack and Woodward, 1977; Burgess and Holmstrom, 1983; Resick and Jackson, 1981). However, there is no clear indication related to the degree of support of the young, unmarried victim or the effect of the victim's physical stamina as it relates to age. Research literature, particularly nursing information in this area is sparse.

Factor 3: Rape as a crisis situation. In this factor, rape was identified as a crisis state requiring appropriate medical and psychological intervention and support. Medical care and supportive nursing actions were viewed as being related to the overall crisis management of the rape victim. However, item 36: "Immediate nursing

care of a rape victim is directed towards reducing the rape victim's feelings of distress, had a low loading (see Table 4.3). It is possible that respondents may have viewed medical treatment, which includes diagnosing of general trauma, gynecological examination and laboratory tests, as the first priority, so reducing the loadings of scales related to emotional distress. In a crisis, psychological treatment/support and counselling become a secondary concern to the physiological aspects of care. Findings in the literature which support the need for crisis intervention in the immediate period for the rape victim are well documented (Aquilera et al., 1978; Foley and Davies, 1983; Burgess and Holmstrom, 1974). As well, documentation that medical treatment is often the first priority in the overall management of the rape victim is also reported (Bellack and Woodward, 1977; Burgess et al., 1974; Foley et al., 1983). However, in this study no conclusion can be drawn as to whether or not the respondents responses were indicative of their priorities in relation to actually providing medical treatment and emotional support.

Factor 4: Degree of personalization with the offender. This factor related to the rapist-victim relationship. The respondents attitude reflected by this factor is that the sex offender is more likely to be a stranger than an acquaintance (see Table 4.4). Research literature supports the attitude reflected in these findings in that in most instances rape is usually committed by a stranger (Bennett, 1977; Bray, 1980; Burgess et al., 1978; Kilpatrick et al., 1979; Metzger, 1976; Resick et al., 1981).

It was interesting to note that item 45: "The accusation of

rape is most often used by the woman seeking revenge", also loaded in this category. One can speculate that this statement may have suggested an acquaintance relationship in which retribution by the female could be procured easily by the report of a feigned assault.

Factor 5: Emergency room nurses' responses towards rape victims. This factor focused primarily on emergency nurses' behavioural responses in the delivery of nursing care to the rape victim. The item loadings indicated that respondents believed that nurses commonly avoided caring for rape victims when they came to the emergency departments (see Table 4.5). These findings are supported by the literature in which it was reported that nurses tend not to want to care for the rape victim and that the attitudes of health care workers may affect the quality of care they offer (Alexander, 1980; Allgaier, 1979; Bellack et al., 1977; Burgess and Holmstrom, 1973, 1974; LeBourdais, 1976; Lefort, 1977).

The degree of empathy for victims assaulted by a stranger was higher, as indicated by item loadings compared to those items in which victims were assaulted by an acquaintance. One can speculate that respondents may attribute more blame toward the victim if the offender was known because the victim should have known her assailant better. While, no clear inferences can be drawn, the research literature supports the speculative explanation in that victim acquaintedness often yields greater attribution of blame towards the rape victim than when the rapist is a stranger (Bolt et al., 1981; Calhoun et al., 1976; Damrosch, 1981; and Smith et al., 1976).

Although the victim's age, in terms of the degree of empathy

displayed by the nurse, loaded in this category, no clear postulates can be stated. It is possible that this statement would have loaded higher if sexually assaulted children had been included in the study. Respondents had been informed that the focus of the study was on the adult female victim of rape, 18 years of age and over. One may speculate that because of this age delineation that the adult victim may have been perceived by respondents as being more able to cope with the assault than a child. Respondents also could have expected that the degree of empathy shown to the adult victim would be relatively even across the sub-groups of the adult population by virtue of the victim being an adult.

Factor 6: Religious belief with a moral conservative overtone. This factor focused on the degree religious beliefs influence the respondents' general view of their lives. Findings, as indicated by high item loadings, revealed that those perceiving premarital sex as not acceptable also perceived that religion was important (see Table 4.6). The fact that these items loaded on a separate factor suggest that religious beliefs and conservatism are not related to the attitudes regarding rape. It should be noted that statements concerning religiosity were developed and included on a speculative basis and that no previous research findings were found in this area.

Factor 7: Psychological profile of the rapist. This factor suggests that the rapist is characterized by an abnormal sex drive, is socially deviant and commits the majority of attacks in the victim's home. The items relating to abnormal sex drives and sexual perversion as characteristics of the rapist loaded strongly. The item related to

the most common site of rape being the home did not load as strongly. Research findings in this area are also contradictory in respect to whether or not the majority of rapes are committed in the victim's home (Amir, 1971; Kilpatrick et al., 1979; Resick et al., 1981). In general, research findings refute the notions that rapists are confined to the classification of social deviant or that they are individuals with abnormal sex drives (Hardgrove, 1976). Indeed, more recent findings in the research literature indicate that all men from all walks of life; fathers, brothers, uncles, etc. are capable of committing the act of rape (Foley et al., 1983). In this sense, the attitude may reflect a 'myth' regarding the rapist.

Responses to a scale item concerning the sex offender's punishment either by prison sentence or public whipping resulted in a low loading (see Table 4.7). Also, a scale item concerning capital punishment as a punitive measure for acts of sexual assault did not load on any factor and therefore was not related to any of the attitudes defined by the factor analysis. These items were intended to measure the respondents degree of conservatism and liberalism, but the choice of content for these items may have influenced the responses obtained.

Differences on Factor Scores by Respondents

This section will examine the differences on factor scores by the various groups of respondents. Findings will be discussed and related to the dimensions of attitudes towards rape victims noted in the previous section.

Relationship Between Age of Respondents and Attitude Scores

The age of respondents ranged from 20 to over 41 years of age, with the majority being in the 26-35 year old group. The major difference between age categories in relation to the factors on the attitude scale was reflected in the first six factors, between Group 1 (20-25 years old) and Group 5 (41 years and over). The largest significant differences between mean vectors occurred between Group 4 (36-40 years old) with Group 5 (41 years and over).

Factor 1: Carelessness and appearance of the rape victim. Group 5 (41 years and over) may have attributed less blame to the victim of rape than did Group 4 (36-40 years). Factor 3: Rape as a crisis situation. Groups 4 and 5 reacted differently to this factor. It is possible that Group 5 respondents perceived that the rape does constitute a crisis situation for the victim whereas Group 4 respondents tended not to do so. Factor 5: Emergency room nurses' responses towards the rape victim. Group 4 respondents may have perceived emergency nurses actions as being acceptable, whereas Group 5 respondents may have perceived the care to be inadequate. In reference to Factor 7: Psychological profile of the rapist, Group 5 respondents perceived the rapist to be more of a social deviant than did Group 4. The reasons for these differences between Group 4 (36-40 years) and Group 5 (41 years and over) may possibly be attributed to the individual's overall accumulated life and work experiences and perceptions.

Confidence intervals established among the various age groups suggested significance at $p \leq .10$ for the various groups on the seven

factor categories. It should be noted that there were no confidence intervals demonstrating significant differences for any of the groups on Factor 6. The findings are reported as follows:

Factor 1: Carelessness and appearance of the rape victim. Age did affect the responses to items related to the rape victim's own carelessness and appearance. Specific differences were noted between Group 1 (20-25 years old; $\bar{x}$=-0.26), with Group 2 (26-30 years old; $\bar{x}$=0.26), and Group 3 (31-35 years old; $\bar{x}$=-0.07), and Group 4 (36-41 years old; $\bar{x}$=-0.26).

Factor 2: Age and marital status of the rape victim. Age affected the responses in relation to items describing the age and marital status of the rape victim. The major difference on this factor occurred between Group 3 (31-35 years old; $\bar{x}$=-0.26), with Group 4 (36-41 years old; $\bar{x}$=0.40), and Group 5 (41-45 years old; $\bar{x}$=0.34).

Factor 3: Rape as a crisis situation. In the third factor category of rape as a crisis situation, there were differences noted between Group 2 (26-30 years old; $\bar{x}$=-0.01), with Group 4 (36-41 years old; $\bar{x}$=-0.56), as well as Group 5 (41-45 years old; $\bar{x}$=0.53), with Group 3 (31-35 years old; $\bar{x}$=0.04), and Group 4 (36-41 years old; $\bar{x}$=-0.56).

Factor 4: Degree of personalization with the offender. The fourth category, the degree of personalization with the offender, resulted in only a difference between Group 3 (31-35 years old; $\bar{x}$=-0.2) with Group 5 (41-45 years old; $\bar{x}$=0.09).

Factor 5: Emergency room nurses' responses towards rape victims. Interestingly, differences were found between Group 5 (41-45

years old; $\bar{x}$=-0.39) with Group 3 (31-35 years old; $\bar{x}$=0.23) and Group 4 (36-41 years old; $\bar{x}$=0.18) on the factor category of emergency room nurses' responses towards rape victims.

Factor 7: Psychological profile of the rapist. There were also differences between Group 1 (20-25 years old; $\bar{x}$=-0.37) and Group 2 (26-30 years old; $\bar{x}$=0.30) and Group 3 (31-35 years old; $\bar{x}$=0.19), as well as Group 5 (41-45 years old; $\bar{x}$=-0.41) compared with Group 2 (26-30 years old; $\bar{x}$=0.30) and Group 3 (31-35 years old; $\bar{x}$=0.19) on Factor 7, psychological profile of the rapist.

Factor 6: Religious belief with moral conservative overtone. There were no significant differences between age groups on factor 6 religious belief with a moral conservative overtone.

Overall, it is interesting that the differences noted in the factor categories between the various age groups were generally between the younger and older respondents. However, further research is needed to clarify the extent to which age affects the respondents responses to the established factor categories and to determine if reasons for the differences can be established.

Marital Status of the Respondents

No significant differences were found between the various attitudes in relation to the marital status of the respondents. In this study 64% of the respondents were married, 29% were single and 7% were either separated or divorced.

Rape Victim Known to Respondent

Only 2% of the respondents had themselves been victims of rape. Another 18% had known of someone close (a friend, relative) who had

been a victim of rape. Due to the small numbers involved this information was not part of the data used to define the dimension of attitudes using factor analysis.

Provision of Nursing Care to the Rape Victim and Rape Protocol

The majority of respondents (87%) had, during their emergency room nursing experience, provided nursing care to a victim of rape. The overall number of rape victims cared for by the respondents ranged from one to 30. Fourteen per cent of the respondents had not yet provided nursing care to a rape victim. As well, 98% of the respondents were aware of a specific rape protocol utilized in their department, but 2% responded the department did not have one. The respondents who did not know of the protocol had all been employed under six months in the emergency department.

Regular Attendance of Respondents at a Religious Institution

A significant difference in attitude was observed between regular attenders and non-attenders at a religious institution. The major difference was that non-attenders reported that they did not view religion as being an integral part of their lives. As well, the non-attenders did not view the rapist as being as sexually deviant as did the church attenders. It would be of value to generate more specific questions for further research in an attempt to gain a better understanding of the degree to which religion affects an individual's attitude.

Variation by Hospital

Responses from each of the three hospitals providing subjects for the study were analyzed and the findings demonstrated that there

was a significant difference in the mean vector for hospital 1, as compared to the average mean vector, based on hospitals 2 and 3. Although the overall test of differences of mean vectors of hospitals was not significant the result is noted because exploration of differences might be a potential area for further research.

Level of Education, Years of Nursing Experience and Months Worked in an Emergency Department

Analyses of the level of education, years of nursing experience and months worked in an emergency department by respondents resulted in no significant differences in attitude. These results were somewhat surprising, as one would expect that through education and/or length of time worked that differences among the various categories of respondents would be evident. Additionally, no significant difference resulted between groups of attenders (42%) and non-attenders (58%) at an educational program (workshop, inservice) on rape. These results, coupled with the results of the various age categories previously discussed, lead one to speculate that it may be the respondent's life experiences rather than individual trait characteristics which influence the individual's attitudes towards rape. Perhaps a more detailed biographical data sheet or a combination of a biographic and life style questionnaire could be used in further research to explore this situation.

Summary Characteristics of the Sample

1. The respondents were all female, and ages ranged from 20 to over 41 years of age with the mode being the 26-35 years of age

group. The majority were married (64%), the remainder being either single (29%) or divorced (7%).

2. The majority of respondents had at one point in time provided nursing care for a rape victim. As well, most of the respondents were aware of a specific rape protocol used in their emergency department. Effect of caring for a rape victim on responses to the attitude scale items could not be measured because of the small number who had not cared for a victim of rape.

3. A small percentage (2%) of the respondents indicated that they themselves had been a victim of rape, whereas 18% had known someone close (a friend, relative) who had been assaulted.

Test Re-test Reliablity

When test re-test responses were compared for the same subjects acceptable correlations of $r \geq 0.40$ were achieved on most scale items. Low correlations were found on five items. It is possible that these items may have been inappropriately worded or have had inappropriate content, for example, public whipping is not an acceptable form of punishment in Canada, but was the content of one scale item. Rewording of items might increase the likelihood of a more consistent response in future use of this questionnaire.

It is noted that one of the difficulties of the test re-test situation is the effect of maturation/history over time. The longer the time period over which the study extends, the greater the problem with the internal validity of a time study (Kerlinger, 1973). In this

study, a one month time lapse between the test re-test was used. While this should not create the problems encountered in the lengthier longitudinal study, discussion between respondents may have occurred and could have resulted in some change in responses between tests. Respondents who had not provided care for the rape victim at the time of the initial administration of the tool may have done so in the period between the test and re-test. However, examination of the means and the standard deviations of the test and re-test show that they approximate each other. This indicates that while respondents answered individual items differently they did not change their overall responses to any significant degree over the one month time period.

In reference to the scale items' a correlation coefficient of $r \geq 0.40$ was accepted as being significant in this study. Individual item correlations between plus or minus .3 are not significant (Gullikson, 1950). It should be noted that lesser r's were taken into consideration because of their importance to the definition of factors. Single item reliability correlations are expected to be lower than total scale reliability. The scale reliability fell well outside the 95% confidence interval of significance for a correlation coefficient.

Conclusions

Components of Nurses' Attitudes Toward the Rape Victim

1. The nurses in this study were perceived to attribute blame for the assault towards the rape victim in terms of the victim's

described appearance and behaviour.

Data collected indicated that the nurses' perceptions of their responses toward the rape victim were influenced by the victim's age and marital status.

Rape was identified by the nurses in this study as being a crisis situation. The physiological aspects of medical treatment were inferred to have priority over the psychological aspects of care. Wording of the items may have contributed to this finding.

The nurses responses indicated that the rapist was more likely to be a stranger than an acquaintance. Nurses responded they were more likely to be supportive and empathetic when the victim was assaulted by a stranger than by an acquaintance.

The nurses in this study perceived that nurses do not want to care for rape victims and therefore try to avoid them when they are admitted to the emergency department.

Responses by the nurses in this study strongly indicated that elements of sexual perversion and abnormal sex drives comprise the psychological profile of the rapist.

Differences in attitude between respondents in terms of age categories occurred. There were no clear indications that would explain these differences. It was noted that the majority of differences were between the youngest (20-35) and oldest (41+) respondents.

Regular attenders at a religious institution regarded religion as an important facet of their lives, while non-attenders did

not. The regular attenders viewed the rapist as being more of a sexual deviant than did the non-attenders.

9. There was a significant difference between respondents from hospital 1 compared to hospitals 2 and 3. The differences can not be explained from the data. There is a possibility that the physical location, and the characteristics of the clients attending emergency may have been different and that this influenced the responses.

10. No significant differences in attitudes toward rape were found in relation to the respondents' educational level, years of general nursing experience or months worked in an emergency department, or attendance at an educational program (workshop, inservice) on rape.

Implications for Improving Emergency Room Nursing

In this study an instrument was developed to measure and describe the attitudes of emergency room nurses towards rape victims. Based upon the findings, several implications for improving emergency nursing care for rape victims are discussed.

One area for improvement in the delivery of nursing may be the education of the caregiver. Advanced learning for professional nurses, namely emergency nurses, who deal with victims of rape could be instituted through inservice and/or educational workshops. The aim would be to provide increased knowledge about rape, the legal implications involved and the overall characteristics of the rapist

and victim.

Administration of the instrument to small groups of emergency nursing staff with subsequent discussion of their responses to the items could provide increased insight into necessary attitudinal change regarding rape. This concept of continuing education could foster the development of a certification program for nurses employed in an emergency department. The major emphasis would be on the development of advanced nursing skills relating to applying crisis intervention techniques, assisting the victims to mobilize their coping mechanisms and organizing the victims' support systems. The program can be geared toward the upgrading and advancement of presently employed emergency department nurses in addition to providing new orientees with factual information regarding rape.

The developed instrument could also be used as a self-evaluative [redacted] by emergency nurses to increase their self-awareness of their perceptions towards the rape victim. In this manner, the nurse can use the research findings to recognize the prevalence or effect fallacies and/or myths may have on her own perceptions. Nurses need to understand their own responses, in order to understand the responses of victims. This then may affect the delivery of nursing care provided for the rape victim.

Nurses, as health professionals and as women, are in an optimal position to facilitate change in the health care delivery system. The ultimate aim would be to increase the quality of care provided for rape victims with the suggestion that research be extended in further study of emergency room personnel as well as other occupational groups.

Recommendations

Although the validity and reliability of the tool was established in this study further testing, revision and evaluation is needed. Problems were identified with the administration of the questionnaire and recommendations for further research with the tool are as follows:

1. The biographic data sheet should be complemented by the addition of a life style questionnaire in order to examine the extent to which life experiences influence the attitudinal set of an individual.
2. The use of a codeword to maintain anonymity of the respondent and confidentiality of responses may be better replaced by respondents using codewords of their own making. In the re-test data 12 questionnaires could not be utilized because the codeword was missing and the respondents indicated that they had misplaced or lost their sheets.
3. Items with low correlation coefficients should be reworded before the questionnaire is used in further research.
4. Items relating to the physiological parameters of a different assault (e.g., beating) could be included as a comparison to attitudes towards sexual assault. In addition, the inclusion of items relating to substance abuse (e.g., alcohol) could also be included.
5. Further testing of the tool be undertaken. Discriminant validity studies using other hospital emergency room personnel,

as well as other occupational groups should be carried out.

Limitations of the Study

1. The use of a codeword to maintain anonymity of the respondent and confidentiality of responses has some inherent drawbacks: the codeword was lost or forgotten by respondents so that matching of test re-test responses on returned questionnaires was impossible, thereby reducing the number in the final usable sample.
2. The length of the Rape Attitude Scale may have affected the respondents' willingness to participate in the study. Five questionnaires were returned partially completed. These responses could not be used for analyses.
3. No data were collected to determine why re-test respondents did not return their questionnaires.
4. There were not enough scale items in regard to age or marital status of the victim to bring about clear definitions in terms of responses.
5. Scale items containing more than one variable would need to be reworded thus allowing for clearer indication of responses to the particular variable being measured.
6. No data were collected on the knowledge content of the workshops/inservice on the topic of rape that respondents had attended.
7. No data were collected to determine if the physical environment, location and clientele of the involved emergency departments

influenced any of the responses.

8. The small sample size may not be representative of the larger population of emergency room nurses therefore inferences should not be made to other emergency room nursing populations.

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APPENDICES

APPENDIX A:

Biographic Data Sheet and The Rape Attitude Scale

Appendix A

Biographical Data

Subject No. _____

Date _____

Part I: Please fill out the following:

1. Age. (Please circle one).

   a) 20-25.9
   b) 26-30.9
   c) 31-35.9
   d) 36-41.9
   e) 41-45.9
   f) 46 and over

2. Sex. (Please circle one). M F

3. Marital status. (Please circle one). M S Sep. D W

4. Do you attend a religious institution regularly? Yes No
   (Please circle one).

5. Level of education attained. (Please circle one).

   a) R.N. Diploma
   b) Basic Bachelor of Science in Nursing
   c) Post-graduate Bachelor of Science in Nursing
   d) Master's Degree in Nursing
   e) Other (Please specify) _____

6. Number of years worked since completion of R.N.? (Please circle one).

   a) 0 - 5
   b) 5.1-10
   c) 10.1-15
   d) 15.1-20
   e) over 20

7. How many months have you worked in an emergency department: (Please circle one).

   a) 0-6 months
   b) 6 months-12 months
   c) 13 months-24 months
   d) 25 months-36 months
   e) 37 months- 60 months
   f) 61 months- 84 months
   g) 85 months-108 months
   h) over 120 months

8. a) Have you provided nursing care for a victim of rape? Yes No
(Please circle one).

b) If yes, how many?
(Please circle one).
1 2 3 4 5 6 7 8 9 over 10

9. Does your department have a specified rape protocol? Yes No
(Please circle one).

10. Have you ever been a victim of rape? Yes No
(Please circle one).

11. Do you know of someone close (a friend, relative) who has been a victim of rape? Yes No
(Please circle one).

12. Have you ever attended an educational program (inservice, workshop) on rape? Yes No
(Please circle one).

Part II: Please read the following statements and circle the response which most closely corresponds to the way which you personally feel. There are no right or wrong answers to this questionnaire. Responses will be strictly confidential and respondents will not be identified.

1. Rapist usually selects an attractive young (19-35 years) woman to assault.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

2. Divorced women are generally viewed as being more sexually approachable and available.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

3. An assault on a married woman is more damaging (because she is married) than an assault on a woman who is divorced or who is single.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

4. Women provoke their own rape by using bad judgement, acting seductively, etc.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

5. More women get raped by a male they know (an acquaintance), than a total 'stranger'.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

6. In most rape cases the victim's carelessness contributes to the assault.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

7. Most rapists have abnormal, unsatisfied sex drives.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

8. An assault on a 18 year old woman is more damaging than it would be to a 40 year old woman.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*9. The majority of rape attacks occur during week days.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

10. Most women provoke an assault by their dress and behaviour.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

11. Nurses tend to be less supportive and sensitive to the victim who is raped by an acquaintance, than a 'stranger'.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

12. A rape victim should have immediate medical attention.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

13. Most rapes occur in secluded locations (alleys, out of town).

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

14. An assault on an 80 year old woman is more damaging than it would be to a 30 year old woman.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

15. The rapist is usually a stranger.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

16. Victims who are 'seductively' dressed are responsible for provoking the rape.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

17. Most rapes can be prevented by using safety precautions (e.g. locking car doors, putting the chain on an apartment door).

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

18. In most cases when a woman is raped, she was 'asking for it'.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

19. Most rapes occur in the victim's home.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

20. Rape constitutes a crisis situation for most victims.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

21. Sexual perversion is a common element of the rapist attack.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

22. An assault on a 50 year old woman is more damaging than it would be to a 20 year old woman.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*23. Assaults usually take place between 8 p.m. and 2 a.m.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

24. Most rape victims are treated in an impersonal manner in the emergency department.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

25. Single and divorced women are more likely to get raped, than married women.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

26. Nurses tend to be more empathetic to the rape victim, if the rapist was a stranger than if he were an acquaintance.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

27. Do you agree that a rape victim's appearance (in terms of dress) encourages the rape in any way?

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

28. When admitted to emergency, rape victims are usually anxious and frightened.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

29. Most rapes occur when women are out alone at night.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

30. Nurses tend not to want to care for rape victims.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

31. Assaults usually take place on summer weekends.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

32. Any female, regardless of age, is a potential victim for rape.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

33. In emergency, more sensitivity and support is needed by the single victim, than by the married or divorced victim.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

34. Women can avoid being raped by staying out of dangerous situations (e.g. hitch-hiking).

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

35. Rape victims blame themselves and feel guilty about the attack.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

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

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

37. The young adult victim (18-25) requires more support than an older victim.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

38. Avoidance of rape victims by nurses is a commonly observed behaviour in the emergency department.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

39. Age of the victim will affect the degree of empathy the nurse has for the victim.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

40. Most rape victims view the hospital emergency staff as providers of medical care and emotional support.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

41. If prostitution were legalized sex offences, such as rape, would decrease.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*42. It is impossible to rape a woman against her will.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

43. People would be better off if religion had a greater influence in their daily lives.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

44. One should avoid trouble at all costs.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

45. The accusation of rape is most often used by the woman seeking revenge.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

46. Respect of authority and obedience are the most important virtues.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

47. A woman who has sexual relations with a man for money should go to jail.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*48. Today people are prying into matters that should remain private and personal.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

49. Having sexual relations before marriage should be acceptable.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*50. Change is a necessary component of life.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

51. I find that my ideas on religion have a considerable influence on my views in other areas.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*52. Women caught in embarrassing situations often 'cry rape' as a defense.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*53. Public places, such as shopping malls should be closed on Sunday.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

54. Taking advantage of a person sexually is morally corrupt.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*55. If there is no evidence of a struggle in a rape case, then the victim must have consented.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

56. To lead a good life is necessary to have some kind of religious belief.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

57. Having sex relations outside the marriage partnership is all right.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

58. Sex crimes, such as rape, deserve more than prison sentences; such criminals ought to be publicly whipped.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

*59. Censorship of pornographic materials (books or movies) is a violation of free speech.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

60. The most humiliating and 'private' crime a woman can experience is rape.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

61. For serious crimes, capital punishment is justifiable.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

* Denotes items deleted from final scale.

APPENDIX B:

Consent from Hospitals

Appendix P

_____, 1984

To Whom it May Concern:

I am currently enrolled as a Masters of Nursing Candidate at the University of Alberta, Faculty of Nursing. The completion of a master's degree requires original research and the submission of a thesis. I am writing to gain permission to conduct a study in the Emergency Department for the purpose of measuring nurses' attitudes towards rape victims. I have enclosed a copy of the research proposal to familiarize you with the nature of the study. My thesis advisor is Dr. Peggy-Anne Field, Faculty of Nursing, University of Alberta.

The study will involve only emergency nurses who will be asked to answer a set of questions related to rape and rape victims. The questionnaire takes approximately 30 minutes to complete. I realize that the emergency department can be extremely busy and in view of this, I will work closely with the emergency Supervisor to ensure that the release of nurses to answer the questionnaire will not be disruptive to the work routine.

All participants will be informed that they have a right to refuse to participate in the study and will be assured of anonymity and confidentiality. A numeric code appears on the questionnaire for purposes of data analysis and will in no way indicate personal indentification of the respondent. A written consent will be obtained from each nurse before the questionnaire is administered.

Sincerely yours,

Dorothy A. Cochrane (M.N. Candidate)

APPENDIX C:

Consent from Emergency Room Nurses

Appendix C

Subject Consent Form

Project title: Emergency Nurses' Attitudes Towards Rape Victims

Investigator: Dorothy A. Cochrane
48 Amherst Crescent
St. Albert, Alberta
(403) 458-6768

Advisor: Dr. Peggy-Anne Field
Faculty of Nursing
University of Alberta
(403) 432-6248

This is to indicate that I, _____, have agreed to participate in a study to be conducted by D. Cochrane, a Masters in Nursing Candidate.

It is my understanding that:

(1) anonymity of the respondent and confidentiality of all materials is guaranteed by the investigator
(2) I can withdraw from the study at any time
(3) I will be required to answer questions concerning rape.

Signature _____

Date _____

A code for purposes of data analysis appears on the questionnaire.

Dorothy A. Cochrane (M.N. Candidate)

APPENDIX D:

Guidelines for Instructing Nurses to Complete Rape Attitude Scale

Appendix D

Dear Volunteer:

Thank you for participating in this study. The questionnaire you are asked to complete consists of two parts. The first section deals with biographic data, while the second section deals with questions pertaining to rape. Part I is the biographic sheet and asks for information about yourself and is extremely important to the study. However, if you do not wish to answer a question on the biographic sheet, you may choose to omit it by leaving it blank. Part II of the questionnaire focuses on the phenomenon of rape and the adult female victim of rape. You are asked to read the statements and circle the response which most closely corresponds to the way which you personally feel.

Each respondent will be given a secret password number which will guarantee anonymity of the respondent and confidentiality of all materials. (Only you will know the password number). You are asked to write your password number in the space provided on the questionnaire.

Please keep the password number noted below, as you will need the password number again for the second phase of this study, in about one month's time from now.

Once again, thank you for your willingness and co-operation in this study.

Sincerely yours,

D. Cochrane, R.N.
M.N. Candidate

DC:dn

Your Password Number is _____.

* Detach this sheet please - keep for future reference.

Dear Volunteer:

Thank you for participating in Phase II of this study. The questionnaire you are asked to complete is identical to the one which you completed a month ago. The reason for this repetition is because the questionnaire's reliability must be tested; a test which measures the questionnaire's stability and consistency over time.

Part I is the biographic sheet and asks for information about yourself and is extremely important to the study. However, if you do not wish to answer a question on the biographic sheet, you may choose to omit it by leaving it blank. Part II of the questionnaire focuses on the phenomenon of rape and the adult female victim of rape. You are asked to once again, read the statements and circle the response which most closely corresponds to the way which you personally feel.

The secret password number you received in Phase I is required to complete Phase II of this study and must be written in the space provided on the questionnaire. The researcher guarantees the anonymity of the respondent and confidentiality of all materials.

Once again, thank you for your willingness and cooperation in this study.

Sincerely yours,

D. Cochrane, R.N.
M.N. Candidate