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2016

**A Grounded Theory Study of Nurses Who Care for Patients Who  
Are Victims of Sexual Violence**

Dara M. Whalen

A GROUNDED THEORY STUDY OF NURSES WHO CARE FOR PATIENTS WHO  
ARE VICTIMS OF SEXUAL VIOLENCE

DISSERTATION

Presented in Partial Fulfillment of the  
Requirements for the Degree of  
Doctor of Philosophy in Nursing

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Dara M. Whalen

2016

A GROUNDED THEORY STUDY OF NURSES WHO CARE FOR PATIENTS WHO ARE  
VICTIMS OF SEXUAL VIOLENCE

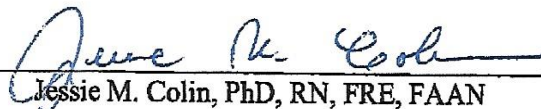
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by

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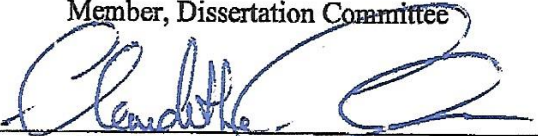
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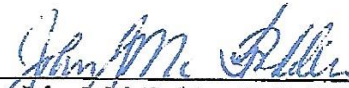
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## Abstract

**Background:** Sexual violence is a widespread traumatic event that has physical, psychological, financial, and spiritual implications for victims, their friends and family, and the community. The negative and long-term effects include poor health outcomes, depression, substance abuse disorders, and post-traumatic stress disorder. Many nurses who treat these patients are inadequately trained.

**Purpose:** The treatment of nurses towards patients who are victims of sexual violence can mitigate or contribute to perceived revictimization of patients. The purpose of this qualitative study was to identify the processes and uncover the attitudes and behaviors of nurses without specialized training who care for patients who are victims of sexual violence. Additionally, the purpose was to generate a theory that describes the process that these nurses use to make decisions about how to provide proper care.

**Philosophical Underpinnings:** This qualitative constructivist grounded theory study was guided by symbolic interactionism and pragmatist philosophy.

**Method:** Charmaz's grounded theory method of inquiry was used for this qualitative study. Data were collected with semistructured interviews with 13 emergency department nurses without specialized training in treating sexual violence victims and a focus group of five Sexual Assault Nurse Examiners. Data analysis took place with a constant comparative process to reveal the conceptual categories and themes. The focus group confirmed the categories.

**Findings:** Four themes emerged: Avoiding, Attempting, Analyzing, and Adjusting. The basic social process and substantive theory that emerged was Apprehending an Unknown

Phenomenon. This framework provides an in-depth understanding of the decision making process of nurses caring for victims of sexual violence.

**Conclusion:** This study provided deeper understanding of nurses' perceptions and experiences in decisions to treat patients who experienced sexual violence. The theory developed can be used to guide nurses' decision making when they have little or no training on which to base their decisions. With further development of an evidence-based model, study findings should help improve outcomes for patients and reduce stress and anxiety in nurses who treat patients who have experienced traumatic sexual violence.

## ACKNOWLEDGMENTS

To acknowledge all of those who helped me along this journey would take more pages than I am allowed. To Mom, you never gave up and have always had my back. I am so blessed to have you with me, forever cheering me on. To my fabulous sisters Dana and Dawn, the laughter, the tears, the encouragement, and support you share with me are truly appreciated. Thank you to all of my family including my brother Jon for forgiving my absences, cheering me on, never giving up on me, and always being by my side. I could not be where I am today without you.

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To the kind, supportive and talented Mureen Shaw, you are an amazing friend, and I thank you with all my heart for your friendship and support.

I want to acknowledge my students—you have inspired me to be my best. To the nurses of the world, I ask you to remember how blessed we are to be part of a noble and trusted profession. I am honored to be among your ranks.

My final acknowledgement is as important as all the others. For those of you who have been touched by violence, I promise to continue to work to help you heal and assure that you feel valued and important. You are not alone.



## **DEDICATION**

I dedicate this work to my wonderful son Darrion. Since the day I became your mom I wanted to make the world a better place for you. You are the best man I know and I am truly blessed to be your mother. Thank you for forgiving my absences and tolerating my wandering path. And of course, thank you for my magnificent grandson Owen and his mom Kim. You all keep me smiling and make my world a better place. Thank you for being my family.

## TABLE OF CONTENTS

TITLE PAGE .....	i
SIGNATURE PAGE .....	ii
COPYRIGHT PAGE .....	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS .....	vi
DEDICATION.....	viii
TABLE OF CONTENTS.....	ix
LIST OF TABLES .....	xiii
LIST OF FIGURES .....	xiv
CHAPTER ONE: THE PROBLEM .....	1
Background of the Study.....	1
Problem Statement .....	13
Purpose of the Study .....	14
Research Questions .....	14
Philosophical Underpinnings .....	14
Grounded Theory.....	15
Symbolic Interactionism.....	17
Pragmatism .....	18
Significance of the Study .....	19
Implications for Nursing Education.....	19
Implications for Nursing Practice .....	20
Implications for Nursing Research .....	21

Implications for Health/Public Policy .....	21
Scope and Limitations of the Study .....	22
Chapter Summary.....	23
CHAPTER TWO: REVIEW OF THE LITERATURE .....	24
Historical Context .....	25
Victims of Sexual Violence.....	26
Attitudes Towards Victims.....	37
Experiential Context.....	46
Chapter Summary .....	47
CHAPTER THREE: METHODS .....	48
Research Design .....	48
Sample and Setting.....	50
Access and Recruitment .....	51
Inclusion Criteria.....	52
Exclusion Criteria.....	53
Ethical Considerations/Protection of Human Subjects .....	53
Data Collection Procedures .....	55
Interview Questions.....	57
Demographic Data.....	58
Data Analysis .....	58
Research Rigor .....	63
Trustworthiness.....	63
Credibility .....	63

Dependability.....	64
Transferability.....	64
Confirmability.....	65
Chapter Summary.....	65
CHAPTER FOUR: FINDINGS.....	67
Overview.....	68
Sample Description.....	73
Demographics.....	74
Personal Experience.....	77
Phase I: Individual Interview Group Participants.....	77
Emergent Categories.....	80
Avoiding.....	81
Attempting.....	84
Presumptive care.....	86
Personally directed care.....	89
Analyzing.....	91
Adjusting.....	96
Phase 2: Focus Group Participants.....	103
Confirmation of the Conceptual Categories by the Focus Group.....	105
The Basic Social Process: Apprehending an Unknown Phenomenon.....	112
Harming.....	116
Personal harm.....	116
Harm to the legal case.....	118

Internalizing.....	120
Restatement of the Research Questions .....	122
Connection to Theory.....	122
Chapter Summary.....	124
CHAPTER FIVE: DISCUSSION AND CONCLUSION .....	126
Exploration of the Meaning of the Study .....	126
Interpretive Analysis of the Findings .....	128
Avoiding .....	129
Attempting.....	131
Analyzing.....	135
Adjusting.....	138
Apprehending an Unknown Phenomenon.....	143
Significance of the Study for Nursing .....	146
Implications for Nursing Education.....	147
Implications for Nursing Practice .....	148
Implications for Nursing Research .....	149
Implications for Health/Public Policy .....	150
Strengths and Limitations.....	150
Recommendations for Further Study .....	152
Summary and Conclusions.....	153
REFERENCES .....	155
APPENDICES .....	165
VITA.....	181

## LIST OF TABLES

Table 1. Open Coding .....	61
Table 2. Focused Coding .....	62
Table 3. Demographics of the Individual Interview Group ( $n = 13$ ) .....	75
Table 4. Demographics of the Focus Group ( $n = 5$ ). .....	76

## LIST OF FIGURES

Figure 1. Grounded theory method.....	59
Figure 2. Conceptual model of <i>Apprehending an Unknown Phenomenon</i> .....	124

## **CHAPTER ONE**

### **THE PROBLEM**

Attitudes of nurses towards patients who are victims of sexual violence can mitigate or contribute to perceived revictimization that is common in people who experience such a traumatic event. Inadequate and insensitive initial care combined with nonexistent or disorganized follow-up support and evaluation may leave patients to deal with the physical and emotional consequences of the violence on their own (Campbell, 2006). An informed and purposeful approach to the care of these patients by nurses is necessary to the formation of a trusting and therapeutic relationship, which can improve the patients' psychological and physical health outcomes.

Nurses practice within the context of a social contract that is designed to meet the needs of society and requires the "provision of a caring relationship that facilitates health and healing" (American Nurses Association [ANA], 2010, p. 5). To meet the obligation of that contract, nurses must be aware of their own values and belief systems that contribute to the process of providing care to the populations they serve. This qualitative study will use a grounded theory approach to gain understanding about the process that nurses use to decide how to care for patients who experience sexual violence.

#### **Background of the Study**

Violence is a complex worldwide phenomenon that is often considered an inevitable part of the human condition (Dahlberg & Krug, 2002). Violence has a significant impact on the physical and psychosocial health of individuals, communities, and society in general. In the 2002 World Health Organization's (WHO) *World Report on Violence and Health* (Krug, Dahlberg, Mercy, Zvi, & Lozano, 2002), it was reported that



an estimated 1.6 million people worldwide died from violence. Approximately, “half of those deaths were suicides, nearly one third were homicides and about one fifth were casualties of armed conflict” (Dahlberg & Krug, 2002, p. 5).

Violence is one of the leading causes of death worldwide for people ages 15-44, accounting for “14% of deaths among men and 7% of deaths among women” (Dahlberg & Krug, 2002, p. 3). Deaths related to violence are nearly twice as likely to occur in countries classified as low- to middle-income as in countries considered high-income. Within countries, variations are evident between rural versus urban populations, rich versus poor communities, and between ethnic and racial groups (Dahlberg & Krug, 2002).

Death is not the only consequence of acts of violence. Physical, sexual, and psychological violence occur in every community on a daily basis and severely affect the overall health of multiple millions of people throughout the world (Dahlberg & Krug, 2002). The economic costs of the immediate and long-term effects of violence are compounded by victims’ continued disability and loss of productivity (Dahlberg & Krug, 2002). In addition, victims of violence are at higher risk than others for psychological disturbances, including depression, anxiety disorders, and post-traumatic stress disorder (PTSD). These victims may also engage in harmful self-medicating behaviors utilizing alcohol and drugs (Dahlberg & Krug, 2002).

Reliable statistics that accurately measure violence are vital. Challenges to an accurate assessment of the problem include variations in the definition of violence, disorganized reporting systems, underreporting of violent acts by victims, and reluctance of governments/institutions to disclose the prevalence of the problem (Dahlberg & Krug,

2002). Mortality rates gathered from death certificates, coroner reports, and registries contribute to the statistics but do not reflect a comprehensive or accurate picture of the problem. Instances of physical and psychological harm from violence are much more common than death and are severely underestimated with existing reporting methodologies (Dahlberg & Krug, 2002).

Defining violence can be difficult when the wide variation of beliefs worldwide is considered that govern cultural, legal, and societal rules and mores. Behaviors that are considered culturally acceptable in one part of the world may be considered illegal in a neighboring country or community (Dahlberg & Krug, 2002). Towards a consensus, WHO developed this definition of the term *violence* (Dahlberg & Krug, 2002):

Violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (p. 5)

Moreover, legal definitions of violence may vary between communities due to the need for language that is specific to the national formation of statutes, regulations, and legislative mandates. The definitions may not include the wide range of intention and consequences included in the WHO definition.

The WHO categorizes violence according to the individual or entity committing the act: self-directed, collective, and interpersonal violence. Self-directed violence refers to suicide and self-abuse, including self-mutilation. This category includes suicide intent and suicidal action without completion as well (Dahlberg & Krug, 2002).

Collective violence is the use of violence by people who identify themselves as members of a group in which the violence is used against another group or individual to achieve a political, economic, or social objective. This category includes a variety of forms including “armed conflict within or between states; genocide, repression and other human rights abuses; terrorism; and organized violent crime, physical, sexual, or psychological” (Zwi, Garfield, & Loretto, 2002, p. 5).

Interpersonal violence is divided into two subcategories: (a) family and intimate partner violence and (b) community violence. Sexual violence is subsumed within the interpersonal violence category. Sexual violence and its victims and the nurses who treat them were the focus of this study.

Family and intimate partner violence is defined by the WHO as violence that takes place between family members or intimate partners. This type of violence typically but not always occurs in the home and includes child abuse, violence and abuse of the elderly, and violence by an intimate partner. The violence can be physical, sexual, or psychological and can include as well deprivation or neglect (Heise & Garcia-Moreno, 2002).

Community violence is described by the WHO as violence between individuals who are unrelated and who may or may not know each other. This type of violence generally takes place outside of the home. Included are youth violence, sexual assault by strangers, and violence in institutions such as schools, workplaces, nursing homes, or prisons (Dahlberg & Krug, 2002, p. 5).

The WHO World Report on Violence and Health defines *sexual violence* as the following:

any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. (Jewkes, Sen, & Garcia-Moreno, 2002, p. 149)

Sexual violence is a global problem that occurs at all levels of society, every culture, and in all countries around the world that takes place in many settings, including homes, workplaces, schools, and communities (WHO, 2003). Available data worldwide suggests that in some countries nearly one in four women experience sexual violence at some point in their lives. Up to 65% of those affected do not report the event (WHO, 2003).

The Centers for Disease Control and Prevention (CDC) defines sexual violence as “any sexual act that is perpetrated against someone's will” and that includes a wide range of offenses (Basile & Saltzman, 2009, p.1). Included are a completed nonconsensual sex act more commonly known as “rape,” an attempted nonconsensual sex act, abusive sexual contact more commonly known as “unwanted touching,” and noncontact sexual abuse, such as threatened sexual violence, exhibitionism, verbal sexual harassment (Basile & Saltzman, 2009, p.1). The CDC recommends the use of these definitions by individuals and institutions in a consistent manner to improve the accuracy of reporting and statistical analysis.

For the purpose of accurate reporting and statistical analysis, the Federal Bureau of Investigation (FBI, 2012) recently updated its definition of *rape* for the first time since 1927. The former definition stated that “forcible rape is the carnal knowledge of a female forcibly and against her will” (FBI, 2012, p 1). The new definition recognized that even though the majority of victims of sexual violence are women, men are affected as well.

There is also the exclusion of force and the inclusion of consent to determine if an illegal act has occurred. The new definition described *rape* as “the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim” (FBI, 2012, p. 1). The new definition clearly outlined acts that are included in the definition and should improve the accuracy of reporting.

According to the results of the 2010 Centers for Disease Control National Intimate Partner and Sexual Violence Survey (NISVS; Black et al., 2011), 1.3 million women in the United States were raped in 2009. Lifetime prevalence of rape in the United States by any perpetrator was 18.3%, or 21.8 million victims, and ranged from 11.4% to 29.2%. Prevalence rates for the state in which this study was conducted, Pennsylvania, was 18.8%, 960,000 victims (Black et al., 2011). The prevalence rates are specifically for rape, which is only one of the acts of sexual violence. Statistics that quantify all acts of sexual violence are difficult to determine, and reported events are widely seen as superficial. Survey research over the last decade has improved the collection of statistics, but a wide variation in the definition of sexual violence throughout the world hampers a clear understanding of the magnitude of the issue (World Health Organization [WHO], 2003).

Estimates related to the incidence of sexual violence, specifically assault, in the United States vary, but according to the National Violence Against Women Survey, “1 out of every 6 women and 1 out of every 33 men in the US will experience a rape or attempted rape” (Tjaden & Thoennes, 2006, p.7). In addition, as noted above, results from the same survey estimated that up to 65% of all victims do not report the event.

Reasons for not reporting varies throughout the literature and include shame, fear of the assailant, fear of the investigation and examination and a desire to “have it all go away” (Talbot et al., 2009; Tjaden & Thoennes, 2006; Ullman & Brecklin, 2003).

Underreporting by vulnerable populations such as the homeless, people in shelters, and people who are institutionalized adds to the inaccurate assessment of the magnitude of the problem.

Regardless of how sexual violence is defined, it is a traumatic event with grave physical, psychological, financial, and spiritual implications for the victims, their friends and family, and the community. The long-term effects include depression, anxiety, flashbacks, and emotional intimacy issues. Further effects can have far-reaching negative consequences, such as poor health outcomes, depression, substance abuse disorders, and post-traumatic stress disorder (PTSD) (Masho & Ahmed, 2007; Sanjuan, Langenbucher, & Labouvie, 2009). Such symptoms can severely interfere with a person’s ability to function at all levels. In addition, studies demonstrate correlations between chronic stress states and physical illnesses, such as cardiovascular disease, hormonal imbalances, and functional bowel disease (National Center for PTSD, 2009).

In the United States, addressing the roots of violence has long been considered a public health priority, and recommendations related to this issue have been included in the *Healthy People* reports since 1979 (Basile, DeGue, Jones, Freire, Dills, Smith, & Raiford, 2016; U.S. Food and Drug Administration, 2016). The repeated inclusion of this priority in recommendations illustrates the failure of the healthcare and social systems to address this issue.

Studies have demonstrated a lack of empathy for victims of sexual violence; they are perceived as partly to blame for their circumstances. For example, in a 1999 study involving 4th-year medical students in London, Williams, Foster, and Petrak discovered a clear gender bias related to victim responsibility for the rape, and “women respondents expressed significantly more positive opinions towards women who had been raped than did their male counterparts” (p. 25). Xenos and Smith, (2002) found that a significant proportion of the students they studied blamed the victim for the rape and had unfavorable attitudes towards the victims, negative stereotypes, and gender bias. Late night partying, excessive drinking, and wearing provocative clothing have all been seen as factors, which negatively influence people’s attitudes towards victims of sexual assault and can result in blaming of the victim (Xenos & Smith, 2002). In more recent years, very few current studies address this issue, especially in the nursing profession.

Attitudes affect behaviors, and attitudes that are more positive can translate to improved therapeutic relationships with victims of sexual violence. Unintended harm due to perceived negative attitudes can affect victims’ willingness to follow-up with medical and psychological recommendations, as well as participate in the judicial process if applicable (Campbell, 2006). The issue of treatment of sexual violence victims needs to be studied, especially with investigation of how nurses can understand how their attitudes and behaviors could affect patient outcomes.

Victims of sexual violence present with diverse and complex needs, and nurses who care for them are typically inadequately prepared to deal with these needs (Ledray, 2010). In addition to outward signs of physical trauma, victims of sexual violence have experienced trauma to their sense of security, safety, and self and need assessment and

treatment. Of the estimated, 200,000-400,000 people over the age of 12 who were victims of sexual violence in 2004, only 57,000 presented to emergency rooms throughout the United States for treatment (Centers for Disease Control [CDC], 2005). The victims were either evaluated and treated by emergency room personnel or referred to one of the approximately 600 Sexual Assault Nurse Examiner (SANE) programs in existence (Ledray, 2010).

Most of these programs are affiliated and located within healthcare institutions, mainly the emergency room. Some of the programs are freestanding centers that have a relationship with the local healthcare system. In most cases, care of sexual violence patients is relegated to emergency department staff; they are often untrained in the care of patients who have been sexually assaulted. These patients are often classified as nonurgent; they may wait for hours before being seen, especially if they exhibit minimal outward signs of trauma. In 2004, the first national protocol for sexual assault medical forensic examinations was established. The protocol recommended that victims of sexual assault be given priority status in emergency rooms (U.S. Department of Justice, 2004). This recommendation has not been consistently adapted in the United States.

SANE programs in the nation began in the late 1970s due to the recognition that victims of sexual assault, mostly women, were not receiving the care and attention they required (Campbell, Patterson, & Litchy, 2005). Poor reporting statistics and even poorer conviction rates of perpetrators supported the call for a change in the system. The women's movement helped to draw attention to the revictimization of women, exacerbated by the legal and healthcare system that contributed to the reluctance of victims to seek help and report the event.



SANEs are registered nurses (RNs) who receive in-depth and comprehensive training on how to assess and treat victims of sexual violence. The nurses function as part of a team that includes law enforcement, advocates, and the judicial system. The teams are called Sexual Assault Response Teams (SARTs). The goal is to coordinate and streamline the process of sexual violence investigation, protection, and prevention (Campbell et al., 2005).

The 40-hour training courses that SANEs receive include assessment, recognition, and treatment of the physical and psychological impact of sexual violence; evaluation, monitoring, and prophylactic treatment of sexually transmitted infections (STIs); and when appropriate, pregnancy prevention. In the courses, RNs without advanced practice designation follow standing orders or protocols that are designed to address the most common needs of these patients. Courses in the identification, preservation, and collection of evidence for victims of sexual violence are integral parts of the training (Campbell et al., 2005).

Due to SANEs' advanced training, they are often called to provide expert witness testimony in court. Appropriate referral for ongoing evaluation, support, and follow-up testing and treatment are vital parts of the training. The training includes a 45-hour didactic and hands-on course in a multidisciplinary setting. The number of precepted exams prior to solo examination varies between programs (U.S. Department of Justice, 2004).

The scope of practice of nurses in this specialty is guided by state mandate, program regulations, and institutional guidelines, combined with national recommendations and guidelines for practice. In 2009, the American Nurses Association

in association with the International Association of Forensic Nurses published the first guide, *Forensic Nursing: Scope and Standards of Practice* (American Nurses Association and International Association of Forensic Nurses, 2009). The guide includes six standards of practice and nine standards of performance. Nurses outside of this specialty do not receive this training and therefore must rely on their prelicensure education and continuing education, which may include as little as 1 to 2 hours of lecture on the subject of sexual assault. This education may have taken place earlier in their academic program or as part of a specialized program offered to those who are interested in the topic.

Little is known about the effect to SANEs of caring for victims of sexual violence, as well as on nurses without specialized training. Vicarious traumatization—the psychological consequences of exposure to others’ traumatic experiences—has been studied in mental health counselors and advocates. Symptoms similar to PTSD have been reported, with an altered view of the world (Maier, 2011). Burnout related to the psychological strain of working with troubled populations has also been seen in counselors and advocates who work with these victims (Maier, 2011).

Although burnout has been studied in nurses, little is known about burnout in nurses who deal with victims of sexual violence. Due to high stress situations and lack of control, emergency room nurses experience higher rates of emotional exhaustion and depersonalization, with greater burnout, than other specialties (Browning, Ryan, Thomas, Greenberg, & Rolniak, 2007). Because victims of sexual violence most often present for care in emergency rooms, it is logical to assume that these already stressed nurses will experience even greater levels of stress when called on to care for these patients.

A gap between the healthcare needs of victims of sexual violence and existing services leads to higher consumption of healthcare services and poorer health outcomes in the future. In the *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, the WHO (2003) called for a comprehensive, gender-sensitive approach to health services for sexual violence patients to improve the quality of treatment and support and to increase the capacity of healthcare professionals to provide an adequate level of care. Recognition that specialized teams and programs may be prohibitive in terms of cost and resources led to the development of the guidelines with the goal of improved professional services for all victims of sexual violence. Widespread institutionalization of these guidelines has yet to take place in the United States or around the world. Uniform and comprehensive guidelines for hospitals, clinics, public health departments, and school health clinics are also lacking, and treatment is often left to the provider on duty, who may or may not have specialized training in the care of these victims.

Long-held beliefs by health professionals that violence is a matter for the law enforcement and judicial systems are changing with the pervasive impact of violence on the health of people worldwide as well as the burden violence places on the healthcare system (Dahlberg & Krug, 2002). The incidence of violence is likely even higher than estimated due to inaccurate and inconsistent reporting processes. For many people in the world, violence is a part of their daily existence, and the effects are pervasive and cumulative. Sexual violence has an additional toll on those affected. As psychosexual development is an important part of the human experience, sexual violence, especially in children, interferes with that development and engenders instead development of deep-rooted fears, phobias, and anxieties (Dahlberg & Krug, 2002).

Nurses are in a position to assure that all victims of sexual violence receive competent, comprehensive, and compassionate care when they enter the healthcare system. Nurses' understanding of the impact of sexual violence on victims' physical and psychosocial well-being is the first step in providing proper care. Awareness of how nurses' attitudes and beliefs can influence that care is the essential next step. It is likely that all nurses in practice will have some contact with a person who has experienced sexual violence sometime in their life. Nurses have a professional and moral obligation to help these patients heal and to do no further harm (ANA, 2010).

### **Problem Statement**

Caring for patients who are victims of sexual violence is complex and challenging for nurses, especially if they do not have adequate training. The patients are typically reluctant to relive the event in detail, and information required to evaluate a patient properly may not be available. In addition, as the researcher has often observed in her practice, the emotional and psychosocial needs of the patient may not be addressed adequately if they have physical injuries that require immediate attention.

For victims who chose to report the event, the interview process, collection of forensic evidence, and medical evaluation and treatment constitute a long and invasive process. Many victims chose not to participate in the process or to leave before all procedures are completed (WHO, 2003). For these patients, adequate initial care and subsequent follow-up treatment and evaluation may not take place. They do not take advantage of follow-up and may have to deal with the physical and emotional consequences of the assault on their own.

The intense, complicated, and invasive process that occurs after sexual violence contributes to the unwillingness of victims to participate. If the process is not handled in a sensitive and professional manner, the individual can be placed at risk for feelings of revictimization and repeated trauma. An understanding of the process used by nurses untrained in handling the vulnerable sexual violence victims to manage their care is needed to assure that therapeutic and comprehensive care is consistently delivered.

### **Purpose of the Study**

The purpose of this study was to explore the process that nurses use to manage the care of victims of sexual violence. A qualitative, grounded theory approach was used. From the findings, a theory was developed that describes the critical influences that guide that process.

### **Research Questions**

The research questions that guided this study were the following:

1. How do nurses decide the way in which they will care for patients who are victims of sexual violence?
2. What are the critical influences that guide that decision making process?
3. What are the nurses' perceptions of their attitudes towards victims of sexual violence?

### **Philosophical Underpinnings**

The philosophical underpinning used in this study was a qualitative paradigm. This view allowed the researcher to acquire knowledge through a constructivist lens in which reality is mentally constructed and subjective meanings are formed through interactions with others and through individuals' historical and cultural norms (Creswell,

2007). The qualitative paradigm allowed the researcher to utilize multiple methods to approach the problem in an interpretive, naturalistic manner in the natural setting.

The hermeneutic approach to the constructivist paradigm requires that the researcher reach an understanding of the essential meaning of the constructions. The goal is to “understand the significance of human actions, utterances, products, and institutions” (Appleton & King, 1997, p. 2). Because the purpose of this study was to explore the process that nurses use to manage the care of victims of sexual violence and to develop a theory, the grounded theory approach was the most appropriate method for conducting this study.

### **Grounded Theory**

Grounded theory methods were developed by sociologists Barney M. Glaser and Anselm L. Strauss in the 1960s. Glaser, who was grounded in quantitative methods, and Strauss, who was grounded in qualitative methods, collaborated on studies of dying patients in the hospital. They and their team observed how dying occurred and how patients and medical professionals handled the process. During the construction of their analysis, Glaser and Strauss developed methodologies that social scientists could use to study many other topics (Charmaz, 2010). The challenge to qualitative researchers at the time was to validate their methods and offer to the scientific community another way of knowing than the quantitative approach.

The analysis and interpretation of research participants’ meanings did not satisfy the prevailing positivist philosophy of scientific inquiry—that knowledge was valid that derived from sensory experience—which sparked disputes about the scientific value of analysis of participants’ meanings. Research questions that did not fit into the positivistic

research design were ignored, and construction of new theories was minimal. Glaser and Strauss answered the criticism with practical guidelines and the development of systematic strategies for qualitative research practice (Charmaz, 2010). Construction of abstract theoretical explanations of social processes and the development of theories were of particular interest to the researchers.

To answer the criticism of the dominant positivist paradigm in routine natural science inquiry, Glaser turned to his roots. Trained in rigorous quantitative methods at Columbia University by the eminent quantitative researcher Paul Lazarfeld, Glaser codified qualitative research methods by specifying explicit strategies for conducting research (Charmaz, 2010). He also advocated building useful “middle range” theories rather than the mid-century “grand theories,” which were developed without systematic analysis of data (Charmaz, 2010, p. 17).

Strauss’s views, which were absorbed in the University of Chicago’s pragmatist philosophical tradition, were also used in the formation of grounded theory. He viewed people as active agents in their lives rather than passive vessels. Strauss assumed that process is fundamental to human existence and that structure is created by engaging in that process. In addition, subjective and social meanings rely on language and emerge through action (Charmaz, 2010).

A shared interest in studying social or psychological processes within a social setting or a particular interest brought these two researchers together to develop and define grounded theory as a valid qualitative research approach. They defined the components of the process as the simultaneous collection and analysis of data, the construction of analytic codes and categories from data not preconceived, deduced

hypotheses, utilization of the constant comparative method, and advancement of theory during each step (Charmaz, 2010; Glaser & Strauss, 1967).

Glaser and Strauss eventually moved in divergent directions. Strauss moved towards verification of the method and, with Juliet Corbin, stressed the use of technical procedures rather than the earlier comparative methods. Glaser's criticism of the developing theory was that the prescribed process forced data and analysis into preconceived categories that violated one of the basic tenants of the original theory (Glaser, 2002). By 1990, grounded theory gained acceptance from quantitative researchers for its rigor and, ironically, its positivist assumptions.

Over the past decade, a growing number of scholars have advocated moving grounded theory away from the positivism in Glaser, Strauss, and Corbin's versions. Viewing the process through a symbolic interactionist lens reminds the researcher that interactions are dynamic and interpretive and meanings emerge and change. How individuals and groups give meaning to their lives and how they interpret experiences influence their actions, including, as in the present study, how nurses care for patients. Identifying those meanings may lead to theory development, which is the goal of grounded theory.

### **Symbolic Interactionism**

The philosophical underpinnings of grounded theory are symbolic interactionism and pragmatism. Symbolic interactionism is a sociological concept developed by George Mead in 1934 and further explicated by his student Herbert Blumer in 1969. This concept provides the "philosophical foundations for grounded theory and guides the research questions, interview questions, data collection strategies, and methods of data analysis"



(Hutchinson & Wilson, 2001, p. 211) Symbolic interactionism further “assumes that people can and do think about their actions rather than respond mechanically to stimuli” (Charmaz, 2010, p. 7). Meaning is constructed by action and interaction that are inherently dynamic and interpretive, and further action is influenced by that interpretation. Language and communication are essential to the construction of meaning (Charmaz, 2010).

### **Pragmatism**

Pragmatist philosophy informs symbolic interactionism, in which “meanings emerge through practical actions to solve problems and through actions people come to know the world” (Charmaz, 2010, p.188). In this philosophy, reality is fluid and open to multiple and individual interpretations. Facts and values are related, and truth is relative. The Chicago School tradition with its pragmatist underpinnings encourages grounded theorists to “construct an interpretive rendering of the worlds we study rather than an external reporting of events and statements” (Charmaz, 2010, p. 184). With regard to the present study, nurses experience and interpret the world in many different ways, and their interpretations inform their actions. The experience of caring for a victim of sexual violence both draws from and forms further interpretations of reality.

In this study, the constructed meaning of interactions that results in actions taken by nurses who care for victims of sexual violence was explored. Multiple realities were elicited, and inductive reasoning was used to extrapolate patterns. The researcher posited that nurses caring for patients who are victims of sexual violence have constructed similar meanings as the patients’ related to their experience. These meanings were used in the study to guide the formation of a theory that addressed how the meanings created a

process of caring for these patients. A positivist-empiricist epistemology utilized by other researchers regarding sexual violence would have been too narrow and risk reductionism of this complex problem (Lea, 2007). Therefore, a qualitative approach using grounded theory to address the question was most appropriate.

### **Significance of the Study**

Identification of the process that nurses use to care for vulnerable patients, specifically patients who experience sexual violence, will be significant to nursing. Eliciting of nurses' attitudes and behaviors and their processes will lead to the development and implementation of comprehensive and consistent guidelines related to the care of these patients. Furthermore, recognition that an informed and purposeful approach to the care of these patients will improve long-term outcomes may meet the requirements for evidence-based practice.

### **Implications for Nursing Education**

Schools of nursing are charged with the preparation of the future nursing workforce as well as the continuing education of practicing nurses. The population in the United States is aging, chronic health conditions are increasing, and care of patients is becoming more and more complex (Centers for Disease Control [CDC], 2003). The impact of the current economic crisis affects access to care that leads to poorer health outcomes. The amount of information that needs to be covered in nursing curricula is increasing at a rapid pace, and nurse educators are having difficulty keeping up with the demands, especially within the context of shorter nursing programs (Aktan et al., 2009). Identification of the process that potential and practicing nurses use to care for vulnerable patients will allow for a focused educational intervention that will meet the needs of both

nurses and their patients. The addition of specific content for addressing vulnerable patients to a curriculum in a focused but comprehensive manner can add to the proficiency of nurses in practice.

Training of nurses should also include self-evaluative processes that identify inherent biases toward various patients or their circumstances. The goal would be to provide nurses with tools with which to mitigate adverse effects on their patients. With nurses' use of these tools, patients may feel more supported, and nurses may choose to follow up with recommendations that will in turn decrease negative consequences for the patients. This study identified areas in nursing education that are lacking related to sexual violence victims and the ability of nurses to care properly for these patients.

Recommendations for inclusion of specific concepts related to sexual violence are made.

### **Implications for Nursing Practice**

Nurses' stress increases when they are tasked with caring for patients who have complex needs, especially if the nurses' prior preparation is inadequate. People who experience sexual violence react in complex and unique ways to the traumas they experience. Nurses who are unaware of the atypical nature of presentation by these patients may inadvertently act in ways that are perceived by the patients to be blaming. Nurses must understand the dynamics of rape trauma and how to help patients avoid revictimization. Such understanding can increase the nurses' perceived competency and improve health outcomes for patients. Inclusion of the topic of sexual violence and patient care in orientation and annual competency programs within institutions will be a first step in the process.

The ANA (2010) and WHO (2003) have established guidelines and standards of practice related to the care of patients who are victims of sexual violence. However, neither of these documents has been widely adopted or operationalized. This study serves to highlight the availability of these processes, which may lead to wider adoption in healthcare facilities throughout the world.

### **Implications for Nursing Research**

Nurses make decisions about how to care for patients in many different ways. The Nursing Process (Castledine, 2011) is the framework that is used to develop plans of care, but it breaks down if assessments are either incomplete or incorrect. Research that considers alternate processes for nurses' decision making that is situational and contextual is lacking. This study may be significant to nursing research because it explored an important issue from the perspectives of nurses who are experiencing the phenomenon and aimed to discover the critical influences that guide their practice. As a result of this study, the themes that emerged can be used to develop an instrument for collection of additional data toward greater help to nurses caring for sexual trauma victims.

### **Implications for Health/Public Policy**

This study is significant to public health policy because it focused on a vulnerable population that is often underserved. Nurses need to advocate for a systemwide requirement in institutions that care for these patients so uniform and comprehensive protocols and/or guidelines are in place. An understanding by administration and the nurses themselves how nurses decide to care for these patients can assist in the development of a plan for institutionalizing the protocols. Due to the prevalence of the

problem, this study can illustrate the need for mandatory education and training for nurses in the treatment of patients who have experienced sexual violence.

In 1996, the executive director of the ANA predicted that within 10 years, the Joint Commission of the ANA would require that every hospital have a forensic nurse available ((Black et al., 2011).The presence of a forensic nurse would assure that sexually assaulted patients would receive standard care, and proper evidence collection would be conducted. That outcome has not taken place. The results of the study may identify why this outcome has not taken place and provide suggestions on actions that can be taken by hospitals to reach that goal.

### **Scope and Limitations of the Study**

The scope of this study was a convenience sample of nurses who worked in emergency rooms in two different hospitals in an urban area of Pennsylvania. Individual interviews and a focus group were conducted. The inclusion criteria for participants in both the interviews and focus group were as follows: (a) included licensed nurses with at least 2 years of nursing experience in the emergency department, (b) English-speaking, and (c) contact with victim(s) of sexual violence during practice as an RN. Nurses who had specialized training in working with victims of sexual violence (SANE training) participated in the focus group.

Limitations of this study included issues surrounding the sensitive nature of sexual violence, a sensitive and disturbing subject. Nurses were reluctant to share their true feelings about the subject and recruitment issues, limiting participation. Since 1 in 6 women in the United States have experienced some type of sexual violence (Tjaden & Thoennes, 2006), it is logical to assume that most nurses have some experience with this

subject, professionally, personally or through a colleague, friend or family member. In addition, nurses may have been unwilling to share their true feelings about victims. The expectation within the profession is that nurses never allow their personal feelings to affect their attitudes while caring for patients. Participants' responses may have reflected social desirability, what they believed was expected rather than what they truly felt (van de Mortel, 2008).

This researcher's experience with the subject can be viewed as a limitation of the study. Careful interviewing techniques with extensive memoing were used to avoid preconceived ideas contributing to guiding the interviews and data analysis. However, due to the complexity of this issue, the researcher's experience allowed for a rich exploration of meanings constructed by the participants.

### **Chapter Summary**

In this chapter, the researcher reviewed the scope and severity of the issue of sexual violence. In addition, the researcher pointed out the lack of insight into the process used by nurses to manage the care of vulnerable patients who are victims of sexual violence. This lack demonstrates the need for further inquiry. The statement of the problem illustrated the complexity of the care of these patients and the harm that may be done to them. The researcher discussed the purpose of the study, which was to explore the process that nurses use to manage the care of patients who are victims of sexual violence and as a result develop a theory that describes the critical influences that guide that process. The significance to nursing in education, practice, research and policy was also discussed. Limitations were reviewed. The next chapter reviews the literature on victims of sexual violence and attitudes towards those victims.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

The purpose of this study was to explore the process that nurses used to manage the care of patients who are victims of sexual violence. A qualitative, grounded theory approach was used. From the findings, the purpose was also to develop a theory that describes the critical influences that guide nurses' decision making in treating these patients.

To accomplish this purpose, a search of the relevant literature across disciplines was conducted to explore the phenomenon of caring for victims of sexual violence. Using the Monsignor William Barry Memorial Library Catalog and electronic resource search engines, the researcher used the following computerized databases for this search: Cumulative Index to Nursing and Allied Health Plus (CINAHL Plus), Medline on EBSCO, OVID, and Psycharticles. The key words used in the search were *attitudes*, *medical providers*, *nurses*, *outcomes*, *perceptions*, *rape*, and *sexual violence*, and combinations of these words. Citations were limited by language to English and by subject to exploration of the concepts. A limitation was imposed to find literature published since 2000, with classics sought by review of citations in the published works. A random selection process delimited the profusion of theoretical references that were found. Synthesis of the literature revealed what is known and not known about the phenomenon, the attitudes of people in general, and the attitudes of nurses specifically related to victims of sexual violence.

A review of the literature revealed few studies that address the specific population of interest: nurses without specialized training who care for patients who are victims of

sexual violence. Studies that considered general attitudes and feelings towards this population are also few in number, and most are 10 to 15 years old. Few studies were found that explored the relationship between sexual assault and poor health outcomes, specifically alcohol disorders and PTSD. The review includes an historical overview of sexual violence and the development of the role that nurses play in caring for patients who are victims of a traumatic sexual event.

### **Historical Context**

Sexual violence has been in existence since the evolution of the human species. Power and control are the purposes of these acts, not sex, and this type of violence has been used to assert dominance over individuals and communities throughout history (Dahlberg & Krug, 2002). Although men are victims of sexual violence, the overwhelming majority of victims are women and children. Nurses have cared for victims of violence since the profession was formed. In the 18th century, midwives testified in cases of rape and attested to the virginity status of women marrying into royalty in Great Britain (Burgess, Berger, & Boersm, 2004). Florence Nightingale cared for victims of community violence in the Crimean War and developed processes that attended to all of their needs, rather than simply the physical effects of their injuries. The foundation for forensic nursing was established by nurses caring for patients who were victims of sexual violence in the United States over the last 40 years.

In the 1970s, the feminist movement focused attention on the care provided to this population, who were mostly women. Emergency room nurses recognized that these patients were not receiving the same standard of care afforded other patients who were victims of traumatic events. In 1974, Ann Burgess, an emergency room nurse, identified



Rape Trauma Syndrome, including the symptomology and proper treatment of the phenomenon. Recommendations for treatment and referral were developed and initiated in several emergency rooms throughout the nation (Burgess et al., 2004).

Over time, the care of these patients evolved, and the role of Sexual Assault Nurse Examiner (SANE) was developed. Today there are 600 SANE programs in the United States that are primarily based in hospital emergency rooms. Although this number is encouraging, in perspective there are currently 5,754 registered hospitals in the nation, with the SANE programs in only 10% of hospitals. No standard process is implemented in the institutions that do not have access to SANE programs (Basile et al., 2016). This deficiency leaves a serious gap in the accessibility of proper care of patients who are victims of this life-altering event.

This study may help to close the knowledge gap in the care given by nurses who do not have training in the care of sexual violence patients. To support the need for this study, literature on patients who are victims of sexual violence and attitudes towards these patients is next reviewed.

### **Victims of Sexual Violence**

Sexual violence has significant short- and long-term consequences for those affected. Poor health outcomes, increased utilization of healthcare services, and high incidence of PTSD have been found in studies of this population, but many are secondary analyses utilizing data from other studies (e.g., Masho & Ahmed, 2007; Suris, Lind, Kashner, Borman, & Petty, 2004; Talbot et al., 2009). Underreporting of the phenomenon makes it difficult to explore this complex issue. Studies addressing health outcomes,

specifically PTSD and functional impairment, are reviewed in this section, as well as risk factors associated with sexual violence victimization.

Masho and Ahmed (2007) conducted a cross-sectional telephone survey from November 2002 through February 2003 of a sample of adult female residents of Virginia. The random digit dialing (RDD) sample selection method was used to create an equal probability sample of the female population of Virginia. With use of the RDD 11,743 phone numbers were called. Of those called, 1,786 (15.1%) who were eligible completed the interview.

The study sample was similar to the general population distribution of Virginia, with slight underrepresentation of the youngest (18-24) and oldest (80+) age groups, Asian/Pacific Islanders, Virginians with less than a high school education, those who were never married, and women with income less than \$25,000. A detailed screening questionnaire adapted from the National Women's Study (NWS) was used to screen respondents for sexual assault victimization and the presence of PTSD. The DSM-IV criteria were used to determine the presence of PTSD (Masho & Ahmed, 2007).

Of the 1,769 women interviewed, 17% were found to have PTSD. Multivariate logistic regression analysis showed that, compared with women reporting no history of sexual assault, women who were victimized before age 18 were 3.8 times more likely to suffer from PTSD (*OR* [odds ratio] = 3.75, 95% CI 2.33-6.53). The risk of PTSD in women who were assaulted after age 18 was 2.9 times higher compared with women who reported no history of sexual assault (*OR* = 2.89, 95% CI 1.46-5.74). The study also showed that not being married, having less education, perceived poor/fair health status,

and perceived threat during the assault were important predictors of PTSD (Masho & Ahmed, 2007).

Relatively low disclosure rates in young victims with a subsequent lack of healthcare and follow-up can partially explain the higher incidence of PTSD in this population. As the researchers pointed out, prevention efforts should focus on increasing the disclosure rates of victims to assure that proper care and follow-up services are provided. Prevention of PTSD and other psychological and behavioral outcomes associated with sexual assault should be addressed when caring for these patients. This study may assist in closing the gap of knowledge surrounding the complex issue of underreporting in this population (Masho & Ahmed, 2007).

In a 2004 study of veteran women receiving medical and/or mental health treatment at the Veterans Affairs (VA) healthcare system in Texas, Suris et al. examined the risk of PTSD, healthcare utilization, and cost of care in those veterans who were sexually assaulted. A convenience sample of 270 women who were receiving care at the VA system participated in the study. The participants had at least one outpatient appointment in the 5 years prior to contact.

A total of 385 women veterans were recruited, with a final sample of 270 women (70%). Participants were interviewed with the Clinician Administered PTSD Scale (CAPS). The Interview of Sexual Experiences (ISE) scale was used to identify participants who were sexually assaulted. A chart review was also conducted to determine the frequency of diagnoses among the women, and healthcare utilization was obtained from self-reports with the Utilization and Cost Patient Questionnaire (UAC-PQ) and VA administrative records (Suris et al., 2004).

Sexual assault categories were determined by the timing of the sexual assault. Participants who reported first sexual assault before the age of 18 were placed in the Childhood Sexual Assault (ChSA) category. Those who were assaulted after the age of 18 but not while on active military duty were classified as Civilian Sexual Assault (CSA), and those who were on active military duty during their assault were placed in the Military Sexual Assault (MSA) category (Suris et al., 2004).

The study results showed that female veterans with a positive history of any type of sexual assault were 5 times more likely to meet the criteria for PTSD than were the veterans without a history of sexual assault (adjusted odds ratio [*OR*] = 5.24, 95% CI = [2.39-11.47], *Wald* [1] = 17.14,  $p < .0001$ ). When the type of sexual assault was examined, MSA was associated with a more than 9-fold increased risk of PTSD (adjusted *OR* = 9.27, 95% CI = [3.75-22.95], *Wald* [1] = 23.18,  $p < .0001$ ). ChSA was associated with a 7-fold increased risk of PTSD (adjusted *OR* = 7.26, 95% CI = [2.75-19.17], *Wald* [1] = 16.02,  $p < .0001$ ), compared with a 5-fold increased risk of PTSD (adjusted *OR* = 4.64, 95% CI = [2.04-10.54], *Wald* [1] = 13.35,  $p < .0001$ ) associated with CSA (Suris et al., 2004).

An unexpected finding of the study was that veterans who were assaulted while on military duty (MSA) utilized healthcare services at a lower rate than those whose assaults were categorized as ChSA or CSA. The researchers posited that women who were sexually assaulted while on duty were less likely to request ongoing care due to the impact on their careers and deployment eligibility. Because of the high incidence of PTSD in veteran women with MSA histories and their underutilization of services, it is essential that the culture regarding ongoing care in these victims be examined and the

benefits of early treatment of associated symptoms be supported. This study may add to the knowledge gap related to the culture surrounding the care of this population (Suris et al., 2004).

Another study that demonstrated the association between childhood sexual abuse (CSA) and cumulative illness burden, physical function, and bodily pain in psychiatric patients ages 50 and older was conducted from 2001 to 2004 by Talbot et al. (2009). The study participants were patients who were being treated at three inpatient units in different hospitals and one mental health outpatient clinic for adults. Participants were recruited from a pool of adults, 50 years old and older, with a suspected mood disorder. Out of 163 patients who agreed to participate in the study, 140 met the criteria for a mood disorder. Their data were used for the final analysis.

CSA was assessed with the sexual abuse scale included in the Childhood Trauma Questionnaire (CTQ), a self-report instrument. Physical illness burden was assessed using the Cumulative Illness Rating Scale (CIRS), a scale that quantifies the level of overall medical burden. Physical function was assessed by the Instrumental Activities of Daily Living (IADL) and Physical Self-Maintenance scales (PSMS). Bodily pain (BP) was assessed utilizing a subscale of a self-report measure, the Medical Outcomes Study 36-Item Short Form (SF-36; Talbot et al., 2009).

The study showed a significant association between severe CSA and medical illness burden, as indexed by the CIRS ( $B = 0.31$ ; standard error ( $SE$ ) = 0.14;  $z = 2.10$ ;  $p < .036$ ). In addition, a significant association was found between CSA and the presence of medical burden in the musculoskeletal-integument system ( $OR = 3.69$ ;  $z = 2.10$ ;  $p = .036$ ) and the respiratory system ( $OR = 3.11$ ;  $z = 2.25$ ;  $p = .024$ ). Finally, severe CSA was

also associated with greater BP on the SF-36, for which higher scores indicated less pain ( $B = -12.76$ ;  $SE = 6.46$ ;  $z = -1.98$ ,  $p = .05$  (Talbot et al., 2009).

Comparison of regression coefficients revealed that severe CSA's influence on illness burden was approximately equivalent to the effects of adding 8 years to current age. For ADL impairment and BP, the effects were comparable to adding 20 years. Among psychiatric patients age 50 and older, a strong relationship existed between CSA and medical illness burden. Talbot et al. (2009) observed that early detection of patients' abuse histories is essential to prevent the long-term consequences of sexual abuse. This study may add to the body of knowledge surrounding the lack of early assessment and screening for sexual violence and its consequences.

For nurses to assess properly the risk of sexual violence victimization is a complex task. The definitions of sexual violence and the acts included within the definitions vary greatly throughout the literature (Basile & Saltzman, 2009; Jewkes et al., 2002). In addition, the relationship between the perpetrator and the victim are not always considered in the analysis when risk is assessed. Most studies in this area have been retrospective secondary analyses of larger studies and have demonstrated commonalities among victims, but the predictive value of those attributes or experiences have not been consistent. Many of the studies reported that results demonstrate a multifactorial process that requires further examination (e.g., Masho & Ahmed, 2007; Talbot et al. 2009). In this section, three studies are discussed that attempt to clarify the phenomenon.

In a 2008 prospective study of college women, Messman-Moore, Coates, Gaffey, and Johnson examined the behavioral, personality, and psychological variables thought to increase vulnerability for college women's experience of rape. Participants were 339

college women who were attending a public university in the Midwest. Most participants, 217 women, were recruited on campus to participate in an 8-month study on “college women’s life experiences” (p. 1730). Other participants were recruited from a basic course pool, Introduction to Psychology. A total of 276 women participated in all four sessions of the study and were included in the analysis. The aims of the study were to examine several behavioral and psychological correlates of sexual victimization and to determine if the variables increased the risk for two types of sexual victimization: rape and verbal sexual coercion (Messman-Moore et al., 2008).

Participants completed anonymous questionnaires during group sessions beginning in the fall semester. Three subsequent follow-up sessions were conducted at 10-week intervals. Various existing instruments were used to measure the variables of interest. A modified version of the 10-item Sexual Experiences Survey (SES) assessed sexual coercion and rape that may have occurred during the term of the study. The Trauma Symptom Inventory (TSI) assessed personality traits and various aspects of sexual psychological functioning. The Self-Criticism subscale of the Cognitive Distortions Scale (CDS) measured correlates of low self-esteem. The Drinking Habits Questionnaire (DHQ) assessed average patterns of drinking alcoholic beverages. The Alcohol Expectancy Questionnaire (AUQ), a valid predictor of drinking behaviors, was used to evaluate beliefs related to the consumption of alcohol (Messman-Moore et al., 2008).

Results of the study showed that, compared to nonvictims, rape victims and verbal coercion victims reported higher levels of sexualized distress, sexual shame, and sexual dysfunction prior to victimization during the term of the study. Similarly, rape and sexual

coercion victims had more partners than nonvictims and higher rates of dysfunctional sexual behavior prior to victimization. Those behaviors are indicative of indiscriminate sexual activity and use of sexual activity to meet nonsexual needs (Messman-Moore et al., 2008).

Personality traits and psychological functioning measures demonstrated higher levels of dissociation and impaired self-reference among victims than nonvictims, again prior to victimization during the study. When substance abuse was analyzed, rape victims compared to nonvictims reported higher levels of alcohol use prior to victimization during the study (Messman-Moore et al., 2008). Some differences were found in risk factors for the two types of victimization. Alcohol and marijuana use were associated only with the rape victims, and depression and self-esteem were associated only with the verbal sexual coercion victims.

With the prospective design of this study, Messman-Moore et al. (2008) were able to identify predictors of rape and sexual coercion that occurred during a single academic year. The design enabled the researchers to distinguish between variables present before and after victimization. The limitations of the study included a somewhat homogeneous sample, self-reporting bias, and participants' limited knowledge of the victimization experience.

However, despite the limitations of the Messman-Moore et al. (2008) study, the high prevalence rates of sexual assault on college campuses should compel study of this population as a priority to help identify risk factors for college women's victimization and subsequent targeted education for them regarding those risks. The study results may



add to the knowledge related to nurses' knowledge of risk factors for victimization of specific populations.

The purpose of a study by Testa, Van-Zile-Tamsen, and Livingston (2007) was to identify predictors of sexual victimization from intimate partners and nonintimate partners. In this prospective study, the authors considered substance abuse, sexual activity, and sexual assertiveness as possible predictors of victimization. Testa et al. hypothesized that the risk factors would be differentially associated with the relationship between perpetrator and victim.

Data were collected by random digit dialing of households in the Buffalo, New York, area between May 2000 and April 2002, with identification of women 18-30 years of age. In-person interviews were completed in three waves with 1,014 women, or 61% of the eligible women identified. The completion rate at the end of the three waves was 91.4%, or 927 participants. The sample appeared to be a good representation of the population, as demographic data revealed by the mix of races, median household income, education, employment, and marital status. Demographic variables included age, ethnicity, and marital/cohabitating status (Testa et al., 2007).

The three waves of data 12 months apart were collected and labeled T1, T2, and T3. The first data collection involved a 2-hour session in which a computer assisted self-interview program was utilized. Subsequent data collection was conducted with mailed questionnaires. Participants were paid \$50. each on receipt of the completed questionnaires.

The measures were childhood sexual assault (CSA), adult sexual victimization (ASV), substance use, consensual sexual partners, and sexual refusal assertiveness. CSA

was defined as unwanted or nonconsensual sexual experiences before the age of 14. ASV was assessed with the Sexual Experiences Scale (SES). Women who reported adult sexual victimization at T1 were interviewed to obtain additional information regarding their most recent experience, including the type of perpetrator. Substance use was determined with multiple measures, which were characterized in different ways, such as heavy episodic drinking and maximum drinks per episode of drinking. At each wave, women were asked about consensual sexual partners. At T1, the Sexual Assertiveness Scale was used to determine the participants' sexual refusal assertiveness score. This scale included questions such as "I refuse to have sex if I don't want to, even if my partner insists" (Testa et al., 2007, p. 55).

The results of the Testa et al. (2007) study showed that at T2 116 women (12.5%) reported experiencing some sort of sexual victimization. At T3, 94 women (10.1%) experienced victimization. For those who were victimized more than once during the study period, the most serious victimization was considered for analysis. Consistent with prior research (Cleveland, Koss, & Lyons, 1999; Testa, Livingston, & Leonard, 2003), the majority of women reported sexual victimization by an intimate partner (67.2% at T2, 65.9% at T3). Women experiencing intimate partner victimization were more likely to report sexual coercion than women reporting nonintimate perpetrator victimization at both T2 (80.5% vs. 15%),  $\chi^2(1, N = 117) = 46.43, p < .001$ , and at T3 (86.2% vs. 33.3%)  $\chi^2(1, N = 88) = 25.48, p < .001$ . Significant predictors of T3 victimization were T1 sexual victimization ( $\beta = 2.11$ , confidence interval [CI] = 1.46, 3.07) T1 sexual partners ( $\beta = 3.23$ , CI = 1.28, 8.16), T1 drug use ( $\beta = 1.10$ , CI = 1.01, 1.21), and T1 sexual refusal

assertiveness ( $\beta = .59$ ,  $CI = .45, .76$ ). Nagelkerke pseudo- $R^2$  was .14, indicating a good fit prediction (Testa et al., 2007).

Testa et al. (2007) also found that women victimized by a nonintimate perpetrator reported heavier drinking and more past-year partners than any other group. Compared with nonvictimized women, women victimized by an intimate showed significantly lower rates in sexual refusal assertiveness. Predictors of T3 intimate partner victimization were marriage or cohabitation, prior intimate partner victimization and additional sexual victimization experiences, more frequent drug use, and low sexual refusal assertiveness. T3 victimization by a nonintimate perpetrator was predicted by single status, more frequent heavy episodic drinking, and more consensual sexual partners. The variable that distinguished women who had experienced both types of victimization from nonvictims was prior intimate partner victimization, although the small number of women in this group may have skewed the results. When sexual victimization was considered separately from different types of partners, nonoverlapping sets of predictors emerged (Testa et al., 2007).

The study of Testa et al. (2007) demonstrates that conventional methods of analyzing sexual victimization as a single construct may overlook or neglect important relationships. Previous inconsistencies in research may be explained by the complexity of this phenomenon. In following the Testa et al. (2007) study, the current research study may include risks differentiated by type of perpetrator in identification of the perceptions of nurses caring for patients who are sexual violence victims.

In summary, the studies reviewed here show the long-term effects of sexual violence on health outcomes and the need for early screening and intervention. However,

the studies did not identify what nurses perceive and experience regarding the impact of sexual violence on victims' health outcomes. Additionally, these studies demonstrated the difficulty in accurate identification of risk factors related to sexual violence victimization. These studies did not focus on how nurses identify those at risk for sexual violence, how they chose who to screen, or how risk stratification contributes to the process of caring for patients. The present inquiry sought to identify the risk factors nurses consider when caring for patients who are victims of sexual violence. In addition, through this study, the researcher sought to identify how nurses decide who requires screening before victimization takes place.

### **Attitudes Towards Victims**

Attitudes, values, and beliefs are acquired early in individuals' development through interactions among family, society, and peers (Xenos & Smith, 2001). As adults, individuals behave, consciously and unconsciously, in large part based on those interactions. This section review studies addressing attitudes towards victims of sexual violence.

A 2001 study by Xenos and Smith examined at Australian adolescents' and young adults' attitudes towards victims of sexual assault. A brief questionnaire was administered to 608 secondary ( $n = 291$ ) and university ( $n = 317$ ) students in the Melbourne area. The participants were male and female students ranging in age from 15.91 years to 24.25 years. Participation was voluntary. The sample of secondary students consisted of 169 males and 122 females, and the university sample 131 males and 186 females. The demographic distribution of the participants mirrored the population of the Melbourne area.

The data collection instrument was a brief, anonymous, self-administered questionnaire booklet comprising three parts. The first questionnaire was the Attitudes Towards Rape Victims Scale (ARVS). The scale was developed to quantify favorable and unfavorable attitudes towards victims of sexually violent behaviors. The 25-item scale rated responses on a 5-point scale to comprise a total attitude score. Higher scores represented negative attitudes towards victims. This scale has been used repeatedly over time to measure attitudes of participants towards victims of sexual violence (Zenos & Smith, 2001).

The second questionnaire in the Zenos and Smith (2001) study utilized the revised Attitudes Towards Women Scale (ATWS). The ATWS assesses attitudes towards the rights and roles of women in society. The 21 items rated those attitudes on a 7-point scale, with higher scores reflecting traditional or conservative attitudes towards women. The third measure was comprised of three sexual coercion vignettes adapted from Muehlenhard (1988) and Giacomassi, and Dull (1986).

The vignettes portrayed a man and a woman involved in a variety of dating situations. The scenarios manipulated the length and intimacy of the pairs and the females' response to the males' suggestive remarks. The male displayed a consistent level of sexual aggression during all three scenarios. After reading each scenario, participants were asked to rate the degree of responsibility they attributed to both the male and the female for the outcome on a 10-point scale ranging from 0 = *very acceptable* to 10 = *very unacceptable* (Xenos & Smith, 2001).

Four factors were identified from the 25-item ARVS, with a multivariate analysis of covariance (MANCOVA) to examine the differences between males and females and

between secondary and university students. Both the main effects of gender, multivariate  $F(1, 511) = 43.44, p < .001$ , and educational level, multivariate  $F(1, 411) = 15.04, p < .001$ , as well as the interaction, multivariate  $F(1, 511) = 2.96, p < .05$ , were significant. Univariate tests showed that the mean ATRVS scores were significantly higher for males than females. Compared to females, males were less likely to believe a woman's claims of rape,  $F(1, 509) = 37.69, p < .000$ . Men were more likely to attribute responsibility to the victim for the occurrence of rape,  $F(1, 509) = 42.77, p < .000$ . Men were also more likely to attribute blame to the victim for the rape,  $F(1, 509) = 10.26, p < .001$ ; and more likely to perceive the victim as deserving of the suffering associated with rape,  $F(1, 509) = 52.80, p < .000$  (Xenos & Smith, 2001).

Univariate tests also showed that ATRVS scores were significantly higher for secondary school students. When gender was held constant, both male secondary students,  $F(1, 509) = 9.37, p < .002$ , and female secondary students,  $F(1, 509) = 7.58, p < .006$ , were significantly more skeptical of a rape claim than were their respective university peers. A substantial proportion of both sets of student scored above the median (12.96) on the ATWS, indicating conservative and traditional attitudes towards women. A two-way (gender by educational level) ANCOVA of respondents scores on the ATWS revealed a significant main effect of gender,  $F(1, 602) = 198.57, p < .001$ ; and educational level,  $F(1, 602) = 19.27, p < .001$  (Zenos & Smith, 2001).

In the analysis of the scenarios, univariate tests showed that, compared to female students, male students attributed significantly more responsibility for the rape to the female subject across all scenarios: Scenario 1,  $F(1, 603) = 6.28, p < .002$ ; Scenario 2,  $F(1, 603) = 10.19, p < .001$ ; Scenario 3,  $F(1, 603) = 10.70, p < .001$ . Compared to male

students, female students attributed significantly more responsibility for the rape to the male subject across all scenarios: Scenario 1,  $F(91,603) = 11.42, p < .05$ ; Scenario 2,  $F(1,603) = 16.63, p < .001$ ; Scenario 3,  $F(1,603) = 20.37, p < .001$ . With respect to educational level, univariate analysis showed that secondary students compared to university students attributed significantly more responsibility for the rape to the female across all scenarios: Scenario 1,  $F(1, 603) = 10.1, p < .05$ ; Scenario 2,  $F(1,603) = 20.50, p < .001$ ; Scenario 3,  $F(1, 601) = 15.62, p < .001$  (Zenos & Smith, 2001).

The results of the Xenos and Smith (2001) study demonstrated that a significant proportion of the students blamed the victim in the scenarios for the rape and had unfavorable attitudes towards the victims. Negative stereotypes were related to conservative and traditional beliefs about women's social role. Gender and educational level differences regarding rape victims were also found. With regard to the current study, attitudes of nurses towards women victims were explored, as well as the critical factors that may influence those attitudes.

Anderson and Quinn (2008) examined United Kingdom (UK) medical students' attitudes towards rape victims. The authors hypothesized that male respondents would view rape victims more negatively than female respondents would, and that male victims would be viewed more negatively than female victims would. The study included 240 UK medical students randomly selected from the University of Birmingham Medical School. The sample was evenly distributed between male and female participants. Participants completed the ARVS questionnaire. Two questions were omitted because of lack of suitability to a male victim scenario.

With the 23-item ARVS, Anderson and Quinn (2008) determined a summed score; higher scores represented more negative attitudes towards victims. Half of the participants received a female victim scenario, and the other half received a male victim scenario. The statements were the same for both scenarios except for victim gender.

A two-factor between-subjects analysis of variance (ANOVA) was conducted on the ARVS to test the hypotheses. A significant main effect was found for participant gender on the ARVS scores ( $F = 20.45$ ,  $df = 1, 236$ ,  $p = .000$ ; partial  $\eta^2 = 0.080$ ). As predicted, males ( $M = 56.16$ ,  $SD = 10.31$ ) exhibited a significantly more negative attitude towards rape victims than females ( $M = 49.96$ ,  $SD = 11.70$ ). A second main effect was observed for gender of the rape victim ( $F = 18.41$ ,  $df = 1, 236$ ,  $p = .000$ ; partial  $\eta^2 = 0.072$ ). Attitudes towards male rape victims ( $M = 56.00$ ,  $SD = 10.35$ ) were significantly more negative than attitudes towards female victims ( $M = 50.12$ ,  $SD = 11.74$ ). No significant interaction between gender of participant and gender of victim was observed ( $F = 2.27$ ,  $p = ns$ ). Thus, both hypotheses were supported (Anderson & Quinn, 2008).

The Anderson and Quinn (2008) study demonstrated significant differences in attitudes toward rape victims based on gender of the participants and gender of the victims. Misconceptions related to sexual violence in medical students should be addressed by inclusion of education related to sexual violence and future research that evaluates its effectiveness. With regard to attitudes toward rape victims and gender, the researcher's exhaustive literature search revealed no studies that addressed this subject in nurses. The present study may add to the significantly sparse body of knowledge regarding this topic.



Frese, Moya, and Megias (2004) conducted a study on judgments of rape scenarios with 182 undergraduate psychology students in Spain. The sample was evenly distributed between men and women. The participants were asked to make four judgments (victim responsibility, perpetrator responsibility, intensity of trauma, and likelihood to report the crime to the police) about each of three rape scenarios (date rape, marital rape, and stranger rape). The study investigated the interactions between Rape Myth Acceptance (RMA), developed by Burt (1980) and characteristics of a rape situation on rape perception.

The RMA, which is widely used to assess attitudes toward rape, consists of 19 statements that involve prevalent myths about rape. A 7-point Likert style rating scale is summed to obtain a RMA score. Higher scores indicate lower acceptance of rape myths and lower scores indicate high acceptance of rape myths. Three short vignettes were developed for the study and were labeled according to the relationship of the perpetrator to the victim (Frese et al., 2004).

Results of the study demonstrated no significant differences between men ( $M = 100.86$ ,  $SD = 10.1$ ) and women ( $M = 99.51$ ,  $SD = 8$ ) in attitudes toward rape,  $F(1, 180) = .92$ ,  $p > .30$ . Separate  $2 \times 2 \times 3$  ANOVAs were performed for each of the four questions. The independent variables were RMA, gender, and type of rape, with the first two factors manipulated between participants and the last one manipulated within participants. When victim responsibility attributions were addressed, a significant main effect was found for RMA:  $F(1, 177) = 11.89$ ,  $p < .01$ , for type of rape;  $F(2, 354) = 239.75$ ,  $p < .01$ ; but not for gender. High RMA participants (indicated by lower scores) attributed more

responsibility to the victim ( $M = 1.5$ ) than low RMA participants ( $M = 1.9$ ) (Frese et al., 2004).

In the Frese et al. (2004) study, a significant interaction between type of rape and RMA was also found,  $F(2, 354) = 6.22, p < .01$ . A significant main effect was found in analysis of perpetrator responsibility only when type of rape was considered. Post hoc LSD tests revealed that participants judged the assailant significantly more responsible in the stranger rape situation ( $M = 5.0$ ) than in the acquaintance rape ( $M = 4.6$ ) and the marital rape situations ( $M = 4.8$ ). Estimation of victim trauma showed a significant main effect for RMA,  $F(1, 177) = 12.3, p < .01$ , indicating that participants with high RMA ( $M = 4.6$ ) judged the trauma of rape as less severe than participants with low RMA ( $M = 4.8$ ). Analysis of the probability that participants would recommend that the woman report the incident to the police resulted in a significant main effect for RMA,  $F(1, 178) = 16.61, p < .01$ , indicating that participants with high RMA were less likely to recommend the report to police ( $M = 4.3$ ) than participants with low RMA ( $M = 4.6$ ). The main effect for type of rape was also significant.

The overall results of Frese et al. (2008) indicated the importance of RMA and situational factors in rape attribution. Victim blame was highest in the acquaintance rape situation, and perpetrator blame was highest in the stranger rape situation. The attribution of blame especially to the victims can add to the trauma of the event and influence the possibility of their not reporting the rape to the authorities. Understanding how RMA influences blame attribution can help to mediate the effects. With regard to the present study, findings may add to the knowledge about nurses' attribution of blame in sexual violence situations.

In a 2010 study, Talbot, Neill, and Rankin explored the rape accepting attitudes of university undergraduate students. The study was conducted to answer the following three questions: (a) What are the differences in rape accepting attitudes in men as compared to women? (b) What are the differences in rape accepting attitudes in individuals who subscribe to more traditional or conservative gender roles as compared to individuals who subscribe to more liberal gender roles? (c) What are the differences in rape accepting attitudes in individuals who personally know a survivor of sexual violence as compared to those individuals who do not know a survivor of sexual violence?

A cross-sectional design utilizing descriptive surveys available on line for 20 days was used by Talbot et al. (2010) for data collection. The two surveys were the College Date Rape Attitude Survey (CDRAS) and the Attitudes Towards Women Scale (AWS). Participants were students over the age of 18 who were attending a university in the Pacific Northwest. Eight thousand surveys were initially mailed, with data collected from 1,602 participants who completed both surveys (response rate 20.2%). The low response rate was considered a limitation of the study.

CDRAS scores for male participants were compared with female participants. For the first question, What are the differences in rape accepting attitudes in men as compared to women? male respondents ( $M = 4.03$ ,  $SD = 0.45$ ,  $p < .001$ ) were significantly more likely than female participants ( $M = 4.25$ ,  $SD = 0.40$ ,  $p < .001$ ) to have rape accepting attitudes. In the CDRAS, higher scores indicated more desirable, antirape attitudes (Talbot et al., 2010).

A Pearson's correlation analysis was used to answer the second question, What are the differences in rape accepting attitudes in individuals who subscribe to more

traditional or conservative gender roles as compared to individuals who subscribe to more liberal gender roles? The mean CDRAS score was compared to the mean AWS score. The total score on the AWS ranges from 0 (most traditional conservative attitudes) to 45 (most liberal attitude). The results,  $r = 0.561$ ;  $p < .001$ ,  $n = 1602$ , indicated a positive correlation between the mean CDRAS score and the mean AWS score. This correlation indicates that respondents who were more liberal in their role beliefs were also less accepting of rape myths and had attitudes that were less accepting of rape. The opposite was true for those who were more conservative in their beliefs (Talbot et al., 2010).

The final question was the following: What are the differences in rape accepting attitudes in individuals who personally know a survivor of sexual violence as compared to those individuals who do not know a survivor of sexual violence? Responses were addressed with a  $t$  test assuming uneven variances. The results indicated that respondents who personally knew a survivor of sexual violence ( $M = 4.03$ ,  $SD = 0.45$ ,  $p < .001$ ) were less likely to have rape accepting attitudes than those respondents who did not personally know a survivor ( $M = 4.25$ ,  $SD = 0.40$ ,  $p < .001$ ). Sexual violence is perpetuated by rape myth acceptance and rape accepting attitudes (Talbot et al., 2010).

The study by Talbot et al. (2010) demonstrated that rape myth and rape accepting attitudes exist. Multiple factors can influence them in a student population. The present study may help to identify the critical factors, such as rape myth and rape accepting attitudes, which influence nurses' overall attitudes towards victims of sexual violence. Findings may contribute to more effective education and training.

In summary, this section reviewed the relevant literature on attitudes towards victims of sexual violence. Many studies used college students for their large samples

(Frese et al., 2004; Talbot et al., 2010), due to accessibility and the relative high incidence of sexual violence in student populations. Smaller studies explored attitudes of medical students (Anderson & Quinn, 2008) and in some cases secondary students, as in Zenos and Smith (2001). The sparse literature related to nurses indicates a great need for research with this population. The current study may help to fill this gap.

### **Experiential Context**

The researcher has been a registered nurse for almost 34 years. During that time, she has worked in a variety of areas of nursing, including critical care, emergency room, public health, and women's health as a family nurse practitioner. She has encountered many individuals who were victims of violence, especially sexual violence. Because of her experiences, she eventually became a SANE and testified as an expert witness in multiple cases of sexual violence. As an educator, she includes in curricula the topic of care of these patients and identification of those at risk.

In the researcher's personal life, she has supported friends and family members who have gone through devastating sexual violence experiences. She has witnessed the care provided from differing viewpoints, both patients and nurses. As a grounded theory researcher, she chose to utilize a constructivist approach in which her knowledge and experience would assist her in understanding the responses of the participants and how their meanings are constructed.

The researcher sought to clarify the influences of her experiences on her interpretations. Thus, she actively journaled throughout the process of data analysis and eventual theory formation. After each interview and review of the recordings, she purposefully debriefed and documented her feelings and interpretations of the

discussions. Descriptions of how “right” or “wrong” the participants’ responses felt to her based on her experience were included. As themes emerged, journaling the process and identifying how her experiences might have influenced the decisions she made allowed her to describe the process. Rather than putting aside her feelings, she carefully journaled and recorded her feelings. This process allowed her to document where those feelings fit into the analysis of the data.

### **Chapter Summary**

Sexual violence is a traumatic event that has physical, psychological, financial, and spiritual implications for the victims, their friends and family, and the community. The prevalence of this phenomenon worldwide is disturbing, and not enough steps have been taken to care properly for victims of sexual violence. In the review of the literature, the researcher demonstrated the need for further exploration of the topic, specifically regarding the care provided by nurses and their attitudes toward the traumatic event and the victims. Studies reviewed supported the significance of the problem because of its the effects on victims’ health, the lack of protocols to identify those at risk, and rape accepting attitudes documented.

## **CHAPTER THREE**

### **METHODS**

The purpose of the study was to explore the process that nurses use to manage the care of patients who are victims of sexual violence. From the findings, additionally the purpose was to develop a theory to describe the critical influences that guide that process. A qualitative, grounded theory approach was used. According to Charmaz (2010), “grounded theory methods consist of systematic yet flexible guidelines for collecting and analyzing qualitative data to construct theories grounded in the data” (p. 2). This qualitative study was guided by the grounded theory tradition. This section discusses the methods.

#### **Research Design**

Grounded theory methods were developed by sociologists Barney M. Glaser and Anselm L. Strauss in the 1960s. Glaser, who was grounded in quantitative methods, and Strauss, who was grounded in qualitative methods, collaborated on studies of dying patients in the hospital. With their team, the researchers observed how dying occurred and how patients and medical professionals handled the process. During the construction of their analysis, the researchers developed methodologies that social scientists could use to study many other topics (Charmaz, 2010).

Construction of abstract theoretical explanations of social processes and the development of theories were of particular interest to both Glaser and Strauss. A shared interest in studying social or psychological processes within a social setting or a particular interest brought these two researchers together to develop and define grounded theory as a valid qualitative research approach. They defined the components of the

process as the simultaneous collection and analysis of data, the construction of analytic codes and categories from data not preconceived, deduced hypotheses, utilization of the constant comparative method, and advancement of theory during each step (Charmaz, 2010).

Glaser and Strauss eventually moved in divergent directions, Strauss towards verification of the method and, with Juliet Corbin, stressing the use of technical procedures rather than the earlier comparative methods. Glaser's criticism of the developing theory was that the prescribed process forced data and analysis into preconceived categories, which violated one of the basic tenants of the original theory (Glaser, 2002). By 1990, grounded theory had gained acceptance from quantitative researchers for its rigor and, ironically, for its positivist assumptions in descriptions of phenomena (Charmaz, 2010).

Over the past decade, a growing number of scholars have advocated moving grounded theory away from the positivism in Glaser, Strauss, and Corbin's versions. Viewing the process through a symbolic interactionism lens reminds the researcher that interactions are dynamic and that interpretive and meanings emerge and change. How individuals and groups give meaning to their lives and how they interpret experiences influence their actions, including, with reference to the present study, how they care for patients. Identification of those meanings may lead to theory development, which is the goal of grounded theory (Charmaz, 2014).

The grounded theory method provided the framework for this research. It involved the systematic collection and ongoing analysis of data, from which theory inductively emerges (Charmaz, 2010). In this study, construction of a theoretical



explanation of the process used by nurses when caring for victims of sexual violence was a major focus of the researcher. Due to a dearth of evidence related to nurses' experiences and processes in caring for victims of sexual violence, and the applicability of the grounded theory method to explicate the process, the researcher chose this method of scientific inquiry. The voice of the nurse without proper training who cares for a patient who has experienced such a deeply personal traumatic event has not been heard before. This study illuminated the processes that nurses use to decide how to care for these patients and to the development of a theory that could inform nursing education and practice.

### **Sample and Setting**

Theoretical sampling was used for this study. Three different geographic locations were planned to obtain the sample with two different groups of RNs in Florida, Alaska, and Pennsylvania for comparison for geographical variability. However, after multiple attempts to recruit in Alaska and Florida were not successful, a decision was made to limit the study to the state of Pennsylvania. Thus, emergency room nurses in two different hospitals in a Pennsylvania urban area were recruited.

Phase 1 participants consisted of RNs with no specialized training; Phase 2 participants consisted of RNs with specialized training who were considered experts in the field of sexual violence. Phase 1 was designated as the individual interview group participants (IIG). The group consisted of 13 emergency room nurses. Saturation of concepts was achieved after nine interviews. Four more interviews were completed to assure that no further theoretical concepts would emerge.

Phase 2 was designated as the Focus Group (FG) participants and consisted of five SANEs who were part of a Sexual Assault Response Team in a different region of the state. These RNs had completed specialized training in the care of victims of sexual violence and were actively caring for patients who experienced sexual violence within the last 5 years. The purpose of the focus group was to ensure confirmability of the individual interviews. The same initial question was asked of both groups: “What is it like to take care of patients who are victims of sexual violence?”

### **Access and Recruitment**

Approval to modify the settings was given by the Barry University Institutional Review Board (IRB). After final approval by the IRB was received (Appendix A), the researcher created the informed consent forms for both interview and focus group participants (Appendix B). She then made a formal request to the chief nursing officer or director of nursing at various hospitals in an urban Pennsylvania area for approval to contact nurses who worked in their emergency departments (Appendix C). Multiple communications via phone and email were attempted, with no response.

Contact with the charge nurses of two hospitals was made by the researcher using professional recommendations. Access was allowed, and flyers for recruitment of participants (Appendix D) were posted in recommended high visibility areas of the emergency departments. After the researcher’s consultation with a SANE working in one institution, a visit to the clinical site was arranged. The researcher was allowed to spend time in the Emergency Room (ER), which allowed the nurses to participate at their convenience if they desired.

With this method, the researcher conducted purposeful sampling, and a total of 12 participants from that institution were recruited. All of the volunteers met the inclusion criteria (Appendix D). Individual interviews were conducted in a private room within the clinical area, and participants completed the consent forms (Appendix B). One additional participant was recruited after multiple phone calls and emails to two other institutions. The nurses in this group were members of the Phase 1 IIG.

Following data collection and transcriptions of the individual interview sessions, recruitment for the FG participants was conducted. During a professional conference, the researcher made contact with the speaker who was the coordinator of a SANE program in a neighboring region of Pennsylvania. SANEs are considered experts in the care of persons who are victims of sexual violence. After the researcher provided a copy of the FG consent form for reference (Appendix B), five participants volunteered. All participants met the criteria for inclusion (Appendix D). The focus group was conducted in a location chosen by the participants.

### **Inclusion Criteria**

For Phase 1 participants, the inclusion criteria included the following factors. They must be licensed RNs with 2 or more years' experience working in an emergency department, English speaking, over age 18, no specialized training in caring for victims of sexual violence, and at least one instance of caring for a victim of sexual violence as an RN. For Phase 2 participants, the inclusion criteria included the following factors. They must be licensed RNs with 2 or more years' experience working in the field of sexual violence, completion of a specialized training program related to the field, English speaking, over the age of 18, and direct care of victims sometime during the last 5 years.

### **Exclusion Criteria**

Exclusion criteria for Phase 1 participants included the following factors. They were nurses who were not licensed RNs, RNs with less than 2 years' experience in the emergency department, attendance at a specialized training for the care of victims of sexual violence, non-English speaking, under the age of 18, and no experience caring for victims of sexual violence as an RN. Exclusion criteria for Phase 2 participants included the same factors as for Phase 1 participants with one additional factor, the exclusion of RNs who completed specialized training in the care of victims of sexual violence but did not provide direct care to victims during the last 5 years.

### **Ethical Considerations/Protection of Human Subjects**

Prior to the recruitment of participants, application to and approval by the Barry University IRB was received (Appendix A). Approval for modification of the setting and sample was also received (Appendix A).

The researcher recognized that the topic of sexual violence is a sensitive area and thus used a careful, thoughtful process to protect the participants and their patients. Pseudonyms were chosen by the participants, and all references to the participants in this study used those names. No individual identifying information was provided during the reporting, discussion, or writing of the results. No identifying information will be used in any further products of this research. The institutions used for access to participants and their locations were identified only with broad characteristics to protect identification of the participants. The specific locations of the hospitals and the SART were not used to protect the confidentiality of the institutions and participants.

At the conclusion of the first interview, Phase 1 participants were given a list of counseling resources, which were confidential organizations they could contact without cost to discuss any feelings that may have emerged during discussion of this subject (Appendix E). A similar list was distributed at the focus group meeting for the Phase 2 participants. The list included contact information for the National Sexual Assault Hotline that is administered by RAINN, the Rape, Abuse and Incest National Network. This organization operates a hotline that connects callers to the nearest RAINN member center. The caller's phone number is not retained, so the call is considered anonymous. The caller has the choice to share personally identifying information or not. In addition, contact information for state and local rape crisis centers was provided to participants to use if they wish.

Confidentiality during the study and beyond was maintained by the researcher. For the IIG participants, the researcher requested confidentiality. Because the FG participants met together, at the start of the meeting, the researcher also requested that confidentiality should be maintained. However, participants in either group may have chosen to discuss the information with others, which was beyond the researcher's control.

As an alternative to face-to-face interviews with individual participants, the researcher set up a separate and unique Skype account for the duration of the study. It is not possible to delete a Skype account after it has been created, but all personal information contained in the profile can be removed. This provision ensures that other people cannot search for the account once the study has been completed. However, none of the participants chose to use Skype for their interviews.

### **Data Collection Procedures**

Individual interviews were conducted in a face-to-face setting per the preference of the participants. The focus group interview was conducted face-to-face and was located in a location of the participants' choice. All individual interviews and the focus group meeting were audiotaped with the full knowledge and permission of the participants. The researcher alone transcribed all interviews and meeting dialogue.

Prior to entering the interview rooms, participants in Phase 1, the IIG, were screened for inclusion and exclusion criteria by the researcher and were given an overview of the process. Initial interview time ranged from 20 to 60 minutes, which included confirmation of the inclusion and exclusion criteria, a review of the study, a choice of pseudonym, review and signing of the consent form (Appendix B), and collection of demographic data (Appendix F). An audiotaped in-depth individual guided interview was conducted with all participants with their full knowledge and consent. All paper records and the audiorecorder were kept in the possession of the researcher at all times.

For the IIG participants, a second interview was offered for member checking and review of the transcripts of the initial interview for accuracy and clarification as needed. All participants in this group refused the offer of a second interview. Instead, email copies of the transcripts were sent to each participant at their supplied email addresses. Participants agreed to respond within 1 week with questions or concerns. If they did not respond within this time, it was agreed with the researcher that they had no changes to the transcribed interview. None of the IIG participants responded within the timeframe, and it was assumed as agreed that the transcripts were acceptable. An Amazon \$10.00 gift

certificate was then emailed to all participants in appreciation of their participation, as agreed upon in the consent form.

To further protect participants, during the interviews they were reminded that they had the right to discontinue the interview, stop the recording, withdraw consent for some or all of the study, or request that parts of the interactions be excluded from the analysis and written report. At the conclusion of the first interview, participants were thanked for their participation and asked if they had any questions or concerns about the study. They were given copies of the resource information (Appendix E) to keep.

Phase 2 Focus Group (FG) participants were recruited after the Phase 1 interviews were completed. This timeframe was necessary to allow for coding of the interview data and development of categories so that FG participants could participate in confirmability of the categories. The FG participants were screened for inclusion and exclusion criteria by the researcher and were given an overview of the process. Prior to the start of the meeting, guidelines for participation in the meeting were reviewed with the group (Appendix G). The guidelines included respectful group participation and a request for confidentiality as well as general group process guidelines. Consent (Appendix B) and demographic forms (Appendix F) were completed prior to the start of the meeting. Each participant chose and agreed to use a pseudonym during the meeting. The group was informed that the discussion was being audiorecorded and the times the meeting began and ended.

During the focus group meeting, the group participants were reminded that they had the right to discontinue participation, stop the recording, withdraw consent for some or all of the study, or request that parts of the interactions be excluded from the analysis

and written report. At the conclusion of the focus group meeting, the participants were thanked for their participation and asked if they had any questions or concerns about the study. Resource information (Appendix E) was given to the participants and reviewed by the researcher. A copy of the focus group transcripts was sent to each participant for member checking. Participants were asked to contact the researcher within a week after receiving the transcripts if there were any errors or questions. As described above for the IIG, no communication from the FG participants took place, and the researcher assumed they had no changes. A \$10.00 gift certificate was sent by email per their request to all FG participants in appreciation of their participation.

### **Interview Questions**

Interview questions are meant to explore, not interrogate, and are used to foster participants' reflections of a topic (Charmaz, 2014). A symbolic interactionist emphasis on learning about the participants' views, experienced events, and actions was used to develop questions that assisted in the exploration of the process (Charmaz, 2010). The questions supported further exploration of the topic as needed during the interviews and were open-ended to allow free exploration by participants (Appendix H). Further questions were developed during the data collection and analysis phases, which took place concurrently, conforming to the grounded theory process described by Charmaz (2010).

The initial request for both the IIG and FG prompted the participants to explore their individual experiences related to the topic of study: "Please tell me what it is like to care for patients who are victims of sexual violence." Intermediate questions were used to gather specific data as the interviews progressed; these questions assisted in the



development of the theoretical framework. At the end of the interviews, all participants were asked if they wanted to add anything else.

In the FG group, the participants were asked to answer the question from the perspective of their experience prior to receiving advanced training. Intermediate questions were used to support the momentum of the group interaction. Categories that emerged from the coding of the individual interviews were reviewed with the focus group participants for confirmability.

### **Demographic Data**

A researcher-designed demographic questionnaire was used to gain information about the participants (Appendix F). The information described the participants and included age, gender, marital status, race, and ethnicity. Information about educational level, years in nursing and the emergency department, and the amount of times they cared for victims of sexual violence were also asked. Responses assured that the participants had shared experiences. This factor is integral to the grounded theory method of inquiry (Charmaz, 2010). A final question asked whether participants knew anyone in their personal life who experienced sexual violence. Responses informed the researcher about how meanings are constructed for these participants.

### **Data Analysis**

The purpose of analysis of data in this study was not to describe the phenomenon but to develop a theory. Following the process developed by Glaser and Strauss (1965) and modified by Charmaz (2010), this researcher gained flexibility and engaged in a constant comparative process. Figure 1 demonstrates the procedure that was utilized. It was adapted from Charmaz's (2010) description of the grounded theory process.

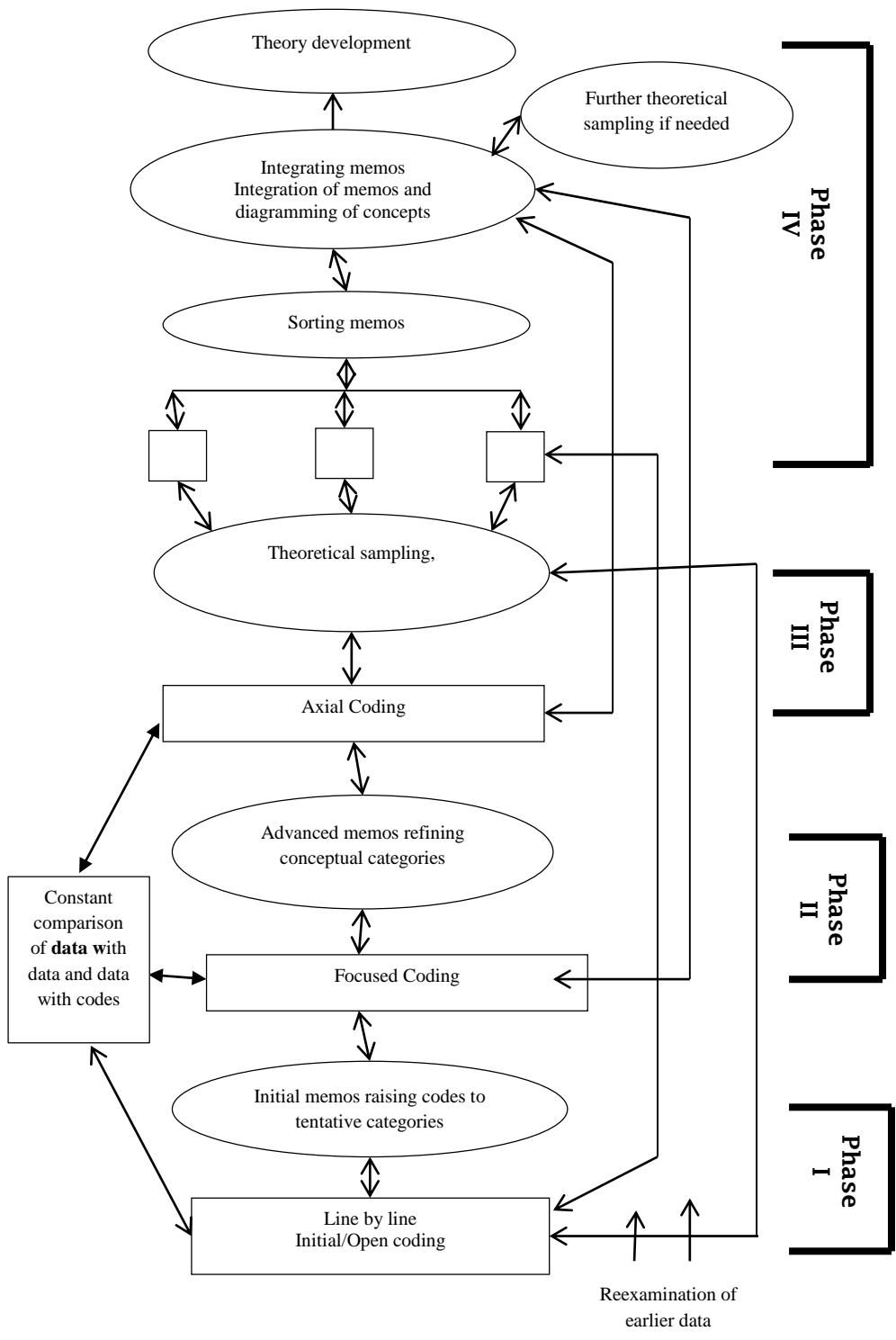


Figure 1. Grounded theory method. Adapted by D. Whalen (2016) from *Constructing grounded theory: A practical guide through qualitative analysis*, by K. Charmaz, 2010, p.

The first phase of analysis took place after the first interview had been transcribed. The researcher read the transcript for a general thematic analysis. Initial/open coding was performed using a line-by-line process. The researcher remained open to exploring whatever ideas came from the data, looking at all the possibilities while ideas emerged. “Initial codes were provisional, comparative, and grounded in the data” (Charmaz, 2010, p. 48).

The data from each participant were then compared internally and with data from the interviews with every other participant. Data were coded as actions to avoid early theoretical leaps (Charmaz, 2010). During initial coding, gaps were located to facilitate the process of further data collection when needed. The researcher’s initial memoing elevated codes to tentative categories. Table 1 illustrates the process used in the open coding step, in which the researcher uses the words of one individual interview group member, **Asystole**.

Focused coding was the second major phase of the analysis. In this phase, the most significant or frequent earlier codes were used by the researcher to sift through large amounts of data and make decisions about which initial codes made the most analytic sense. In this phase, the data were categorized completely (Charmaz, 2012). This process was not always linear, because further data required rethinking of the earlier data to render the codes more explicit. The researcher repeatedly reviewed and rereviewed previous data for words, phrases, and concepts that may have been missed or initially thought of as unimportant.

Table 1

*Open Coding*

Participant	Narrative	Open Coding
<b>Asystole</b>		
3/21/15	I wasn't really taught that in school . . . we take psychology classes sociology classes . . . they teach you basically. . . get the best for the patient. Not that I have been necessarily a victim of sexual assault . . . been a patient. So just drawing on my experiences as a patient how I would like to be treated as a patient how I would like to be talked to as a patient for somebody to come in stand over me and talk quickly would I like that, no.	Wasn't taught Psychology classes, Teach you basically For the patient Not a victim, have been a patient Drew on experience How I would like to be treated  Personally directed care, Attempting
Field Notes	Met in her office (her choice) interrupted once. Appeared to refocus easily.	
Memo	Talked a long time, thoughtful. Interested, working out how to explain.	

The focused coding phase of the grounded theory coding process is active, and the researcher acted on the data during analysis, allowing concepts to emerge. At this time, her advanced memos helped refine conceptual categories that emerged through the constant comparative process, as illustrated in Table 2. This table reflects an example from **Beth** that demonstrates the way in which the data were recombined with subcategories that supported the emergence of the conceptual categories, *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*.

Table 2

*Focused Coding*

Participant	Narrative	Focused Coding
<b>Beth</b>		
3/21/15	Like the first people to come in actually nobody really wants to take care of them . . . there for hours . . . then usually if they're done with the SANE exam they go to another room and have a different nurse . . . kind of tough for patients.	Avoiding/distancing/passing Along
	How I want to be treated is kind of how I treat them . . .if I was a victim what would I want to have happen to me and how would I like to be treated and how would I like to be looked at . . . I kind of go with my gut.	Attempting/presumptive care/personally directed care
	It's stressful like they're emotional . . . they're not thinking rationally most of the time . . . you never know what's going on in their mind . . . I just try to deal with all patients with respect . . . keep an open mind . . . you kinda have to go in there and let all your judgments go away.	Analyzing/reflecting/processing
	Now I'm more confident, I kind of go in there and be direct matter-of-fact, use simple terms . . . take a step back . . . spend more time with them . . . little more leniency . . . they're not processing as well as they could.	Adjusting/situational/revising
Field Notes	Very thoughtful, pausing to reflect. Focus is on emotions, takes a personal perspective.	
Memo	Exploring her growth and how she's changed over time. Has insight into the meaning she has constructed.	

The third phase of the process was axial coding. During this step, categories were redefined and reassembled to relate to subcategories and specify the dimensions of the category. Whereas initial coding fractured the data information, axial coding helped to recombine it with meaning. Theoretical sampling was used as new categories and concepts emerged from the constant comparison of data. Re-examination of earlier data was ongoing.

In the fourth phase, certain categories were accepted as theoretical concepts and further concepts were refined. Memos were sorted. Then they were integrated into a diagram of the concepts. See Figure 1 for all phases.

## **Research Rigor**

### **Trustworthiness**

Trustworthiness deals with the researcher's ability to convince the reader that the data and findings of the research are valid representations of the people and the circumstances studied (Bloomberg & Volpe, 2008). Quantitative researchers use the terms *validity* and *reliability* to ensure research rigor (Creswell, 2007). In qualitative research, trustworthiness is assured utilizing credibility, dependability, transferability, and dependability as the criteria.

### **Credibility**

“Credibility involves generating confidence in the truth value of the findings of qualitative research “(Barusch, Gringeri, & George, 2011, p. 12). The desired outcome is that the “participants’ perceptions match up with the researchers’ portrayal of them” (Bloomberg & Volpe, 2008, p. 11). In this study, credibility was assured by member

checking and peer debriefing. All participants had the opportunity to review the transcripts of their interviews for content and accuracy. As described above, at their request, the participants agreed to contact the researcher within 1 week after receiving the transcripts to make suggestions or clarify meanings. No contacts were made, and the data as transcribed were used in analysis. Peer debriefing took place by the researcher asking three colleagues in the field of sexual violence to review field notes, memos, and categories that were developed during the process. With this examination, discussions took place between the researcher and colleagues regarding examining assumptions and possible alternate ways of looking at the data. These discussions helped to refine the categories and establish greater credibility.

### **Dependability**

Dependability refers to the reader's tracking the processes used to collect and interpret the data (Bloomberg & Volpe, 2008). This criterion parallels reliability in quantitative research. For dependability in the present study, the researcher engaged in careful and extensive journaling and memoing that thoroughly explained how the data were collected and analyzed.

### **Transferability**

In qualitative research, findings are not expected to be generalizable to all other settings. The goal is to enable readers to decide how well the study can be transferable for similar processes in their own settings (Bloomberg & Volpe, 2008). In this study, rich descriptions of participants' experiences with detailed information regarding context was reported to improve the possibility of transferability.

## **Confirmability**

*Confirmability* is defined by Lincoln and Guba (1985) as “a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest” (p. 325). In qualitative research, neutrality is difficult to achieve and in some cases undesirable. Grounded theory research with a constructivist lens requires that researchers immerse themselves in the process. By doing so, researchers learn about and interpret nuances of meanings and actions that allows for awareness of the emerging nature of the data and the analysis (Charmaz, 2014). Pragmatist foundations encourage the researcher to “construct an interpretive rendering of the worlds we study rather than an external reporting of statements and events” (Charmaz, 2010, p. 184).

Nevertheless, a measure of confirmability is desirable. Throughout this study, utilizing a reflexive journal, the researcher made regular entries to record methodological decisions and the reasons for them. Reflections emerged upon the researcher’s own values and interests as she dealt with the data. In this manner, a clear representation of the content of knowledge construction was documented. In addition, categories that emerged from coding of the individual interviews were reviewed with the focus group participants for confirmability.

## **Chapter Summary**

Caring for patients who are victims of sexual violence can be difficult and stressful to the nurse who is inexperienced with the process. In this chapter, the researcher reviewed the purpose of this qualitative grounded theory study and justification of the grounded theory method to guide the inquiry. In the chapter, the



researcher described the sample and setting, access and recruitment procedures, inclusion and exclusion criteria for both the individual interview and focus groups, and ethical considerations for protection of human subjects. An in-depth description of the data collection procedures and the interview questions followed. The chapter concluded with a description of the purpose of the demographic data collection, an illustration of the procedure that was used for data analysis, and methods that were instituted to meet the criteria for research rigor in a qualitative research study.

## CHAPTER FOUR

### FINDINGS

The purpose of this qualitative grounded theory research was to identify the processes that nurses without specialized training use to manage the care of patients who are victims of sexual violence. For these patients, little training is available to nurses (CDC, 2005; Ledray, 2010). Additionally, the purpose was to generate a theory that describes the process that these nurses use to make decisions and the critical influences that guide that process.

Caring for patients who experience sexual violence requires a thorough understanding of the short- and long-term physiologic, psychological, and psychosexual effects of this traumatic event. The standard nursing curriculum in most academic programs at the undergraduate and graduate level offers inadequate preparation to meet the complex needs of those affected (Aktan et al., 2009). Incidence of sexual violence is high (Black et al., 2011), and long-term negative consequences related to the experience with ineffective posttrauma care by medical providers requires that nurses become better prepared to meet the needs of this population.

The purpose of this chapter is to present the findings of this grounded theory constructivist study of nurses who care for patients who are victims of sexual violence. In this chapter, the researcher provides descriptions and demographic data of the individual interview group participants and focus group participants. Their exemplar quotations are included, with a presentation of the findings coconstructed with participants from the data.

## Overview

The grounded theory approach described by Charmaz (2014) was utilized in this study and provided rich data that led to the construction of the social process of the phenomenon of interest. With intensive interviews, the participants reflected on their relevant experiences in caring for victims of sexual violence in a flexible and supportive environment. The interview method allowed for immediate follow-up of ideas and a coconstruction with participants of the interview conversations (Charmaz, 2014). Glaser (1978) developed theoretical codes that help to iterate the identification of the ensuing theoretical concepts. In this study, the theoretical code “steps” subsumed in Glaser’s coding family “process” helped develop emergence of a core category. The core conceptual category, *Apprehending an Unknown Phenomenon*, evolved organically from the coding process and later was constructed as the social process of interest. The gerund form of apprehension was appropriate in the context of the active process of data analysis. Quotations from participants using their chosen pseudonyms support the development of the category and the subsequent categories within the process. Four categories emerged through refinement of the subcategories of the data, and the examples supported the findings.

During Phase 1 of the data collection process, 13 individual semistructured intensive interviews were conducted with the Individual Interview Group participants. All participants chose their own pseudonyms to protect their identities. The IIG consisted of nurses who worked in emergency departments and had experience caring for patients who were sexually assaulted, but the nurses did not have formalized training in the

process. The pseudonyms were used for the audiotaped sessions and the subsequent transcripts and for the report of the study.

In Phase 2 of data collection, five Sexual Assault Nurse Examiners (SANEs) took part in the focus group (FG). They were considered experts in the field of sexual violence and worked together in an active SANE program. The SANE participants chose their individual pseudonyms for use during the audiotaped session, as well as the subsequent transcripts and for the report of the study. Demographic descriptions of both groups are presented in the sample characteristic sections to follow.

Upon approval from the Barry University IRB (Appendix A), the researcher sent requests for access to emergency department nurses (Appendix C) from multiple institutions in three different states, Alaska, Florida, and Pennsylvania. Numerous requests were made to the institutions in Alaska and Florida but no responses were received. Consequently, a decision was made to focus the recruitment efforts on the Pennsylvania sites, because responses to requests for access were encouraging and the researcher was relocated in that state during the study. A request for modification of the study was submitted to the Barry University IRB. The modification was approved (Appendix A), and the study continued.

Nurses without formalized sexual violence training who worked in emergency departments were purposefully chosen for the IIG, because these nurses most likely cared for patients who were victims of sexual violence. The purpose of the study was to identify the process that untrained nurses use to make decisions regarding how to care for these patients. SANEs who received in-depth formalized training related to the care of

these patients were chosen for the FG as part of the theoretical sampling phase and for assurance of confirmability of the data.

To recruit participants for the IIG, permission was obtained to access nurses who worked in the emergency departments of two inner city hospitals in Pennsylvania. Recruitment flyers were posted in areas accessed frequently by the nurses. Minimal interest in participation was elicited from the flyers alone. The researcher then contacted unit managers, and suggestions for increasing interest were implemented. Word of mouth and referrals were integral to the success of participant recruitment. The researcher made herself available at many times of the day and night to facilitate participation in the study.

A total of 13 emergency department nurses in two of the Pennsylvania hospitals participated in the IIG. All participants were screened and met the study inclusion criteria. Ten participants chose face-to-face interviews and three chose telephone interviews. None of the participants chose to utilize the option of Skype for their interviews.

Data collection for the IIG was conducted with semistructured intensive interviews, which were held in quiet spaces within the emergency departments of the two institutions. The locations were determined based on the preference of the participants. The researcher used open-ended questions developed prior to the study (Appendix H). As the interviews progressed, clarifying and probing questions were added to facilitate the most extensive exploration of the subject. All interviews were audiotaped, and the researcher took notes before, during, and after the interviews as part of the memoing process.

The duration of the interviews varied between 20 and 60 minutes. Prior to audiotaping, the purpose of the study was discussed and the consent form was reviewed and signed by the participants. The researcher pointed out the sensitive nature of the subject and the possibility that the discussion could bring up unexpected or difficult feelings or emotions. The participants were assured that they had full control over their participation in the process, as stated in the consent form, which included their request for cessation of the interview if desired. The participants were also assured that they would receive support and referral to services should they require them as a result of their participation in the study.

A demographic form was completed by each participant, and each chose a pseudonym. All references to the participants during the audiotaped session were made utilizing the chosen pseudonyms. At the conclusion of the interviews, the researcher gave a resource referral sheet to the participants and reviewed it with them. The follow-up procedure was discussed and all paper records were collected and kept in the possession of the researcher at all times.

The audiotapes of the interviews were transcribed by the researcher and sent via email to the participants within 1 week for member checking. The participants were asked to review their transcripts for accuracy and respond within 1 week if they had any questions, concerns, or suggestions. If no contact was made at the end of that timeframe, it was to be assumed that they had no objections. At that point, a \$10.00 Amazon gift certificate was sent electronically to each participant, as discussed during the initial interview and described in the consent form.

Data were obtained through the researcher's extensive memo writing and constant comparison of data with other data and of data with the codes that emerged. A four-phase process was used for ongoing analysis, as depicted in the modified grounded theory process (Figure 1). Data analysis was guided by the grounded theory process developed by Glaser and Strauss and revised by Charmaz (2010). As the researcher utilized a constructivist approach, "priority was placed on the phenomena of interest and data and analysis were created from shared experiences" (Charmaz, 2014, p. 239).

Line-by-line initial coding began the process and resulted in development of a framework in which the analysis would occur. Constant comparison of data with other data and data with codes was used during Phase 1 and Phase 2 of the analysis process (Figure 1). These procedures led to identification of categories that were coconstructed with the participants. A comparison of different participants' accounts regarding the issue combined with a comparison of data from the same participant at different times enabled the researcher to assure that the categories were true to the data.

Saturation of the conceptual categories was achieved after nine interviews with IIG participants, completed during Phase 1 of the data collection process. An additional four interviews failed to elicit any new data or insights. The iterations of the Phase 1 IIG participants led to the coconstructed conceptual categories: *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*.

Refinement of the constructed categories took place in the first two phases of analysis (Figure 1). The third phase of analysis, theoretical sampling, took place with data from the focus group session, which was comprised of five nurses who were certified as SANEs. SANEs are recognized as experts in the field because of their completion of

advanced training in the care of patients who have experienced a sexual assault. Each of the participants was currently an active member of a busy Sexual Assault Response Team (SART) and participated in the forensic examination and comprehensive care of this population.

In this study, theoretical sensitivity was considered. Within the pragmatist paradigm, the researcher recognized that she could not and should not disconnect or minimize her presence in the data collection or analysis process due to contextual knowledge and experience. Bracketing served as a way to identify and address her preconceived ideas and situational biases that occurred throughout the research process. Frequent memoing and extensive field notes helped to elucidate where decisions may have been made within the context of the researcher's experience, and alternate decisions or paths were then considered.

Data were continuously examined, rereviewed, and contemplated. As the research progressed, multiple realities were illuminated, considered, and either adopted or set aside for future examination. Throughout the entire process, categories became clearer and linkages between categories arose. Refinement of the categories led to the elucidation of the basic social process, *Apprehending an Unknown Phenomenon*. The following sections describe the participants of the IIG, who provided the data that contributed to emergence of the theory.

### **Sample Description**

The IIG participants in the study were 13 registered nurses who worked in two emergency departments located in an urban area of Pennsylvania. None of the nurses in this group had formal training in the care of patients who were victims of sexual violence.



The FG participants were five SANEs, all of whom had received formal training in the care of patients who are victims of sexual violence. The nurses were members of an active SART. The focus group findings were used in the theoretical sampling phase and for assurance of confirmability of the categories emerging from the IIG interviews.

### **Demographics**

A demographic data sheet (Appendix F) was completed by all participants. The data for the IIG and the FG participants were calculated (frequencies and percentages) and reviewed separately and compared (Table 3 and Table 4). The age range of both groups was similar, ages 24-54 ( $n = 13$ ) for the IIG and ages 24-50 ( $n = 5$ ) for the FG. Mean age in both groups was 35 years old. The majority of participants in both groups were female, 84.6% ( $n = 11$ ) in the IIG and 80% ( $n = 4$ ) in the FG. The majority of nurses in both groups held at least a bachelor's degree in nursing, 46.2% ( $n = 6$ ) in the IIG and 80% ( $n = 4$ ) in the FG.

The question regarding how many patients with the complaint of sexual assault the nurses cared for was difficult to quantify for most participants in both groups. The responses included ranges and the words "several" or "many." The majority of nurses in the IIG, 77% ( $n = 10$ ) reported 1-6 patients, and the nurses in the FG most often reported "many," 40% ( $n = 2$ ). One nurse in the IIG reported caring for more than 25 but less than 100 patients. In the FG, one participant reported caring for more than 20 patients and another reported caring for more than 200 patients with the complaint. Overall, as expected, the FG nurses reported caring for more patients with the complaint than the IIG nurses did. The FG participants were all SANEs as well as emergency department nurses. Their positions routinely exposed them to more patients with this complaint.

Table 3

*Demographics of the Individual Interview Group (n =13)*

Criteria	No.	%
Age	35	
Mean		
Gender	11	84.6
Female	2	15.4
Male		
Marital Status	8	61.5
Single	5	38.5
Married		
Education		
ADN	2	15.4
Diploma	2	15.4
BSN	6	46.2
MSN or greater	3	23.0
Race		
White non-Hispanic or Latino	11	84.6
Black	1	7.6
Asian	1	7.6
Years as a nurse		
2-5	4	30.8
6-7	1	7.6
8-10	2	15.4
11-14	2	15.4
>15	4	30.8
Number of experiences		
1-6	10	77.0
Many	2	15.4
>25 -<100	1	7.6
Personal experience		
Yes	5	38.4
No	8	61.6

Table 4

*Demographics of the Focus Group (n =5)*

Criteria	No.	%
Age		
Mean	35	
Gender		
Female	4	80.0
Male	1	20.0
Marital Status		
Single	2	40.0
Married	3	60.0
Education		
Diploma	1	20.0
BSN	4	80.0
Race		
White non-Hispanic or Latino	3	60.0
White Hispanic or Latino	1	20.0
Black	1	20.0
Years as a nurse		
2-5	2	40.0
6-7	1	20.0
>15	2	40.0
Number of experiences		
Several	1	20.0
Many	2	40.0
>20	1	20.0
>200	1	20.0
Personal experience		
Yes	5	100
No	0	0

## **Personal Experience**

In comparison of the nurses in the IIG and FG, a difference between the participants emerged relating to personal experience with sexual violence. The question was asked, “Do you know anyone in your personal life who has been a victim of sexual violence? (For example, friend, relative, colleague, self. Please do not specify).” The participants were instructed to avoid disclosing who had been a victim. All of the FG participants reported having personal experience with sexual violence, 100% ( $n = 5$ ), and the majority of IIG participants reported having no experience with sexual violence, 61.6% ( $n = 8$ ).

### **Phase 1: Individual Interview Group Participants**

**April.** April is a 38-year-old married female with a diploma degree in nursing. April is White Non-Hispanic or Latino and identifies with an Eastern European ethnic group. April has been a nurse for 11-14 years and has been an emergency department nurse for 8-10 of those years. April has cared for “many” patients who were victims of sexual violence. April denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Mom.** Mom is a 33-year-old married female with a bachelor’s degree in nursing. Mom is Black and identifies with the African American ethnic group. Mom has been a nurse for 2-5 years and has been an emergency department nurse for 2-5 of those years. Mom has cared for five patients who were victims of sexual violence. Mom denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Daisy.** Daisy is a 37-year-old married female with a diploma degree in nursing. Daisy is Asian and identifies with the Filipino ethnic group. Daisy has been a nurse for

more than 15 years and has been an emergency department nurse for all 15 of those years. Daisy has cared for “many” patients who were victims of sexual violence. Daisy admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Asystole.** Asystole is a 28-year-old single female with an associate degree in nursing. Asystole is White Non-Hispanic or Latino and identifies with no ethnic group. Asystole has been a nurse for 6-7 years and has been an emergency department nurse for 6-7 of those years. Asystole has cared for two patients who were victims of sexual violence. Asystole admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Yellow.** Yellow is a 27-year-old single female with a bachelor’s degree in nursing. Yellow is White Non-Hispanic or Latino and identifies with no ethnic group. Yellow has been a nurse for 2-5 years and has been an emergency department nurse for all of those years. Yellow has cared for one to two patients who were victims of sexual violence. Yellow denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Beth.** Beth is a 26-year-old single female with a master’s degree in nursing. Beth is White Non-Hispanic or Latino and identifies with no ethnic group. Beth has been a nurse for 2-5 years and has been an emergency department nurse for all of those years. Beth has cared for more than five patients who were victims of sexual violence. Beth admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Violet.** Violet is a 42-year-old married female with a bachelor’s degree in nursing. Violet is White Non-Hispanic or Latino and identifies with no ethnic group. Violet has

been a nurse for more than 15 years and has been an emergency department nurse for all of those years. Violet has cared for “many” patients who were victims of sexual violence. Violet denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Mary.** Mary is a 31-year-old single female with an associate degree in nursing. Mary is White Non-Hispanic or Latino and identifies with no ethnic group. Mary has been a nurse for 8-10 years and has been an emergency department nurse for all of those years. Mary has cared for one to five-5 patients who were victims of sexual violence. Mary denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Sunflower.** Sunflower is a 40-year-old married female with a bachelor’s degree in nursing. Sunflower is White Non-Hispanic or Latino and identifies with the Irish ethnic group. Sunflower has been a nurse for more than 15 years and has been an emergency department nurse for all of those years. Sunflower has cared for five patients who were victims of sexual violence. Sunflower admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Frances.** Frances is a 37-year-old single female with a bachelor’s degree in nursing. Frances is White Non-Hispanic or Latino and identifies with the Irish ethnic group. Frances has been a nurse for 11-14 years and has been an emergency department nurse for 6-7 of those years. Frances has cared for “many” patients who were victims of sexual violence. Frances denies any personal experience with victims of sexual violence (e.g., self, friend, family).

**Joe.** Joe is a 24-year-old single male with a bachelor's degree in nursing. Joe is White Non-Hispanic or Latino and identifies with the Irish ethnic group. Joe has been a nurse for 2-5 years and has been an emergency department nurse for all of those years. Joe has cared for three to five patients who were victims of sexual violence. Joe admits to having personal experience with victims of sexual violence (e.g., self, friend, family).

**Jedi.** Jedi is a 54-year-old single male with a doctoral degree in nursing. Jedi is White Non-Hispanic or Latino and identifies with an eastern European ethnic group. Jedi has been a nurse for more than 15 years and has been an emergency department nurse for all of those years. Jedi has cared for more than 25 and less than 100 patients who were victims of sexual violence. Jedi denies having personal experience with victims of sexual violence (e.g., self, friend, family).

**Elizabeth.** Elizabeth is a 34-year-old single female with a master's degree in nursing. Elizabeth is White Non-Hispanic or Latino and identifies with no ethnic group. Elizabeth has been a nurse for 8-10 years and has been an emergency department nurse for all of those years. Elizabeth has cared for three patients who were victims of sexual violence. Elizabeth denies having personal experience with victims of sexual violence (e.g., self, friend, family).

### **Emergent Categories**

Four conceptual categories were constructed from the data to describe the process of interest in this study. These were *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*. In the *Attempting* category two subcategories were constructed, *Presumptive care* and *Personally directed care*. The categories were constructed through the constant comparison process of the data provided in the Phase 1 IIG interviews. The following

excerpts from the intensive interviews illustrate the process in the participants' words. These excerpts contributed to the emergence of the conceptual categories.

### **Avoiding**

In the current study, the category of *Avoiding* was defined as keeping distance from the care of a patient with a complaint of sexual assault, either in a purposeful or unconscious manner. Implicit and explicit examples of avoidance behaviors include classification of sexual assault patients as low priority or a culture within the institution that recommends minimal contact with patients until the "experts" arrive. In some cases, the nurses were specifically instructed to avoid contact with the patients as much as possible until the SANE nurses arrived or the patient was transferred to the Special Victims Unit (SVU). In some cases, the sexual violence patients were classified as low priority, and an assumption was made that limited contact assured that the negative effect of emotional trauma was minimized. Being too busy was a common nurses' excuse for lack of interaction and implied that the other patients with real or obvious conditions needed their care to a greater extent. Sub themes that emerged included *keeping distance and protecting self*.

**April** stated, "That's the hardest part. Like being too busy for them. Being too busy to be there for them."

In her reflection, **Asystole** prioritized potential physical injuries versus emotional trauma prior to performing an assessment:

I did want to make sure that there was no emergent injuries with the patient so I did kind of, I didn't do that much of a hands-on assessment at that time. I did an



assessment from across the room and got my thoughts together and thought how I'd like to approach this patient.

During a follow-up conversation, **Asystole** described her observations of the care provided by other nurses:

I think some other people that I've encountered . . . I've really encountered both spectrums. Some who provide excellent care to the patient and they went above and beyond and made sure that all of the patient's needs were met. And then I've seen other people just shut down and not want to deal with it, not want to process it not, want to have anything to do with the patient. And they almost come off a little bit cold to the patient. In the ER, we compartmentalize because that's the only way we make it through. We see so much tragic issues and situations that there's times that if you don't compartmentalize you're not gonna make it through your shift.

Disconnecting was mentioned by a number of participants as a purposeful protection against the traumatic experiences of their patients affecting their own emotional well-being. **Daisy** reflected on the balance between being available to patients and creating a protective distance:

You know, everybody that comes through the ER they really think that it's the worst day of their life so you know it's kind of helped me be more aware of people's emotions, I guess. In school, they teach you how to be more disconnected but not really disconnected, but you have to distance yourself emotionally from the patient so you're not affected by it but at the same time you have to be present. I don't really know how to explain it.

In an attempt to differentiate between the care provided to patients presenting with more commonly seen diagnoses and those presenting with a complaint of sexual assault, the researcher asked, “What things do you do differently for a person who is having a heart attack versus one who comes in for a sexual assault?” **Elizabeth’s** response initially described her approach as less aggressive but then she expanded on her true meaning:

I think I was less , , , I want to say aggressive but you’re not . . . it doesn’t feel as time sensitive as like I need to do your EKG now, I need to do this now, I need to get your blood now. You try to give them a sense that you’re taking enough time with them, that you’re not rushing them because that would be the last thing that somebody would want to feel like that, like being controlled by somebody else.

**Mary’s** connection with this type of patient appeared to be peripherally supportive and with minimal contact:

We usually care for their injuries, but they’re usually transferred out to the sexual assault center. So if they don’t have any injuries we usually call the police and they come and they take the patient to the special victims’ unit and we have a trained SANE nurse who always helps facilitate those things.

**Mom** described a similar process:

As an ER nurse, sometimes I’m a triage nurse and sometimes I have patients who actually walk in with this complaint. So most of the time when they come in we want to make sure that we move them into a different room, try to talk to them first, and then we call the SANE nurse. Because I’m not a SANE nurse.

**Violet** specifically described the limitations of the role of the nurse and purposely avoided in-depth interaction:

Well, it's hard to ask someone exactly what happened. And sometimes it's hard for them to tell us what happened. In the same part that you want them to tell us what happened, we don't need the whole gory details. Basically were just looking to help them through this situation.

**Yellow** described her frustration when time limitations interfered with her ability to care for the patients who should be in the ER:

I think they need one-on-one attention and I can't give them that in the ER that I'm working in. I barely have time to go in and introduce myself and grab lab work because I'm always, always, busy, and I don't think they should be put in with the regular ER patients. They can't really receive the care that they need in a timely manner. With other patients, my main concern is their physical elements, and with those types of patients it would be more like their emotional state since I can't really do anything. What's been done is already been done. I really can't physically heal them.

### **Attempting**

A common concern of the participants was the possibility of doing permanent harm to the sexual violence patient. In most cases, that concern altered the steps they took to care for these patients. In all cases, the participants related a complete lack of instruction during their academic programs regarding the care of patients who experience sexual assault. Those who received instruction during their orientation to the emergency department environment described a cursory introduction to the mechanics of evidence

collection, with no information regarding the psychological needs of the patient experiencing this event. Courses related to psychology and normal human development were not found to be helpful in dealing with such a traumatic event. Without adequate training in the care of patients who have experienced sexual violence, nurses have difficulty managing their care.

In this study, the category of *Attempting* emerged from the data as an unavoidable event. In some cases, minimal contact was recommended with the patient, but in other cases, the nurses were required to provide full care, including evidence collection. *Attempting* was defined by the researcher as a constellation of actions provided by the nurse under suboptimal circumstances. Subthemes that emerged included *Figuring it out*, *Trial and error*, and *Reasonable care*. From these subthemes, the subcategories of *Presumptive care and Personally directed care* were constructed. The theoretical concept of *Attempting* was supported by the subcategories of *Presumptive care and Personally directed care*. Participants' responses supported the categories and are related below.

**Mary** described how she attempted to provide proper care after being provided with some cursory information:

One of our nurses told me the protocol. He's the SANE nurse here; he's trained. He told me what to do. We got an email memo about how to do assessments, basically the collection of evidence.

**Joe** talked about the things he felt he could do to make patients feel better:

I try to be as nurturing as possible and as understanding as I can. You know, if they need anything for them. You never want to have these kinds of patients in the hallway, Obviously make sure that they had their privacy. Just like you would

never wish that kind of thing on your worst enemy, so you just kind of cater to their every whim.

**Yellow** spoke about having nothing specific available to guide her care:

For that specific sexual violence patient, I guess there is a lack of specifically what to do for them, so just generalized nursing care. Nothing like really specifically directed for them.

**Presumptive care.** The nurses provided care that they thought was reasonable and adhered to what they generally knew about pathophysiology, psychology, and human development. In many cases, the nurses admitted to deciding what care to provide based on trial and error. If it worked, they reasoned, they would use it again; if not, they would change their approach. Most participants were unable to relate their decisions to specific evidence.

When asked the question, “What influenced how you care for patients who have had this experience,” **Beth** responded with a telling statement: “I kind of go with my gut.”

**Asystole** responded to the same question as follows:

At a previous location where I worked at a different facility, my clinical educator there had specific training, had SANE training for these types of patients. When I was on orientation at this facility, it kind came up, and she was telling me a little bit about it. It's definitely something that interests me because I think you can provide nursing care to someone with a heart attack, you can provide nursing care to someone with a stroke, but these particular patients I think you can make the biggest impact on how you care for them. So that kind of means a lot to me that I

can have a very big impact on someone just in how I care for them. So that kind of drives me and drives my interest in it.

**April** stated: “I don’t know; I just did it, I guess.

In a situation in which a patient with dementia presented with multiple complaints including sexual assault, **Elizabeth** found herself in the midst of an ethical dilemma. The patient was assumed to be unable to report the event accurately, but **Elizabeth** felt that something was wrong:

I didn’t have the skill to check and think, like look at her vagina to look and see if there were scratches on her somewhere. I didn’t think that when it was happening. I just kind of thought, well, something’s weird. We should do something but kind of not knowing what it was that we needed to do. We did something, but it took really long. I feel guilty that I let the patient leave the emergency department and kind of dumped them off. Not intentionally dumped them off, but they were with somebody else by the time they decided they were going to go through with the exam.

**Sunflower** approached the situation in a similar way to **April** and **Beth**:

Well, obviously, trial and error. You know if they don’t respond well or you don’t get very good verbal or nonverbal cues from them. Then you know what not to do. Like, for example, the touch on the shoulder I talked about. If they wince, which I’ve obviously seen. Or if they seem more withdrawn or if their body language isn’t as open, which I assume it would be. I guess you would be less tactile. And also just experience, I guess. Doing it more it becomes easier to anticipate things, get a feel of how and what works and what doesn’t.

**Yellow** included collaboration as a way of navigating care and attempting to do her best:

I guess I would just use other resources like collaborate with the doctors, and if I really have no idea what to do I go to the charge nurse. But I kind of feed off the patient, like how much do they want me to dig into it, or kind of see what they are here for and what they want to get out of their ER experience. Like how they came in and did they come in willingly and kind of go from there.

When comparing her ability to care for a person having a heart attack and a person who has been sexually assaulted, **Yellow** made a compelling argument:

I think a heart attack . . . I see millions of them, but like a sexual assault I've seen between one and five. So a heart attack I know exactly what to do. There's like an algorithm for that. But for a sexual violence victim, there is not that I'm aware of so just generalized nursing care. Nothing like really specifically directed for them.

When exploring the process that she followed when caring for someone who experienced sexual violence, **Daisy** confirmed that her nursing education did not address this condition:

In school, we didn't really talk about how to take care of this type of patient.

Throughout the years, you kind of figure out how to take care of the patient and how to be there emotionally for the patient too. We didn't learn that from school.

We learned that from experience.

**Jedi** described the way that he learned to care for these patients and what his experience over time contributed to his skill set:

Different hospitals that I've worked at, and I've only worked at three different hospital systems in my almost 30 years of nursing, so within the system there is an expectation on you to know the slideshow. This is how we handle this. This is the policy. This is the kit that we use, and there was a time before this even came about where we had seen nurses or the SANE team. It was us and the local police department. Twenty years ago we did get a little more training than we do now, because now the SANE's are pretty well entrenched everywhere I've seen. Twenty-five years ago, there was no such thing, so we were trained and we had a kit, a brown paper bag on how to collect things, the fingernail kit, and there was the specimen bag. We pretty much emulated what we did for a crime scene collection, like collecting bullets, collecting fragments, anything removed from a patient. We put it in certain ways so that we could preserve the evidence. Clothing goes in a brown paper bag so molded and created. So years ago I think we got a little more training at that time than we do now. Now it's just call the SANE nurse. We don't get involved. Put the patient over here. Or send them out to wherever. I'm probably more in the dark now on how to handle these patients in this setting than I was back 25 years ago.

**Personally directed care.** The subcategory of *Personally directed care* emerged from the participants' personal perspectives on the event—that they would be subject to the same experience. Internal constructs informed their decisions regarding how to structure the care of those affected. **Elizabeth** described how this concept drove her care:

I think like firstly it would be that I would rely on how I would want to be treated myself if something like that were to happen to me. Then I think when you take a



lot of the courses in school they talk about empathy and really not specific to this. But you can draw from some of the materials for this.

**Joe** had a unique perspective because of his father's position in a law enforcement sex crimes unit. When asked what influenced his care, Joe discussed how his upbringing layered his approach:

Yeah, my upbringing. Being that my dad has had such extensive experience in that field, he kind of brought me up pretty well versed on the topic my whole life. You know, it's one of the worst things if not the worst thing that can happen to a human being. That person is as vulnerable and as upset as someone can be. They are really fragile at that point. I guess I just kind of know that from my upbringing. More specifically my dad.

**Asystole** elaborated on the opening question and referred to how sexual assault could actually happen to her. Although nurses may reflect on the possibility that they could at some point be the patient on the stretcher, the all-encompassing effect of this traumatic event added a level of fear that went beyond other conditions. In **Asystole's** reflection, it can be surmised that her care was affected by her personalizing the possibility that she was at risk:

It's scary because you always hear about sexual assault and sexual violence, but to have someone in front of you. It's very real, it's there, and you are kind of experiencing it with them in a way, especially sexual violence against females. Especially if they're the same age or similar demographic, it makes you feel like-- Wow, that could really happen, and it could happen to me. And it's frightening to think that it could happen to you. You're scared for them in a way.

**Jedi** discussed a parallel experience related to his sister, and the experience elicited feelings of anger:

You know, my sister wasn't sexually assaulted, but she was physically assaulted by her boyfriend at one time. And so that impacted me from an anger perspective.

**Jedi** then talked about how conversations with peers can elicit stories and personal experiences that may influence care:

And you talk among yourselves, and when you talk among yourselves like that you can talk out some of the prejudices that some people have. You can talk out some of the physical—Well, how did you collect this? You can talk out even some of the emotional roles, like He was really just upset, and maybe they bring their own personal experiences, like Well, my friend, or this happened to me or this happened, so you get more of the personal stories but from your own group peers.

### **Analyzing**

For this study, *Analyzing* was defined within the context of reflective thinking. This meaning can be traced back to Dewey (1933) and Habermas (1987), with the definition as “careful consideration and examination of issues of concern related to an experience” (Kuiper & Pesut, 2004, p. 384). *Analyzing* was constructed from the subthemes *Talking it out*, *Seeking assurance*, and *Observing the experts*.

After providing care to these patients, most nurses reflected on their actions either internally or in conversation with a more experienced colleague. The nurses were required to care for a patient with a condition that was not familiar and for which adequate training was not provided. They did the best they could within the context of the

situation. The situation was certainly not ideal and caused stress for the nurses, accompanied by feelings of inadequacy. The nurses intentionally sought out staff members they trusted or, in some cases, they utilized the expertise of the medical staff

**Frances** recognized the value of modeling other nurses whom she trusted:

Modeling after other nurses who I work with, who I trust, who I go to for questions. I know who I want to go to in any situation. In this work environment, I know who I would trust to give me an honest and truthful answer and who would be sympathetic and who would have a response that would be similar to me. I wouldn't go to someone who I don't trust. I wouldn't go to someone who wouldn't have the same values or morals as I do.

Knowing who to go to is an important part of analyzing performance and the next step of adjusting practice. **Asystole** described the way that she decided:

I think we rely on the experiences of others and taking them with a grain of salt. Hey, have you experienced this before and can you kinda help me out. I think I'm really good at knowing my resources and utilizing them by talking to other nurses who are more experienced than me. It's something that I rely on.

Talking to the physicians also to see what their experiences are with it and when in doubt I look it up. I have a textbook of nursing that basically encompasses everything. It's kind of down and dirty and I focus in on the things I need. As an ER nurse, the main thing I'm concerned about are the ABCs, making sure those kinds of needs are met. Sometimes, you know, the psychological and emotional needs of the patient go to the wayside because we are so emergency focused. And as I grow in my career I'm trying to maintain that, trying to uphold

that at all times. And instead of just looking at tasks and assessments and such, I want to look at the big picture.

**Daisy** valued her experience as a way of improving her skills when caring for sexual violence patients but recognized the need to reach out to others in her department:

Well, everybody's different so you kind of know what to do. Some cases you really think that this is BS and this is really not really happening, but you really have to think that maybe this is true, that this happened to this person. So, like I said, every case is different so you just learn from the last one. Throughout my years as an ER nurse I do this for all of my patients, but I tend to be more connected to them when they've gone through this type of experience. I am aware of what they need and try to get what they need and offer them everything that they need.

I would go to other people and ask them how to deal with it, like my friends. Most of my friends are nurses, so we go out and talk about not the patient but how we feel about things and how you learn from what they say. Hey, I did this in this way. Maybe that will help the next time. It might help you out to kind of deal with it. Just when nurses get together and we talked about things and I listen to them too.

**Elizabeth** identified her areas of weakness and mentioned other people who could add their expertise:

I think that technically what feels the worst is the specimen collection. But also the psychosocial aspects and the support. I don't think that nurses think they have the time or the ability. We often call other resources to deal with that, with these

types of patients and other kinds of patients. We will call pastoral care, we'll call social work. We will call somebody else who we feel is better at it than us.

**Frances** was asked the question, "How have you changed or how has your care for them changed over time?" She replied:

I think ultimately my care is probably the same. However, my level of comfort has improved regarding asking people about violence or if they see it in their life. When I first started as a nurse in the emergency room, I didn't feel comfortable asking a lot of questions, but I got more comfortable with that over time.

**Jedi** discussed his debriefing process:

Just by talking to other nurses and talking to peers and within the emergency room. You just talk to your peers and, Oh, what was that patient like? Or how is that patient doing? That patient really seemed upset. And you talk among yourselves, and when you talk among yourselves like that you can talk out some of the prejudices that some people have. You can talk out some of the physical-- Well, how did you collect this? You can talk out even some of the emotional roles, like, He was really just upset. And maybe they bring their own personal experiences like, Well, my friend or this happened to me, or this happened, so you get more of the personal stories but from your own group peers. This has the benefit of years of peers. You just kind of absorb that information as you go along.

**Joe** described how the nurses on his unit helped to support him and how the patients who were assaulted helped him to self-evaluate. They reminded him of what he was doing in the profession, his contributions and mission:

A lot of nurses here who do those kits and they collect evidence and all that kind of stuff. They are great when it comes to that kind of stuff. They're all very nurturing and very kind and they lead by example. They didn't have to tell me to make sure you speak very softly those kinds of things. They lead by example, and you just kind of do what they do. One thing it does as far as in the moment: at the very least they kind of brings you back down to earth.

Because when you're working in a very busy ER, you can really get a little pissed. You know you're sick of their complaining and their whining and this and that and you get really bitter. It happens over an extended period of time. But when you see a person who has this experience, and they're so vulnerable and broken, it forces you to step back for a second and empathize why you got into this. Kind of brings the nurturing back into the field you know.

**Sunflower** reflected on how caring for patients who had a sexual assault experience changed how she looked at the world:

I mean a sexual assault can happen to anyone, male, female—you know, it could be a businesswoman or a woman of the night. It doesn't matter. We are all the same when we have that gown on. No matter who you are. So you kind of have to look at it through all perspectives. Maybe a person that you don't like at work or not is a nurse—we are all persons. You have to kind of look back at maybe what they've been through. Maybe thinking about the back stories a little bit more, you know their experiences.

When **Sunflower** was asked if there was anything else she wanted to say, she described the range of emotions she experienced and the perspective of someone, as she was, who practiced reflective thinking:

Just like I said, realizing that when you're in that situation and you see that on your board and it shows up, you don't know what's behind that curtain. You need to be open, nonjudgmental, empathetic, sympathetic, caring. You know they're going through one of the worst days of their life. Something was taken from them. They were violated in more ways than one. And you just really have to have an open mind and come with an open heart too. You need to be there as much you can.

### **Adjusting**

In this study, *adjusting* was defined as the alteration of something slightly in order to achieve the desired result (*Merriam-Webster's Online Collegiate Dictionary*, 2012). The emergence of the concept that described a slight alteration was consistent with the data provided by the participants. The changes participants described were small and varied, depending on the events of their situations. *Adjusting* was constructed from the subthemes of *Realizing*, *Trying new ways*, and *Changing perspective*. Nearly all the participant described changes in their approach and revision of their practice based on the reactions of the patients they cared for. The changes were especially evident with patients who were sexually violated. If the nurses observed a negative reaction to something they themselves did or said, they changed their responses with the next patient. In some cases, after reflecting with a more experienced nurse, they would adopt the advice of their

colleague and “see how it goes.” Most reported that, over time, through trial and error they became more comfortable with their performance.

Nevertheless, none of these untrained nurses felt entirely comfortable with the care they provided, even after more exposure to the sexually assaulted patients. Yet the participants admitted a higher degree of comfort. When asked how they might have changed or if there was anything they might do differently over time when working with this population, **Beth** stated:

I’m not as scared anymore. Like the first people to come in—actually nobody really wants to take care of them because you’re there for hours. It’s kind of one-on-one when we did the SANE exams here. And then usually if they’re done with the SANE exam, they go to another room and have a different nurse. Which I think it’s also kind of tough for patients. Now I’m more confident, I kind of go in there and am direct, matter-of-fact, use simple terms because I’m sure they’re not processing as well as they could. But definitely I’ve gotten confidence over the years. I come—like before I’d ask questions.

Now I let them talk. I don’t ask specific questions about the assault, like Did you know the person? Mostly now I’ll go in there and say, Where do you hurt? That kind of stuff. Do you have any pain or discharge? Do the police know, do you want us to notify the police? Before I used to ask, you know, Do you know the person and Where were you? Now I don’t do all of that. I just need to know what is going on with you, and do you want me to call the police?



**Daisy** described how she adjusted her approach based on the unique experience of the patient. She continued with suggestions about what was needed to improve her care of these patients and what the needs of the nurses were:

It's kind of different. Let's say, for example, if you have a medical patient coming in having problems, maybe cardiac issues, then you know that you know how to take care of that. But with somebody who was physically abused, sexually abused, I tend to be more patient with them. I listen to them and I'm more present with them. You know? I am more emotionally connected to them.

I wish that there would be more courses available or even a support group for nurses who actually take care of these patients, because like I said, it is very emotional and you do get affected. Even just a little bit. It would be good if we could help people who are just starting out by talking about things like--Hey, this is how we take care of these kinds of patients. And we can talk about the situation and the physical manifestation of what happened to them. I wish there would be more support group for nurses also, not justification, but also for nurses that had to deal with this type of situation.

**Elizabeth** reflected on the two people she cared for and how each case affected her perspective. She talked about the lessons she took with her from the interactions:

I think the first person was kind of easier in the way that they came in. The physician cleared them to be able to go to be examined and have specimen collection elsewhere. Then the second person was the more difficult one. They came from a nursing home, and the person was demented, but they kept saying that somebody had assaulted them. They said somebody raped them. And I

remember it being ignored—She’s demented, she doesn’t know what she’s talking about. And even I felt that way to a point, but then she kept saying it.

She was admitted to the hospital, and they decided then that she wasn’t going to be able to go get examined by the city. And we had to do it, and before we did the exam she ended up in the MICU [Medical Intensive Care Unit]. And it was like this big ordeal because I think they have less training than we do. That it was a big ordeal with them calling for help and us feeling like we couldn’t help them as well as we wanted to.

We had a couple of SANE nurses, but they weren’t working and where I worked before. There’s really not much attention paid to having one on every shift. I think I learned to be stronger in advocating for patients who are saying something like that, and not letting people blow them off. Even if they are not telling the truth or even if they are demented and they don’t know what they’re saying. If someone says something like that, just like if someone says, I want to kill myself, I can’t decide personally whether they really want to do that or not. I can’t decide if they were really assaulted or not, and I need to act as if everything they are saying is true.

**Frances** became more comfortable with the subject of violence and reflected on the impact that perspective brought to her practice:

I can’t think of anything specific in particular. I just think being comfortable asking patients if they have been exposed to violence and if they would like assistance or anything like that. I think that’s a big point in the whole thing—that people are afraid of saying if they don’t have a safe environment or something

like that. I think that if I'm not comfortable with it, then the patient certainly will not be, so I think just being better at that has helped.

**Joe** discussed how his experiences in the emergency department, especially with the sexually assaulted patients, changed him and how he changed his approach. This change also reinforced lessons he learned in his person life:

It definitely has changed. At least it has been magnified. Before I had any actual experience, it was just going off of what I've heard in the news or what my dad had told me and that kind of stuff. I knew it was a terrible thing, but now, after working here and seeing it firsthand, I know firsthand how bad it is. I know how delicate these people are at that particular moment. It's kind of tough. Because I do have some exposure but I haven't been doing this for very long time.

The first time I remember I was really nervous. I kind of walked into the room, and I was trying to be cheery and trying to lighten the mood. Then I realized—let them be upset, they should be upset if they want to. I'm not going to change their mood and make them feel 100% better in a half hour or hour that they're with me. So let them be upset and kind of just be an ear for them. If that's what they need, that's what they need. Don't try to do too much for them. Try to do what they need me to do, but don't do too much. Don't kind of like walk in all—Hey, how are you? You know how they're doing just going in, and if they need anything just get it for them.

**Mom** reflected on how her experience with sexual violence patients changed her perspective and how she adjusted over time the process that she used to care for them:

It has changed, because I remember my first encounter with somebody who's been through this. I was never trained professionally about this. So each time I spoke with this person, I was taking notes, and I would mention, for instance, So you were raped, but you're not supposed to say that. I noticed that each time I said this to the person they would cry even louder. And then I was told later that you don't say words like *rape*. Because they think about it, and it comes right to their head. They remember the incidents and it makes them even more upset. So I have learned as I've seen several, just intake them. Not really sit down and talk to them much, just get the basics of what happened before I send them over to the SANE nurse. This kinda helped me to realize that there are certain things you don't say because they've been through so much. It's a devastating incident.

When **Sunflower** reflected on her personal experience with a friend who was in a relationship with an abuser, Sunflower was able to use the insights she gained to guide her approach to vulnerable patients:

I guess I'm aware of these kinds of sensitive matters. I had a friend in college who went through domestic violence, never sexual violence. I saw, I guess, the dynamic between this and some sexual assaults can be with someone that you know, so you kind of see the dynamic. I guess I could see the abuser-abusee relationship.

And that can sometimes make you a little more aware. It makes you, I guess, more human, and you realize that there are some people going through some real serious things in their life. We need to know you are lucky for the fortunes that you have. And on top of that, it makes me feel as if I'm really doing

what I'm supposed to be doing. If I can be there for someone who is going through these hard times. I can be there to support them mentally, physically, in whatever way. Even just to get a warm blanket—something I can do to help them through this time.

**Violet** described the evolution of her approach over time:

I think in the beginning I would ask more questions about what happened and have them tell me what happened. And then I kind of went away from that for them not to tell me the whole story. Because they have to tell it to me, have to tell it to the doctors. They're going to tell it to the detectives when they come. So if they got emotional, if they want to tell me, fine, but I'm not going to try to get more information from them. I'm trying to get the basic story, because they have to tell that story. It's just like any patient who comes into the ER, but especially for them to tell that story 10 and 15 times or however many times they are gonna tell it it's harder to tell that story of what happened to you if you were raped versus I'm here because I fell and broke my leg.

That story is easy to tell then someone being raped and going through those graphic details and remembering or living through it again. So I think towards the end I would kind of be like—Just tell me where you were, what happened. You don't have to tell me everything. I just need to know the basics so I know how to take care of you. I wouldn't say it in that basic way. I would say, Just tell me what you think I need to know, and I would tell them what we were going to do before we actually did it instead of just—you know what I mean.

**Yellow** did not have much exposure to this type of patient but decided to modify her approach in the future:

I guess like in regards to my first patient she wasn't sure if she could go through with, like, an exam and did this really happen to her blah blah. I kind of let her make up her own mind. I guess now I would give her a little more encouragement like, You're in a safe place and you should get it checked out even if you're not sure it happened, as opposed to just sweeping it under the rug.

### **Phase 2: Focus Group Participants**

The focus group was held in a meeting area near the emergency department arranged by one of the participants. The time was arranged to facilitate participation after the nurses' shifts. Each member chose a pseudonym to use during the session and for the study report. To open the meeting, the researcher reviewed the purpose of the study and distributed and reviewed the consent forms (Appendix B), which were signed by the participants. Demographic information was obtained with the demographic form (Appendix F).

At the start of the focus group, the opening question used during the IIG interviews was asked of each participant in the context of their experience before receiving training. After all participants responded, the researcher presented the findings from the IIG, utilizing the notes she took during analysis. Participants discussed the findings for confirmation of the evolving themes. Further discussion took place regarding the evolution of these nurses' skills and comfort in caring for patients who were victims of sexual violence. At the conclusion of the focus group, referral information was distributed and reviewed.

**Charlotte.** Charlotte is a 45-year-old married female with a diploma degree in nursing and a SANE. Charlotte is White Non-Hispanic or Latino and identified with an Eastern European-French ethnic group. Charlotte has been a nurse for more than 15 years and an emergency department nurse for all of those years. Charlotte has cared for more than 200 patients who were victims of sexual violence. Charlotte admits having personal experience with victims of sexual violence ((e.g., self, friend, family)).

**Olivia.** Olivia is a 31-year-old married female with a bachelor's degree in nursing and a SANE. Olivia is White Hispanic or Latino and identifies with the Puerto Rican ethnic group. Olivia has been a nurse for 6-7 years and an emergency department nurse for 2-5 of those years. Olivia has cared for "many, many" patients who were victims of sexual violence. Olivia admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Jett.** Jett is a 50-year-old single male with a bachelor's degree in nursing and a SANE. Jett is Black and identifies with the African American ethnic group. Jett has been a nurse for more than 15 years and an emergency department nurse for all of those years. Jett has cared for more than 20 patients who were victims of sexual violence. Jett admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Penny.** Penny is a 24-year-old single female with a bachelor's degree in nursing and a SANE. Penny is White Non-Hispanic or Latino and identifies with no ethnic group. Penny has been a nurse for 2-5 years and an emergency department nurse for all of those years. Penny has cared for "several" patients who were victims of sexual violence. Penny admits having personal experience with victims of sexual violence (e.g., self, friend, family).

**Penelope.** Penelope is a 27-year-old married female with a bachelor's degree in nursing and a SANE. Penelope is White Non-Hispanic or Latino and identifies with no ethnic group. Penelope has been a nurse for 2-5 years and an emergency nurse for all of those years. Penelope has cared for "many" patients who were victims of sexual violence. Penelope admits having personal experience with victims of sexual violence (e.g., self, friend, family).

### **Confirmation of the Conceptual Categories by the Focus Group**

The purpose of the focus group was to confirm the conceptual categories that were coconstructed during Phase 1 of this study. The FG participants were five nurses who actively practiced as SANEs within a busy Sexual Assault Response Team in Pennsylvania. To be designated as a SANE, the nurses were required to meet rigorous standards and requirements included in the publication *Forensic Nursing: Scope and Standards of Practice* (American Nurses Association and International Association of Forensic Nurses, 2009), in addition to state and organizational guidelines. These nurses are considered experts in the care of people who have experienced sexual violence. Three of the five participants were qualified as expert witnesses in court and participated in court proceedings related to the subject.

Prior to the FG meeting, the participants were aware of the purpose of the study and the role of the group. However, no advance information was provided regarding the theoretical categories that were constructed during Phase 1 data collection and subsequent analysis. The FG session was audiorecorded with the participants' permission. At the conclusion of the session, the FG participants confirmed the core categories and subsequent theoretical concepts constructed during Phase 1 of the study. The participants



were thanked and the session ended. Even though the participants were well known to each other, they chose pseudonyms and used them during the taping to protect confidentiality after the event. The following section includes excerpts from the transcribed comments made during the 60-minute focus group.

At the start of the meeting, participants were asked the same opening question used during Phase 1, “Can you please tell me what it is like to care for people who have experienced sexual violence?” They were asked to answer the question from their previous perspective prior to their SANE training. The responses confirmed the core category of apprehending and the conceptual category of *Avoiding*.

**Olivia** recollected:

I think prior to training it was kind of stressed to us by other nurses who did not have training to have as little possible contact with these patients’ because we didn’t want to end up going to court. So it was minimal physical assessment, very minimal story, and then vital signs and kind of done until the SANE nurse would get there to do the exam.

**Penny** described a similar process:

I just try to avoid them. Like they had vitals in triage and they are talking and crying, so they are probably okay. I’m not even going to go in there. It just made me really uncomfortable.

**Jett** concurred:

We were told initially to have minimal contact. So we basically stayed away. I would just go in in the beginning to make sure from a physical standpoint they

were okay that way. Then the door or the curtain was closed and God help you until the SANE nurse gets there.

**Penelope** had a different experience:

Mine was a little bit different only because of the fact that my preceptor was one of the SANE coordinators, so I had a little bit more education to the program before I became one. So that was initially when I started nursing in general, so I had a little more information about it. I felt a little bit more comfortable but, still more or less, I'd be happy to answer questions about general nursing questions as far as regular nursing was considered. When he came to that specific thing, saying it was like, Oh just wait because that nurse is coming.

**Charlotte** described her journey from a novice nurse to her current role as expert in the area of sexual violence. Her observations accorded with many of the participants' experiences in both groups:

I was fortunate. When I was in nursing school, forensic nursing was just coming to life. I went and saw Virginia Lynch [forensic nursing expert] speak at a conference. I was like a first-year nursing student, so I just thought it was something that everybody did because I was still in nursing school. When I did my ER rotation, I realized that sexually assaulted patients were treated like they were contagious. So when I came down to the ER from the ICU I thought, That needs to change. And I started doing work to make that change.

It's been a long road but now I think that people don't just shove them in a corner. They have to be given a room. They see a physician, they see a nurse, and then they wait for the safe nurse to show up. In school, they didn't teach any

forensics or any domestic violence wasn't mentioned or child abuse. And I knew from personal experiences that all those things existed and I couldn't understand why nurses weren't being taught those things. Since nurses were right there.

The topic of training was brought up and explored further with the group. When asked about their prior education and training in nursing and how it may have helped them care for people who have experienced sexual violence, most of the group admitted to a gap in preparation. **Penelope** described her impressions:

There probably should be something, but I'm a very hands-on learner. I have only been a nurse for 3 years. Almost all of the stuff I'm remembering came from when I started nursing. I can't say there was anything I recall from school or during my education that I remember making you feel comfortable with all that.

**Jett** stated:

I can remember from school being taught in a psychology course the symptoms when someone goes through a traumatic experience, but it wasn't specific to sexual assault. It was any kind of trauma. I'm remembering that they told us you wouldn't expect one type of reaction; it could be all over the board. It was very general, the education we got as far as the kind of symptoms a person would have. But I remember not being able to do anything worthwhile with it at the time.

**Olivia, Charlotte, and Penny** described similar experiences:

**Olivia:** I would say the same thing. In general, psych in nursing school taught you how to speak to people who might be going through an acute psychotic event or who were highly stressed. It could be applicable to sexual assault victims but nothing specific to those types of patients.

**Penny:** Yeah, kind of the same thing just really generic. Nothing specific to sexual assault. We did do a day of domestic violence, and it was just making sure they had a safe place to go and setting that up but nothing geared towards sexual violence.

**Charlotte:** I would agree with what Jett said. We were taught the five stages of grief, and people might go through those, but nothing specific to sexual or intimate partner or child violence.

**Jett** and **Olivia** described the way that they decided to care for these patients prior to their training. This same procedure was previously explicated by the Phase 1 participants. The other group members concurred with their comments. The theoretical concept of *Attempting* was confirmed in this way:

**Olivia:** I think that I would basically almost like Maslow's [needs hierarchy]. You got to start at the bottom. Are they safe? Do they need to vent to you if you have the time to talk to them? And what can you do to make them feel comfortable until they're able to be treated for what they're here for? It's a very basic level of caring for another human being so that they know that they're safe and they know that there's help coming.

**Jett:** I can agree with what **Olivia** said, but I think my approach would be to just go in to the room and let them set the tone. Then I would respond to however they responded to me. If they wanted silence, then silence it is. If they all of a sudden started crying, or whatever reaction they would have, I would just deal with the reaction at the time. I wouldn't go in with any kind of I'm going to do this this or this. I would let the person set the tone for what was going to happen.

The question was asked, “Was there any time prior to having formalized training that you thought you might do something different?” The other members of the group concurred with Penelope and **Charlotte** and confirmed the theoretical concept of

*Analyzing.* **Penelope** said:

Yes, to answer that question. I think it might be attributable to the fact that people handle things differently, so you would change her approach based on that. As **Jett** said, you might walk in and someone would just want silence. You might walk in and someone might be laughing about it. And not knowing how to deal with that as well. Just more or less accepting the fact that everyone’s going to deal with this individually. It’s kind of going to be a blind thing when you walk in there every time.

**Charlotte** stated:

I see with nurses who haven’t gone through the safe training and even some of those nurses who have what Penelope was saying. A lot of people could deal with the crying and the flat affect, but what people couldn’t deal with was the laughing. Or the just not seeming—the anger. Because those weren’t the emotions that were expected if this type of violence happened to you. And so now we know from studies related to the neurobiology of trauma, now we understand that all of those emotions are common. It’s just different ways, and different chemicals get released when you go through that trauma.

It’s really hard to get nurses to see that, because we have nurses both on our team and off of our team that may say, You know, they were laughing. It’s

not real. So I think that's an area that really needs to be, that all nurses need to be educated on.

*Adjusting* was confirmed by the FG participants in this way:

**Jett** was asked, "Before your training, did you have an idea in your mind about who would be someone who would be most at risk, or someone who this would happen to versus someone else"? His response:

I guess I think because of what we see on movies or TV that usually it's the woman who is at a bar by herself dressed scantily or sexually suggestive and lets a stranger buy her drinks, so she must've wanted it. That kind of stuff. I'm not saying that's how I viewed it, but that's how it's been portrayed. That's the typical person. Or it's the person who is on drugs or the prostitutes, so you would never think that would be somebody as normal middle-class in your neighborhood. That would never happen to somebody like them.

It would happen in the low lower income neighborhood where they wouldn't have the same advantages as someone, let's say, in Beverly Hills. That it wouldn't happen there—that would happen in Forest Hills. That was the typical idea, you think that your next door neighbor, it wouldn't happen to them or the person across the street because it's not in this neighborhood. After, you know that it happens in every neighborhood.

**Charlotte** described how the team evolved over time based on what they experienced:

When we took over the team a few years ago, we weren't happy that the children were going to a different county. We decided that it couldn't happen anymore. So

we told the team that everybody had to be trained in doing pediatric cases. We lost some team members because of that. We gained some other team members. I think that children have been the biggest eye opener for me. Because I really did have preconceived notions about how a child would be and how they would react.

And the children in a lot of regards are what keep me in this. Because the kids come in, and they don't realize they are victims. They just come in and they are kids. And they can have some significant injuries and they're still just kids. Their parents might be a mess, but the kids are laughing or playing or they're shy, whatever their personality is before the assault took place. They are still that when you're doing the exam.

**Penelope** related how her ideas changed and how her reaction to the shocking details of the events her patients experienced evolved over time:

My idea and view of how someone would react changed drastically after the training. I won't say that it made it easy. I will be the first to say that the first time I had someone who was laughing about it during the case, after I completed the case, it was still a little bit shocking. I was educated on it and I knew about it, but I'd never actually witnessed it or experienced it. I think the education taught me how to react to it, like Jett was saying, and how to go along with it and continue to make them feel as comfortable as I possibly could.

### **The Basic Social Process: Apprehending an Unknown Phenomenon**

A main theoretical concept evolved during the Phase 1 interviews which led to identification of recurring themes and precipitated the development of the concepts that drove the decision making process (Charmaz, 2010; Figure 1). Phase I of the analysis

included line-by-line coding, which raised the codes to tentative categories. In Phase II, constant comparison of data with other data and data with codes was conducted as an essential part of the grounded theory analysis process. In Phase III, focused coding and advanced memoing allowed for the refinement of the conceptual categories.

Phase III included data from the FG interviews as part of theoretical sampling and refinement of the categories occurred from the addition of this data. Phase IV comprised integration of memos and eventual diagramming of the concepts. The analysis revealed four main categories of *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*. Subcategories of *Harming and Internalizing* led to the core category of *Apprehending an Unknown Phenomenon*. The core and subcategories were supported in the data by a majority of the participants. These data provided the framework for the core category, the basic social process of *Apprehending an Unknown Phenomenon*.

*Apprehension* is defined as “suspicion or fear of future harm or misfortune, an uneasy state of mind usually over the possibility of an anticipated misfortune or trouble” (*Merriam-Webster’s Online Collegiate Dictionary*, 2012). All participants described some measure of fear, uneasiness, and concern related to the potential and actual care of patients who have experienced sexual violence.

When asked, “What is it like to care for patients who have experienced sexual violence, **April** described her concern and appeared to be confused as to how she should proceed. Her response demonstrated uneasiness, which helps to confirm the concept of apprehending:

Well, psychologically it’s pretty difficult. You don’t really know what to say. You don’t know if what you say is the correct thing to say. They are usually tearful,



and you don't really know who they want to come back. There may be people here for them or people not here for them. And sometimes if they do have someone with them, they can be more emotional or it can be helpful. So it varies, it's very different. Like you can't say It's okay, because it really isn't. It's just finding words and what to say or how to help them deal with it.

**Asystole** described caring for these types of patients as challenging. Her concern regarding meeting their needs reflected an uneasy mind:

It's definitely a challenge. You want to make sure that the patient's healthcare needs are met, but you also need to meet their emotional needs, which can be very challenging because they don't always let you in.

**Beth** spoke about the stress of caring for patients who are very emotional. Since most of the injuries are emotional, it can be difficult to see them. Medical screening takes place in the emergency department, which is familiar to the emergency department nurse. Then the patients are released to the experts to deal with the emotional trauma and evidence collection:

It's stressful—like they're emotional. They're not thinking rationally most of the time. So you kinda have to go in there and let all your judgments go away. And then you really have to provide emotional support above everything else. A lot of times most of the ones that I've seen, they haven't had a lot of injuries—it's all been emotional. If they do have any injuries, we try to treat them, but here we do medical screening and then we call the police and send them over to the SVU.

**Jedi** reflected on his experience and the philosophy he developed to deal with the uncertainty of the patients' presentation:

For me personally, I guess it's like a hybrid of a psychosocial as well as a physical experience. Someone who comes in complaining of chest pain versus someone who you know has psychotic issues and is complaining of chest pain for attention. And this is kind of like a hybrid. Because it is the physical component, but you also have to take into consideration the behavioral and mental health aspect of it.

So it's kind of a cross between the psych patient you have to take care of very carefully and the physical patient aspect of it that you have to at least address like you would any sensitive issue in the triage setting. Because it's not just a sexual assault piece of it. There may have actually been some physical damage that has occurred. Torn tissue and so on until you get in and do the actual inspection you are not really sure what you're dealing with.

**Sunflower** described how it was hard to gauge how to deal with people who have this experience:

It's definitely hard, and difficult. It can be uncomfortable at times because you feel as though you can't do anything or say anything to make it go away. It doesn't matter what I say. It still happened. You know, some people want for example therapeutic touch. You may touch her shoulder. And some people wince. So it's very hard to gauge. Even experienced nurses, I feel, have this problem. It's obviously sad, you feel for these women or men, depending on the situation, and it's also very grounding. You really want to be there for them, you feel bad for them, empathize, sympathize.

When **Yellow** described her unease, she referred to the inability to provide proper care in the context of inadequate resources. Her frustration was clear:

It makes me feel like an adequate, like I don't have enough time to do the proper job. But you know, and like that's one of my big things that's really unfair. If you don't give an employee tools and the time to do the best job she can, then it's not fair to patients or the employee. Especially without proper training and stuff. I had tons of training in cardiac and respiratory stuff and I deal with those patients all the time. For the patients that come in that I don't necessarily have all the tools to treat them seems a little unfair to the patient and to myself.

### **Harming**

The conceptual category of *Harming* emerged and was constructed from the data from all participants. In many of their responses participants reflected on their feelings of inadequacy related to their training. This reflection left them worried about doing something wrong. They uniformly felt ill prepared to meet adequately the needs of the patients who came to the emergency department with a complaint of sexual assault. *Harming* evolved from two perspectives, personal harm and harm to the legal case. The participants were worried that their actions would cause their patients further trauma, which supported the core category of apprehending.

**Personal harm.** Participants were concerned that something they said or did not say would cause the patient further trauma. Lack of training related to the care of patients experiencing this type of trauma creates stress for nurses and has the potential to cause harm when comprehensive care is not provided. This potential is stressful to patients and providers alike. When answering the primary question, "What is it like to care for people

who experience sexual violence?” **Elizabeth** described her concern related to harming the patient if she could not find the right thing to say:

You feel kind of powerless. You want to help but you’re not sure. And sometimes I’m worried that something I say won’t be the right thing. And it will make it worse.

In addition to being untrained, other factors were pointed out that participants believed may also cause harm. **Joe** was concerned that because he was male, the patient, most often a female, would see him as an aggressor and identify him with the attacker. **Joe** provided a vivid description of his concerns and how they made him feel. He referenced his gender as an issue and how it could complicate an already complex situation:

Especially being male, it’s really kind of—you’re walking on eggshells. It’s really tough figuring out how to know what to say, what to do, especially since most of the victims are female. Especially nine times out of 10, the victim is female and the perpetrator is male. So it’s like is she scared of me. Obviously, she is emotionally and physically distressed. How I go about approaching this, you know. It’s nerve-racking. Most of the time, they’re not the sickest patients in the world. They’re not to code and die at any second. But they’re definitely one of the more complex patients of how to approach treatment.

**Elizabeth** was asked, “How do you feel about the emotional aspect of caring for someone who has experienced sexual violence? She responded:

You feel terrible. I can imagine what it would feel like, but I don’t really think I can. I’ve never personally experienced something like that. Sometimes I get the

impression that they are worried that we won't believe them. Sometimes I see that some people don't believe them. You feel kind of powerless. You want to help, but you're not sure. And sometimes I'm worried that something I say won't be the right thing. And it will make it worse.

**Harm to the legal case.** Many participants expressed a concern about doing something wrong which might damage the legal case against the perpetrator. In addition, participants were reluctant to be drawn in to the legal process, in part because, having no formal training in the treatment process, they would be unable to defend their actions.

In the excerpts below, **Elizabeth** described in a number of ways her concern regarding "ruining" the investigation:

I found myself feeling sorry for the victim, confused and worried that something that I do will ruin an investigation. And I'm really worried that I don't know the procedure well enough to make sure that everything is done right. So it's almost as if I wanted to avoid doing anything because I didn't want to mess up or do something wrong.

To promote further exploration of the meaning of the construct to participants, a follow-up reflexive statement was posed: "So you're worried about the possibility that you might mess up an investigation in some way? Because you didn't know if you could do it properly?" **Elizabeth** explicated her concern:

Yeah. I feel like it was reviewed very briefly, and when it was reviewed I was told that we don't really have to do this that much. They go to a centralized place where they will do it there. So kind of when it comes to the point where the patient can't leave and you are going to have to do it here, it's concerning. It's in

a different way. It doesn't feel like you're going to harm them in not being competent, but you're going to be doing something that's going to affect them down the road if they were to choose to go forward with charging somebody.

**April** referred to the need to protect the patient, especially when the case was considered high profile. In this example, the potential to interfere in the legal case was implied:

You want to protect them. There is a protection factor as well. Especially if there's something like a high profile case. You might have the media camped outside, or people, other visitors passing by rooms. You want to make sure that they are not overhearing anything. So you really want to protect them from having to see that the media is camped outside the door or there's people trying to overhear was going on.

**Violet** described how over time the process in this particular emergency department changed and how glad she was that her role in the process had diminished. In the following reflection, she described the complexity of the rules in proceeding with a legal case:

I'm glad it's gone. I'm glad about the process that they do now and that the old process is gone. We recently had someone who came in who went to another hospital and didn't want to press charges and then she was brought in by her mom. She said, I don't even know who it was, what happened. And I was like, So this is what we are going to do. You don't want to tell the police you can get everything collected and you can then not press charges. But you can't decide not to do the kit and then decide. I wish I pressed charges, you know what I mean.

You need to go down this road now or you don't. And I kind of told her that you need to decide now. If you want to go and press charges or if you think at any time you want to press charges you want to go to the police. And then I said if you want to just be treated, that you're afraid you got STDs, you can do that here. But if you want to pursue this rape case, then you need to go down a different avenue.

### **Internalizing**

Most of the participants referenced a fear of the potential that they or someone they cared about could be a victim of a sexual assault. They described the situation as “scary,” “disturbing,” and “traumatic.” This concern colored how they approached the patient and in many cases limited their ability to provide adequate support. In most cases, the fear led to avoidance in order to do no harm or to protect the self. Several IIG participants related their feelings.

**Asystole** referenced her “female empathy” as a way to picture herself in the situation:

You know I feel like with those types of patients because I am female my empathy really kicks in because you can almost picture yourself in that situation. It's really scary if nothing else.

When **Beth** was asked, “How do you figure out how to care for these types of patients when you have had no training?” her response described the way she has decided to care for them by internalizing the experience:

How I want to be treated is kind of how I treat them. Like if I was a victim, what would I want to have happen to me and how would I like to be treated and how

would I like to be looked at? Because a lot of them feel ashamed, or they haven't hit the angry stage, yet they're mortified. I kind of like to treat them the way that I would want to be treated.

**April** referred to the potential to become a victim because of the area surrounding the hospital in the inner city, especially during the night shift:

It's just hard to know what to say. You know you feel really bad, but it's scary.

Being in the city, things can happen around the corner. We work night shift, so 2 in the morning you might have a break and go down two blocks to go to the store and you're by yourself. So a lot of people have been assaulted right out front.

When discussing what it was like caring for people who experienced sexual violence, **Daisy** reflected on the difficult balance between protecting herself and being emotionally present for the patient:

It's very emotional, and because you feel sorry for them and at the same time you want to make sure they're okay physically. I try to be there for them, so it's kind of hard trying to distance yourself and take care of them while thinking this could've been you too. It is hard.

When **Jedi** was asked if there was anything in particular that influenced how he cared for patients over time, he responded:

You know, my sister wasn't sexually assaulted, but she was physically assaulted by her boyfriend at one time. And so that impacted me from an anger perspective. So when I see somebody who comes in who's been victimized in some sort of way it's like, you just really want to go out and clobber the person who did it.



### **Restatement of the Research Questions**

The following questions guided the journey towards the discovery of the process that nurses used when they were required to provide care to vulnerable persons without being adequately trained. In this study, the focus was on patients who experienced sexual violence. The basic social process, *Apprehending an Unknown Phenomenon*, emerged as the force that for the nurses began and guided the decision making process. This social process constructed through the data and contained the conceptual categories of *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*.

The research questions that guided this study were the following:

1. How do nurses decide the way in which they will care for patients who are victims of sexual violence?
2. What are the critical influences that guide that decision making process?
3. What are the nurses' perceptions of their attitudes towards victims of sexual violence?

### **Connection to Theory**

The basic social process used by emergency department nurses who were untrained in the care of patients who experienced sexual violence was positioned within the theoretical framework of *Apprehending an Unknown Phenomenon*. The theoretical framework precipitated the beginning steps for the nurses and informed their decision making process. *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting* were the main categories and subsequent theoretical concepts that propelled the nurses to structure their care.

The concepts were dependent on each other and are related in a stepwise progression. For example, in the steps *Attempting* and *Analyzing*, some of the participants

required a pause in the process, enabling them to navigate between the two steps simultaneously before moving on to the next step. The social process and conceptual categories were confirmed by the focus group. Figure 2 represents the basic social process that was discovered and the theoretical concepts that emerged through the data with application of a social constructivist lens.

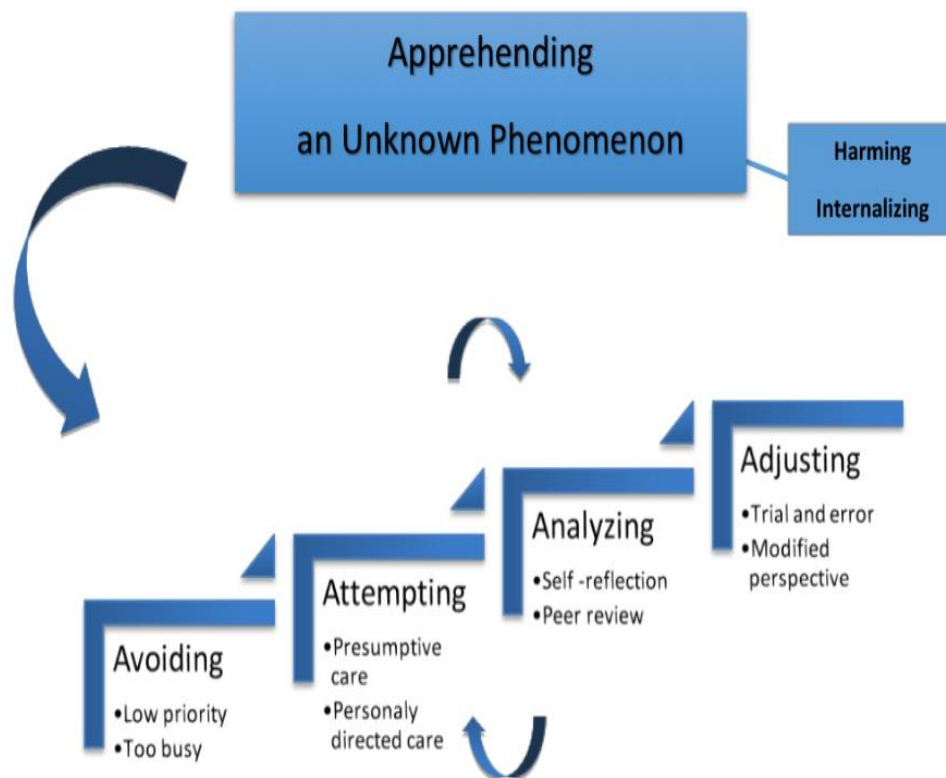


Figure 2. Conceptual model of *Apprehending an Unknown Phenomenon*. By author.

### Chapter Summary

In this chapter, the researcher included a discussion of the data obtained from participants during Phase 1 and Phase 2 of the study and the results of the ongoing analysis of data throughout. Thirteen participants contributed to the Phase 1 data by participating in individual interviews. In Phase 2, five nurses who were experts in the subject matter confirmed the coconstructed categories that evolved from the data. A core category, *Apprehending an Unknown Phenomenon*, supported by the subcategories of *Harming and Internalizing*, was created from the data and was elevated to the level of the basic social process of interest during the fourth phase of data analysis (Figure 1). Four conceptual categories were constructed: *Avoiding*, *Analyzing* and *Adjusting*, and

*Attempting* from the subcategories of *Presumptive care* and *Personally directed care*.

The social process precipitated the steps described in the conceptual categories which guided the participants in their decision making process when caring for patients who have experienced sexual assault.

## CHAPTER FIVE

### DISCUSSION AND CONCLUSION

The purpose of this qualitative grounded theory study was to identify the process that nurses without specialized training use to care for patients who are victims of sexual violence. The development of a theory that framed the process was sought because of the lack of substantive theory surrounding the way in which nurses make decisions in the face of an unknown phenomenon. Using the constructivist grounded theory method outlined by Charmaz (2010, 2014) with aspects of the structural process developed by Glaser (2002), the core category *Apprehending an Unknown Phenomenon* was coconstructed from the data and provided the framework for the conceptual categories of *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting* to identify the social process of interest. *Apprehending an Unknown Phenomenon* was supported by the subcategories of *Harming and Internalizing*. The conceptual category *Attempting* was supported by the subcategories of *Presumptive care* and *Personally directed care*. In this chapter, the researcher presents an exploration of the meaning of the study, an interpretive analysis of the findings, the significance of the study to nursing, and the study strengths and limitations. The chapter concludes with recommendations for future study.

#### **Exploration of the Meaning of the Study**

A social constructivist approach to this grounded theory study informed the process and allowed for a dialectical discovery of “how” nurses who are untrained in sexual violence treatment decide to care for sexually assaulted patients. Through the IIG and FG, the participants were led to explore the situation of interest and to explain how they attached meaning to their decisions and actions. Utilizing inductive analysis, the

researcher began to theorize how and why they acted as they did (Silverman & Marvasti, 2008). Charmaz (2009) purported that the grounded nature of the research strategy is threefold: (a) researchers attend closely to the data, (b) their theoretical analyses build directly on their interpretations of process within the data, and (c) they must ultimately compare their analyses with the extant literature and theory.

In this study, the participants shared their thoughts with the researcher, including their experiences, values, and beliefs surrounding the roles they played in the care of the vulnerable population of sexual assault victims. Following the constructivist paradigm, the researcher viewed the data and analysis as created from a shared perspective. In opposition to the more objectivist perspective of Glaser and Strauss (1965), the researcher interacted with the data and analysis. This interaction led to the discovery of the categories and subsequent theoretical concepts that supported the basic social process (Charmaz, 2009). The analyses will be compared with the applicable extant literature below in the interpretive analysis of findings. This discussion will serve to ground the constructed social process, *Apprehending an Unknown Phenomenon*.

The grounded theory methodology used in this study was first employed by the researcher's following the established approach supported by Glaser and Strauss (1967) of simultaneous data collection and analysis. Inclusion of the divergent recommendations of Charmaz (2014) by building on the pragmatist underpinnings contributed to the construction of an interpretive portrayal of the studied world (Charmaz, 2014). The analysis revealed four main categories of *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*. *Attempting* was supported by the subcategories of *Presumptive care and Personally directed care*. These conceptual categories provided the framework for the core category,

the basic social process of *Apprehending an Unknown Phenomenon*. The subcategories of *Harming* and *Internalizing* supported the basic social process.

The pragmatist underpinning of this study emphasized a problem solving perspective as the participants described their actions when faced with a patient who has experienced the traumatic event of sexual violence. “The fluid nature of the participants’ realities aided the researcher in defining multiple perspectives, combined with facts and values in the search for an abstract understanding of the phenomenon” (Charmaz, 2014, p. 230).

### **Interpretive Analysis of the Findings**

In Chapters One and Two, the background, purpose, and literature review were presented to explicate the need for this study. In the literature review, the issue of sexual violence and its impact on individuals, families, and communities was well represented in the scientific literature. These studies supported the need to address nurses’ experiences with sexually assaulted patients. Studies on caring for those affected were reviewed to a lesser degree, but the need for further inquiry is evident with regard to nurses both trained and untrained in the specialty. Specialized programs do exist in this country and globally, but these programs are sparse and in some cases poorly sustained. Subsequently, the majority of care provided to this population falls to emergency department nurses who are for the most part untrained and unprepared (Campbell et al., 2005).

As an exhaustive literature search revealed, exploration of the process that nurses use to address the needs of those presenting with sexual assault is nearly nonexistent. The focus of the current research was to contribute to an understanding of the process used by nurses and examine the critical influences that drove their decisions and actions. The

ultimate goal of the study was to base the findings about the process on scientific evidence and that the outcomes for both patients and nurses would be positive.

Individual participants were interviewed in the IIG, and the data were coded and analyzed with a constant comparative process. Comparing data from and between participants, data from the same participants at different times, and properties found in the data with other properties led to saturation of categories that generated theoretical concepts (Charmaz, 2009). The theoretical concepts that emerged were *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting*. These concepts supported the core category and subsequent basic social process, *Apprehending an Unknown Phenomenon*. The experts in the field in the FG were able to confirm the constructed process as consistent with their experiences and interpretations. The model was accepted as a feasible conceptual rendering of the basic social process *Apprehending an Unknown Phenomenon*. The main concepts are next discussed, interpreted, and supported with extant literature.

### **Avoiding**

The category of *Avoiding* emerged as participants described how they responded to the assignment of a patient who was sexually assaulted. For the purpose of this study, *avoidance* was defined within the context of moral distress. In their 2012 study, DeVillers and DeVon proposed that “avoidance is more than the absence of physical presence” and that it “has been associated with repeated exposure to morally distressing situations” (p. 594). Utilizing the Moral Distress Scale (MDS), DeVillers and DeVon conducted a quantitative cross-sectional study that was used to compare the relationship of moral distress and avoidance behavior. The results showed that moral distress and avoidance occur in nursing practice, especially when nurses are faced with impediments



to perceived moral practice (DeVillers & DeVon, 2012). The findings led the researchers to include avoidance in a revision of the model for the MDS of the impact of moral distress on patients and organizations.

In the current study, *Avoiding* is supported by implicit and explicit examples of avoidance behaviors that relate to either a classification of sexual assault patients as low priority or a culture within the institution that recommends minimal contact with patients until the “experts” arrive. If forced to provide care to the patient, many of the participants described “shutting down” or “disconnectedness” as methods of protecting themselves from the morally distressing situation. **Asystole** described her observations of the care provided by other providers in this way:

I think some other people that I’ve encountered—I’ve really encountered both spectrums. Some who provide excellent care to the patient, and they went above and beyond and made sure that all of the patient’s needs were met. And then I’ve seen other people just shut down and not want to deal with it, not want to process it, not want to have anything to do with the patient. And they almost come off a little bit cold to the patient. In the ER, we compartmentalize because that’s the only way we make it through. We see so much tragic issues and situations that there’s times that if you don’t compartmentalize you’re not gonna make it through your shift.

This theme recurred in most of the participants’ responses when asked how they decided to care for these patients. The categories that emerged from the participants, “disconnecting,” “protecting,” and “shutting down,” were subsumed into the theoretical concept of *Avoiding*. As the participants spoke, the researcher observed that the process

was active, so the gerund of the concept was used to reflect the fluid nature of the experience.

Siminoff, Erlen, and Sereika (1998) found in their study on nurses' avoidance of patients diagnosed with AIDS no significant difference in physical care provided to AIDS patients versus those without the diagnosis. However, the researchers demonstrated that nurses spent less time with patients diagnosed with AIDS and engaged less in positive verbal mannerisms with them than other patients. The study also demonstrated that psychological avoidance could negatively impact patient outcomes, even if physical needs are adequately met.

In a qualitative study with a hermeneutic phenomenological approach, Michaelsen (2011) explored nurses' relationships with patients they regarded as being difficult. Data were collected in a home nursing unit over 18 months and included participant observations and extensive interviewing. Patients' case records were studied, in addition to four meetings with the staff to discuss the findings. Three strategies were identified: persuasion, avoidance (emotional distance), and compromise. Nurses' use of the avoidance strategy resulted in important social and health problems not being recognized of some patients. A provocative finding was the nurses' fear of losing contact with their emotional lives (Michaelsen, 2011). In the current study, *Avoiding* emerged as a protective mechanism. Introspection of the effects on the participants' emotional states as they used this process was not discovered in the data.

### **Attempting**

In this study, the category of *Attempting* emerged from the data as an unavoidable event. In some cases, minimal contact was recommended with the patient, but in other

cases the nurses were required to provide full care, including evidence collection. *Attempting* was defined by the researcher in this study as a constellation of actions provided by the nurse under suboptimal circumstances. Without nurses' proper training, the data supported the construction of the subcategories of *Presumptive care* and *Personally directed care*. *Presumptive care* in this study was care that is thought of as reasonable and within the parameters of general nursing knowledge.

The actual connection to general nursing knowledge within the context of caring for patients who have experienced sexual violence is tentative at best. Most of the trauma inflicted on these patients is psychological and emotional and does not necessarily conform to familiar presentation of signs and symptoms. The reference points that general nursing knowledge provides to nurses when dealing with unfamiliar diagnoses can mitigate the anxiety related to their decision making process. However, standard nursing curricula do not include the reference points related to this type of phenomenon. The nurse must, as participants expressed, "go with my gut" or rely on "how I would want to be treated."

The voices of the participants led to the construction of the subcategories, which subsequently led to the theoretical category *Attempting*. When asked the question, "What influenced how you care for patients who have had this experience?" Beth made a telling comment: "I kind of go with my gut."

**Asystole** responded to the same question in this way:

At a previous location where I worked at a different facility, my clinical educator there had specific training, had SANE training for these types of patients. When I was on orientation at this facility, it kind of came up and she was telling me a

little bit about it. It's definitely something that interests me because I think you can provide nursing care to someone with a heart attack, you can provide nursing care to someone with a stroke, but these particular patients I think you can make the biggest impact on how you care for them. So that kind of means a lot to me—that I can have a very big impact on someone just in how I care for them. So that kind of drives me and drives my interest in it.

*Personally directed care* emerged from the participants' personal perspectives in the event—that they would be subject to the same experience. Internal constructs informed their decisions regarding how to structure the care of those affected. **Elizabeth** explained how this concept drove her process:

I think like firstly it would be I would rely on, how I would want to be treated myself if something like that were to happen to me. Then I think when you take a lot of the courses in school they talk about empathy and really not specific to this, but you can draw from some of the materials for this.

Similar responses from many of the participants contributed to emergence of the subcategories and led to the construction of the theoretical concept *Attempting*. As in the theoretical concept *Avoiding*, the active form *Attempting* reflects participants' movement within the process.

Saevareid and Balandin (2011) conducted a qualitative study using a constructivist grounded theory approach that explored nurses' thoughts and attitudes about cardiopulmonary resuscitation (CPR) of oldest old patients. At the conclusion of the study, the researchers discussed the ethical dilemmas surrounding the lack of a concrete process in end-of-life decisions. These dilemmas created anxiety and discomfort

for nurses in their working situations. The use of “slow codes” and the underutilization of “do not attempt resuscitation” created the most confusion in how to care properly for these patients (p. 1739).

The connection of Saevareid and Balandin’s (2011) research to the current study was made in the expressions of uncertainty the nurses in the care facility experienced when they had ambiguous or absent direction in providing proper care. As the nurses in the current study identified, they often had been given or no direction but proceeded with care based on an assumption that “something is better than nothing.” Neither group could adequately base their decisions on concrete evidence, either because of a lack of evidence or lack of implementation of standard evidence-based protocols.

In a grounded theory study, Sobel and Sawin (2014) explored the nursing care that leads to culturally competent care for Hispanic patients. The research described both actual and hypothetical suggestions for operationalizing a model of ideal nursing care (Sobel & Sawin, 2014). In the Sobel and Swain study, both the patients and the nurses were attempting to navigate a complex and power-infused system without a clear path. They relied on trying different activities to meet their needs. The aim of the study was to identify a theoretical model that could guide the process. Guidance of the process of culturally competent care with Hispanic patients developed the process from a trial-and-error approach to an informed and purposeful method of partnering with patients toward improvement of their health outcomes.

A 2011 grounded theory study by Muganyizi, Nystrom, Axemo, and Emmelin explored the experiences of rape victims and supporters’ experiences of barriers within the police and the healthcare system in Tanzania. The need for the study was

demonstrated by the identification of a complex process with numerous barriers that is known to be inadequate to meet the needs of those who experience sexual violence. In Tanzania, it is estimated that 10% to 20% of women aged 12 or more are estimated to have been raped at some time (Muganyizi, Kilewo, & Moshiro, 2004; Williams, McCloskey, & Larsen, 2008). The Muganyizi et al. (2011) study was conducted for understanding and conceptualization of the experiences of the informants in the help-seeking process.

This study confirmed that, even with government reform related to the issue, victims and supporters found clear path to assistance and they were left to navigate through the system utilizing a trial-and-error approach. The core concepts of negotiating truths and knowing what to do paralleled the theoretical concept *Attempting* that was constructed in the current study.

### **Analyzing**

For this study, *analyzing* was defined within the context of reflective thinking. This meaning can be traced back to Dewey (1933) and Habermas (1987) with the definition as “careful consideration and examination of issues of concern related to an experience” (Kuiper & Pesut, 2004). In studying cognitive and metacognitive reflections and reasoning skills of nurses, Kuiper and Pesut advanced the idea that both cognitive and metacognitive skills support the development of clinical reasoning skills. Although the participants in the current study rarely engaged in the metacognitive phase, they expressed differing levels of self-reflection and discrimination related to the source of evidence used to advance their skills. The participants generally relied on an internal process of reflection, although some of them actively sought out guidance from more

experienced colleagues. In participants' seeking of advice, they frequently vacillated between the former step of *Attempting* and the next step of *Adjusting*.

Caring for trauma patients who are critically ill presents a challenge to nurses during an often challenging phase of patients' recovery. The emotional needs of the nurse are not often addressed, and high rates of stress and burnout in these settings is a constant problem (Maier, 2011). Bostrom, Magnusson, and Engstrom (2012) conducted a qualitative thematic content analysis of eight critical care nurses to describe their experiences with nursing patients suffering from physical trauma. In this study, the critical care nurses felt "it was good to reflect over their work both by themselves and others, it improved the care the next time" (p. 25).

The nurses described their processes of introspection at multiple times before, during, and after their shifts. One critical care nurse described how she ended her day at work by thinking a positive thought. "Sometimes when I get such thoughts I think: What has been positive about today? If you try to see something positive, you will find it, you do that" (Bostrom et al., 2012, p. 25). It is apparent that the nurses in the critical care study were quite purposeful in their self-analyses of their performance and that the process was helpful to avoid burnout. The nurses in the current research study were more likely to utilize the step *Analyzing* in a situational context, and this theoretical concept is supported by the Bostrom et al. (2012) findings with critical care nurses.

In a study on the use of reflective learning journals for online graduate nursing students, Langley and Brown (2010) examined the perceptions of graduate nursing students and a small sample of faculty on the effect of reflective learning journals on outcomes. The learning outcomes included professional development, personal growth,

empowerment, and facilitation of the learning process. An instrument was developed that measured the participants' perception of the four learning outcomes. The results of the study supported the existing literature that reflective learning journals enhance the development of the professional self in practice. An additional finding of interest was that the graduate students agreed that reflective journaling enabled them to examine their own attitudes and see problems from the perspective of others (Langley & Brown, 2010).

With reference to the present study, recommendations for the use of reflective journals can easily be made for emergency room nurses who care for patients who experience sexual violence. Journal practice would facilitate nurses' ability to discern problems from the perspective of others. Many of the nurses in the current research study described the step of *Analyzing* and already appeared to be engaging in self-reflection.

**Sunflower** spoke of how she changed due to her experience and the subsequent self-reflection the situation stimulated:

So you kind of have to look at it through all perspectives. Maybe a person that you don't like at work or not is a nurse as a person, you have to kind of look back at maybe what they've been through. Maybe thinking about the back stories a little bit more, you know their experiences.

**Mom** reflected on how she cared for all of her patients in the same way but made a distinction when reflecting on how she would handle the emotional needs of the patient who has experienced sexual violence:

As a practicing nurse I do like to take care of my patients all the same way, you have to care for them no matter what brings them to you or to the ER. As an ER nurse you have to provide excellent care all the time. It hasn't really changed



much because I care for my patients the same way except the fact that this one situation needs extra care I guess when you speak to the patient how you just handle their emotional needs at that point.

### **Adjusting**

In this study, *adjusting* was defined as the alteration of something slightly in order to achieve the desired result (*Merriam-Webster's Online Collegiate Dictionary*, 2012). The emergence of the concept that described a slight alteration was consistent with the data provided by the participants. The changes described by the participants were small and varied, depending on the events of their situations. Rather than relying on scientific evidence or protocols, the participants used trial and error as their guiding principle. Concrete changes in practice were not reflected in their descriptions of subsequent exposures. Nor did these exposures lead to elevation from adjustment to modification of the process.

Most participants reported that over time, through trial and error, they became more comfortable with their performance. However, none of the untrained nurses felt entirely comfortable with the care they provided, even after more exposure to sexually assaulted patients. When **Beth** was asked how she might have changed or if there was anything she might do differently over time when working with this population, she stated:

I'm not as scared anymore. Like the first people to come in, actually nobody really wants to take care of them because you're there for hours. It's kind of one-on-one when we did the SANE exams here. And then, usually if they're done with the SANE exam, they go to another room and have a different nurse. Which I

think it's also kind of tough for patients. Now I'm more confident. I kind of go in there and be direct matter-of-fact, use simple terms because I'm sure they're not processing as well as they could. But definitely confidence over the years. I come like—before I'd ask questions.

Now I let them talk. I don't ask specific questions about the assault like Did you know the person. Mostly now I'll go in there and say where you hurt, that kind of stuff. Do you have any pain or discharge? Do the police know? do you want us to notify the police? Before I used to ask, you know, Do you know the person and where were you? Now I don't do all of that. I just need to know is going on with you, and do you want me to call the police?

**Daisy** described how she has adjusted her approach based on the unique experience of the patient. She continued with suggestions about what was needed to improve her care of these patients and the needs of the nurses:

It's kind of different. Let's say, for example, if you have a medical patient coming in having problems, maybe cardiac issues, then you know that you know how to take care of that. But with somebody who was physically abused, sexually abused, I tend to be more patient with them. I listen to them and I'm more present with them. You know? I am more emotionally connected to them.

I wish that there would be more courses available or even a support group for nurses who actually take care of these patients, because like I said, it is very emotional and you do get affected. Even just a little bit. It would be good if we could help people who are just starting out by talking about things like--Hey, this is how we take care of these kinds of patients. And we can talk about the situation

and the physical manifestation of what happened to them. I wish there would be more support group for nurses also, not justification, but also for nurses that had to deal with this type of situation.

**Elizabeth** reflected on the two people she cared for and how each case affected her perspective, as well as the lessons she took with her from the interactions:

I think the first person was kind of easier in the way that they came in. The physician cleared them to be able to go to be examined and have specimen collection elsewhere. Then the second person was the more difficult one. They came from a nursing home, and the person was demented, but they kept saying that somebody had assaulted them. They said somebody raped them. And I remember it being ignored—She's demented, she doesn't know what she's talking about. And even I felt that way to a point, but then she kept saying it.

She was admitted to the hospital, and they decided then that she wasn't going to be able to go get examined by the city. And we had to do it, and before we did the exam she ended up in the MICU [Medical Intensive Care Unit]. And it was like this big ordeal because I think they have less training than we do. That it was a big ordeal with them calling for help and us feeling like we couldn't help them as well as we wanted to.

We had a couple of SANE nurses, but they weren't working and where I worked before. There's really not much attention paid to having one on every shift. I think I learned to be stronger in advocating for patients who are saying something like that, and not letting people blow them off. Even if they are not telling the truth or even if they are demented and they don't know what they're

saying. If someone says something like that, just like if someone says, I want to kill myself, I can't decide personally whether they really want to do that or not. I can't decide if they were really assaulted or not, and I need to act as if everything they are saying is true.

**Frances** became more comfortable with the subject of violence and reflected on the impact that perspective brought to her practice:

I can't think of anything specific in particular. I just think being comfortable asking patients if they have been exposed to violence and if they would like assistance or anything like that. I think that's a big point in the whole thing—that people are afraid of saying if they don't have a safe environment or something like that. I think that if I'm not comfortable with it, then the patient certainly will not be, so I think just being better at that has helped.

**Joe** discussed how his experiences in the emergency department, especially with sexually assaulted patients, changed him and how he changed his approach. This change also reinforced lessons he learned in his person life:

It definitely has changed. At least it has been magnified. Before I had any actual experience, it was just going off of what I've heard in the news or what my dad had told me and that kind of stuff. I knew it was a terrible thing, but now, after working here and seeing it firsthand, I know firsthand how bad it is. I know how delicate these people are at that particular moment. It's kind of tough. Because I do have some exposure but I haven't been doing this for very long time.

The first time I remember I was really nervous. I kind of walked into the room, and I was trying to be cheery and trying to lighten the mood. Then I

realized—let them be upset, they should be upset if they want to. I'm not going to change their mood and make them feel 100% better in a half hour or hour that they're with me. So let them be upset and kind of just be an ear for them. If that's what they need, that's what they need. Don't try to do too much for them. Try to do what they need me to do, but don't do too much. Don't kind of like walk in all—Hey, how are you? You know how they're doing just going in, and if they need anything just get it for them.

Nursing homes were studied by Teresi et al. (2013) with a quasiexperimental design to estimate the effects on falls, negative affect and behavior, and the associated societal costs of implementing evidence-based education and best practice programs. Forty-five nursing homes participated in the study. A low-cost intervention resulted in a significant reduction in falls between 5 and 12 annually. In comparison with the process the participants used in changing practice, the referenced study was formalized and consistent between sites.

The process of women's disclosure to healthcare professionals of intimate partner violence was studied by Catallo, Jack, Ciliska, and MacMillen (2013) with a two-phase mixed-methods study. The process identified related to the basic social problem of "being found out" by healthcare providers while the patients received care (Catallo et al., 2013, p. 1366). A concept discovered points to the need for adjusting practice by nurses who participate in the care of persons who experience interpersonal violence. From the participants' responses, evaluation of their trust level of trust in the healthcare provider was an integral part of their decision to disclose in an active way. In this study, the choice to self-disclose was linked to an increased ability to create change. The study suggested

that emergency department nurses play an important role in facilitating intimate partner violence disclosure if nurses are skilled in creating a supportive and trusting environment. In the current study, over time many of the participants were able to adjust their practice to include a supportive and safe place for disclosures by patients who experience sexual violence so their needs can be better met.

Krupp, Madhivanan, and Kara (2007) sought to discover an effective way to recruit sexually active women in Mysore, India, for a study investigating the relationship between bacterial vaginosis and acquisition of HSV-2. Traditional clinic- and hospital-based recruitment was found ineffective, so a novel approach was taken to improve the number of study participants. The study focused on past practice and a clear understanding of the complex nature of sexuality in the local culture.

A community supported enrollment process was compared with the traditional clinic-based strategy and was found to be significantly more effective in recruitment and retention of study participants (Krupp et al., 2007). With reference to the current study, researchers and healthcare providers should be willing to adjust and improve their routine methods based on results of previous interventions. The nurses in the current study contributed to the discovery of the conceptual category of *Adjusting*. The literature reviewed here supported the construction of this theoretical concept.

### **Apprehending an Unknown Phenomenon**

The basic social process used by emergency department nurses who were untrained in the care of patients who experience sexual violence is described within the theoretical framework of *Apprehending an Unknown Phenomenon*. This theoretical framework precipitated the entry into the steps and informed the participants' decision

making process. *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting* were the main categories by which the nurses structured their care. The concepts were dependent on each other and nurses proceeded in a stepwise progression. In the steps *Attempting* and *Analyzing*, some of the participants required a pause in the process, enabling them to alternate between the two steps before moving to the next step.

*Apprehending an Unknown Phenomenon* in this study reflected the basic social process used by the participants to navigate the complex and daunting process of caring for the vulnerable patients who experienced a sexual assault. Through the interviews and research process, the nurses explored the meaning of their actions and discovered the critical influences that drove their decisions. These explorations took place perhaps for the first time in their careers. *Apprehending an Unknown Phenomenon* linked the main categories and provided the basis for a description of the process, grounded in rich, thick data.

The literature related to the explicit process of decision making used by nurses who have little or no foundation in the care of patients presenting with unique experiences is sparse. Curricula in nursing programs emphasize the physical and biological sciences. Psychosocial components of the human experience are certainly covered, but the focus, especially in the clinical setting, is on the assessment, care, and management of the priority issues (Aktan et al., 2009). These are usually related to illness discoverable by various means.

In most cases, an adequate foundation of knowledge and understanding of the biophysical parameters and responses enables nurses to transfer concepts from one condition to another when deciding how to care for patients with a unique presentation of

a physical condition. A framework is present for reference, as well as empirical evidence to access and analyze. With these tools, nurses may provide at the minimum supportive care. In the case of the “unseen” injuries caused by a sexual assault, the lack of a foundational framework leads to the use of a process that is not based on empirical evidence. In this study, the participants described “winging it,” proceeding by their “gut”, and “trial and error” as guiding principles in the process of treatment. The basic social process discovered, *Apprehending an Unknown Phenomenon*, supports the nurses’ need to construct and adhere to an alternate method of providing care for patients who have experienced the traumatic event of sexual assault.

In a qualitative study conducted with nurses in Australia, Cecil and Glass (2014) sought to discover nurses’ perceptions, emotions, and regulation in patient care delivery. The researchers utilized reflective journaling and interviews with five nurses to elicit the ways in which they regulated their emotions. Emotional regulation demonstrated by a “professional face” allowed the nurses to provide quality care, even though this professional face resulted in emotional containment. The regulatory process was protective and served for nurses to look after the self, especially in the face of emotional dissonance.

The findings of Cecil and Glass (2014) supported the subcategories of the present research. These emerged in the discovery of the basic social process *Apprehending an Unknown Phenomenon*. In the construction of this core category, *Harming* and *Internalizing* were recognized as important. The participants repeatedly used words such as “unknown,” “unsure,” “scary,” “frightening,” “unsatisfying,” and “concern.” At the same time, they described putting on their “therapeutic face” to a certain degree. Their



underlying concern related to harming an already damaged individual. This concern informed all of their actions and drove their progression through steps of the discovered process.

### **Significance of the Study for Nursing**

Identification of the process that nurses use to care for vulnerable patients, specifically patients who experience sexual violence, is significant to nursing because identification addresses a gap in nurses' ability to construct an evidence-based process when faced with an unknown phenomenon. The literature is scarce in directly exploring this issue, although a corresponding proliferation of literature exists that supports the need to improve the care delivered to patients who experience sexual violence. The difference between what is available and what is needed is unacceptable, and the responsibility to change that dynamic rests squarely on the shoulder of those tasked with protecting the vulnerable.

Research into the process of comprehensive and unflinching care will lead to the development and implementation of comprehensive and consistent guidelines related to the care of sexually assaulted patients. Long-term outcomes can be improved by an informed and purposeful approach to the care of these patients; such an approach could significantly change the trajectory of their lives. Nurses are positioned to be leaders in advocating for a change in perspective related to this traumatic experience, from a singular event to a serious risk factor for chronic disease. The elicitation of the process and formation of the substantive theory *Apprehending an Unknown Phenomenon* in this study can lead to the development and implementation of comprehensive and consistent guidelines related to the care of these patients.

Use of the theory in the investigation of other unknown phenomena is possible and is significant because it can lead to an increase in knowledge related to the profession of nursing. How nurses decide, what factors influence their decisions, and why they chose differing paths are all essential questions to uncover so that nurses can continue the path towards an informed and evidence-based practice model. As healthcare becomes more complex, nurses must find new ways of dealing with the challenges to be faced in the future.

### **Implications for Nursing Education**

Schools of nursing are charged with the preparation of the future nursing workforce as well as the continuing education of practicing nurses. The population in the United States is aging, chronic health conditions are increasing, and care of patients is becoming more and more complex (CDC, 2003). The impact of the economic crisis affects access to care that leads to poorer health outcomes. The amount of information that must be covered in nursing curricula is increasing at a rapid pace, and nurse educators find it difficult to keep up with the demands, especially within the context of shorter nursing programs (Aktan et al., 2009).

Identification of the process that potential and practicing nurses use to care for vulnerable patients will produce development of a focused educational intervention that will meet the needs of both patients and nurses. Addition of content expressly for vulnerable patients to a curriculum in a focused but comprehensive manner can add to the proficiency of nurses and better assure competent care. Training of nurses should include self-evaluative processes that help nurses identify inherent biases toward certain patients or presenting conditions. Self-evaluations can lead to the goal of development and use of

tools in which to mitigate negative effects on their patients. Patients can then feel more supported and may choose to follow up with recommendations that will in turn decrease further negative consequences. This study identified areas in nursing education that are lacking related to sexual violence and the ability of nurses to care properly for these patients. Recommendations for inclusion of specific concepts related to sexual violence are made.

### **Implications for Nursing Practice**

With regard to nursing practice, stress increases when nurses are tasked with caring for patients who have complex needs, especially if prior nursing preparation is inadequate. People who experience sexual violence react in complex and unique ways to this type of trauma. Nurses who are unaware of the atypical nature of presentation by these patients may inadvertently act in ways that are perceived by patients to be blaming or judgmental. An understanding of the dynamics of rape trauma and nurses avoidance of revictimization of their patients can increase the nurses' perceived competency and improve health outcomes for these patients. Inclusion of the topic of sexual violence in orientation and annual competency programs within institutions will be a first step in the educational and training process toward more comprehensive practice.

The ANA (2010) and the WHO (2003) established guidelines and standards of practice related to the care of patients who are victims of sexual violence. However, neither of these documents has been widely adopted or operationalized. This study serves to highlight the availability of these processes, which may lead to wider adoption and institutionalization in nursing practice.

The results of this study clearly demonstrate a need for inclusion of the topic of nurses' training in care of sexual violence patients in all areas of nursing education, including orientation for new staff, annual competency requirements, and licensure renewal. There is no place in nursing practice for a trial-and-error approach to patient care described by the nurses in this study. The study is significant in shining a light on that process. None of the participants recalled any information related to sexual violence in their nursing programs, postlicensure positions, hospital orientation, or precepted experiences. It is of concern that even in the emergency department, where most of these patients present, little or no training exists for the care of these vulnerable patients. The frustration the participants felt was evident, and this study allowed their voices to be heard.

### **Implications for Nursing Research**

Nurses make decisions in many different ways about how to care for patients. The Nursing Process (Castledine, 2011) is the framework that is used to develop plans of care, but it breaks down and is inadequate if assessments are either incomplete or incorrect. Research that considers alternate processes is lacking for nurses' decision making that is situational and contextual. This study may be significant to nursing research because it explored the issue from the perspective of nurses who are experiencing the phenomenon and illuminated the critical influences that guided their practice. As a result of this study, the themes that emerge can be used to develop an instrument to collect additional data for greater understanding. The data regarding this population may have broader implications, and additional studies will enhance generalizability of the results.

### **Implications for Health/Public Policy**

This study is significant to public health policy because the study focused on a vulnerable population that is often underserved. Nurses need to advocate for a system wide requirement that institutions in which nurses care for these patients provide uniform and comprehensive protocols and or guidelines. Understanding how nurses decide to care for these patients can assist in the development of a plan for institutionalizing such protocols. As a result of the problem and long-term negative outcomes, sexual violence is considered a public health crisis, both in the United States and globally (Tjaden & Thoennes, 2006). This study illustrates the need for mandatory education and training for nurses in the area of sexual violence and the care of patients who have been assaulted.

In 1996, the executive director of the ANA predicted that within 10 years, the Joint Commission would require that every hospital have a forensic nurse available (Black et al., 2011). This requirement has not been realized. The results of this study may lead to discussion and exploration of why this outcome has not taken place and what can be done to reach this goal.

### **Strengths and Limitations**

The major strength of this study lies in the rich data elicited and the shared voices of the participants. Although the nurse participants were busy and in some cases found the subject difficult to discuss, the ability to speak to the anxieties and frustrations surrounding their lack of preparation in a safe and supportive environment may validate the work they do under trying circumstances. In qualitative research, the goal is to hear the voices of the participants and discover the meanings they attach to their words. Charmaz (2014) pointed out that through the qualitative interview process participants

are able to “reflect in ways that seldom happen in everyday life” (p. 58). Much of the time, nurses are the ones who are listening, especially when their patients are in crisis. This study approached the nurses’ contributions with a different perspective, in which the researcher listened to the nurses.

The formation of the substantive theory *Apprehending an Unknown Phenomenon* is a strength of this study. The theory will be used to frame the path to improved care for patients who have experienced sexual violence, with appropriate training for the nurses charged with their care. The theory can also be used to investigate experiences of other healthcare professionals, which may elicit a similar state of being in which participants are faced with an unknown phenomenon, such as exposure to new pathogens like Ebola and the Zika virus. The search for identification of the process that nurses, nursing students, and other healthcare professionals use to make decisions in extreme circumstances can become less difficult when viewed through the lens of this theory.

Several limitations are acknowledged for this study. The nurse participants were all busy with their required duties and preferred to minimize the amount of time required for participation. During data collection, some participants discussed their difficulty talking about the subject, both at work and in general. Even though part of their job required the ability to ask sensitive questions of the patients they cared for, many participants felt uneasy and inadequately prepared to ask those questions. Specific questions regarding sexual violence are not typically asked unless the patient is in the emergency department with that complaint.

As expected, none of the nurses in the IIG group felt comfortable with those questions, especially because they had no training related to the process. In comparison, a

question required in all emergency departments by all registered nurses during the initial encounter with a patient pertains to feeling safe at home. The purpose of this type of question is to screen for domestic violence, and this is a topic that is covered in academic programs as well as most hospital orientation programs.

Depending on the circumstances surrounding the visit to the emergency department and the chief complaint of the patient, many in this study admitted to asking the question in a way that diminished its validity. For example, they prefaced the question with the statement, "I know this sounds silly but we have to ask all patients these questions." Some of the participants admitted to neglecting to ask the question altogether and believed that they were not alone in this omission. Even though information regarding personal feelings and/or personal experience with sexual violence was not a part of this study, the sensitive nature of the topic may help to explain the participants' desire to minimize their time discussing the subject. The lack of geographical variability and the fact that participants were drawn from only two hospitals are recognized limitations of the study. Further studies should consider additional locations and a greater number of hospitals. With replication of the present study, comparison of differences may strengthen the transferability of the findings.

### **Recommendations for Further Study**

Many avenues related to the topic of this study require further exploration. Replication of the study in other locations may elicit similar results, or different locations may have an impact on the process used by other nurses. The development of an instrument that quantifies the theoretical concepts discovered in this study will allow for a deeper understanding of the gaps in education and practice related to the care of

vulnerable patients. Such an instrument may lead to the provision of evidence-based practice guidelines for nurses in the care of people who experience the trauma of sexual assault. Further studies evaluating the effectiveness of instituted guidelines would be the next step in improving care.

Addressing of the issue by exploration of the effects of a practice change for nurses and patients alike will reinforce further studies, in which a variety of scientific inquiry methods can be utilized. These will advance the body of knowledge in the profession of nursing. The model developed here can be used in other studies to explore processes used by different groups to make decisions, which may in turn improve outcomes of interest. The model can be used in other disciplines as well, in which potential unknown phenomena may be experienced.

### **Summary and Conclusions**

This study utilized grounded theory within the social constructivist paradigm to identify the process that nurses without specialized training use to care for patients who are victims of sexual violence. Critical influences that govern the nurses' attitudes and behaviors were explored. Data were collected from a purposive group of 13 emergency room nurses from two urban hospitals in Pennsylvania. Five SANEs comprised the theoretical group that confirmed the major categories and led to the construction of a model depicting the process. The constructivist approach to the study provided the groundwork for the discovery of the created categories through eliciting of rich data.

The data were concurrently analyzed, and four categories emerged: *Avoiding*, *Attempting*, *Analyzing*, and *Adjusting* emerged. These categories created the conceptual model framework that supported the basic social process, *Apprehending an Unknown*



*Phenomenon.* This model was substantiated in the literature. Implications for nursing, education, research, and public health policy were outlined. Strengths and limitations of the research were addressed, and recommendations for further study were explored.

With further development of an evidence-based model, study findings should help improve outcomes for patients and reduce stress and anxiety in nurses who treat patients who have experienced traumatic sexual violence. The model has the potential for use in circumstances other than emergency departments, as well as within different disciplines and for different populations. It is hoped that this study will fill a gap in the nursing literature concerning nurses who care for victims of sexual violence. Findings should encourage further research, protocols, and guidelines to support these nurses in the difficult and sensitive care of these patients.

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## APPENDIX A

## Barry University IRB Approval



OFFICE OF THE PROVOST  
INSTITUTIONAL REVIEW BOARD

11300 NE Second Avenue  
Miami Shores, FL 33161-6695  
**phone** 305-899-3020  
800-756-6000, ext. 3020  
**fax** 305-899-3026  
www.barry.edu

Research with Human Subjects  
Protocol Review

Date: May 30, 2012

Protocol Number: 120510  
Title: A Grounded Theory Study of Nurses Who Care for Patients Who are Victims of Sexual Violence

Meeting Date: May 16, 2012

Researcher Name: Ms. Dara Whalen  
Address: 9 Lees Avenue Apt 2  
Collingswood, NJ 08108

Faculty Sponsor: Dr. Jessie Colin  
Barry University – Division of Nursing

Dear: Ms. Whalen:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on May 16, 2012 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may, therefore, proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

All changes must be made to the protocol not the dissertation. Also, the changes must be provided to the IRB office in writing and approved prior to data collection. Please submit 2 copies of the protocol. One copy should have the changes highlighted and numbered and the other copy should be a "clean" copy (no markings).

Regards,



Doreen C. Parkhurst, M.D., FACEP  
Chair Institutional Review Board  
Associate Dean, SGMS &  
Program Director, PA Program  
Barry University  
Box SGMS  
11300 NE 2nd Avenue  
Miami Shores, FL 33161

Cc: Dr. Jessie Colin

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.



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OFFICE OF THE PROVOST  
INSTITUTIONAL REVIEW BOARD

Research with Human Subjects  
Protocol Review

To: Ms. Dara Whalen  
9 Lees Avenue Apt 2  
Collingswood, NJ 08108

From: Linda Bacheller Psy.D., J.D.  
Chair, Institutional Review Board

Date: June 16, 2014

Protocol Number: 120510  
Protocol Title: A Grounded Theory Study of Nurses Who Care for Patients  
Who are Victims of Sexual Violence

Dear Ms. Whalen:

Thank you for sending the request for modifications indicating that you would like to make changes to your protocol regarding:

1. Deleting Alaska and Florida cohorts and will only be using participants from Pennsylvania.
2. End date extension from December 1, 2013 to August 30, 2014.

The above changes are accepted. You may proceed with your collection of data. The approval granted expires on August 30, 2014.

Sincerely,

Linda Bacheller, Psy.D., J.D.  
Chair, Institutional Review Board  
Barry University  
Box Psychology  
11300 NE 2nd Avenue  
Miami Shores, FL 33161

Cc: Dr. Jessie Colin

If you have any questions, please contact Barbara Cook at: 305-899-3020

\*\*\*\*\*  
Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

## APPENDIX B

## Participant Consents: Individual Interviews and Focus Group

Approved by Barry University IRB #

Date: MAY 30 2012

Signature: 

Dara M. Whalen, MD, PhD

Institutional Review Board  
Protocol Form  
17Appendix G  
Participant Consent – Individual Interviews**Barry University  
Informed Consent Form**

Your participation in a research project is requested. The title of the study is "A Grounded Theory Study of Nurses Who Care for Patients Who Are Victims of Sexual Violence". The research is being conducted by Dara M. Whalen, a doctoral student in the College of Health Sciences, Division of Nursing at Barry University, and is seeking information that will be useful in the field of nursing. The aim of this study is to identify the process that nurses without specialized training use to care for patients who are victims of sexual violence. In accordance with these aims, the following procedures will be used: Two audiotaped interviews will be conducted using open-ended questions, related to the topic of caring for victims of sexual violence. The first interview will last approximately 90 minutes and the second approximately 60 minutes. A maximum of 15 nurses in each of three locations will be utilized (45 participants in total). A smaller number of participants may be used if saturation of the data occurs at an earlier point in the analysis.

If you decide to participate in this study, you will be asked to participate in two audiotaped interviews either face to face or by utilizing Skype videoconferencing by mutual agreement. For face to face or Skype sessions, the first interview will last approximately 90 minutes and will include: selecting a pseudonym to protect your identity which will be used throughout the study, participating in an interview that will be guided by open-ended questions regarding your experience(s) caring for victims of sexual violence, and completing a confidential demographic questionnaire, which will be used in aggregate form for descriptive purposes. This first session should take no longer than 90 minutes in total. A second session will take place approximately 3 weeks later, face-to-face or utilizing Skype per mutual agreement. This session is to clarify and reflect on your statements and to check the accuracy of the transcription. It will last approximately 1 hour.

Both sessions will be audiotaped with your permission and transcribed verbatim by the researcher. Notes will be taken by the researcher regarding nonverbal communication. You have a right to refuse to answer any of the questions presented to you or not answer the questions posed unless the taping is paused and resumed at your discretion. The tapes will be held in a secure file cabinet, separate from any identifying information, and will be available only to me. I will be doing the transcription into text and when that is completed, and you have checked the accuracy of the transcription, the tape will be destroyed/erased.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects.

The risks of involvement in this study are minimal and may include uncomfortable feelings that arise from the interview. The following procedures will be used to minimize the risk: 1) at any time during the study you have the right to discontinue the interview, stop the recording, withdraw consent for some or all of the study or request that parts of the interactions be excluded from the analysis and write up, and, 2) you will receive a list that includes a number of ways in which you may contact a counselor anonymously to discuss those feelings and receive help at no cost. There are no known benefits of participation in this study.

After the first interview, you will receive a \$10 Amazon gift certificate by email as a token of

appreciation for your time. You may keep the certificate even if you decide to discontinue your participation in the study.

As a research participant, information you provide will be held in confidence to the extent permitted by law. Any published results of the research will be in aggregate form using only the pseudonym you have chosen. Data will be kept in a locked file in the researcher's home office for five years after the completion of the study and then destroyed. The audio-tapes will have no participant identifiers and will be destroyed once the transcription is completed and member check is confirmed. Your signed consent form will be kept separate from the data.

For participants who choose to utilize Skype for interviews, a link to Skype's privacy policy is included here for your review. <http://www.skype.com/intl/en-us/legal/privacy/general/?intsrc=client--windows--5.8--privacy>. The statement regarding their policy on privacy is "Skype is committed to respecting your privacy and the confidentiality of your personal data, traffic data and communications content". All Skype sessions will be audiotaped only using a tape recorder placed near the researchers' computer speaker. Skype does not have the ability to record video sessions.

If you have any questions or concerns regarding the study or your participation in the study, please contact me, Dara Whalen, at (856) 906-1279, my dissertation chair Dr. Jessie Colin, at (305) 899-3830, or the Institutional Review Board point of contact, Barbara Cook, at (305) 899-3020. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

#### **Voluntary Consent**

I acknowledge that I have been informed of the nature and purposes of this study by Dara Whalen and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this study.

\_\_\_\_\_  
*Signature of Participant*

\_\_\_\_\_  
*Date*

**For participants utilizing Skype, please type your name and the date below. This will serve as your electronic signature and consent to participate in the study.**

\_\_\_\_\_  
*Typed full name of Participant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Researcher*

\_\_\_\_\_  
*Date*



Approved by Barry University IRB ■

Date: MAY 30 2012

Institutional Review Board  
Protocol Form  
19Signature: *Dara M. Whalen, MD, PhD*

Appendix G  
Participant Consent – Focus Group  
**Barry University**  
**Informed Consent Form**

Your participation in a research project is requested. The title of the study is “A Grounded Theory Study of Nurses Who Care for Patients Who Are Victims of Sexual Violence”. The research is being conducted by Dara M. Whalen, a doctoral student in the College of Health Sciences, Division of Nursing at Barry University, and is seeking information that will be useful in the field of nursing. The aim of this study is to identify the process that nurses without specialized training use to care for patients who are victims of sexual. In accordance with these aims, the following procedures will be used: Individual interviews will be conducted with nurses who have no specialized training in the care of patients who are victims of sexual violence. After those interviews have been conducted, focus groups consisting of nurses who are experts in the field of sexual violence will be conducted. One audiotaped focus group per location will be conducted and will last approximately 60 minutes. I anticipate the maximum number of focus group participants in each of the three locations to be five (15 participants in total).

If you decide to participate in this study, you will be asked to participate in one audiotaped face-to-face focus group session with at most 4 other participants. The date, time, and location of the session will be determined by mutual agreement. The session will last approximately 60 minutes and will include: selecting a pseudonym to protect your identity which will be used throughout the study, participating in a focus group discussion that will be guided by open-ended questions regarding your experience(s) caring for victims of sexual violence, reviewing and discussing the categories identified from previously obtained individual interviews, and completing a confidential demographic questionnaire, which will be used in aggregate form for descriptive purposes. The session will be audiotaped with your permission and transcribed verbatim by the researcher.

You have a right to refuse to answer any of the questions presented to you or not answer the questions posed unless the taping is paused and resumed at your discretion. The tapes will be held in a secure file cabinet, separate from any identifying information, and will be available only to me. I will be doing the transcription into text and when that is completed, and you have checked the accuracy of the transcription, the tape will be destroyed/erased.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects.

The risks of involvement in this study are minimal and may include uncomfortable feelings that arise from the focus group session discussion. The following procedures will be used to minimize the risk: 1) at any time during the study you have the right to discontinue your participation in the session, stop the recording, withdraw consent for some or all of the study or request that parts of your interactions be excluded from the analysis and write up, and, 2) you will receive a list that includes a number of ways in which you may contact a counselor anonymously to discuss those feelings and receive help at no cost. There are no known benefits of participation in this study.

After the focus group session, you will receive a \$10 Amazon gift certificate by email as a token of appreciation for your time. You may keep the certificate even if you decide to discontinue your participation in the study.

As a research participant, information you provide will be held in confidence to the extent permitted by law. Any published results of the research will be in aggregate form using only the pseudonym you have chosen. Focus group participants will be asked to maintain confidentiality of the participants and the process but individuals may choose to share the information, which is beyond the control of the researcher. Data will be kept in a locked file in the researcher's home office for five years after the completion of the study and then destroyed. The audio-tapes will have no participant identifiers and will be destroyed once the transcription is completed and member check is done. Your signed consent form will be kept separate from the data.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Dara Whalen, at (856) 906-1279, my dissertation chair Dr. Jessie Colin, at (305) 899-3830, or the Institutional Review Board point of contact, Barbara Cook, at (305) 899-3020. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

**Voluntary Consent**

I acknowledge that I have been informed of the nature and purposes of this study by Dara Whalen and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this study.

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*Signature of Participant*

---

*Date*

---

*Signature of Researcher*

---

*Date*

## APPENDIX C

## Request for Access to Nursing Staff for Recruitment

Dear \_\_\_\_\_,

My name is Dara Whalen and I am a doctoral student in the Division of Nursing at Barry University, Miami Shores, Florida. I am conducting a qualitative research study for my dissertation titled: *A Grounded Theory Study of Nurses Who Care for Patients Who Are Victims of Sexual Violence*. The purpose of the study is to identify the process that nurses without specialized training use to care for patients who are victims of sexual violence and as a result, develop a theory that describes the critical influences that guide that process. I am interested in nurses who have not received specialized training in this area.

I would like to ask your permission to post the attached recruitment flyer in your emergency department, specifically areas frequented by your nursing staff like the break room, staff mailboxes, and communication bulletin board. In addition, I would like to ask for an opportunity to speak with your nursing staff during a scheduled meeting or in-service. I would require no more than five minutes to hand out flyers and briefly introduce the study and myself.

I can be reached at 856-906-1279 or by email at [dara.whalen@mymail.barry.edu](mailto:dara.whalen@mymail.barry.edu) if you have any questions or concerns.

Respectfully,

Dara M. Whalen, MS, RN, Researcher

## APPENDIX D

## Recruitment Flyer



**Volunteers Needed  
Emergency Department Nurses**

Dara Whalen, a doctoral nursing student at Barry University, Miami Shores, Florida invites you to participate in a research study to explore the process used by nurses to manage the care of **Victims of Sexual Violence**

Study participation will include:

- One 90 minute interview with the researcher at a mutually agreed upon location
- One 60 minute follow-up interview to member check the transcribed interview

<u><b>Inclusion Criteria:</b></u>	<u><b>Exclusion Criteria:</b></u>
<ul style="list-style-type: none"> <li>• Licensed RNs with two or more years' experience working in an emergency department (ED)</li> <li>• English speaking</li> <li>• Over age 18</li> <li>• No specialized training in caring for victims of sexual violence</li> <li>• At least one instance of caring for a victim of sexual violence as an RN</li> </ul>	<ul style="list-style-type: none"> <li>• Nurses who are not licensed RN's</li> <li>• RNs with less than 2 years' experience in an ED</li> <li>• Non-English speaking</li> <li>• Under age 18</li> <li>• Attendance at a specialized training for the care of victims of sexual violence</li> <li>• No experience caring for a victim(s) of sexual violence as an RN</li> </ul>

***At the conclusion of the first interview, each participant will receive a \$10.00 Amazon gift certificate by email as a token of appreciation for your time***

If you would like more information or would like to participate, please contact:

Researcher: Dara Whalen: 856.906.1279, Email: [dara.whalen@mymail.barry.edu](mailto:dara.whalen@mymail.barry.edu)

Faculty Supervisor: Dr. Jessie Colin: 305.899.3830, Email: [jcolin@mail.barry.edu](mailto:jcolin@mail.barry.edu)

Barry University IRB Contact: Barbara Cook: 305.899.3020, Email: [bcook@mail.barry.edu](mailto:bcook@mail.barry.edu)

The researcher will respond to all calls and emails

## APPENDIX E

## Counseling Resources Pennsylvania

Dear Study Participant,

The information you have shared during this study may bring up uncomfortable feelings due to the sensitive nature of the subject. Even if you have no personal experience with sexual violence, you may feel the need to discuss your concerns or fears. Below are a number of ways in which you may contact a counselor anonymously to discuss those feelings and receive help at no cost. Please take advantage of these services if needed and thank you again for participating in this study.

Sincerely,

Dara M. Whalen, MS, RN, Researcher

National Sexual Assault Hotline

1.800.656.HOPE (4673)

When a caller dials 1.800.656.HOPE, a computer notes the area code and first three digits of the caller's phone number. The call is then instantaneously connected to the nearest RAINN member center. If all counselors at that center are busy, the call is sent to the next closest center. The caller's phone number is not retained, so the call is anonymous and confidential unless the caller chooses to share personally identifying information.

Pennsylvania Coalition Against Rape (PCAR)

Enola, PA  
717-728-9740

## APPENDIX F

## Demographic Data Form

This questionnaire consists of personal and professional information as well as historical data. The professional and historical information is related to your experience caring for victims of sexual violence. Please write or check the appropriate response as listed below.

1. Your age\_\_\_\_\_
2. Gender            a. Female                      b. Male
3. Marital Status
  - a. Single
  - b. Married
  - c. Separated
  - d. Divorced
  - e. Widowed
4. Educational Level
  - a. ADN
  - b. Diploma
  - c. BSN
  - d. MSN
  - e. Doctoral. Please specify the category\_\_\_\_\_
  - f. Degree not in nursing. Please specify\_\_\_\_\_
5. What best describes your race?
  - a. White Non-Hispanic or Latino

- b. White Hispanic or Latino
  - c. Black
  - d. Asian
  - e. Pacific Islander
  - f. Alaska Native
  - g. American Indian
  - h. Other\_\_\_\_\_
6. What ethnic group do you identify with?
- a. Hispanic or Latino – please specify\_\_\_\_\_
  - b. African American
  - c. Haitian
  - d. Caribbean – Please specify\_\_\_\_\_
  - e. Eastern European. Please specify\_\_\_\_\_
  - f. Other. Please specify\_\_\_\_\_
7. How many years have you worked as a nurse?
- a. 2-5 years
  - b. 6-7 years
  - c. 8-10 years
  - d. 11-14 years
  - e. > 15 years
8. How many years have you worked in the emergency department?
- a. 2-5 years
  - b. 6-7 years

- c. 8-10 years
  - d. 11-14 years
  - e. > 15 years
9. How many times have you provided any type of care to a victim of sexual violence? \_\_\_\_\_
10. Do you know anyone in your personal life who has been a victim of sexual violence? (For example: friend, relative, colleague, self. **Please do not specify.**)
- a. Yes
  - b. No



## APPENDIX G

### Focus Group Introduction and Guidelines

#### **WELCOME**

Thank you for agreeing to participate in the focus group. I appreciate your willingness to share your experiences and opinions.

#### **PURPOSE OF FOCUS GROUP**

The purpose of this focus group is to explore the process that you use to manage the care of victims of sexual violence. In addition, as experts in the field, you will be asked to give your opinion of the themes and categories that have been developed by the analysis of previous individual interviews of non-expert nurses.

#### **GROUND RULES**

**1. I Want You To Do The Talking.**

- a. I would like everyone to participate.
- b. I may call on you if I haven't heard from you in a while.

**2. There Are No Right Or Wrong Answers**

- a. Every person's experiences and opinions are important.
- b. Speak up whether you agree or disagree.
- c. I want to hear a wide range of experiences and opinions.

**3. What Is Said In This Room Stays Here**

- a. I would like everyone to feel comfortable sharing when sensitive issues come up. Please refrain from sharing specific information about individuals, the group, and the information shared when you leave here.

**4. I Will Be Tape Recording The Group**

- a. I would like to capture everything you have to say.
- b. I don't identify anyone by name in my report. Your information will remain confidential. Please use the pseudonyms you have chosen when speaking.

## APPENDIX H

## Focus Group Guide for Interview Questions

The purpose of this interview is to explore the process that nurses use to care for victims of sexual violence. All responses are confidential. There is no right or wrong answer to these questions.

1. Can you tell me about what it is like to care for patients who are victims of sexual violence?
2. Who or what, if anyone or anything, influenced your actions?
3. What happened next?
4. How if at all has your view of the needs of victims of sexual violence changed?
5. How have your feelings changed regarding caring for these patients?
6. How if at all has your view of yourself as a nurse changed?
7. As you look back, what might you have done differently?
8. *Questions for the focus group will be formulated after categories have been developed from the individual interviews.*

**VITA****Dara M. Whalen, MS, FNP-BC, CNE, SANE**

July 25, 1958	Born - New York, New York
1982	AAS, Nursing Orange County Community College Middletown, NY
1982-1986	Staff Nurse, ICU Mt. Sinai Hospital New York, NY
DATES	Staff Nurse, ICU Shands Hospital Gainesville, FL
1986-1990	Staff Nurse, Coordinator New York Hospital New York, NY
1990-1995	Senior Charge Nurse, ICU St. Anthony's Hospital Warwick, NY
1995	BSN, Dominican College Orangeburg, NY
1996-1997	Research Assistant University of North Carolina Chapel Hill, NC
1999	MS, Public Health Nursing University of North Carolina Chapel Hill, NC
1999	Post Masters Certificate, FNP University of North Carolina Chapel Hill, NC
1998-2002	Family Nurse Practitioner Wilmington, NC
2002-2006	Nurse Educator, Maniilaq Association Kotzebue, AK

2003-2007	Clinical Instructor/Site Coordinator Weber State University, Ogden UT
2003-2007	Clinical Instructor/Site Coordinator University of Alaska Anchorage, AK
2003-2007	Sexual Assault Nurse Examiner Kotzebue, AK
2007	Post Masters Certificate, Nurse Education University of Alaska Anchorage, AK
2008-2011	Assistant Professor, Nursing Barry University Miami Shores, FL
2011-2016	Adjunct Faculty, Nursing Philadelphia, PA
2016-	Assistant Professor, Nursing Temple University Philadelphia, PA

## PUBLICATIONS

2011	Lavandera, R., Whalen, D. M., Perkel, L. K., Hackett, V., Molnar, D., Steffey, C., Hershorin, I. R., . . . Harris, J. Value-added of HESI exam as a predictor of timely first-time RN licensure. <i>International Journal of Nursing Education Scholarship</i> , 8(1) [online]. doi:10.2202/1548-923X.2152
2014	Whalen, D., Molnar, D., Milne, F., Schwal, L., Hackett, V., & Coffman, J. Flu vaccine experiences and beliefs influence vaccination decision making more than knowledge. <i>F1000Research</i> , 3, 224 [online]. doi:10.12688/f1000research.3018.2