EMERGENCY ROOM NURSES' ATTITUDES AND KNOWLEDGE OF HUMAN SEXUALITY AND RAPE

A THESIS

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BETTY J. BRAXTER, B.S.N.

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INTRODUCTION

Many people in today's society still view rape as a taboo subject. The rape victim often finds herself in the position of defending her actions while the rapist may be viewed as a heroic-type lover. Societal attitudes are such that many novels, records, and films glamorize as well as romanticize rape with great commercial and financial success. The old myth that every woman wants to be raped and females provoke the incident still exists permeating many aspects of daily living. Unfortunately, these types of attitudes are often reflected in the behavior of those who provide services to the victim of rape.

Rape victims are repeatedly questioned by police officers, laywers, judges, physicians and nurses, and family members about every detail of the rape assault. In many instances across the nation, as a part of the rape victim's experience in the courtroom, the woman finds her reputation on trial instead of the accused rapist. It often appears that no one believes the woman and instead of the woman being viewed as a victim of a crime, she is categorized as indeed the perpetrator or the criminal.

An increasing number of women, however, will report the crime to law enforcement officers and seek medical care from health professionals who work in hospital emergency rooms. How are health professionals such as nurses meeting the challenge of caring for victims of rape? Are nurses cognizant of the physical and psychological trauma women suffer as a result of the assault?

This study has hopefully identified the type of knowledge and attitudes nurses possess and answered the above identified questions.

Statement of Problem

The problem investigated was identified as: How do nurses' attitudes and knowledge of human sexuality affect their attitudes and knowledge of rape and care for rape victims?

Purposes

The purposes of the study were:

1. To identify nurses' attitudes and knowledge of selected physiological and psychological aspects of human sexuality

2. To identify nurses' attitudes and knowledge of selected physiological and psychological aspects of rape

3. To evaluate the adequacy of nurses' knowledge of selected physiological and psychological aspects of human sexuality and rape

4. To identify whether or not a relationship exists between nurses' attitudes and knowledge of human sexuality and their attitudes and knowledge of rape and care for rape victims

5. To identify whether or not various selected demographic data affect nurses' attitudes and knowledge of human sexuality, rape, and care for rape victims

Background and Significance

For many women rape is only a scare word, but for others rape is a reality. The Federal Bureau of Investigation's crime report for 1976 lists the number of reported rapes at 56,730 (Uniform Crime Report 1977). The reported number of rape comprised approximately 1 percent of the total crime index and 6 percent of the volume of crimes of violence. In one major southwestern metropolitan area, identified as the setting for this research study, the number of reported rapes for 1975 was listed at 902 (Uniform Crime Report 1975). The most recent available statistics from this metropolitan area's police department for 1977, however, indicated a slight decrease in the number of rapes

reported--748 (unpublished report, Dallas Police Department 1977).

Even though some areas in the country were reporting a decrease in the number of rapes for 1977, the national crime report continued to indicate that the number of rapes has increased by 17 percent since 1972. Between 1970 and 1975, the previously mentioned southwestern area's crime statistics also indicated a 70 percent increase in the number of reported rapes even with the noted decline for 1977. The Federal Bureau of Investigation's crime clock, which reports the incidence of violent crimes in the United States, supported the aforementioned findings. In 1970, the crime clock indicated that a rape occurred every fourteen minutes in comparison to a murder every twenty-six minutes. The 1976 crime clock indicated an increase in the frequency of reported attacks at one rape every nine minutes with the number of murders remaining at one every twenty-six minutes. Due to the continuous increase in the number of reported rapes, the crime report now indicates that 52 women out of every 100,000 females were raped in 1976 (Uniform Crime Report 1977).

Unfortunately, published reports from the Federal Bureau of Investigation as well as city and state police departments do not give the actual number of rape attacks.

Some law enforcement officers state that for every rape reported, there are five to ten rapes that are not reported. Most officers state that rape is still one of the most underreported crimes in this country because women are too embarrassed and ashamed to report the crime. Many authorities on the subject of rape also feel that the quality of care that rape victims receive from the legal and medical profession discourage women from reporting the crime (Williams and Williams 1973, Burgess and Holmstrom 1974, Uniform Crime Report 1977).

Strides are being made and it appears that more victims are now reporting the crime to law enforcement officers. In 1975 the Texas Legislature passed a rape reform bill which aids in the prosecution of rape and sexual crimes. The bill changes the wording of previous laws that appeared to favor the accused criminal and discouraged women from reporting rapes. According to the new rape reform bill

> . . . a woman who is forced to submit or participate by any threat, communicated by actions, words or deed that would prevent resistance by a woman of ordinary resolution, under the same or similar circumstance, because of a reasonable fear of harm is identified as a victim of a rape attack (Texas, Penal Code 1975, art. 1185, sec. 21:02 B-2).

Prior to 1975, victims who were not terribly brutalized or physically injured could not proceed with rape charges.

Seth S. Searcy and James R. Patterson of the Austin Bar in their commentary in Vernon's Texas Code 1973 stated that article "1185 on Rape" speaks of fear or death or great bodily harm, but it was not so applied in court. This revision in the law is hopefully encouraging women who have been beaten or bruised to file rape charges.

Like the legal profession, the medical profession is making great strides in improving the quality of care victims of rape receive. The American College of Obstetrics and Gynecology provides guidelines for the protection of the rape victim and the physician. These guidelines identify what type of procedures should be obtained if possible. These procedures include an examination, collection of specimens, photographs, and permission to release the information to the proper authorities (ACOG Technical Bulletin Number 14 1970). The technical bulletin also indicated the type of medication that can be used to prevent venereal disease and pregnancy resulting from the sexual attack. Physicians are also advised to provide follow-up services to their rape victims in order to reduce the incidence of venereal disease, pregnancy, and delayed psychological effects.

The nursing profession is also turning more of its attention toward rape and the victims of rape. Nurses and

their associates are writing articles on the responses of victims of rape (Burgess and Holmstrom 1974, Donadio and White 1974). Other nurses are turning their attention toward the potential of nurses who care for rape victims (William and William 1973, Donadio and White 1974). Donadio and White (1974) stated in their article "Seven Who Were Raped" that because the nurse interacts with the victim frequently, she can help the victim feel that her safety has been restored. The very constancy of this nurse-patient interaction, according to the acticle, may help the victim feel that she is in a secure environment with a supportive person. One of the major reactions of victims to rape is fear (rape trauma syndrome) (Burgess and Holmstrom 1974).

Burgess and Homstrom (1974), in their book Rape: Victims of Crisis, described the rape trauma syndrome as physical, emotional, and behavioral stress reactions which persons who face life-threatening situations exhibit. In this instance, the life-threatening situation is rape. As a result of counseling and talking with approximately 146 victims in Boston during 1972, the above authors concluded that victims suffer these type of reactions immediately following the rape and over a considerable time period after the rape. Therefore, the rape trauma syndrome

consists of two phases--the immediate or acute phase and the long-term reorganization process.

During the acute phase, these authors noted that a complete disruption in the lives of the victim occurs. Victims coped with changes in their sleeping and eating patterns as well as physical symptoms specific to the area of the body receiving the focus of the attack. The authors also stated that during this phase, rape victims begin to identify various needs. These needs were in the form of requests and were identified by victims within the first hours and days following the rape incident. Victims in the study requested in order of frequency the following: medical intervention, police intervention, psychological intervention, an uncertainity as to needs and control. Psychological intervention, for an example, was "I need to talk to someone." Victims who expressed this need wanted to talk about what had happened to them. These victims also requested that a supportive person serve as a listener. Some of these victims then identified their emotions and reactions while others asked specific questions of the supportive individual (Burgess and Holmstrom 1974).

Rape victims started to reorganize their disrupted lives during the long-term reorganization process of the syndrome. A majority of victims during this phase coped

with various symptoms such as changes in life-style, changes in job as well as changes in address. Victims also continued to indicate the need for support from others during this phase. Approximately 75 percent of the victims in the Burgess and Holmstrom study turned for support to either family members or close friends. Victims often traveled to their hometown to talk with their parents even when it meant traveling long distances. Other victims sought the comfort of being with, and talking with close friends about what had happened to them. However, for some victims, the support that was evidently needed was not available (Burgess and Holmstrom 1974).

Because victims expressed a need for someone to talk with and provide support, Burgess and Holmstrom (1974) stated that nurses involved in providing care to these victims should be nonjudgmental and understanding. Unfortunately, however, only a small number of articles survey health professionals' attitudes and knowledge of selected physiological and psychological aspects of rape. A review of 101 articles indicated that nurses are not being asked about the above identified aspects. An article, however, by McGuire and Stern (1973) examined physicians' attitudes toward sexual assault. In this survey of 1,101 physicians listed on King County Medical roster,

the writers noted a 50 percent return rate. According to the identified results, only 60 percent of the physicians correctly answered each item in the information section of the questionnaire which consisted of ten questions on sexual assault. As a result of their findings, McGuire and Stern recommended that physicians be given as medical students information regarding the physical and emotional treatment for sexual assault. Does this same need exist for nurses?

A review of the literature also indicated that there are only a few surveys which examine nurses' and physicians' attitudes and knowledge of selected physiological and psychological aspects of human sexuality (Lief 1964; Sheepe and Hain 1967; McCreary-Juhasz 1967; Mins, Ferns et al. 1974). Sexuality is an important concern of rape victims. Burgess and Holmstrom (1974) stated that victims expressed various concerns relating to sexual fears and difficulties only during the long-term phase of the rape trauma syndrome. Victims in the study during this phase often expressed concern over whether or not they would ever be able to have sex again without fear. Other victims focused their concerns on the lack of sexual desire after the rape attack. This was a major concern of women who were currently involved sexually with a man

when the rape occurred. A thorough understanding as well as a nonjudgmental attitude toward aspects of human sexuality appear to be required of those caring for the rape victim.

Unfortunately, articles which examine health professionals' attitudes and knowledge on human sexuality indicate that nurses and physicians possess an inadequate amount of knowledge in this area and have the same misconceptions as the lay population (Lief 1964; Sheepe and Hain 1967; McCreary-Juhasz 1967; Mins, Ferns et al. 1974). Lief (1964) concluded that courses in anatomy and physiology do not provide enough information to allow the physician to be a consultant for those who have sexual problems. McCreary-Juhasz (1967) studied graduate nurses, working either for a bachelor's degree or a diploma in nursing at the University of British Columbia, and she indicated that nurses do not possess complete knowledge of the essentials needed for instructions in the physiology of sex. As a result of the findings, McCreary-Juhasz (1967) recommended that nurses be taught the basic facts about sex. Again does this same need exist for nurses in regard to rape?

According to the review of literature, rape victims require those who provide care to them be both

knowledgeable and nonjudgmental. These victims also identify a need for individuals who feel comfortable with their own sexual identities to serve as consultants. The theoretical framework upon which this study was based provides further clarification on attitude formation, crisis theory and the comfort of nurses caring for victims of rape.

Theoretical Framework

A study which attempts to identify attitudes and knowledge of aspects of human sexuality and rape is based upon many different theories. This study was based upon three theories. These theories include a theory of attitudinal formation through the process of classical conditioning, crisis theory, and cognitive dissonance theory.

Ivan Pavlov, a Russian physiologist, identified the basic principles of classical conditioning in the 1920's. Pavlov was interested in identifying and observing the various reflex reactions of animals. He conceptualized a reflex as an inevitable reaction of an organism due to the inherent organization of its nervous system (Pavlov 1927). As a result of his experiments, he was able to identify what is now called an unconditioned stimulus (UCS) and ununconditioned response (UCR). An unconditioned

stimulus is defined as that which causes the manifestation of a reflex reaction or response. The term unconditioned response is defined as an unlearned response. Pavlov also identified the classical conditioning chaining process which is identified as a learned conditioned stimulus (CS) and a learned conditioned response (CR). Pavlov stated that classical conditioning occurs when an originally neutral stimulus after being paired with an unconditioned stimulus acquires the power to elicit a response similar to the unconditioned response. Dr. Krylov, an associate of Dr. Pavlov, added to the aforementioned chaining process by identifying higher order conditioning. He identified this as being the process by which a conditioned stimulus serves as a substitute for the original conditioned response and itself produces the response.

Arthur and Carolyn Staats in 1957 described a theory based upon the principles of classical conditioning in regard to attitudinal formation. Staats and Staats (1957) conceptualized an attitude as a response. One of the major assumptions of the theory stated that responses can be learned by utilizing classical conditioning principles. They further conceptualized an attitude as having an emotional or affective quality. At this point in their theory, Staats and Staats borrowed from their fellow

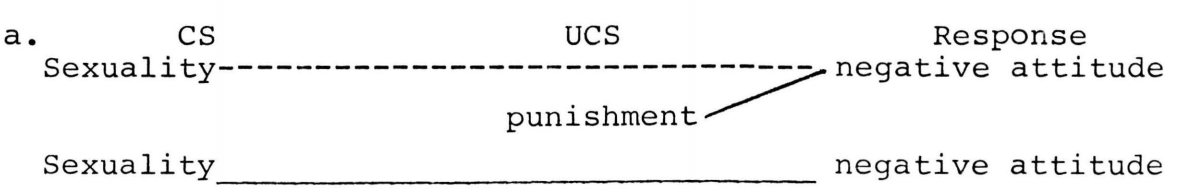
colleagues Mowrer (1954) and Osgood (1952). Mowrer (1954) and Osgood (1952) indicated that when a word is constantly paired with a stimulus object, the conditionable part of the response elicited by the object is conditioned to the word and becomes the meaning of the word. This supports the idea that words only become meaningful after they have acquired an emotional aspect or an attitude.

Staats and Staats (1957) also stated in their theory that one of the powerful aspects of language is that words that have come to elicit responses that have positive or negative meanings (attitudes) transfer their meaning to other environmental stimuli with which they have been paired. Therefore, the emotional simulus or unconditioned stimulus (UCS) elicits an emotional response of unconditioned response (UCR). If a word is continuously paired with an unconditioned stimulus, the word becomes the conditioned stimulus and acquires an ability to elicit a similar emotional response. Staats and Staats (1957) performed an experiment to study the formation of attitude (evaluative meaning) to socially significant verbal stimuli through classical conditioning in order to support a hypothesis which stated that attitudes already elicited by socially significant stimuli can be changed through the

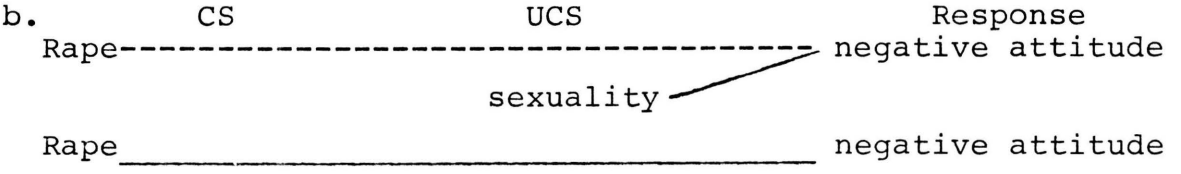
conditioning process using other words as unconditioned stimuli.

The subjects who participated in the two studies in 1957 were presented national names such as Dutch eighteen times. Each time the name was presented on slides, the experimenter orally presented another word such as happy, sad, pretty, and others. The subjects were then required to verbally repeat the orally presented word. Prior to the beginning of the experiment, the subjects received directions which indicated that they will also have to learn the list of national names presented to them. In the second experiment, male first names were presented instead of national names. The results of both studies indicated that subjects gave a more positive evaluation on the semantic differential to the national and male names paired with positive words than the names paired with negative words. Staats and Staats' (1957) hypothesis that attitudes can be changed through the conditioning process was thus tested and supported. Three other studies by Staats, Staats and associates further supported their theory of attitudinal formation through classical conditioning (Staats, Staats, and Biggs 1957; Staats and Staats 1959; Staats, Staats, and Crawford 1962).

The above identified classical conditioning process for attitudinal formation provided the basis upon which this study's hypotheses were based. Each individual possesses certain emotions based upon past experience, environment, and knowledge. Because of past experience and the other above identified concepts, certain words have become stimuli that elicit emotional responses (attitudes) in the individual. These attitudes are either positive or negative, depending upon what the term means to the individual (Staats and Staats 1957). If the term sexuality, for example, has been paired with aversive stimulation during the individual's lifetime, the responses elicited by punishment may be conditioned to the word sexuality. Punishment is, therefore, viewed as an unlearned simulus or unconditioned stimulus (UCS) which elicits a negative response or attitude from the individual. The term sexuality is viewed in the conditioning process as a conditioned or learned stimulus (CS) which through classical conditioning elicits a negative response or attitude also. This conditioning process is schematically shown as:



Assuming that the conditioning is strong if the word sexuality is contigously paired with the term rape, higher-order conditioning may occur. In this instance, the individual who receives information that identifies rape as being an aspect of sexuality may respond in a negative manner. Sexuality is, therefore, viewed as an unlearned stimulus or unconditioned stimulus (UCS) and rape is viewed as a learned stimulus or conditioned stimulus (CS). This process is depicted in the next diagram as:



The entire process as depicted in diagrams a and b can occur because the word sexuality for this individual due to past conditioning elicits a negative response. As identified in the introduction, the purpose of this study was to identify the emotional responses (attitudes) elicited when selected aspects of human sexuality and rape were presented to a specified group of individuals, emergency room nurses.

This study also utilized concepts of crisis theory. One of the basic assumptions of this study was that rape

constitutes a crisis situation for most victims. Caplan (1961) defined a crisis as that which occurs when a person faces an obstacle which is important to his life goal. The obstacle appears insurmountable and old coping mechanisms prove fruitless which leads the individual into a state of disequilibrium and disorganization. The individual also appears upset. It is at this point in time that the individual makes many attempts at trying to solve the problem (Caplan 1961). This is an excellent example of the behavior of rape victims.

For the victim of rape, the obstacle important to life goal is the actual attack. The immediate life goal for the rape victim is simply surviving the attack. The rape attack for the victim is insurmountable because even though she tries to resist her attacker as hard as she can, the rape still occurs. Physical resistance as well as the utilization of various psychological strategies in order to prevent the attack in this instance may be identified in Caplan's definition as old coping mechanisms proving fruitless. Because old coping mechanisms fail, the victim of rape becomes disorganized and enters into a state of disequilibrium (Burgess and Holmstrom 1974). Most victims exhibit this state of disequilibrium through two distinct emotional styles. Some victims become highly emotional

after the attack while others show no type of emotion (Burgess and Holmstrom 1974). Finally, Caplan (1961) stated that the individual attempts to solve the problem. For some rape victims this attempt comes in the form of seeking help from the police and the health professional. Burgess and Holmstrom (1974) suggested that emergency room nurses are in an optimal position to provide therapeutic assistance to these victims if nurses are nonjudgmental and understanding. One of the major purposes of this research study was to identify and evaluate emergency room nurses' attitudes and knowledge of rape and care for rape victims. For other victims this attempt to solve the problem of rape comes in the form of denying the rape attack which often leads to development of emotional scars (Burgess and Holmstrom 1974). The criteria which Caplan identified in his definition of crisis is met in regard to rape.

Concepts derived from cognitive dissonance theory were also utilized in this study. Festinger (1957) stated that tension arises when there is inconsistency between two or more cognitions in a relationship to each other and of importance to the individual (Festinger 1957). Festinger (1957) conceptualized cognitions as an individual's knowledge, opinions, or beliefs about the

environment, himself, or others. Areas of dissonance develop around logical inconsistency, cultural mores, opinions, and past experience (Festinger 1957).

According to Festinger (1957), an individual feels uncomfortable and tense when dissonance develops from, for example, logical inconsistency between two or more cognitions. The individual then attempts to reduce the dissonance and achieve consonance. Festinger (1957) identified the need to reduce dissonance and achieve consonance as one of the major hypotheses of dissonance theory. Consonance was identified as a consistent relationship between relevant cognitions (Festinger 1957). The individual achieves consonance and reduces dissonance by either changing his opinion, belief, knowledge, or rationalizing. Festinger (1957) also stated that in addition to trying to reduce dissonance, the individual will actively attempt to avoid situations and information which would increase dissonance.

Nurses who work with rape victims may feel a degree of cognitive dissonance as a result of logical inconsistency. Most nurses are women. Most rape victims are also female. The nurse may strongly identify with the rape victim because they are both of the same sex. The nurse may, therefore, acknowledge to a degree that she is

also, because she is female, vulnerable to being sexually assaulted. By acknowledging her own vulnerability and by working with the rape victim, the nurses' concern about her own independence and security may be revived (Notman and Nadelson 1976). At this point, the nurse may begin to feel discomfort and tension. In order to reduce this tense-like state, the nurse may either deal with her own feelings of vulnerability or she may avoid situations and information regarding rape. Avoidance may be in the form of leaving the victim alone in the room, not providing support, rationalizing, stereotyping the victim, and refusing to accept current information regarding the effect of rape on its victim.

To reiterate, one of the major purposes of this study was to identify emergency room nurses' attitudes and knowledge of human sexuality, rape, and the care of the rape victims. The brief review of literature, theoretical framework as well as the following hypotheses were derived from the study's purposes.

Hypotheses

Based upon the purposes, review of literature, and theoretical framework, the following hypotheses were formulated.

1. There will be no relationship between the attitudes of emergency room nurses regarding human sexuality and their attitudes regarding rape

2. There will be no relationship between the knowledge of emergency room nurses regarding human sexuality and their knowledge of rape

3. There will be no relationship between the attitudes of emergency room nurses regarding human sexuality and their knowledge of rape

4. There will be no relationship between the attitudes of emergency room nurses regarding rape and their knowledge of human sexuality

Definition of Terms

For the purposes of this study, the following terms were defined.

1. Attitude--an implicit, drive-producing response considered socially significant in the individual's society (Doob 1947)

2. Human sexuality--the total characteristics of of an individual--social, personality, and emotional--that are manifest in his or her relationships with others and that reflect his or her gender-genital orientation (Shope 1975)

3. Knowledge--that which is known or understood; a learning process whereby concepts are identified or developed (Mandetta and Woods 1974)

4. Nurse--a licensed registered professional nurse (staff nurse, head nurse, and supervisor) and/or a licensed vocational nurse who is currently engaged in the practice of nursing and provides care to patients in the emergency room setting of a hospital. (Master's-prepared nurses were excluded from this study)

5. Rape--legally referred to as an offense committed by a person if he has sexual intercourse with a female not his wife without the female's consent (Texas Penal Code)

Limitations

The following limitation was identified: Sample size was too small to generalize to the population of nurses providing care to victims of rape. The following limitations were not controlled, but were described:

1. Age
2. Sex
3. Ethnic origin
4. Marital status
5. Religious affiliations
6. Previous nursing experience

7. Type of nursing program attended

8. Length of nursing experience in the emergency room

9. Personal experience with rape assault

10. Levels of experience with sex

Delimitation

The following delimitation was identified: Only those nurses involved in working in the emergency room setting during the assigned week for the collection of data were asked to participate.

Assumptions

This research study assumed the following:

1. Each individual has certain attitudes based upon life experiences

2. Attitudes can be changed by knowledge

3. Attitudes and knowledge can be measured

4. Rape constitutes a crisis situation in the lives of the victims

5. Rape may precipitate a sexual identity crisis

6. Each individual has a sexual identity

7. Nurses responded to the data-gathering instruments candidly

8. The data-gathering instruments utilized were valid and reliable

Summary

A brief review of the literature has indicated that victims of rape exhibit various physical and psychological symptoms following the actual assault. Because nursing is a caring profession, nurses must become more aware of the concerns and problems that rape victims will be required to cope with during the hours, days, and months after the attack. It is hoped that this study will help nurses become cognizant of their feelings toward and knowledge of rape and victims' responses so that they can provide nursing care to these victims in a more effective manner. In conclusion, a statement by Sr. Charlotte Van Dyke (1977) appears appropriate. Sr. Van Dyke wrote that a woman who has been raped is viewed as a body by the rapist, a client by the prosecutor, a patient by the physician, and a victim by the police and no one sees the woman as a person. In reply to Sr. Van Dyke's statement, the nurse who is compassionate, understanding, and knowledgeable of rape can be the individual who views the raped woman as a "total person."

In the following chapter, Chapter 2, a conceptual approach to human sexuality and rape has been developed.

The chapter, a review of the literature, has been divided into four areas. The major structure under consideration in area one is sexuality. Rape and its affect upon sexuality is the structure considered in area two. A discussion on sex education courses in nursing and medical schools in the United States is the structure considered in area three. The final and fourth area considered is a review of recent studies on nurses' attitudes and knowledge of certain aspects of human sexuality and rape. The chapter concludes with a summary paragraph.

Chapter 3 discusses the procedure utilized for the collection of data in this study. This chapter has been divided into several areas of discussion. The method by which the tools utilized in the collection of data were designed along with an in-depth description of the tool designed by the investigator is described. The method of data collection, as well as the treatment of data, is also discussed and then a summary statement concludes the chapter.

Chapter 4 describes the analysis of data obtained from the study. A discussion of grouping procedures is presented along with a discussion of each group. Chapter 4 concludes with findings resulting from the analysis of data in summary form.

Chapter 5 discusses four major areas. A general review of the study and its major ideas are presented in area one. Area two describes the conclusions derived from the analysis of data. Implications for nursing practice, nursing education, continuing education, in-service hospital education and research are considered in area three. The chapter concludes with recommendations for further study based upon this study's findings.

CHAPTER II

REVIEW OF LITERATURE

The major purpose of this chapter is to present in a conceptual manner an extensive discussion on the topics under investigation, human sexuality and rape. Areas considered in the discussion on sexuality include the following: gender identity, femininity, and masculinity. A brief summary of Sigmund Freud and Erick Erickson theories on sexual growth and development has also been included under the discussion on sexuality. The areas considered in the discussion on rape include the affect of rape on sexual growth and development, rape victims' response patterns and characteristics of rapists. A brief overview of major theories on rape has also been included. Finally, two other pertinent and relevant areas to nurses' attitudes and knowledge of human sexuality and rape has also been included in this chapter. The latter part of this chapter has been devoted to discussing human sexuality as a course in nursing and medical schools in the United States. A brief survey of recent studies on nurses and physicians' attitudes and knowledge of human sexuality and rape as well as general societal attitudes toward rape concludes the chapter.

Sexuality

Fonesca described human sexuality as that

> . . . powerful and purposeful aspect of human nature that is expressed in everyday life and which can lead to a satisfactory, creative relationship with a mate or sublimated and expressed in positive outlets (1970, p. 25).

Fonesca's definition implies sexuality is more than feelings, beliefs, and attitudes toward sex. Sexuality is the whole person and encompasses the total personal makeup of each individual--beliefs, feelings, intellect, physical attributes, philosophy, as well as spiritual functioning (Shope 1975). Sexuality is, therefore, that aspect of humanness which essentially begins with birth and ends with death.

Because sexuality is a broad and all-encompassing facet of human nature, it cannot and should not be viewed in isolation from other aspects of life such as culture, society, and human interactions. The society and culture in which the individual lives as well as the personal interactions he engages in all help to mold his perception of himself as a sexual being. As cultural and societal viewpoints change, generally the individual's sense of awareness regarding his sexuality changes (Kogan 1975, Money 1977). If sexuality is viewed in isolation from other aspects of life, some of its very essence as a human quality is lost. Therefore, sexuality is an interrelated

part of each individual's life along with culture, society, and human interactions which helps the individual develop a sense of or a perception of himself as being either female, male, or ambivalent.

Gender Identity

Man's sense about himself as either female, male, or ambivalent is defined by Mandetta and Woods (1975) as gender identity. According to Mandetta and Woods this sense of awareness is expressed outwardly as "a gender role which the individual exhibits in order to indicate whether or not the individual is male, female, or ambivalent" (1975, p. 530). Several factors influence the individual's sense of awareness about himself as exhibited in his gender role and they include biological factors, genital anatomy, assigned sex role, parental rearing practices, and a conditioning practice type process which serves to indicate what can and cannot be done in the assigned role (Mandetta and Woods 1975).

Because factors such as genital anatomy help to determine how an individual views himself, it is fortunate that gender identity is usually congruent with biological sex. Mandetta and Woods (1975) reported that because of the usual congruency between gender identity and genital anatomy "A man, therefore, tends to view himself as a male

and behave in a masculine manner" (1975, p. 530). The gender-genital congruency as identified by Mandetta and Woods also allows a woman to view herself as a female and behave in a feminine manner. Scientists, however, have not yet identified the main reason why some individuals do not develop a gender identity congruent with their biological sex as in the case of homosexuality. Gender identity does not, therefore, develop just because of gender-genital congruency. Gender identity is formed to a great degree as the result of inculcated learned patterns of responses taught to each individual by parents and society as a whole (Stolar 1976).

One of the first questions most parents and friends ask upon the birth of a child is "What is the baby,a boy or a girl"? Once the reply is given, parents as well as friends begin the conditioning process of attaching certain actions, emotions, as well as behavior patterns to the infant based on the observed genital anatomy present. The old idea of sweetness and niceness for girl infants and tough and strong for boy infants still exists for many parents. With the statement "It's a boy" or "It's a girl," parents and society as a whole indicate the type of rearing practice to be utilized in order to accomplish the appropriate sexual role in the society.

Gadpaille reported that gender of assignment and rearing predictability

> . . . takes precedent over and overrides all contradictory determinants including; chromosomes, hormones, gonads, internal and external sexual morphology (structure) and secondary pubertal change (1972, p. 200).

Money's survey in 1955 on hermaphrodites supported Gadpaille's (1972) statement. Money (1955) indicated in his survey that those hermaphrodites and pseudo-hermaphrodites who had been reared as boys behaved and thought as boys and those who had been reared as girls thought and acted as girls even though the individuals may have been incorrectly sexually assigned. Money (1955) suggested that genetics, environment and various childhood experiences which he termed the "socio-biography program" influenced the psychosexual differentiation in the hermaphrodites studied.

As Money's (1955) findings indicated, even though sexual assignment may be incorrect, each individual develops a sense of awareness about himself or herself as either being female, male, or ambivalent. Gadpaille (1972) reported that what the child is taught by his culture concerning gender identity transcends all other factors with the critical period for core formation of gender identity occurring, perhaps, between twelve and eighteen

months of age. It is during the toddler stage of development that the infant's interest in his genitalia increases and the child discovers whether he is a boy or she is a girl (Kogan 1973). This time period also correlates well with the reported increase of interest children exhibit in regard to their own genitalia as described by both Sigmund Freud and Erick Erickson in their two respective theories on sexual growth and development. Gadpaille (1972) also indicated that after two to two and one-half years of age, a shift in core identity cannot take place without some types of psychologic havoc or tragedy developing.

Femininity

After gender identity formation develops, each individual usually begins to view himself or herself in terms of the accepted societal role he or she is assigned to play. The female infant, therefore, begins to identify what is considered acceptable for females in that particular society and culture. Like the concept of sexuality, femininity is influenced by society, culture, and rearing practices utilized by parents in order to help the female define with a degree of consistency and clarity what being a girl means in behavioral terms. Perhaps femininity can best be identified as an ambiguous aspect of humanness an individual adopts for himself or herself

which helps to contribute to that individual's sexual development (Katachadourian and Lunde 1975). This ambiguous factor, femininity, has changed drastically in the past fifty years.

Femininity in the past has meant softness, nuturance, beauty, and dependence (Kagan 1969). These attributes were viewed as qualities which made women worthy of placement on a pedestal for all, meaning all men, to admire. Other traditional attributes associated with femininity have included passivity, submissiveness, fear, and idealism (Shope 1975). Freud posited in his treatise on sexual development an association between femininity and passivity (Ashy 1972, Bornhen 1972). Helen Deutsch (1944), a disciple of Freud's theory, reported that the major accomplishment of each woman was to bear children and care for her offspring. With the backing of members of the psychatric community, the concept of femininity became entrenched in the ideas of passivity, nuturance, child-bearing, and mothering (Brownmiller 1975).

Traditionally, the idea of passivity in terms of femininity was extended to include and describe a woman's sexual needs and activities. Men were viewed as the aggressor or the introjector in regard to sexual activities and women were viewed as respondents or the sexual

receptors (Massmen, Manton, Labby et al. 1968; Steinmann and Fox 1974). Many of the novels, movies, and records which were commercially successful in the past presented the male character as a strong, ardent, and sexually tintillating lover who initiated sexual activity. The female character was usually portrayed as a weak and fragile individual whose main source of happiness was to make her male companion happy. Although some women resisted and revolted against the idea of female sexual passivity (Chelser 1972), most women accepted this idea and taught it to their sons and daughters.

As previously indicated, the concept of femininity has undergone a dramatic change. No longer is motherhood and nurturance considered by all women to be the main focus of feminine existence and enjoyment. More and more women have become involved in the world of business, science, and medicine with many achieving great success in these areas while enjoying being a feminine woman (Kagan 1969). More and more women have even decided to remain single and not enter into marriage. Other females in today's society have adopted children and become single parents, thereby allowing themselves to fulfill their desire of motherhood. In essence, the feminine role has been expanded in today's society to not only include the woman

with a husband and children but also the single woman and the single parent female.

The old idea that femininity means passivity in regard to sexual interests has also changed. In today's society, some women are loudly rebelling against the idea of being viewed as an object of sexual pleasure for males. Other women are demanding that their male companions provide them with sexual pleasure and excitement. Centers' study (1971) of 296 undergraduate college students reported that current ratings of desirable male and female characteristics indicated that female as well as male respondents should have as much erotic activity as men. Steinman and Fox's (1976) study of several thousand men and women in the United States supported Centers' findings. Steinman and Fox suggested that sexual equality has been tipped in favor of the female and no longer is the male allowed to only satisfy his own needs without considering the needs of his female sex partner.

Regardless of whatever view of femininity a woman incorporates into her personality structure, for most women in the past as well as women of today, the behavior pattern exhibited in regard to femininity will be congruent with their innate awareness of sexuality and the expected

patterns of behavior assigned to them by family, friends, and society as a whole. Kagan (1969) indicated that the definition of the idea of femininity is influenced by the values of the individual's culture. It is apparent that the quality of and characteristics regarded as feminine "change from culture to culture, time to time and even from family to family" (Kaplan 1973, p. 1).

Masculinity

Just as the concept of femininity has undergone dramatic changes in the past fifty years, so has the concept of masculinity. In the past masculinity has meant strength, aggressiveness, superiority, and competitiveness. During their early formative years, most little boys were taught by parents and their society to be tough, engage in aggressive type sports, and not to cry (Mead, Frohmen, et al. 1976; Stanley 1977). In some instances, males were informed that they were sexually superior to females. In the art of courting, many a young male received instructions from their fathers and older brothers to be forceful and domineering when they approached a female. The old idea that women want a strong man who tells them what they feel and want was prevalent. In some instances, males incorporated into their dating practices the idea that when

a girl said no to sex, she really meant yes, even when the girl was struggling against him (Sherman 1972).

Many of these old traditional ideas on masculinity have been in recent days challenged from all sides. In many instances, masculinity has become more difficult to describe in today's society than the concept of femininity (Steinman and Fox 1974). The idea of masculinity meaning male superiority has been challenged by Sherfy (1974) and her findings. Sherfey reported that all fertilized eggs at conception are female in character rather than male. Males only develop from the female eggs as a result of the action of fetal androgen which suppresses the growth of oviducts and ovaries at around the sixth week of gestation. Sherfey indicated that indeed the male's sexual organ, the penis, may more accurately be considered as an enlarged clitoris.

The idea of males having an innate sexual power has also been badly tarnished as a result of findings from the scientific community. Masters and Johnson (1966) reported that females were more sexually active in terms of achieving multi-orgasmic experiences than their male counterparts. Masters and Johnson (1966) identified a refractory period which most males exhibit during which time they are not able to respond to any type of sexual

stimulation. No such refractory period was identified in females.

Other traditional attributes such as strength, leadership ability, and athletic ability continue, however, to be associated with masculinity in today's society (Shope 1975). Centers (1971) reported, however, that the idea of leadership ability in terms of being the head of the household has been expanded to include the terms arbitrator, analyst, and advisor in a joint decision-making process with the female companion. The idea of strength has also been expanded to include the ability to show compassion and emotions which in some instances includes crying (Grearson, Bernard, English et al. 1968).

As a result of changing societal attitudes, the concept of masculinity now encompasses attributes which perhaps encourages man to view his own sexuality in a broader manner incorporating not only previously traditional roles, but also new ideas without the loss of his own sense of basic masculine ideas. Perhaps Money was accurate when he said that

> The American male's loss of masculinity is a misinterpretation and should be more accurately interpreted simply as an accommodation of certain traditional facets of gender role, male-female, to changing times and circumstances (1977, p. 73).

Sexual Growth and Development

Just as the concepts of femininity and masculinity change in order to accommodate society's shifting views, each individual's view of himself as a sexual being changes as the individual grows and develops physically and emotionally. Each time an individual has a birthday or interacts with a fellow human being, his view of himself as a sexual being is usually changed or expanded. Because each individual's view of himself changes as he grows and develops physically and emotionally, a brief overview of Sigmund Freud and Erick Erickson's respective theories on sexual growth and development is presented as the next area considered under the discussion on sexuality.

Psychoanalytic Theory of Sexual Development

Few scientific paradigms have had as monumental an impact on Western culture as had Freud's psychoanalytic theory on human sexual development. Freud (1920) conceptualized sexuality as a psychophysiological process which has both physical and psychological characteristics. The term "libido" was coined by Freud in order to describe and define sexual instinct. Libido was defined as "the psychological manifestation or the erotic longing aspect of the sexual instinct" (Katachadourian and Lunde 1975,

p. 234). Freud considered sex as a source of all pleasurable experiences and not just a sense of pleasure associated only with the sex act. Freud's theory is based upon this broad concept of sex and it is divided into five stages.

Each child has a certain amount of "libido" or energy and at certain stages in the developmental process, this libidinal energy becomes invested in a certain area of the body (Katachadourian and Lunde 1975). The idea of the "libido" was conceptualized by Freud (1920) in order to explain the nature and manifestations of the sexual instinct. Areas invested with this libidinal energy were described in the theory as pleasurable zones of the body which change at successive stages in childhood (Freud 1920). The sexual functioning of the individual as well as his entire personality structure and psychological health are determined by changes in these focus areas of pleasure (Katachadourian and Lunde 1975).

The first phase of psychosexual development is described as the oral phase and it extends from birth to approximately one year of age. At this point in the individual's life, his very survival depends upon his ability as an infant to consume some type of nourishment. Because the young infant usually possesses an innate

ability to suck, he receives both nourishment and pleasure from engaging in sucking a bottle or the breast of his mother. The first site of libidinal investment is, therefore, identified as the oral zone. The infants' main source of pleasure is his mouth with the primary mode of gratification identified as taking in or incorporation (Freud 1920, Katachadourian and Lunde 1975). Fortunately, the areas of libidinal investments described in the theory are all correlated with basic maturational processes.

The next stage of development is described as the anal phase (Freud 1920). This phase of development extends from one year of age to two years of age. In this phase, the anal area becomes the part of the body invested with libidinal energy (Freud 1920, Katachadourian and Lunde 1975). Physiologically, the two-year-old child is beginning to control his eliminatory processes, specifically, control of his bowels. The two-year-old is also beginning to exhibit interest in the world around him and he is capable of moving about quite effectively utilizing his developing muscles.

The main source of pleasure during the anal phase is identified as retention and elimination (Katachadourian and Lunde 1975). Retention and elimination are viewed as counterparts of the previous source of pleasure in the

oral phase, incorporation and consumption. The two-year-old child, therefore, views his ability to eliminate as a happy experience and many mothers suffer through this stage frantically trying to clean up behind their two-year-old's pleasurable activity.

Even though most two-year-olds are happy and playful, the latter part of the anal phase is characterized by the child exhibiting signs of intense ambivalence (Katachadourian and Lunde 1975). Many parents and friends recognize the two-year-old's signs of ambivalence in the form of their frequent outbursts of stubbornness, willfulness, and cruelty. Katachadourian and Lunde (1975) indicated that this sense of ambivalence develops as a result of the "primary conflict between retention and elimination which characterizes this phase" (Katachadourian and Lunde 1975, p. 236).

The oral and anal stages of development are collectively referred to as the pregenital phase and it extends through the first three years of a child's life (Freud 1950, Katachadourian and Lunde 1975). This phase of development is referred to as the pregenital phase because the genital area has not yet become invested with libidinal energy. Both the oral and anal stages or the pregenital stage is identical for both males and females

(Freud 1920, Katachadourian and Lunde 1975). It is in the subsequent phases of psychosexual development that female and male sexual development begins to differ.

At about three years of age, the child becomes aware of his own genitalia and he begins to view this area as a source of pleasure (Freud 1920, Katachadourian and Lunde 1975). This interest in the genitalia that the three-year-old exhibits is characteristic of the phallic phase of development which extends from the age of three to that of five or six (Freud 1920, Shope 1972). As a result of three-year-old's insatiable curiosity regarding their own body parts, many a parent has had to cope with finding their own three-year-old engaged in a methodical examination of his own genitalia as well as the genitalia of his friends. For some parents the phallic phase of their child's psychosexual development becomes a source of embarrassment. Kogan (1973) suggested that parents who understand that the child needs to explore his own body can lessen childhood anxiety and subsequent adult anxiety about sexuality.

Unlike the embarrassment that some parents cope with upon finding out that their three-year-old is aware of the difference between boys and girls through deliberate sexual explorations, the three-year-old child copes with a

major psychoanalytic issue in the so-called Oedipus complex (Freud 1920). The Oedipal complex is described as "a strong attachment by a child to the parent of the opposite sex and feelings of aggressive rivalry toward the parent of the same sex" (Katachadourian and Lunde 1975, p. 236). Because of the complex, the child faces a dilemma. On one hand the child is aware that he is not yet physically mature enough to satisfy his genital impulses. The child also recognizes the fact that he still needs and loves the parent of the same sex. As a result of the dilemma, a sense of guilt and confusion often develops (Freud 1920, Katachadourian and Lunde 1975). Sword (1978) indicated that this sense of guilt and confusion is more disturbing to males than to females because of the fear of castration.

The male child imagines that because of the feelings he has toward his mother, he is going to be punished by his father who is larger and physically stronger. This punishment is often perceived as the actual loss of his penis. Freud (1920) referred to the male's fear of actual loss of the penis as castration anxiety. Castration anxiety develops, according to Katachadourian and Lunde (1975), because the child expects punishment of the offending part. By this point in his life, the child has discovered that girls do not have the same type of sexual

organ and his fear that his penis can be lost is thus substantiated (Katachadourian and Lunde 1975). Even though the Oedipal complex may be more disturbing for males, Sword (1978) also suggested that the complex is more rapidly resolved in males because of the discomfort of castration anxiety. The discomfort of castration anxiety forces the male to quickly begin to identify with the parent of the same sex in hopes of one day acquiring comparable privileges with a woman like his mother (Katachadourian and Lunde 1975). Both the male and female child generally resolve the Oedipal complex by the process of identifying with the parent of the same sex (Sword 1978).

Like the male child, the female child during the Electra complex develops a strong attachment toward the parent of the opposite sex, her father. It is during the complex that the female first becomes aware that she does not have a penis and, therefore, concludes that for some reason she has lost the organ (Katachadourian and Lunde 1975). The female child's reaction may be one of envy of the male's penis (Freud 1920). In recent years, however, the psychiatric community has conceded that the idea of "penis envy" as presented by Freud in his psychosexual development theory has major weaknesses because it was developed from a male's viewpoint using the male model as

the prototype (Katachadourian and Lunde 1975, Stolar 1976). Sword (1978), however, suggested that the Electra complex is less intense in females but takes longer to be resolved because the discomfort felt is evoked due to penis envy. The idea of whether or not penis envy exists is still debatable.

If the Oedipal complex is not resolved, deep-seated emotional problems such as sexual inhibition, masochism, or narcissism may develop later on in life (Katachadourian and Lunde 1975, Stolar 1976). Successful resolution of the complex, however, leads the child to give up the parent of the opposite sex as a sexual object while continuing to love the parent of the same sex. The child also as a result of successfully resolving the complex develops an independent and internalized conscience or superego (Katachadourian and Lunde 1975). The functioning superego enables the five- to six-year-old child to keep his basic drives in control which allows him to go to school, learn, study, and interact with other children (Katachadourian and Lunde 1975). Intellectual growth and social maturity begin to develop at the end of the phallic phase upon successful resolution of the Oedipal complex.

After the phallic phase ends, the child enters into the latency phase of psychosexual development. This

phase extends from the time the Oedipal complex is resolved in some manner to puberty. During this period of development, there is limited sexual interest and activity (Freud 1920). One explanation is that during latency sexual activity is reduced because "sexual impulses and curiosity become repressed and remain dormant until the physical-hormonal changes of puberty take effect" (Kaplan 1973, p. 19).

The final phase of psychosexual development is described as the genital stage. During this phase of development, sexual interests are once again reawakened. The genital stage extends (Freud 1920, Katachadourian and Lunde 1975). The psychoanalytic idea of genitality as described by Freud was indeed quite broad and all encompassing. Genitality

> . . . encompasses the integration of all the developmental stages in order to indicate that genital orgasm with love helps facilitate and lead to a satisfactory life pattern of sex, procreation and work throughout life (Katachadourian and Lunde 1975, p. 239).

One of the major ideas Freud's theory purported was identified as the main purpose of life--work and love (Katachadourian and Lunde 1975).

Psychosocial Theory of Sexual Growth and Development

Among those who built upon and to a degree expanded upon the Freudian approach to sexual growth and development included Erick Erickson. Erickson's theory incorporated to an even greater extent than Freud's theory the idea that sexuality is strongly influenced by various environmental factors such as society, culture, and parental-rearing practices (Kogan 1973). Erickson's schema of development is divided into eight different stages each of which takes place at a particular age. In each stage, the individual is faced with a specific task. If the task is satisfactorily resolved, the individual healthily moves into the next stage. If it is not, the individual is usually unprepared to meet the next task and future attempts to solve tasks are hampered (Kogan 1973). Continuous inadequate resolution of the tasks identified, often, according to Kogan (1973), cause emotional scars and personality disorders in adulthood.

The first stage of Erickson's schema is described as the period during which the individual decides that "the world is a safe place or a place of fear" (Kogan 1973, p. 5). Infancy extends through the first eighteen months of life and the major task to be accomplished is identified as trust versus mistrust. Erickson identified each stage

of his theory in terms of both the desirable resolution of the task and the contrary development that occurs if the task is not adequately resolved (Kogan 1973).

Each individual learns to a great degree to trust or mistrust as the result of the quality of maternal care he or she receives (Kogan 1973). During the first year of life, the infant's whole world centers around his mother. Mother provides him with all the essentials to survive--nourishment and love. If his experience with the world (mother) is one which promotes safety and trust, he gains a sense of self-esteem. If, however, his experiences are characterized by anxiety and fear, he learns to approach future problems with fear and anxiety (Kogan 1973). According to Offer and Simon (1976), the infancy period of development is critical if the individual is to develop into a normal sexually responsive person. The trust versus mistrust stage correlated with the oral phase in Freud's psychoanalytic theory of sexual growth and development.

The infant passes into the next stage of development in Erickson's schema which is identified as the toddler stage. The toddler stage extends from eighteen to thirty-six months. During this stage, the major task the toddler copes with is identified autonomy versus shame and doubt. Freud's anal stage correlates well with this period of development in Erickson's schema.

Erickson suggested that one of the major issues which either hinders or helps a child achieve autonomy is toilet training (Kogan 1973). Control over eliminatory processes helps the individual develop a sense of autonomy or independence (Kogan 1973). This quest for independence begins in the toddler stage and continues throughout life. For the toddler, however, independence is "marked by increasing muscle control and the beginning of control of his bladder and bowel" (Kogan 1973, p. 8). Unfortunately, the toddler period is often viewed as a traumatic one for both the parent and the child in regard to achieving toilet training.

Besides the trauma of achieving toilet training, some parents must also cope with their child's increased interest in his genitalia. Most children begin to exhibit an increased interest in their genitalia around the age of two, but in some instances this interest is delayed until the child becomes four (Kogan 1973). Because of this increased interest, the child usually through methodical examination of his sexual organ becomes aware of whether or not he or she is a boy or girl which generally occurs during the latter part of the toddler phase.

As the toddler advances into the next stage, the main issue once again for the three- to six-year-old or

the preschooler is the Oedipal complex. The major task to be accomplished is identified, however, as initiative versus guilt. Freud's phallic phase of psychosexual development correlates with the preschool-age phase identified by Erickson.

According to Erickson's schema, the child either enters into the Oedipal complex with a sense of self-esteem, trust, and a degree of autonomy or a sense of unworthiness, mistrust, and guilt resulting from previous interactions with his culture, society, or parents (Kogan 1973). During the Oedipal complex, generally, if the parents handle the situation with understanding and love, many of the child's anxieties evoked by the complex may be alleviated and the child's sense of self-worthiness may be augmented (Kogan 1973). Parents who exhibit signs of embarrassment or coyness may unknowingly, however, increase their child's anxieties as described in Freud's description of the complex (Katachadourian and Lunde 1975).

Beside the various anxieties evoked by the Oedipal complex, the preschooler may also develop a deep sense of guilt and fear because of his continuously intense curiosity about sex. By this point in his development, the child is usually quite aware of his own gender and he knows the pleasure associated with handling the genitals.

Because of this curiosity and the gratification he may receive from engaging in autoerotic-type activities, the child may without any apparent cause in some instances, develop the following fears: castration anxiety in males and questionable penis envy in females (Kogan 1973).

Not all children exhibit these fears in the same manner or to the same degree, "nor are these fears necessarily based upon something the parent has said or done" (Kogan 1973, p. 13). Understanding parents, however, can usually help their child cope with these fears. Scolding or belittling may on the other hand cause the child, especially the sensitive child, to view his genitals as dirty which subsequently leads to the formation of a negative attitude toward sexuality (Kogan 1973, Kaplan 1973).

Following the resolution of the Oedipal complex, the child enters into the school-age phase of development with the major task identified as industry versus inferiority. The school-age period extends from age six to age twelve. Intense sexual interests as exhibited by the child in the previous stages of Erickson's schema are drastically abated during this period (Kogan 1973). Freud's latency phase of psychosexual development correlates with the school-age phase.

The school-age period of development is generally characterized by the child's acquisition of skills he will need as an adult. He learns to read, to use tools, and to do things he considers useful. In essence the school-age period is characterized by the idea that the child is becoming what he learns (Kogan 1973). Once again parental attitudes play an important part in the child's development of a sense of industry, the healthy task, in this period. If the child approaches his parents with the fruits of his industrious labor only to receive a scolding or a criticism, a deep sense of inadequacy and inferiority may develop (Kogan 1973). The child who receives praise from his parents will generally, on the other hand, continue to be motivated to do better and be more productive.

At approximately twelve years of age, the school-age period ends and for most children, puberty and adolescence begin according to Erickson's theory (Kogan 1973). During adolescence, identity versus self-diffusion is identified as the major task. In Freud's psychoanalytic theory, adolescence is referred to as the genital stage of development.

For some teenagers the beginning of adolescence and puberty heralds the beginning of many sexual anxieties. These anxieties are often associated with or in the form of

inconsistent emotions and thoughts, frighteningly powerful new sexual urgings, and rapid body changes (Kogan 1973). Once again patience and understanding are required of parents in order to help the teenager cope with these anxieties. Kogan (1973) suggested that if some of these types of anxieties are not resolved, the "individual's entire personality structure, and, with it, his sexuality is affected adversely" (Kogan 1973, p. 16).

Puberty and adolescence, even though they begin at approximately the same time, are not synonomous concepts. Puberty is defined as a biological event which begins with the development of the reproductive organs. Adolescence is generally viewed as a cultural term (Kogan 1973). Adolescence usually continues beyond the end of puberty and it leads the individual into adulthood. If the teenager enters the adolescent period, however, without having reasonably resolved tasks in the previous four stages, not identity but identity diffusion may result and sexual adulthood may be delayed (Kogan 1973).

From adolescence, the individual enters into adulthood. According to Erickson's schema, adulthood is divided into three different stages--early adulthood, middle adulthood, and old age (Kogan 1973).

In early adulthood, the major task is identified as intimacy versus isolation. For most young adults, the major focus of their lives becomes the giving and receiving of love. Because the young adult has successfully resolved previous tasks, he or she is able to engage in an intimate type of relationship with another person. Freud described this period of development as "the period during which true genitality can develop" (Katachadourian and Lunde 1975, p. 239). Kogan (1973) referred to intimacy not in terms of genitality but rather in terms of intimacy being an aspect of "earned humanness" (p. 22). Intimacy is in essence that quality of humanness which motivates most individuals to not only give love but also to take love without exploitation.

Because the mature individual has successfully resolved the previous task identified in young adulthood, he or she is able to move into middle adulthood ready to achieve generativity. The major task in middle adulthood is identified as generativity versus stagnation. The mature individual is aware that love is giving and taking without exploitation and this knowledge allows him to share himself with others, especially children. Parenthood becomes a way for him to share his creativity or generativity (Kogan 1973). By helping his offspring achieve

the strength necessary for effective living, the sexually mature adult usually achieves generativity. Kogan defined generativity as "a mutual desire for parenthood, for creating the next generation" (1973, p. 24). Generativity can also be achieved by those who are childless by providing care to members of the younger generation through adoption or just working with children in general.

The final phase of adulthood is identified as old age. The major task in this phase is identified as integrity versus despair and disgust. In essence, this stage of development brings the individual in a full circle back toward his beginning. If in the beginning, early tasks were adequately resolved, the individual usually dies "with a sense of integrity and trust" (Kogan 1973, p. 25). If, on the other hand, early tasks were not adequately resolved, the individual may die fearing as well as despising his very existence (Kogan 1973). This individual often painfully realizes that he has missed something and it is now too late to turn back the hands of time and start anew.

Both Freud and Erickson's respective theories emphasize that sexual growth and development is strongly influenced by environmental factors. What each individual is taught by family, friends, and society as a whole, molds

his adult personality structure as well as his view or attitude toward sexuality. In describing Freud's and Erickson's theories, Kogan (1973), Kaplan (1973), and Katachadourian and Lunde (1975) further suggested that the development of a child's attitude toward sexuality results from being taught or conditioned how to view sexual matters. If the parent exhibits disgust with the child who plays with his genitalia, as previously documented, the child may begin to view himself as being unworthy of love and subsequent negative attitudes toward sexuality may develop (Kogan 1973, Kaplan 1973). The school-age child and/or the adolescent who does not receive support and understanding from his parents during these developmental stages in regard to sexual matters may, according to Kogan (1973), have his personality structure as well as his sexuality adversely affected.

The ideas presented by Kogan (1973), Kaplan (1975), and Katachadourian and Lunde (1975) are all supported by Staats and Staats' (1957) theory on attitudinal formation by classical conditioning. Staats and Staats' (1957) theory forms the basis upon which this research study was developed. They reported that through classical conditioning, attitudes, either negative or positive, may be formed. Kaplan (1973), Kogan (1973), and Katachadourian and Lunde (1975) have all

indicated in their respective discussions on sexual growth and development that parental conditioning of their children toward sexuality can cause the development of either a positive or negative attitude toward this aspect of humanness. Staats and Staats' (1957) theory perhaps adds more validity to Kaplan (1975), Kogan (1973), and Katachadourian and Lunde's (1975) ideas.

Rape

The effect of a sexual attack upon a victim is critical at any stage of sexual growth and development. For most victims of a sexual attack, rape constitutes a crisis situation which often results in the formation of emotional scars (Burgess and Holmstrom 1974, Notman and Nadelson 1976). Emotional scars such as fear of future sexual relationships with men, the development of a sense of inadequacy to control one's life, and the development of varied fears often remain with the victim for the rest of her life (Burgess and Homstrom 1974, Notman and Nadelson 1976). In the following discussion, rape is the topic under consideration, and it is divded into the following four areas--the affect of rape upon sexual growth and development, victim's response patterns, types of rapists, and finally an overview of several theoretic approaches to rape is presented.

As previously indicated, rape constitutes a crisis situation for most victims (Burgess and Holmstrom 1974). Caplan defined crisis as occurring

> when a person faces an obstacle to important life goals that is, for a time insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made (1961, p. 18).

The definition of crisis as presented by Caplan (1961) is fulfilled in regard to rape. Rape is an obstacle important to life goal which is simply surviving the attack itself. Many women indicated in the Burgess and Holmstrom (1974) study that one of their major fears during the attack was that of dying. The attack is indeed for a time insurmountable because for most women even though they may fight, the rape generally still occurs. Customary problem-solving methods utilized by the victim such as fighting or utilization of some type of psychological strategy generally fails to stop the rapist (Burgess and Holmstrom 1974). As a result of the attack, most victims enter into a disorganized state with some victims attempting to resolve the problem by either seeking police-medical intervention or refusing to tell anyone about the assault.

Another view of rape as a crisis event is described in terms of Rapoport's three interrelated crisis-producing factors which she identified in the following manner.

Rapoport hypothesized that a crisis develops when one of the following occurs:

> "1. a hazardous event poses some threat
> "2. a threat to instinctual needs develops which is symbolically linked to earlier threats that resulted in vulnerability or conflict or
> "3. there is an inability to respond with adequate coping mechanisms" (1965, p. 25).

Williams and William (1973) posited that rape easily fits into Rapoport's (1965) criteria. The authors suggested that first, rape is a direct threat to the victim's physical and emotional health. Williams and William (1973) reported that most victims suffer some form of physical and mental anguish during and after the assault. Secondly, according to the authors, rape constitutes a threat to a woman's sense of independence. They indicated that rape often evokes sexual fears and concerns which a woman may have previously repressed. Third, rape is generally an event which is entirely new to the woman and new to the woman's life experience. Therefore, old problem-solving methods generally do not prove adequate.

Aguilera and Messick's (1978) description of rape as a crisis situation supports Williams and William's (1973) ideas. According to Aguilera and Messick (1978), many victims of rape perceive the assault as being their fault. The feeling of guilt plus the fact that some women do not tell anyone about the assault often leads the victims into

a state of increased anxiety and depression (Aguilera and Messick 1978). This increase in anxiety and depression produces a panic state or a disorganization of thought processes which culminates into the development of a crisis. Aguilera and Messick (1978) developed this schema in the form of a paradigm in order to illustrate that rape is a crisis.

Caplan's definition (1951), Rapoport's criteria (1965), and Aguilera and Messick's paradigm (1978) all support the idea that rape presents a crisis situation for most of its victims. How then does such a crisis event affect the sexual growth and development of its victims? One of the few studies which addressed the issue of rape and sexual development was presented by Burgess and Holmstrom (1974). Burgess and Homstrom (1974) identified the responses and concerns of rape victims as they differed according to Erickson's schema of sexual growth and development. Therefore, Burgess and Holmstrom's (1974) reported findings are utilized as the primary reference source in the next area under consideration.

Rape and Human Sexuality

Erickson's first task of development, as previously identified, is trust versus mistrust (Kogan 1973). The infant becomes aware of the environment in which she lives

during his first eighteen months of life. It is during this period that she perceives the world as either safe or threatening. Burgess and Holmstrom (1974) reported that any attempt at sexual assault during this stage causes the young victim to exhibit signs of fear and pain. In the authors' description of an attempted sexual assault of a one-year-old little girl, Burgess and Holmstrom reported that the little girl cried out in fear and pain. The child's crying fortunately caused the would-be assailant to flee. The authors indicated that the fear and pain that this child exhibited may be exhibited in future relationships with people other than her parents. In essence, a rape assault during the infancy period of development may cause a sense of mistrust or fear to develop in the growing child.

The next stage of Erickson's schema is the toddler period (eighteen to thirty-six months) with autonomy versus shame identified as the major task. The toddler stage is often characterized by the three-year-old venturing forth in search of her own independence leading her to inspect and explore the world in which she lives. Burgess and Holmstrom (1974) indicated that this sense of autonomy or independence is easily disturbed by rape assault. If the rape occurs as a result of the toddler wandering off to

explore his world, the authors indicated that the child generally develops a sense of shame because she feels that she has precipitated the event. Burgess and Holmstrom further posited that this sense of shame is often heightened by the parents' reaction to the assault. The toddler tends to perceive the angry reaction of her parents as being directed toward herself and she is in most instances unable to understand that the anger is directed toward the assailant.

Burgess and Holmstrom (1974) reported that one of their three-year-old victims became extremely disturbed and depressed following the rape assault. The source of the depression and anxiety was finally directly traced to the father of the child who had shown a great deal of anger upon being told of the incident. After therapeutic counseling with both child and parent, the child became able to talk about what had happened.

During the preschool period (three to six years), the child is still seeking to find out more about the world in which she lives (Kogan 1973). The major task is identified as initiative versus guilt. Because the child has developed by this time, a functioning superego, she is capable of distinguishing right from wrong (Katachadourian and Lunde 1975). Burgess and Holmstrom (1974) reported that

victims in this stage were indeed able to understand the need for going to the hospital because something bad had happened to them. These victims also, generally realized that the anger that their parents exhibited was directed toward the assailant who they identified as trying to hurt them (Burgess and Holmstrom 1974).

The rape of a school-age child (six to twelve years), according to Burgess and Homstrom, presents another problem. The major task of the school-age child is identified as industry versus inferiority (Kogan 1973). Curiosity as well as changing body image are major issues in this period. The school-age child is also in the midst of acquiring skills and knowledge necessary as an adult. Sexual interests, per se, are reportedly at a low ebb (Kogan 1973). Burgess and Holmstrom (1974) indicated that even though sexual interests may be low during this stage, victims in their study correlated a rape assault with the sex act based upon both their knowledge and understanding of the body parts involved. These victims frequently reacted to the knowledge of a rape assault by joking about the idea.

Perhaps one of the most critical times for a victim in regard to sexual development to suffer a rape assault is the adolescent period. The major task in adolescence

is identified as identity versus identity diffusion (Kogan 1973). The young adolescent copes with various concerns such as changing body image and reawakening sexual interests. When so many other issues are vying for attention, rape generally tends only to complicate this stage of development.

Burgess and Holmstrom (1974) reported that the adolescent victim is perhaps the most difficult victim to whom the health professional provides care. Adolescents involved in their study generally refused to talk about the assault, and thus, the crisis in many instances remained unresolved. Some adolescents did express their feelings about a possible pregnancy. Most adolescents did not, however, seek medical care or intervention even though they indicated that they feared that they would become pregnant. The authors suggested that crisis workers should be alerted to the fact that adolescence is indeed a critical period, and it is significantly affected by a rape assault.

With the end of adolescence, early adulthood usually begins with the major task identified as intimacy versus isolation (Kogan 1973). During this stage of development, the major focus is on the giving and sharing of love. At this point in her life, the young female generally turns her thoughts toward marriage or she decides upon the type

of sexual life-style she wants to adopt. Her decision may vary from that of a swinging single to that of a loving housewife.

Burgess and Holmstrom (1974) did not report a noted difference in the concerns and responses of victims who were virgins compared to non-virgin victims. Their report did indicate, however, that one basic concern expressed by all victims in this developmental stage was the problem of pregnancy. Some of the victims expressed a definite way of coping with the possibility of pregnancy. Other victims indicated a degree of ambivalence in terms of what they would do if pregnancy resulted from the assault.

Besides the issue of pregnancy, Burgess and Holmstrom (1974) reported that victims in the early adulthood developmental indicated a need to talk with others about various concerns. These concerns included the following: telling people about the assault, especially husbands and boyfriends; anxieties about their own sexuality and sex in general; and the possibility of contracting a venereal disease as the result of the assault. The last major issue most of these victims indicated was that of fear. Many of these women feared that they would not ever be able to form any degree of intimacy with a member of the

opposite sex. It is at this point in most women's lives that they marry and begin a family.

In the next stage of development, middle adulthood, the major task is identified as generativity versus stagnation (Kogan 1973). Women in this phase are very concerned about caring for members of the younger generation, in most instances, their own children.

Burgess and Holmstrom (1974) reported that victims in their study were extremely concerned about how the rape would affect those they loved. Most victims expressed a deep concern in regard to how the rape would affect their children. One young mother reportedly indicated that she was particularly worried about her older children's reactions to the assault. Pregnancy was also indicated by these women as a major issue.

In the last stage of Erickson's development schema, old age, integrity versus disgust is identified as the major task (Kogan 1973). If previous tasks have been successfully resolved, the mature woman is able to look over her life with a sense of tranquility and appreciation (Kogan 1973).

Women over fifty years of age who were interviewed by Burgess and Holmstrom (1974) indicated the following concerns: fear of death resulting from the aggressiveness

of the assault, concern for family members, and their family's reactions to the news of the assault. Pregnancy was not viewed as a major issue because most of the women were postmenopausal.

The issue of sexuality was, however, a major concern of these women. Unfortunately societal attitudes are such that sex after about sixty years of age is often considered a nonexistent activity (Poneroy 1977). Many of the victims indicated that they worried about what their friends would say about this sexual encounter even though it was rape. Burgess and Holmstrom (1974) suggested that victims in this developmental stage need to talk about the sexuality issue associated with the assault as well as discuss their fears about dying as a result of the assault.

Even though concerns and problems identified by the victims in the Burgess and Holmstrom study (1974) differed according to the developmental stage the victims were in at the time of the assault, one idea was constantly expressed by the victims. Rape assault did indeed constitute a crisis situation in their lives. Burgess and Holmstrom's findings further supported the idea presented by Williams and William (1973) and Aguilera and Messick (1978) that rape presents a crisis situation in the lives of the victims. Burgess and Holmstrom's findings from their study also

suggested that rape has both an immediate as well as a long-term effect on victims' lives. The following area under consideration, victims' response patterns, describes the varied effect of rape on victims.

Victims' Response Patterns

Morton Bard, M.D. suggested in a speech to the New York City Mayor's Task Force on a Rape Symposium that "short of homicide, rape is the ultimate destruction of the self and the ultimate violation of a human being" (Seltzer 1977, p. 114). Upon reviewing the limited number of studies which describe rape victims' response patterns to the assault, Dr. Bard's statement appears accurate. Rape affects every facet of the victim's life as well as the lives of family members and friends.

Three studies, all of which were conducted within the past fifteen years, indicated that rape victims respond and react in a similar manner. Burgess and Holmstrom's study (1974), which has been discussed in an earlier section, reported that victims' responses could be divided into two distinct phases collectively referred to as the rape trauma syndrome. Sutherland and Scherl (1970) reported that victim responses could be divided into three stages instead of two--acute reaction phase, outward adjustment phase, and the phase of resolution. Unlike the previous two studies,

Notman and Nadelson (1976) reported victims' responses in terms of the developmental and/or life stage the victim was in at the time of the assault.

Sutherland and Scherl (1970) based their findings on their personal interviews with thirteen victims of rape, studied over a year's period, whose ages ranged from eighteen to twenty-four years. Most of these young women were interviewed during the acute course and several weeks after the assault. The authors indicated that the major purpose of the study was to "identify a specific predictable sequence of responses to rape viewed as a psychological traumatic event . . ." (1970, p. 504). As a result of their findings, Sutherland and Scherl designed a pattern of short-term mental health intervention to alleviate the concerns and distresses exhibited by these victims.

As previously indicated, Sutherland and Scherl divided victims' response patterns into three stages. The first stage was described as the acute reaction phase. During this phase, victims exhibited signs of shock, disbelief, and dismay. Unlike the Burgess and Holmstrom findings (1974), Sutherland and Scherl (1970) did not report that their victims exhibited fear or anger during their acute phase, which correlated well with the acute reaction

phase identified as part of the rape trauma syndrome described by Burgess and Holmstrom (1974).

During the acute reaction phase, the authors also noted a difference in terms of reactions and responses of those victims who immediately reported the crime to the police or to another person. Sutherland and Scherl (1970) suggested that women in the study who felt they had not precipitated the crime immediately reported the assault and sought medical care. Those women in the study who felt some degree of complicity, which was characterized by an inner sense of guilty involvement confirmed by data obtained by the authors during subsequent interviews, did not report the crime immediately. The authors reported that eight of the women interviewed in the study immediately reported the assault and the remaining five women waited from one day to two months before they reported the assault.

Beside the feeling of complicity some of the victims exhibited, all of the victims expressed concern in regard to telling their parents about the assault. Most of the victims were confused as to whether or not they should tell their parents, friends, boyfriends, and neighbors about the assault during this period of acute anxiety. Phase one, or the acute reaction phase, usually resolved itself within

a period of a few days to a few weeks (Sutherland and Scherl 1970).

The second phase in the victim's emotional response pattern, according to Sutherland and Scherl was "a logical outgrowth of the resolution of the preceding phase" (1970, p. 507). After the immediate anxiety-producing issues had been settled, most victims in the study appeared to be coping adequately and some even returned to work. The authors found that the calm exterior was misleading and did not represent the final resolution of the event. Sutherland and Scherl (1970) indicated that this phase identified as the outward adjustment phase, developed due to a "heavy measure of denial or suppression" (p. 507). In essence, the victims in the study during the outward adjustment phase refused to think about what had happened to them and they attempted to begin the process of reorganizing their lives. The concerns and reactions identified by Sutherland and Scherl (1970) in this phase correlates with the Burgess and Holmstrom (1974) transitional phase as described in the rape trauma syndrome.

Sutherland and Scherl (1970) reported that during the second phase, victims began to deal with their feelings about the assailant. Some of the victims rationalized the reason why the rape occurred. Many of the victims assessed

the blame for the assault on various social conditions such as mental illness and/or poverty. Perhaps the denial and suppression utilized by the victims as a coping mechanism helped them to deal with their feelings about the assailants (Sutherland and Scherl 1970).

The final phase as identified by Sutherland and Scherl (1970) was called the integration and/or resolution phase. During the integration phase, the victims once again coped with feelings of depression and feelings about the rape which were suppressed during the previous stage. The authors identified the depression exhibited by the victims as a normal response resulting from coping again with feelings previously denied (Sutherland and Scherl 1970). In most instances, the resolution phase began as a result of a specific incident such as the beginning of the courtroom trial, a glimpse of someone who looked like the rapist and/or a marriage proposal.

Two major issues emerged for resolution in the last phase. First, the victims began to integrate a new view of themselves and secondly in most instances, they began to resolve their feelings about the assailant and their relationship to him. Interestingly, victims' earlier attitudes of understanding the assailant's problem in regard to rationalizing why the rape occurred, generally

turned to "anger toward the assailant for raping her and anger toward herself for in some way having permitted or tolerated this 'use'" (Sutherland and Scherl 1970, p. 508). Amir (1971) indicated a similar response by victims in what he identified as a victim precipitated assault. Amir (1971) described the term victim precipitated assault as a process whereby the victim's behavior and the situation which surrounds the encounter determines the course of events which leads to rape. Would victims feel and exhibit the need to, as Sutherland and Scherl noted, "come to a realistic appraisal of her degree of complicity" (1970, p. 508), if those who provide care to rape victims would help them cope with the reality of the situation without displaying a judgmental type attitude?

Based upon their study's findings, Sutherland and Scherl (1970) recommended that victims receive the following support. During the acute phase, psychological support should be focused on helping the victim with realistic concerns. A discussion of the victims' feelings rather than supporting defense mechanisms should be attempted. Management and counseling during the outward adjustment phase, however, should be given only if the victim specifically requests help. Because depression generally characterized the reaction of victims in the integration

phase, the authors suggested that individuals who work with rape victims should help the victims understand the cause of the depression. When victims were forewarned during the acute reaction phase that the feelings they were suffering then would probably return later, they were able to cope with the panic and fright that developed during the resolution phase (Sutherland and Scherl 1970).

One of the major disadvantages of the Sutherland and Scherl (1970) study was identified as the limited sample size. As previously mentioned, the authors' findings were based upon their personal interviews with thirteen victims. Sutherland and Scherl reported that the reaction to rape which they had reported and observed among the thirteen victims in their study, could not without further study on a less narrow population be considered generic responses. The narrow age range of the victims, eighteen to twenty-four years, further reduced the authors' ability to generalize. Even with these disadvantages, Sutherland and Scherl's report provided a glimpse into an area which has received little research.

Unlike the Sutherland and Scherl study (1970) and the Burgess and Holmstrom study (1974), Notman and Nadelson (1976) described victims' response patterns according to age and life stage--young single women, divorced or

separated women, and middle-aged women. The authors reported, however, that it is difficult for anyone to predict how she will react when rape actually occurs but there are some specific issues related to age and life stage (Notman and Nadelson 1976).

The young single woman between the age of seventeen and twenty-four generally becomes a victim of rape according to the authors, because of her limited experience with men. "She is vulnerable often by virtue of being alone and inexperienced" (Notman and Nadelson 1976, p. 411). Prior to entering into adulthood, many young women's experiences with men have probably been limited to father, brother, and special boyfriend. Because of a degree of naivete, the young woman may unwittingly become involved in an unwelcomed sexual encounter (Notman and Nadelson 1976). If rape results from one of these liaisons, the authors indicated that feelings of shame, guilt, and a sense of vulnerability often develops. Rape may even revive concerns the young female has regarding separating from parents and achieving independence (Notman and Nadelson 1976). In some instances, the young female even begins to question whether or not she is capable of caring for herself.

Notman and Nadelson (1976) reported that rape may also affect the young woman's perception and tolerance for

the gynecological examination which is a routine part of the physical examination performed following a rape assault. The authors suggested that the trauma associated with the rape assault causes the victim to sometimes view the pelvic examination performed in the hospital setting as another rape. Even though she is concerned about the possibility of contracting a venereal disease or becoming pregnant, she may have difficulty coping with the pelvic examination because it revives memories of the original rape experience (Notman and Nadelson 1976).

The divorced or separated woman is confronted with different problems and concerns. Notman and Nadelson (1976) indicated that the divorcee is more likely to be blamed and her credibility in terms of type of life-style, morality, and character is frequently questioned. Because of these type of attitudes, the authors suggested that the victim may view the rape as a confirmation of her feelings or failure identified as failure in regard to her marriage and now failure to care for herself. As a result of this sense of failure, the authors further suggested that guilt feelings develop which lead the divorced or separated rape victim to not report the crime or seek medical care. As a result of the rape, Notman and Nadelson (1976) also reported that the divorced or separated woman's ability to

care for her children if she has them is questioned. "If she has children, she may worry about her ability to protect and care for them and others will probably raise questions about her adequacy as a woman" (Notman and Nadelson 1976, p. 411). Succinctly stated the woman must, therefore, cope with the problem of what, how, and when to tell her children about the assault.

Rape, according to the authors, presents a major problem for the middle-aged women because her ability to have control and her concerns about independence may be accentuated. At this point in her life, the middle-aged female may be coping with the problem of an empty home. Generally, the children are grown-up and the spouse is oftentimes completely involved in his career. Because of these changes, she may look at her life only in terms of the changed relationship with her less dependent children and her career-oriented husband viewing all of this as an indication of no longer being needed.

Notman and Nadelson (1976) reported that there is a misconception that middle-aged women may be past their most sexually active period and have less to lose in regard to rape. The authors indicated that the middle-age woman who is suffering with feelings of worthlessness and self-devaluation may be more traumatized by the assault than a

younger woman. Burgess and Holmstrom's study (1974) supported Notman and Nadelson (1976) on the reactions of middle-aged women to rape. Burgess and Holmstrom (1974) indicated that rape is extremely traumatic for the mature female.

As previously stated, victims' response patterns are quite similar. Beside identifying response patterns according to life stages, Notman and Nadelson (1976) reported that rape in essence could be divided into four broad stages--anticipatory or threat phase, impact phase, post-traumatic or recoil phase, and post-traumatic reconstitution phase.

The first stage identified by Notman and Nadelson (1976) is characterized by anxiety which facilitates perception of potentially dangerous situations so that the situation can be avoided. During the second stage, the impact phase, varying degrees of disorganization develops in the previously well-adapted person. Emotional expression and behavioral control are generally regained during the recoil phase. During the fourth and final phase, the post-traumatic reconstitution phase, the victim decides upon her future life.

Notman and Nadelson (1976) reported that rape response patterns are similar to crisis reactions in

general. The authors indicated that rape as a crisis situation is a "traumatic external event which breaks the balance between internal ego adaptation and the environment" (Notman and Nadelson 1976, p. 409). The four broad stages of individual reactions to life-threatening situations as identified by Notman and Nadelson (1976), have also been documented by several other theorists (Lindemann 1944, Kubler-Ross 1972). Lindemann (1944) provided the major focus point for understanding the symptomatology of bereavement crisis. Kubler-Ross (1972) described the process patients go through to come to terms with the fact of dying. Burgess and Holmstrom suggested that

> The broad sequence of the acute phase, group support, and the long-run resolution described by Kubler-Ross (1972) and Lindemann (1944) is compatible with the psychological work rape victims must do over time (1974, p. 327).

Classification of Rapists

Unlike the similarities noted by the various authors (Sutherland and Shcerl 1970, Burgess and Holmstrom 1974), Notman and Nadelson 1977) in regard to rape victims' response patterns, the scientific community has been unable to describe with any degree of certainty why rapists rape. Cohen and associates reported that the "act of rape clearly cannot be understood inidimensionally simply in

terms of motivation or, in fact in terms of any single factor (1971, p. 311). At the present time, there is no apparent correlation between rape and other specific diagnostic characteristics such as neuroses, character disorders, and varying degree of psychotic states (Amir 1971).

Amir (1971) indicated in his extensive research report on forcible patterns of rape that the list of variables utilized to classify the rapist varies. Rapists, according to Amir (1971), have been classified in the past according to motivational syndromes, general psychiatric categories, modus operandi of the offense, danger to the community, and finally as the normal sex offender. Amir described the normal sex offender as those who are identified as normal according to legal definitions, the occasional offender and the offender who belongs to a subculture.

In his typology of rapists, Amir (1971) suggested that rapists should be classified according to roles rather than according to personality factors such as sadism or satyriasis. Amir reported that the new typology would allow rapists to be classified into the following three types.

> . . . offenders to whom the crime is a symptom or an idiosyncratic act either psychopathological or due to special circumstances; offenders for whom the crime is mainly performed for the purpose of

> maintaining membership in a group or for sheer sexual gratification; and offenders for whom the crime is performed not so much for the sexual satisfaction as because of participation in the context which it occurred (Amir 1971, p. 319).

Cohen and his associates (1971), on the other hand, presented a typology of rapists based upon observed descriptive dynamic characteristics of the rapists interviewed at the Treatment Center as Massachusetts Correctional Institution. Rape was conceptualized by the authors as involving two components--aggression and sex. The part played by these components in the actual assault tended to vary and be quite different. In some instances aggression was identified as the major impulse with sexual impulse identified as secondary. At the opposite pole, sexual impulse was identified as the dominant force and aggression was secondary. A third pattern emerged in the study and was identified by the authors as a merging of the two components which was viewed in terms of sexual sadism.

Cohen and associates (1971) reported that when the primary impulse was identified as aggression, sexual behavior was utilized to achieve the dominant impulse and humiliate the victim. This type of rapist usually exhibited a varied range of violence from that of simple assault to brutal attack sometimes resulting in the victim's

death. This type of rapist also frequently identified his primary emotional state at the time of the attack as anger (Cohen and associates 1971). Cohen and his associates posited that this rapist feels anger towards his victim because it is a displacement of rage on a substitute object identified in most instances as the assailant's mother, wife, or girlfriend. Because this type of rapist is angry with a significant female in his life, he usually goes out and rapes any woman he meets. Most of the rapists in this category were reportedly either married, engaged, or sexually involved in a dating situation. Many of the marriages were, however, marked by periods of violence and these rapists openly indicated that women were hostile, demanding and ungiving in their relationships.

The rapist who utilized sex as the primary impulse reaction differed drastically from the first type of rapist previously described. When aggression was the secondary impulse, the rapist exhibited little or no violence in his modus operandi. If the victim struggled against this type of rapist, he generally fled the area (Cohen et al. 1971). Cohen and his associates posited that the sex aimed rapist generally perceives the act as a compulsive event which he often utilizes in order to combat homosexual wishes. Most of the victims of the sex-aimed rapist were identified as

strangers who the rapist came upon by accident. Finally, this type of rapist was identified by the authors as the quiet, shy, good-looking young man who tends to be a loner but who is otherwise normal in appearance.

The third type of rapist observed by Cohen and his associates (1971) was identified as the rapist who possesses sadistic tendencies. This type of rapist reportedly does not achieve any type of sexual excitation without utilizing some degree of violence. The degree of violence utilized may be to the point of killing the victim as in the case of the highly publicized lust murders. The authors reported that the sadistic rapist teases his victims in order to elicit excitement and anger which excites him. Even though the rapist may rough-up his victim, Cohen and his associates reported that this rapist's emotional state at the time of the attack is not that of anger in most instances.

Once again, the authors reported that most of the sadistic-type rapists they interviewed were married. The authors indicated that for this offender the constant search and seduction involved in rape assault was essential in order to satisfy the aggressive component of his sexual wishes. Many of the rapists in this category expressed the belief that women liked to be roughed-up and enjoyed

struggling against their male sex partner. Cohen and his associates (1971) further reported that during the interviews with this type of rapist the assailant maintained that the woman enjoyed the assault. This same type of idea is prevalent in society in general in the form of the old adage that every woman secretly dreams of being raped and really enjoys the event if it occurs (Pomeroy 1977).

Theoretical Considerations

Because there is no unified theory on the psychology of rape, the existing writings on sexual deviation and sexual crimes provide a glimpse into why rape occurs according to the psychiatric and psychologic community. Amir (1971), a sociologist on the other hand, reported that a sociological orientation provides the answer to the question why rape occurs. Both the psychiatric-psychologic community and the sociological community have in the past purported ideas on the subject under investigation only to have the approaches remain unsubstantiated in terms of empirical referrents. Nevertheless, the psychological approach to the phenomenon of rape at the present time appears to dominate the literature.

The psychoanalytic approach to rape is based upon the theory of sexual development as surmised by Sigmund Freud. According to this theoretical approach, rape is

viewed as a perversion (Amir 1971). Perversion is defined as the persistence of infantile sexuality into adulthood at the expense of adult genitality (Amir 1971, Katachadourian and Lunde 1975). Fixation on infantile forms of sexuality has been generally traced to strong inborn drives or pathological experiences which occurred in infancy or early childhood (Amir 1971). According to the theory, a traumatic or pathological experience deprives the boy, who develops into a rapist, of basic needs such as "security, affection, and suitable identification or they increase his fears and anxieties" (Amir 1971, p. 303). Because the trauma occurs early in the child's sexual development, perception of the relationships between males and females also becomes distorted. The child may even begin to view sexual activities as aggressive and cruel while the idea of receiving pleasure from such activity is identified in a negative manner (Amir 1971). Unfortunately for the child, the above identified ideas and feelings are often carried into adulthood.

Like the psychoanalytic approach to rape, the psychiatric approach is based upon the concept of normal and abnormal sexual behavior. The psychiatric approach expands upon the concept of normalcy by incorporating the idea of a problem-solving aspect of behavior and by looking

at "the various sources of internal conflict and the adaptive and learning mechanism which produces substitute and symbolic behavior" (Amir 1971, p. 294). Rape, according to the psychoanalytic approach, is, therefore, viewed as a substitute and symbolic expression of innate instinctual drives by the ego or superego on the mother figure or a representative of that figure (Amir 1971). Cohen and his associates (1971) reported a similar finding in their description of the aggressive type rapist.

Both the psychiatric and psychoanalytic approach assume to a degree that normal adult sexual behavior or deviation is the result of the socialization process (Amir 1971). Unfortunately, a definite linkage between adult sexual behavior and sexual socialization lacks definite evidence. McCord and McCord (1962) attempted in one of the latest studies on rape and sexual socialization unsuccessfully to formulate hypotheses about the relationship between sexual deviants and parental authority, parental sexual behavior and subjects' early sexual experiences. No definite relationship between the variables were identified. Other variables such as failure to solve the Oedipus complex, castration fears, feelings of sexual inferiority, as well as homosexual tendencies have all been purported as the one answer to the question of rape

without receiving adequate scientific support for identifying the exact relationship involved (Amir 1971).

The sociological approach reported by Amir (1971) incorporated various social factors. Amir described several sociological approaches, two of which have been the subject of much discussion. Amir reported that in some way the victim is always the cause of the crime and every crime needs a victim. The concept of victims precipitated rape, identified by Amir, incorporates the idea that in some situations the behavior exhibited by the victim is interpreted as a direct invitation for sexual relations. The victim's behavior generally consists of either acts of commission or omission. In both instances, the behavior leads the rapist to believe that she is vulnerable to the assault. In essence, the victim precipitation approach described by Amir incorporates the idea that both the victim's behavior and the offender's imputations make them possible candidates for participation in a rape assault.

The second sociological approach described by Amir (1971) in regard to rape which has also received much attention is the subculture theory on rape. This theory assumes that "there is a unique subculture of violence of which rape is an epiphenomenon occurring under

speical circumstances" (Amir 1971, p. 320). This theoretical approach is based upon the Durkheimian model which identified that there exists a connecting relationship between rates for the offense, the participants and other social aspects (Amir 1971). Amir elaborated on the basic model and indicated that

> certain groups situated in the subculture of rape hold a particular conduct norm which emphasizes and condones aggressive behavior. In this subculture, members exhibit only a minimal degree of opposition toward aggressive sexual behavior (1971, p. 320).

Members in the subculture react more aggressively than non-members and this allows violence, such as violence against women, to be viewed as a normal type of behavior. The rapist is, therefore, conditioned to react according to the cultural norms and the social organization of which he is a member.

Chappell, Geis and others (1971) presented another sociological approach. These authors hypothesized that rape in itself is a reflection upon the permissive nature of society in general and is not the result of a specific subcultural approach. Chappell, Geis and others suggested that forcible rape occurs more frequently in a "social setting in which there is a relatively permissive sexual ethos rather than in one in which contacts are less readily available because of cultural prohibitions" (Chappell, Geis

et al. 1971, p. 175). The authors suggested that in a less permissive society a rejected man's self-image is better sustained because he can rationalize his rejection in terms of the prohibitiveness of the social setting. The male, therefore, does not in most instances have to utilize force to achieve his goal. In the permissive society, the rejection hard presses the male to interpret or identify the cause of the rejection outside of the rejection of him as an individual. As a response to this threat to self-image, the man may aggressively pursue his goal without thought of degree of force (Chappell, Geis et al. 1971).

According to Chappell, Geis and others (1971) the number of rapes committed, the manner in which they are committed and the persons involved are all tied to the social and sexual climate of the area. The authors based their proposed hypothesis on the assumption that there are societies in which the social and sexual climate are such that rape is virtually unknown. Margaret Mead's (1963) study of the Arapesh supported this assumption. In her study of the Arapesh, Mead reported that rape was virtually unknown to the members of the New Guinea tribe. She reported that the Arapesh knowledge of rape was limited and the people in that society viewed such an assault as an unpleasant custom.

One fact becomes apparent based upon the varied theoretical approaches presented. At the present time, there is no one unified theory on rape. Various theories have been purported only to have some of the scientific community accept them while others rejected the ideas.

Sex Education in Nursing and Medical Schools

Patients with sexual problems and concerns as well as rape victims are utilizing more and more frequently the services of nurses and physicians (Hill 1969, Pauley and Goldstein 1970, Burgess and Homstrom 1974, Donadio and White 1974). Nurses and physicians are, therefore, expected and required in most instances to provide some form of counseling when approached. Lief (1969) reported that more and more patients turn to their family physician with their sexual concerns than any other professional individual. Calderone (1968) wrote that professionals who provide services to patients should be prepared to deal with sex-related concerns. Calderone further purported that it is feasible to say that at some point in an individual's lifetime a sexual problem or concern will arise. Based upon the following ideas presented in the review of literature, the following area under consideration for

discussion is identified as human sexuality in nursing and medical education.

According to an article written by Mary Scoville Elder (1970), many nurses and physicians tend to feel insecure about their own sexuality and in order to cope with this insecurity "they either avoid counseling situations or counsel with decreased sensitivity, objectivity and empathy patients with sexual concerns or problems" (Elder 1970, p. 38). In an earlier section of this paper, a statement by Lief (1964) tended to lend credence to Scoville's assumption. Lief reported from his studies of medical students that these students had the same misconceptions about sexuality as the lay population. Lief also indicated that these physicians in general were not prepared to serve as counselors for patients with sex-related concerns. Why have past studies and various writers indicated that those who provide medical and nursing services to patients have been generally unprepared?

Perhaps part of the answer to the previously-asked question lies in the fact that as recently as 1969 many medical schools and nursing schools did not include a course on human sexuality as a component in their curriculums. Cade and Jesse (1969), in their study of sophomore and junior medical students on the committee of medical

education of the Student Medical Association, indicated that 70 percent of the respondents replied that their respective schools did not include a systematic presentation of information on human sexuality. A few years earlier Lief (1964) reported that at that time only one medical school was even attempting to provide formal instructions in the area of sexuality. Unfortunately, information on human sexuality as a part of the curriculums in nursing schools during the 1960's was unavailable.

Much has happened in the past twenty years and reports now indicate that most medical and nursing schools offer some formal sex education course to their students. Holder (1974) wrote that courses in sexuality have become standard fare in medical schools. Ebert and Lief (1975) reported similar findings and they indicated that almost all medical schools in this country are now involved in providing a course in human sexuality. Golub (1975) indicated that even though sex education had been virtually ignored in most nursing schools, the situation appears to be changing at the present time.

Nursing, however, apparently continues to lag behind medicine in its attempt to educate their students regarding sex-related concerns. In one of the few surveys on human sexuality courses in nursing programs

conducted nationwide, Mandetta and Woods (1976) surveyed 220 baccalaureate nursing programs accredited by the National League of Nurses during 1973-1974. A 69 percent return rate was noted with about 151 schools responding to the questionnaire. In response to whether or not their nursing program incorporated some aspect of human sexuality in their curriculum, a staggering 63 percent indicated that a formal course in human sexuality was not offered anywhere in their curriculum. Respondents replied, however, that some aspect of human sexuality was offered to their students. Sexuality as a course was offered in only 10 percent of the schools who returned the questionnaire. Approximately 31 percent of those who reported that sex education was not offered in their curriculums indicated that sexuality was offered by other disciplines in the university setting such as biology, humanities, and social science as well as the affiliated medical school to their nursing students.

Mandetta and Woods (1976) further indicated that sexuality was most emphasized in order of frequency in the following areas: maternal-child health nursing, psychiatric nursing, community health nursing, and medical-surgical nursing. From the report, the survey implies that if a patient is not involved in receiving maternal or child care,

she is less likely to be asked about any sexual problems or concerns she might have. Based upon their findings, Mandetta and Woods (1976) suggested that perhaps the apparent reluctance to discuss sexuality outside of maternal child health nursing may be due to several factors such as faculty comfort and preparation to deal with the topic and the continuing controversy as to the role of nurses in sex education and counseling.

Patients other than just those in need of maternal and/or gynecologic services require help in regard to sexual concerns from nurses and nurses are becoming aware of this. Fontaine (1976), in her study of 124 faculty members at 14 schools of nursing in the Chicago area, supported the previous statement. Fontaine reported that 60 percent of her respondents indicated that at least one-fourth of their patients had sexual problems and another 30 percent wrote that one-half or more of their patients had such problems. A report by Levenson and Croft (1977), which surveyed 102 physicians randomly selected in three Texas cities with a 63.7 percent return rate, noted support for Fontaine's findings. The respondents in the study indicated that more and more of their patients were indeed utilizing their services in regard to the following sexual concerns in order of frequency: impotence,

dyspaurenia, premature ejaculation; frigidity, and lack of orgasm during sexual intercourse (Levenson and Croft 1977). Levenson and Croft's findings suggested that sexual concerns and problems are not just limited to patients who receive maternal or child care only.

Even though most nurses and physicians are aware that many of their patients have sexual concerns, many continue to exclude from their routine examination a sexual history or just general questions regarding possible sexual concerns. Fontaine (1976) reported that approximately 60 percent of the nurses who participated in the study indicated that they seldom were never asked about sexual concerns. Levenson and Croft (1977) reported a similar finding. Levenson and Croft reported that only 66 percent of the physicians who responded indicated that they routinely asked their patients about sexual adjustment. Approximately 91 percent of the physicians, however, indicated that they offered help to the patient once the problem was presented or exhibited. Both the Fontaine (1976) study and the Levenson and Croft (1977) study implied that if the patient does not verbalize or physiologically-psychologically exhibit a sexual concern, such a concern may not be in many instances initially approached by the health professional.

When both the participating nursing faculty member and the physicians in each of their respective studies were asked to compare their own understanding of human sexuality with those of their respective colleagues, an interesting pattern emerged. Fontaine (1976) reported that 84 percent of the instructors believed that their own general understanding was a great deal better or more adequate than that of their nursing colleagues. Levenson and Croft (1977) reported that approximately 63 to 64 percent of the physicians felt that their colleagues knew as much as they did and felt as equally as comfortable in performing the task of counseling patients. Eighty-six percent of the physicians responded that they frequently to always felt competent in managing sexual matters and they indicated that they tended to always feel comfortable in doing so (Levenson and Croft 1977).

In her conclusion, Fontaine indicated that

> It is disappointing to note that those in the survey group who recognized that many patients have sexual concerns and who considered their own understanding and ability to discuss sexuality as adequate usually did not include sexual aspects in taking a nursing history (1976, p. 176).

Fontaine explained the discrepancy identified by suggesting that even the people who are aware of problems associated with sexuality have a difficulty in discussing the topic. Levenson and Croft (1977) agreed with Fontaine's explanation

to an extent. Levenson and Croft (1977) reported that the comfort of the counselor in dealing with sexual topics determines his competency in dealing with the issue. Fortunately, as previously indicated once the sexual problem or concern manifested itself, the patient received help.

Even though Fontaine's study (1976) did not address the issue of what type of help nurses offered once sexual problems were exhibited, Elder (1970) suggested that nurses can be helpful and instrumental in obtaining a sexual history, helping the patient feel comfortable in discussing sexual concerns and helping the patient arrive at his/her own decisions. Nelson (1977) wrote that she believed that nursing education provides the nurse with the necessary knowledge to cope with sexual problems. Other authors (Jacobson 1974, Golub 1975, Juvera 1975) have also indicated in their respective writings that nurses can play an important role in counseling patients with sexual problems but preparation for this responsibility is necessary at the baccalaureate level and in the continuing education programs in nursing schools.

A review of the literature revealed that at the present time many nursing schools are utilizing one of three models in order to provide their students with

knowledge and understanding regarding aspects of human sexuality. Each of the models reviewed varies in design, length of course, method of teaching, and claimed results. The developers of these three types of sexuality programs (Walker 1971; Mims, Yeaworth and Hornstein 1974; Mandetta and Woods 1975) reported that their programs were indeed successful in improving students' knowledge base and two of the authors reported a change in attitude.

Walker (1971) described a sexuality program for nursing students which was designed to facilitate discussion around topics on sex roles, parenthood, and marriage. This course was presented to the students during the maternal child health rotation. Walker indicated that the major purpose of the course was to increase students' awareness about sex role, discuss changing sex within the families to whom they provided care, and discuss the students' feelings about sexual issues especially attitudes toward masculine and feminine roles. The course was presented in a seminar form consisting of twelve one-hour sessions. Five faculty members who were teaching a correlated course of community health and maternal child nursing were utilized as group leaders for the five groups of students who served as participants. Student groups were limited to five to six individuals. A positive evaluation of the

course was reported by Walker (1971) based upon students' quotes on an evaluation form presented to them at the end of the twelve sessions. Most of the students indicated that "they had gained insight into their own identity as a sexual being as well as they now had a better understanding of the sexual roles of their patients" (Walker 1971, p. 27).

In 1974, another type of sexuality program was purported by Mims, Yeaworth and Hornstein. The developers of this program utilized an interdisciplinary approach with both medical and nursing students attending the five-day course. The process of desensitization, sensitization, and incorporation was utilized as the teaching method. Prior to beginning the course, participants received a pretest and upon completion of the course, a posttest was administered. The pre-posttest method was used to determine if the program was indeed effective in changing attidues and increasing the knowledge base of the participants.

Mims, Yeaworth, and Hornstein (1974) reported that the process of desensitization, sensitization and incorporation was utilized as the teahcing method because "human sexuality content has strong emotional connotations for both teacher and student" (1974, p. 249). The method of teaching such a course according to the authors was generally met through this process as described by Vincent (1968).

Vincent (1968) reported that desensitization refers to a process by which "an individual is constantly exposed to that which has been a source of anxiety, becomes accustomed to it and no longer shows anxiety toward the subject" (1968, p. 114). Mims, Yeaworth, and Hornstein (1974) in their sexuality course, achieved desensitization through the use of large group sessions on various topics and films which displayed a wide range of explicit sexual behavior and video tapes. Vincent (1968) referred to sensitization as the second step in the process. Sensitization is identified as the process by which the individual is repeatedly exposed to various aspects of the subject, becomes more cognizant of its relationship with other areas and is better able to recognize its affect on behavior. In the Mims, Yeaworth, and Hornstein (1974) course, sensitization was achieved by utilizing small group discussions. During these small group discussions, participants were encouraged to explore their own feelings in order to help each other develop an expanded understanding and tolerance for varied sexual behavior. According to Mims, Yeaworth, and Hornstein (1974), incorporation was in essence measured by the posttest. Vincent (1968) referred to incorporation as the "integration of a new body of information into a previously formed data base in such a manner that the new

and old are equally available for uses when needed" (1968, p. 115).

Mims, Yeaworth, and Hornstein (1974) also, as Walker (1971), reported a positive evaluation of the course based upon posttest scores and participants' comments. The authors indicated that by the posttest scores, participants had significantly increased their knowledge base on sexual issues. A more liberalized viewpoint toward various issues was also indicated by the students on the posttest. The authors utilized the Sexual Knowledge and Attitude Test (SKAT) as their measuring tool. SKAT measures both attitudes and knowledge of various sexual issues.

The final model revealed in the literature search is identified as the sexuality program described by Mandetta and Woods (1974). Mandetta and Woods (1974) described their course as an elective one-semester course given to undergraduate students utilizing small group discussions, stimulus sessions, and student projects as the method of teaching. According to Mandetta and Woods, the small group sessions focused upon affective learning or helping the student become more aware of his or her own feelings and attitudes. The stimulus sessions were designed to increase the student's knowledge base. Student projects focused upon

helping the participants explore particular areas of interest. The authors also utilized the pre- and posttest method for identifying the effectivenss of the course. A 163-item questionnaire, the Human Sexuality Knowledge and Attitude Inventory, was utilized as the testing tool.

Mandetta and Woods (1974) concluded that the course was an effective vehicle for increasing student's knowledge about sexuality. There were no apparent changes in the participants' pre- and posttest attitude scores, however. Mandetta and Woods indicated, however, that some of the participants demonstrated after taking the course a striking improvement in their ability to discuss sexual issues and problems.

In essence the models presented provide empirical referents which suggest that such courses are indeed effective in increasing knowledge about sexual issues if not totally effective in changing attitudes. Mims, Yeaworth, and Hornstein (1974) reported that any course which helps the health practitioner become aware of patients who have different attitudes and life-styles from their own is important. Marcotte (1972) indicated a similar feeling when he said that sexuality courses should focus upon helping the student develop a tolerant attitude toward others while she

or he may continue to hold conservative or liberal personal views.

Mandetta and Woods (1976) reported that nurses are indeed required and expected to be tolerant of others' sexual behavior patterns. According to the instructors who participated in Mandetta and Woods' study, most expected their graduates upon completion of their nursing program to be able to cope with patients' sexual problems and concerns. In order of frequency, instructors indicated that graduate nurses would be able to provide sex education to patients, particularly adolescents and youths; counsel patients about health sexual practices; counsel patients on potential sexual problems which may occur following illness or surgery; manage the incident of sexual inadequacies and finally to educate, and counsel patients about their sexuality. This finding is very similar to one of the findings from the Fontaine (1976) study. Fontaine reported that over 56 percent of the nursing faculty members who participated indicated that their own nursing education prepared them in regard to human sexuality. Apparently from the findings of these two studies, graduate nurses are expected and some feel that they are indeed prepared and competent in terms of providing information and managing patients with sexual concerns.

The expectation indicated by the nursing instructors in the Mandetta and Woods (1976) survey, however, were not supported by other reports. In a study conducted by Shea, Werley, and others (1973) which surveyed 6,333 nursing students and 712 faculty members in 47 nursing schools, the opposite findings to the Mandetta and Woods (1976) study were reported. Shea, Werley, and others (1973) reported that most of the students and faculty indicated that they felt inadequate in coping with sexual problems. Faculty members wrote that one of the greatest instructional deficiencies they perceived was in the area of human sexuality. Shea, Werley, and others proposed their study in order to identify attitudes toward various aspects of family planning and sex education.

Human sexuality was reported as being the most important topic necessary in order to provide family planning services (Shea, Werley, and others 1973). More than 50 percent of the students and 40 percent of the faculty indicated, however, that they felt inadequately prepared to work with patients in the area of family planning because of the issue of sexuality. Only 12 percent of both groups of respondents (faculty and students) reported that they were more uncomfortable than should be when discussing sexual issues. The overall findings by Shea, Werley, and

others (1973) indicated that 75 percent of the faculty and 50 percent of the students responded that the average health professional at that time was not adequately informed in the area of human sexuality.

Woods and Mandetta (1975), in a study of changes in students' knowledge and attitudes following a course in human sexuality, contradicted to a degree their reported findings from their survey of sexuality in baccalaureate nursing curriculums (1976). In their study on changes in students' knowledge and attitudes, Woods and Mandetta (1975) surmised that if a course in human sexuality had not been instituted, most of the graduating students would not have had the following: a basic knowledge of coital activity itself; enough knowledge to counsel patients with sexual concerns, and adequate information in the areas of venereal disease, sexual standards, sterilization, and sexual variation. All of these areas were significantly improved after the sexuality course. Woods and Mandetta (1975) measured the effectiveness of their instituted human sexuality course by utilizing the Human Sexuality Knowledge and Attitude Inventory which was designed to measure attitudes and knowledge of sex. Succinctly stated, according to Mandetta and Woods (1975), if nursing schools do not provide information in some form regarding sexuality,

the graduate nurse will probably not be able to provide counseling regarding sexual issues in an effective manner.

The pre- and posttest scores obtained from the sexuality model developed by Mims, Yeaworth, and Hornstein (1974) supported Mandetta and Woods (1975) inferences. Mims, Yeaworth, and Hornstein (1974) reported that in their study of seventy medical students and thirty-seven nursing students, pretest scores were quite low. Some medical students scored as low as 13 out of 73 in the attitude section and 25 out of 71 in the knowledge section on the Sexual Knowledge and Attitude Test (SKAT). Nurses' performances were equally as low. Nursing scores ranged from a low of 34 on the knowledge section and 13 on the attitude section. A score below 40 on the attitudinal sections, particularly the sexual myths scale, generally indicates an acceptance of the various myths and misconceptions. Nurses on an average scored 54.93 on the pretest in terms of sexual myths and 57.65 on the posttest. Mims, Yeaworth, and Hornstein (1974) suggested that nurses who were unaware of the type of sex myths presented in the SKAT would tend to make a less than effective sexual counselor in many instances.

Mims, Yeaworth, and Hornstein (1974) reported that approximately 19 percent of the medical students responded

that they believed that certain mental and emotional conditions were caused by masturbation. This is a great improvement over the 50 percent of graduates in a Philadelphia medical school who responded that they believed that masturbation frequently caused mental illness in Greenbank's study (1961). Greenbank also found in his study conducted eighteen years ago that one in five members on the faculty at the school also believed the same misconception. Apparently, the human sexuality courses now being offered to medical students have reduced the number of misconceptions regarding sexual issues that they possess. Mims, Yeaworth, and Hornstein (1974) indicated, however, that there is still a long way to go in eliminating sexual misconceptions among health professionals.

Another survey performed by Marcotte, Kirkpatrick, and Willis (1977) also indicated that medical practitioners still need sex education. In 1966 Sheppe and Haine administered the Sex Knowledge Inventory, a test designed for lay individuals, to both entering medical and law students in order to compare their responses with graduating students from the two professional schools. Results from the test indicated that senior medical students were more knowledgeable about sexual issues than graduating law students. Graduating medical students missed, however, ten

items out of an eighty-item questionnaire designed for the average lay person. Sheppe and Haine (1966) reported no difference between the knowledge of entering medical and law students. The authors surmised that graduating medical students had attained their knowledge as a result of their medical education. Marcotte, Kilpatrick, and Willis (1977), eleven years later, replicated the original Sheppe and Haine (1966) study.

Instead of just utilizing one test, Marcotte, Kilpatrick, and Willis (1977) utilized a battery of tests which included the Form E of the Rokeach Dogmatism Scale, which measured dogmatism or closed-mindedness; Sexual Attitude and Behaviour Surveys, which measured the liberality of sexual attitudes and behaviour; and the Sex Knowledge and Attitude Test, which assessed sexual attitudes and knowledge. The sample size consisted of 160 first-year medical students enrolled at Medical University of South Carolina and 71 first-year law students at the University of South Carolina. No differences were noted between law students' and medical students' tolerance of different belief systems on the dogmatism scale. On the SABS, law students indicated that they accepted and engaged in a wider variety of sexual activities more frequently than the medical students. Law

students' responses on the SKAT reinforced the findings obtained from the SABS. Their general knowledge of various sexual aspects was higher than that of the medical students with the law students less frequently accepting sexual myths as factual.

Marcotte, Kilpatrick, and Willis (1977), in their conclusion, reported that based on the findings, medical students appear to know less about sex and hold less tolerant views towards others' sexual behavior than law students. The authors emphasized in their conclusion that medical sex education is needed to equip doctors with both knowledge and tolerant attitudes. The same type of statement applies to nursing students based upon the findings of Mandetta and Woods (1975) and Mims, Yeaworth, and Hornstein (1974).

Societal Views Toward Rape

The subject of rape generally evokes from most individuals a strong emotional reaction. For many people in today's society, rape has a strong emotional connotation. A review of the literature has revealed that victims of the assault perceived the incident as a crime which disrupted their established patterns of living (Sutherland and Scherl 1970, Burgess and Holmstrom 1974, Notman and Nadelson 1976). On the other hand, Cohen and his associates (1972) reported that rapists often perceive the assault as a way of

exhibiting their feelings of anger and aggression toward women. In essence, rape is a phenomenon which evokes varied emotional responses from individuals. The area considered and discussed in the following section, societal attitudes toward rape, presents some general attitudes or prevalent ideas in today's culture and society regarding rape.

Bernstein and Rommel (1975) reported that prior to a rape experience most victims subscribe to various myths and misconceptions about rape. Kozol (1971), in his review of myths about sex offenders, defined a myth as an erroneous popular belief which usually represents to a large extent the attitudes of the culture and society. Kozol further posited that, like most generalizations, myths are usually inaccurate and represent prejudices rather than fact. Unfortunately, there is widespread ignorance prevalent in today's society about rape (Bernstein and Rommel 1975). This idea is supported in the literature by various other authors who reportedly draw from a behavioral and social sciences framework (Medea and Thompson 1974; Brownmiller 1975, and Chappell, Geis and Geis 1977). Schultz and DeSavage's study (1975) further supported the idea that society is in general uninformed in regard to rape. Schultz and DeSavage interviewed approximately one hundred university

students in order to determine their knowledge of rape. In response to the question what is rape, almost 50 percent of the group composed of males and females incorrectly defined legal rape. Schultz and DeSavage, therefore, surmised that there seems to be little knowledge among students about what rape is, what constitutes a sexual crime, or types of sex crimes.

Bernstein and Rommel (1975) indicated in their writing that one of the major problems, which has led to the development of the various misconceptions and to a degree the ignorance exhibited by members in society about rape, lies in trying to define the act itself. The legal definition of what constitutes rape often varies from state to state. Most states, however, agree that rape is coitus by a male with a female other than his wife. In many of the various states' respective penal codes, the phrase without consent has been eliminated because of the legal controversy which often arises in defining what is consent.

Perhaps it is not unrealistic then to understand why society in general appears to know so little about the phenomena of rape. The experts (legal, social, psychological and psychiatric) have not as yet charted a clear course which would probably help most people understand what rape

is. Amir (1971), one of the leading experts on the subject, reported that there is indeed no clear and unified theory which explains the phenomenon. Criminologists, psychiatrists, and psychologists have yet to institute a thoroughly successful rehabilitative treatment technique for rapists. Society, in general, has, therefore, been left to identify for itself what causes rape and what is the best way to cope with it. As noted previously, unfortunately society adopted ideas regarding rape which recent studies have proven erroneous.

Bernstein and Rommel (1975) reported that one of the most prevalent of these erroneous ideas or myths about rape is that rape victims are as guilty as rapists. This myth is generally based upon the premise that rape is the most falsely reported of all crimes, and that the rapists themselves are the true victims (Bernstein and Rommel 1975). This myth has become so entrenched in society that Burgess and Holmstrom (1974) reported that one of the main responses of rape victims is guilt with many of the women blaming themselves for somehow having invited the attack. Although the figures vary, a review of the literature revealed that this myth is not supported (Burgess and Holmstrom 1974; McCombie, Bassuk, Savitz, and Pell 1976).

Another myth which Bernstein and Rommel (1975) reported is that nice girls don't get raped. The image that the victim is one who flaunts her sexuality on the street corner is still entrenched in societal attitudes toward rape. In fact, Bernstein and Rommel (1975) suggested that the opposite may be true. Medea and Thompson (1974) and Selkin (1975) suggested that women who are kind and helpful are possibly courting danger. The rapists often perceive the helpfulness and kindness exhibited by these women as signs of weakness or defenselessness. Cohen and associates (1971) indicated that rapists tend to prey upon victims who exhibit signs of being cowed or frightened. Cohen and his associates also reported that when rape is clearly motivated by sexual wishes, if the victim struggles against this type of rapist, he generally releases her and flees from the area.

The third common myth which Bernstein and Rommel (1975) reported is that rape is mainly an interracial crime. According to the writers,

> while it is commonly believed that most rapes involve black men assaulting white women, in reality, interracial rapes constitute only a very small percentage of the total (1975, p. 39).

Amir's study (1971) supported Bernstein and Rommel's findings. Amir reported that less than 4 percent of the

1,300 cases reviewed involved a member of one race against a member of another race.

The final myth described by Bernstein and Rommel is that rape is an act of sexual passion. This particular myth is clearly refuted by both Cohen and his associates (1971) and Groth, Burgess, and Holmstrom (1977). Both teams of investigators, respectively, reported that rape is an act of violence. According to Groth, Burgess, and Homstrom

> Rape is a pseudo-sexual act . . . a pattern of sexual behavior that is concerned much more with status, aggression, control, and dominance than with sensual pleasure or sexual satisfaction (1977, p. 1240).

In summary, it is apparent that society, in general, is indeed quite unprepared in terms of knowledge to cope with the issue of rape. The research material presented in the preceding discussion provides data which indicates that these myths about rape are indeed erroneous. Only by providing accurate information to the general public according to Bernstein and Rommel (1975) will a basic understanding of the phenomenon of rape begin to develop.

Based upon the previous review of literature, there are apparently various misconceptions and rape myths prevalent in today's society (Bernstein and Rommel 1975). Are nurses who work with victims of rape affected to any

degree by the attitudes and knowledge of society in general toward rape? Again, a review of the previous literature presented has indicated that physicians and nurses subscribe to various myths and some of the same misconceptions as the average lay person on sexual issues (Lief 1968; Sheppe and Hain 1966; Mandetta and Woods 1974; Mims, Yeaworth, and Hornstein 1974). Does this same type of phenomena exist in regard to health professionals' attitudes and knowledge of rape? Unfortunately, there is a limited amount of literature on health professionals' attitudes and knowledge about rape. Two aspects are known, however, in regard to nursing and rape and these are the aspects discussed in the following section.

Both the Mandetta and Woods' (1976) study and Shea, Werley, and other (1974) indicated that rape is generally not being included as discussion topic in the sex education programs utilized in nursing schools. In the Mandetta and Woods survey of 151 baccalaureate schools' nursing programs, programs who responded that they did have a formal course in sex education did not report that rape was discussed in their course. The Shea, Werley, and others' (1973) study reported a similar negligence. A review of the literature also revealed, however, that sexuality is indeed a major concern of rape victims and

that rape is a sexual issue (Burgess and Homstrom 1974, Notman and Nadelson 1976).

Secondly, research in the area has generally been done by males who have presented their findings within a sociological, psychological, and/or medical framework. In the past medical literature has generally addressed itself exclusively to the particulars of the medical-legal examination, and the nursing literature on the subject has remained almost non-existent (Massey and others 1971). Besides the writings of Burgess and Holmstrom (1974) and Williams and William (1973), nurses have not been involved in investigating the phenomena of rape. Nurses have, therefore, had little upon which they could base their nursing care and management techniques.

A study by Donadio and White (1974) perhaps indicated the effect of the negligence in nursing research on rape. Donadio and White interviewed seven women who had been raped. The authors were particularly interested in determining the absence or presence of certain nursing interventions for the victims. Donadio and White (1974) indicated that in their overall findings, one pattern emerged which suggested that nurses at that time were not meeting the needs of the rape victims adequately. The investigators were limited in their ability to generalize

to any degree, however, because of the extremely small sample size utilized. Another disadvantage of this study is the fact that it was done in a retrospective manner. Because rape is a crisis event and victims' memory of the situations surrounding the event may be hazy, victims' responses to the questions may have been somewhat distorted by time and the circumstance.

The Donadio and White (1974) study revealed that most of the women interviewed felt that the nurse did not recognize their needs or concerns. Both the Sutherland and Scherl (1973) and the Burgess and Holmstrom (1974) study indicated that rape victims have many concerns. Several of the women also indicated that the nurse did not inform them of how to best take care of themselves in the days following the assault. The American College of Obstetrics and Gynecologists published guidelines which suggested that each victim of rape should be given follow-up treatment in order to prevent venereal disease and reduce psychological trauma. The guidelines described what the patient needs to do in the interim time period between the institution of medications in the emergency room setting and the assigned follow-up appointment date. Patients interviewed by Donadio and White (1974) responded that nurses did not generally explain what would be happening

to them in the days and weeks following the assault. The authors suggested that perhaps in the emergency room setting, there is a tendency for nurses to focus upon the physical and emotional aspect of the immediate situation and not on the long-term aftermath.

In their conclusion, Donadio and White (1974) indicated "that the nursing care of the woman who has been raped is an area which has received little critical thinking or research" (1974, p. 247). Unfortunately, the number of rapes continues to rapidly increase. If nursing research in this area does not increase, the nurse may more and more frequently find herself without a solid nursing framework upon which to build her plan of care. Therefore, the potentials which nursing possess as a caring profession may never in regard to caring for victims of rape be attained.

Summary

The review of the literature has suggested that, as health professionals, both physicians and nurses require more information in regard to human sexuality and rape. Based upon the literature search, it appears that medical and nursing schools throughout the country have become aware of the past inadequacies of many of their students in regard to aspects of sexuality. Both medical and nursing

schools, according to the literature search, are trying to provide their students with the information and understanding necessary to provide effective and compassionate care to patients with sexual problems. There is no apparent trend, however, according to the literature search, which indicates that nursing and medical schools are offering any type of discussion on rape.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

One of the main purposes of a nursing study is to investigate an observed problem within nursing practice. The problem observed in this study, which also interested the investigator, was identified as how do nurses' attitudes and knowledge regarding human sexuality affect their attitudes and knowledge regarding rape and care of rape victims. In order to obtain the information, the investigator designed a means by which the data were gathered for analysis. Two measuring tools were utilized in order to gain insight into emergency room nurses' attitudes and knowledge of human sexuality, rape, and care of rape victims. A more in-depth description of the procedure utilized for the collection of data follows.

Setting

The study was conducted in two local county hospitals in two cities located in northeast Texas. The cities were within a fifty-mile radius of one another. The two selected hospitals are utilized as the primary respective agencies which provide medical services to all

rape victims in the two cities. Hospital A listed the number of rape victims who received medical services during 1977 at 189, while the other hospital, Hospital B, reported that they provided services to approximately 805 victims in their emergency room setting. The emergency room nursing staff of each of the respective hospitals consisted of predominantly female registered and licensed vocational nurses. Hospital A utilized an approximate total of twenty-five registered and licensed vocational nurses. Hospital B utilized an approximate total of fifty-two registered nurses in their emergency room.

Population

The sample consisted of female and male nurses (registered and licensed vocation) on the emergency room staff of two county hospitals who provided emergency medical services to rape victims in two cities located in northeast Texas. Only one male, however, served as a participant in the study. Prior to approaching the sample population, permission was obtained from the Director of Nurses at the two hospitals.

Permission was also obtained from the emergency room manager in Hospital A and the emergency room supervisor in Hospital B. Both the manager and supervisor granted permission with two stipulations. The manager and

supervisor asked that participants in the study complete the questionnaires at their homes and not while they worked in the hospital setting. The second stipulation was that the emergency room manager specified that the investigator meet with the sample population as a group on two separate assigned occasions. The emergency room supervisor, in Hospital B, on the other hand, specified that the investigator approach the sample on an individual basis. As a courtesy, the investigator received a list of fifteen randomly selected registered nurses from the emergency room supervisor. The investigator approached some of the nurses whose names were on the list given by the emergency room supervisor as well as all of the other nurses working in the emergency room in Hospital B during the assigned period of time.

A convenience sample was used. Only those who voluntarily agreed to participate served as subjects. The selected sample population consisted of subjects who met the following criteria: registered or licensed vocational nurse, and full-time employee in the emergency room setting. Master's prepared nurses were excluded from the study because of their absence among the staff nurses identified in the setting. As previously indicated, only one male participated in the study. The target population was

approached on two different assigned occasions as a group at Hospital A. The 7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M. shifts were approached on February 6, 1979. On tne morning of February 7, 1979, the investigator approached the 11:00 P.M. to 7:00 A.M. shift. In Hospital B, members of the target population were approached during the week of February 8 to 14, 1979, on an individual basis. The investigator approached a total of forty-five members of the target population and thirty-eight agreed to participate in the study. Subjects were informed per the general directions and in the investigator's verbal presentation to return their completed answer sheets by February 21, 1979 in Hospital A and by February 23, 1979 in Hospital B.

At the end of tne respective identified week in tne two hospitals, the investigator extended the data collection period another week in each of the agencies. The data collection period was extended due to the low number of answer sheets returned during the assigned time period. The subjects were informed per memo placed on the bulletin board in the emergency room in Hospital A and the circulating daily log book in Hospital B of the extension. The memo tactfully urged subjects to return their answer sheets by February 21, 1979 in Hospital A and February 23,

1979 in Hospital B. The investigator also personally contacted subjects at Hospital B within the hospital setting and told them of the extension. The subjects were asked as well as urged to return their completed answer sheets before the cut-off date. A 50 percent return rate was obtained with nineteen of the thirty-eight subjects who consented to participate returning their completed sheets.

Tools

Two separate tools were utilized in the study. The Sexual Knowledge and Attitude Test (SKAT) was utilized to measure attitudes and knowledge of selected aspects of human sexuality. The Rape Attitude and Knowledge Survey (RAKS) was utilized to measure attitudes and knowledge of selected aspects of rape.

Standardization and Development of Tools

Sexual Knowledge and Attitude Test (SKAT)

Harold I. Lief, M.D. and David H. Reed, Rh.D. developed the SKAT based upon an extensive survey of literature, clinical experience, and socially controversial sex-related topic areas (SKAT Preliminary Technical Manual). The following description of the SKAT was based upon the

information provided in the Sexual Knowledge and Attitude Test Preliminary Technical Manual.

The SKAT was developed as the result of administering the tool to a total of 3,108 students in 3 countries and 43 institutions. The attitude section consisted of thirty-five items based upon four scales listed as heterosexual relations (Items 3, 7, 10, 16, 23, 27, 33, 34), sexual myths (Items 1, 2, 5, 8, 14, 17, 26, 29, 30), autoeroticism (Items 6, 9, 12, 19, 24, 32, 35), and abortion (Items 4, 11, 13, 15, 18, 22, 25, 31) with each item worded in a proconservative direction and a proliberal direction only. A 5-point Likert-type response scale was utilized--strongly agree, agree, uncertainty, disagree, and strongly disagree. Items were scored from 1 to 5 with liberal responses, whether strongly agree or strongly disagree scored 5 points. The knowledge section, however, consisted of seventy-one true-false questions. Heuristic value provided the basis upon which twenty-one of the knowledge questions were developed while the other fifty questions were based upon psychometric considerations.

In regard to the reliability and the validity of the test, the reliability was listed as .87 with a construct validity based upon correlational data of .10. The attitudinal scales were based upon coefficient alpha and

were listed as heterosexual relations--.86, sexual myths--.71, abortion--.80, and autoeroticism--.81. Among the knowledge items difficulties ranged from .25 to .75 with a biserial correlation of .30 or greater with each item adding a positive increment to the external consistency of the overall test.

Rape Attitude and Knowledge Survey (RAKS)

Based upon the problem statement, purposes, and a review of the literature, an appropriate measuring tool on the phenomenon of rape was not found. Therefore, the investigator developed the Rape Attitude and Knowledge Survey (RAKS). The questionnaire was modeled after the SKAT and was taken from a survey of literature based upon physiological, psychological, and socially controversial aspects regarding rape. The major purpose of the RAKS was to gather information about rape attitude, knowledge, degree of experience in encounters with rape or sexual molestation, and a diversity of biographical information from the sample population. Like the SKAT, two sections composed the RAKS--attitude and knowledge.

The present form of the RAKS resulted from incorporating recommendations received from a three-member panel of judges. Each panel member had been involved in

providing counseling services to rape victims for at least a year.

Panel member A, at the time she served as judge, was involved in providing counseling services to rape victims at the local rape crisis center. This panel member also had for the past year served as the director of the crisis center and she had been actively involved in presenting various workshops to paramedical professionals and the public at large on rape. Prior to the time she assumed the role of director of the center, she had been totally involved in providing counseling to rape victims at the center for several years. Panel member A had a master's of science degree in rehabilitative counseling.

Panel member B, also at the time she served as judge of the RAKS, was involved in providing counseling services at the rape crisis center. The panel member had also served as the assistant director of the crisis center for the past year and had been equally as active as Panel Member A in trying to inform the public in general about rape. Panel member B had a master's of science in social welfare degree.

Panel member C had been interested in the phenomenon of rape for several years. The panel member had a doctor of philosophy degree. She was involved in her own private

psychology practice at the time she served as judge. Panel member C in the past had written grants for the establishment of rape crisis centers for women. She had also presented various workshops on the psychological trauma associated with rape assault.

Panel members reviewed each item in the RAKS for adequacy, accuracy, clarity, and placement of information as well as simplicity of directions. The three-panel members were also advised that only those items approved by all three members would be accepted for inclusion in the instrument that was implemented in the pilot study and then in the actual study. Based upon the panel's recommendation, several items were reworded and a few items were deleted in the subsequent revised versions. Upon the fourth revision of the tool, all members of the panel agreed upon the items in the present form of the tool. Content validity was established in essence through the consensus of the three panel members.

Like the SKAT, RAKS was composed of five aspects or dimensions of rape--rape myths (Items 1, 2, 4, 5, 6, 11, 18, 19), rapists' characteristics (Items 3, 8, 9, 16), victims' characteristics (Items 12, 14, 22), treatment and handling of victims (Items 7, 15, 17, 20, 21, 23), and nursing care of rape victims (Items 10, 13, 24). All of

the items in the sections were attitudinal and they conceptually ranged from most conservative to most liberal. Fifteen items were worded in a negative or proconservative direction and nine items were poistive or proliberal in direction. As in the SKAT, a 5-point Likert-type response scale was used--strongly agree, agree, uncertainty, disagree, and strongly disagree. Items in this section were scored from 1 to 5 with the most liberal response whether strongly agree or strongly disagree, scored 5 points. The range of possible scores varied from 24 (most conservative) to 120 (most liberal). A 5-point Likert allowed the extremes to fall on either side of the mid-position which provided greater variance results (Kerlinger 1973).

In keeping with the general purposes of the RAKS, the knowledge section was designed to tap the range of information the respondent possessed on various physiological and psychological aspects of rape. The section was composed of forty true-false items. Twenty-five items were identified as true and the remaining fifteen items were false. The items were presented in a straightforward manner.

The RAKS was administered to a pilot group prior to the actual study implementation. Eight graduate nursing

students in a graduate nursing program in a university setting volunteered to serve as participants. The subjects were asked to evaluate the RAKS upon completion for clarity of each item presented as well as clarity of the accompanying instructions. The pilot study was also utilized in order to identify the average length of time needed to complete the questionnaire.

Based upon the comments obtained from the participants in the pilot study, the RAKS was minimally revised with only one sentence grammatically altered. Participants in the pilot study indicated, however, that the accompanying answer sheets for both SKAT and RAKS were not well labeled nor were they adequately explained. As a result of the comments, the investigator relabeled each of the respective sheets and the sheets were colored differently in order to reduce participants' confusion. An illustrative example on how to mark the answer sheets was also provided. Finally, results obtained from the pilot study suggested that the average length of time required to complete the RAKS was thirty minutes. Participants on an average required an hour to complete both questionnaires. The SKAT Preliminary Technical Manual reported that respondents usually required on an average of thirty minutes to complete it.

Based upon the Wilcoxon's nonparametric paired t-test the reliability of RAKS was determined. The Wilcoxon test was utilized in order to match paired scores obtained from the even-numbered and odd-numbered items presented in both sections of the tool. If the two halves of the test produced approximately equal scores, this suggested that the test was completely reliable (Hayes 1973). According to the results obtained, complete reliability for the tool was not determined. Matched scores for the attitude section was identified as .02 and .05 for the knowledge section. The low reliability score obtained was perhaps related to the small number of items included in the attitude section of the RAKS.

Data Collection

Members of the target population who met the identified criteria were approached on two separate assigned occasions as a group in Hospital A and on an individual basis in Hospital B during a two-week time period. Subjects were introduced to the investigator who provided an explanation of the two areas under investigation. Members of the sample population were told that they would receive complete anonymity and that participation was entirely voluntary. Each participant received a letter stating the general purposes, benefits, and possible risks

associated with serving in the study (appendix A). Participants were also required to sign an accompanying consent form (appendix B) prior to receiving the questionnaires and answer sheets.

Participants were asked not to place their name, social security number, or employee number on the answer sheets. The investigator coded the two answer sheets with a number ranging from one to thirty-eight and the assigned number was placed in the right-hand corner of the sheets circled in black ink. Coding numbers allowed information from the SKAT to be matched with information received from the RAKS.

Each participant was asked to return the answer sheets within forty-eight hours, if possible, or before the end of the assigned collection of data time identified on the general directions sheet (appendix D). Participants were also advised per the general direction to place the answer sheets in a locked box located in the nursing lounge area in Hospital B. Because Hospital A did not have a nurses' lounge area, the emergency room manager agreed to allow the investigator to place the locked box in the right-hand corner of her office. Participants from Hospital A were verbally informed of this by the investigator in the oral presentation they received.

Because of the nature of the two subjects under investigation, the possibility of a participant suffering some degree of psychological or an adverse emotional response were identified as risks. Therefore, the investigator upon receiving agency approval asked both the emergency room manager and the emergency room supervisor in the two selected agencies to recommend a qualified individual (clergyman, psychiatrist, psychologist) on staff to serve as a counselor in case a participant exhibited any untoward effects. The emergency room manager in Hospital A recommended the Director of Medical Services in the emergency room and the emergency room supervisor in Hospital B recommended the local Rape Crisis Center. Both the medical director and the rape crisis center agreed to serve in a counseling role, if necessary. The name of the medical director and the rape crisis center was placed on the general direction sheet. Each participant also received, per the general purposes letter and the general directions, the telephone number of the rape crisis center. The rape crisis center provides a rape crisis hot line for victims of rape or any one who has a concern regarding aspects of rape or sexual abuse. No adverse emotional response, however, was reported.

Treatment of Data

A type of descriptive study, the analytical survey, was utilized as the research design for the study. This type of design generally generates new facts by naturally observing characteristics of the research subject without deliberate manipulation of the variable or control over the research study (Abdellah and Levine 1965). An analytic survey also attempts to establish an associate relationship between two phenomena. In this investigation the relationship between attitudes and knowledge regarding human sexuality and attitudes and knowledge regarding rape was examined.

The data collected as a result of utilizing the analytic survey design was analyzed and reviewed in the following manner. Data collected from the SKAT and the RAKS were reviewed separately. Frequencies and percentages of responses to each item in both the knowledge and attitude sections were identified. A total score for each section in the two tools were calculated for each respondent. After obtaining the total score, an overall average score was then calcualted for each section. Finally, a subset of the items in both sections was reviewed.

Because the research design utilized in the study was an analytic survey, a correlation analysis using

Pearson's correlation coefficient and Kendall's Tau-B measure of association was utilized as appropriate statistical measures. The following areas within the two tools and between the two tools were correlated. The knowledge section of the SKAT was correlated to the attitude section of the SKAT. A knowledge to attitude correlation was also performed on the RAKS. Attitudinal items on the SKAT were then correlated to attitudinal items on the RAKS. Consideration was given to the correlation obtained from the sexual myth scale of the SKAT and the rape myth group of the RAKS. Knowledge items of the SKAT were also correlated to the knowledge items in the RAKS. Attitudinal items on the SKAT were also correlated to knowledge items on the RAKS. Finally, attitudinal items on the RAKS were correlated to knowledge items on SKAT.

Summary

The analytic survey approach utilizing two tools consisting of two sections, attitude and knowledge, was utilized in the study. The Sexual Knowledge and Attitude Test (SKAT) was developed by Harold I. Lief, M.D. and David H. Reed, Ph.D. The Rape Attitude and Knowledge Survey (RAKS) was developed by the investigator. Prior to the administration of the RAKS in the actual study, the

instrument was submitted to a three-member panel of judges which consisted of two counselors who worked with rape victims and a practicing clinical psychologist. The RAKS also was administered to a pilot group. Two county hospitals in two cities in Northeast Texas were utilized as the setting for the study. The sample population consisted of registered and licensed vocational nurses who worked in the emergency room setting of the two hospitals. Only one male, however, participated in the study. A correlation analysis using Pearson's correlation coefficient and Kendall's Tau-B measure of association were utilized as appropriate statistical measures on the data obtained from the study.

CHAPTER IV

ANALYSIS OF DATA

An analytic survey approach, which is a nonexperimental design, was conducted to determine how nurses' attitudes and knowledge regarding human sexuality affect their attitudes and knowledge regarding rape. The purposes of the study were to (1) identify nurses' attitudes and knowledge of selected physiological and psychological aspects of human sexuality, (2) identify nurses' attitudes and knowledge of selected physiological and psychological aspects of rape, (3) evaluate the adequacy of nurses' knowledge of selected physiological and psychological aspects of human sexuality and rape, (4) identify whether or not a relationship exists between nurses' attitudes and knowledge of human sexuality and their attitudes and knowledge of rape and care of rape victims, and (5) identify whether or not various selected demographic data affect nurses' attitudes and knowledge of human sexuality, rape, and care for rape victims.

The investigator conducted the study over a two-week period of time (February 7 to February 23, 1979) in the emergency room setting of two county hospitals who

provide emergency medical services to rape victims. The sample population consisted of emergency room nurses (registered and licensed vocational) chosen by the convenience sampling method. Two questionnaires were utilized as measuring tools. Pearson's correlation coefficient and Kendall's Tau B measure of association were utilized to measure the degree of relationship between sections in the two tools and the selected demographic variables. Frequency distributions were utilized to group data in order to indicate the number of subjects who responded in the same manner. The null hypotheses formulated in the study were either supported or rejected at the 0.05 level of probability. The data gathered are presented in the tables and narrative form which follow in this chapter.

Demographic Data

Age, Sex, and Ethnic Origin

Socio-demographic data revealed that subjects ranged in age from twenty-two to over forty-one years. There were eighteen (94.7 percent) female subjects and one (5.3 percent) male subject. Racial characteristics of the subjects included two (10.5 percent) black individuals, and seventeen (89.5 percent) white individuals (table 1).

TABLE 1

AGE, SEX, ETHNIC ORIGIN, MARITAL STATUS, AND RELIGION

Demographic Variables	Number in Each Group	Percentage of Total*
Age:		
17-21	--	--
22-26	4	21.0
27-31	5	26.3
32-36	3	15.7
37-41	4	21.0
41 and over	3	15.7
Sex:		
Female	18	94.7
Male	1	5.3
Ethnic Origin:		
Black	2	10.5
White	17	89.5
Mexican-American	--	--
Other	--	--
Marital Status:		
Married at sometime	16	84.2
Never married	3	15.8
Religion:		
Catholic	1	5.3
Protestant	14	73.7
Jewish	1	5.3
Other	3	15.8

*Percentages are rounded off.
N = 19.

Marital Status and Religion

The data regarding marital status indicated that sixteen (84.2 percent) subjects reported they had been married at some time and three (15.8 percent) subjects

reported they had never been married. One (5.3 percent) subject was identified as Catholic and one (5.3 percent) subject was identified as Jewish. Fourteen (73.7 percent) subjects were identified as Protestant while three (15.8 percent) subjects were identified as other (table 1).

Nursing Experience and Type of Nursing Program

In regard to length of nursing experience, the data revealed eight (42.1 percent) subjects reported that they had one to five years of experience; four (21.1 percent) subjects reported they had six to ten years of experience; and seven (36.8 percent) subjects indicated they had ten years or more of nursing experience. Five (26.3 percent) subjects were graduates of an LPN/LVN program and five (26.3 percent) subjects reported that they were diploma graduates. Only two (10.5 percent) subjects reported that they were ADN graduates with the remaining seven (36.8 percent) subjects reporting that they were baccalaureate graduates (table 2).

Length of Emergency Room Experience and Number of Rape Victims Cared for in 1978

The data on length of emergency room experience revealed that eight (42.1 percent) subjects reported one to five years. The remainder of the subjects were somewhat

TABLE 2

NURSING EXPERIENCE AND TYPE OF NURSING PROGRAM

Demographic Variables	Number in Each Group	Percentage of Total*
Nursing Experience:		
Less than 1 year	-	--
1-5 years	8	42.1
6-10 years	4	21.1
10 years and over	7	36.8
Type of Nursing Program Attended:		
LPN/LVN program	5	26.3
Diploma program	5	26.3
ADN program	2	10.5
Baccalaureate	7	36.8
Other	-	--

*Percentages are rounded off.
N = 19.

evenly distributed with four (21.1 percent) subjects working less than one year in the emergency room; and four (21.1 percent) subjects reported working six to ten years in the emergency room. Three (15.8 percent) subjects reported working ten years or better in the emergency room. In regard to the number of rape victims cared for during 1978,

twelve (63.2 percent) subjects reported less than twenty-five while five (26.3 percent) subjects reported caring for twenty-five to fifty rape victims. The remainder of the subjects were evenly distributed with one (5.3 percent) subject reporting caring for fifty-one to one hundred victims and one (5.3 percent) subject reporting caring for one hundred or more rape victims (table 3).

TABLE 3

EMERGENCY ROOM EXPERIENCE AND NUMBER OF RAPE VICTIMS CARED FOR IN 1978

Demographic Variables	Number in Each Group	Percentage of Total*
Emergency Room Experience:		
Less than 1 year	4	21.1
1-5 years	8	42.1
6-10 years	4	21.1
10 years and over	3	15.8
Number of Rape Victims Cared for in 1978:		
Less than 25	12	63.2
25-50	5	26.3
51-100	1	5.3
100 and more	1	5.3

*Percentages are rounded off.
N = 19.

Levels of Experience with Sex

Data on levels of experience with sex based upon the subjects comparing themselves with other members in their peer group regarding sexual knowledge and experience indicated the following. Sixteen (84.2 percent) subjects reported that they were as experienced or more experienced than their peer group. The remainder of the subjects were evenly distributed with one (5.3 percent) subject reporting far less experience, one (5.3 percent) subject reporting less experience and one (5.3 percent) subject reporting far more experience. A similar pattern of responses was obtained when subjects compared themselves with their peer group in regard to sexual knowledge (table 4).

Levels of Experience with Rape

Fourteen (73.7 percent) subjects indicated that they had never been raped in their lifetime. Two (10.5 percent) subjects reported that they had been raped once; while one (5.3 percent) subject's response fell in the two to five times category. Finally, two (10.5 percent) subjects reported that they had been raped over five times in their lifetime. A similar pattern of responses were reported by the subjects in regard to the following areas. Sixteen (82.4 percent) subjects reported that they had never encountered statuatory rape defined as the rape of a

TABLE 4

LEVELS OF EXPERIENCE WITH SEX

Levels of Experience	Number in Each Group	Percentage of Total*
How do you rate yourself in comparison with your peer group's experience in sex?		
Far less experienced	1	5.3
Less experienced	1	5.3
As experienced	8	42.1
More experienced	8	42.1
Far more experienced	1	5.3
How do you rate yourself in comparison with your peer group's knowledge about sex?		
Far less knowledgeable	-	--
Less knowledgeable	1	5.3
As knowledgeable	8	42.1
More knowledgeable	9	47.3
Far more knowledgeable	1	5.3

*Percentages are rounded off.
N = 19.

female under seventeen. Two (10.5 percent) subjects' responses fell in the two to five times category and one (5.3 percent) subject's response fell in the over five times category regarding encounters with statuatory rape. Fourteen

(73.7 percent) subjects indicated that they had never been sexually molested, while 5 (26.3 percent) subjects' responses fell in the one and two to five times categories. Fifteen (78.9 percent) subjects indicated that they had never encountered aggravated sexual abuse (victims suffer serious bodily injury associated with the sexual abuse) while 4 (21.1 percent) subjects' responses fell in the once category. Finally, twelve (63.2 percent) subjects indicated that they had never had a sexual encounter as a child; five (26.3 percent) subjects indicated that they had such an encounter once; one (5.3 percent) subjects' response fell in the two to five times category; and one (5.3 percent) subjects' response fell in the over five times category (table 5).

The data also revealed that five (26.3 percent) subjects reported they had never had family members (wife, mother, daughter, sister, aunt, cousin, female in-law) or friends involved in a rape assault. The remaining fourteen (73.7 percent) subjects reported that these categories were inapplicable.

Finally, data based upon the subjects comparing their personal level of experience and knowledge about rape with their peer group revealed the following. Nine (41.4 percent) subjects reported that they were as experienced

TABLE 5

ENCOUNTERS WITH RAPE

Type of Encounters	Number in Each Group	Percentage of Total*
Rape:		
Never	14	73.7
1 time	2	10.5
2-5 times	1	5.3
Over 5 times	2	10.5
Statuatory rape:		
Never	16	82.4
1 time	--	--
2-5 times	2	10.5
Over 5 times	1	5.3
Sexual molestation:		
Never	14	73.7
1 time	3	15.8
2-5 times	2	10.5
Over 5 times	--	--
Aggravated sexual abuse:		
Never	15	78.9
1 time	4	21.1
2-5 times	--	--
Over 5 times	--	--
Sexual encounter as child:		
Never	12	63.2
1 time	5	26.3
2-5 times	1	5.3
Over 5 times	1	5.3
Rape of family members or friends:		
Never	5	26.3
1 time	--	--
2-5 times	--	--
Over 5 times	--	--
Not applicable	14	73.7

*Percentages are rounded off.
N = 19.

with personal rape encounters as their peers and one (5.3 percent) subject reported far more experience. The remainder of the subjects were evenly distributed with three (15.8 percent) subjects reporting far less experience; three (15.8 percent) subjects reporting less experience; and three (15.8 percent) subjects reporting more experience. In regard to knowledge, one (5.3 percent) subject reported far less knowledge; three (15.8 percent) subjects reported less knowledge; ten (52.6 percent) subjects reported being as knowledgable as; four (21.1 percent) subjects reported more knowledge; and one (5.3 percent) subject reported being far more knowledgeable (table 6).

Identification Information

Identification information provided data on whether the subjects had received a specific course in sex education or providing nursing care to victims of rape prior to or after completing the SKAT or RAKS. Eleven (57.8 percent) subjects reported that they had not received a specific course in sex education while eight (42.1 percent) subjects failed to respond to the item. The same pattern emerged in regard to a course in caring for rape victims. Eleven (57.8 percent) subjects reported that they had not received a course in regard to nursing care of rape victims, while

TABLE 6

LEVELS OF EXPERIENCE WITH RAPE

Levels of Experience	Number in Each Group	Percentage of Total*
How do you rate yourself in comparison with your peer group's experience with rape?		
Far less experienced	3	15.8
Less experienced	3	15.8
As experienced	9	47.4
More experienced	3	15.8
Far more experienced	1	5.3
How do you rate yourself in comparison with your peer group's knowledge about rape?		
Far less knowledge	1	5.3
Less knowledgeable	3	15.8
As knowledgeable	10	52.6
More knowledgeable	4	21.1
Far more knowledgeable	1	5.3

*Percentages are rounded off.
N = 19.

eight (42.1 percent) subjects failed to respond. Perhaps the eight subjects who failed to respond to the items overlooked the questions due to the placement of the items at the beginning of each of the two respective instruments.

Presentation of Findings

Two main purposes of the study were as previously identified: (1) to identify nurses' attitudes and knowledge of human sexuality and rape through the utilization of the RAKS and SKAT, and (2) to evaluate the adequacy of nurses' knowledge of human sexuality and rape. The following section presents the data obtained in regard to the above identified areas.

Sexual Knowledge and Attitude Test (SKAT)

Attitudes--Sex

The SKAT was composed of four separate attitudinal scales--Sexual Myths, Heterosexual Relationships, Abortion, and Autoeroticism. Each of the four scales was examined separately.

Scale I--Sexual Myths

The sexual myths scale deals with an acceptance or rejection of commonly held sexual misconceptions. High SM raw scores (above 39) indicate a rejection of myths while low scores (below 31) indicate acceptance of popular misconceptions. The attitudinal mean score obtained for the group of nurses in this study was 34.63 (table 7).

TABLE 7

SEXUAL KNOWLEDGE AND ATTITUDES TEST (SKAT)
MEAN SCORES FOR TOTAL GROUP

Items	Mean	Standard Deviation
Attitude scores:		
Sexual Myths	34.63	5.30
Heterosexual Relations	26.42	7.80
Abortion	25.42	5.25
Autoeroticism	24.26	4.91
Knowledge scores:		
Raw Score	33.47	5.51

N = 19.

Scale II--Heterosexual Relations

The heterosexual relations scale deals with general attitudes toward pre- and extramarital heterosexual encounters. Individuals with high HR scores (above 34) regard premarital sexual relations as acceptable, or even desirable for both men and women. Low scores (below 23) imply conservative attitudes in this area. The attitudinal mean score obtained for the group of nurses in this study was 26.42 (table 7).

Scale III--Abortion

This scale deals with general social, medical, and legal feelings toward abortion. High scores (above 35) imply an orientation which sees abortion as being acceptable while scores below 24 imply just the opposite. The attitudinal mean group score for the group of nurses in this study was 25.42 (table 7). Mandetta and Woods (1974) suggested that the topic of abortion is of an emotional significance to many people. In the Mandetta and Woods (1974) study of seventy nursing students enrolled in a baccalaureate nursing program, the authors reported that scores on the abortion scale were the lowest obtained. Mandetta and Woods (1974) also utilized the SKAT.

Scale IV--Autoeroticism

This scale deals with general attitudes toward the permissibility of masturbatory activities. High scores (above 35) imply acceptance of autoerotic stimulation as healthy while scores below 24 imply an orientation which sees masturbation as an unhealthy practice. The attitudinal mean group score for the group of nurses in this study was 24.26 (table 7).

Knowledge-Sex

Data obtained from this section of SKAT indicated that the group mean score was 33.47. Lief and Reed (1972)

reported that a raw score below 39 indicated a lesser degree of knowledge than the average medical student. Eighteen (94.7 percent) subjects in this study scored below 39 while only one (5.2 percent) subject scored above 39. The raw knowledge scores obtained in this study ranged from 22 to 44 (table 7).

The group response pattern identified in all four attitudinal scales as well as quite vividly in the knowledge section of the SKAT is possibly related to the following factors: (1) the absence of formal sex education courses in the various nursing programs throughout the country, (2) previous as well as prevalent societal misconceptions about sex and sexual behavior, and (3) the existence of a common personality trait possessed by nurses which is conservative and restrained in regard to sexual issues. Woods and Natterson (1967) suggested that physicians, as medical students, possess an obsessive compulsive pattern which suppresses their sexual aggression and sexual interests. Perhaps a similar behavior trait exists in regard to nurses.

Rape Attitude and Knowledge Survey (RAKS)

Attitudes--Rape

The RAKS was composed of five dimensions of rape--Rape Myths, Rapist's Characteristics, Victim's

Characteristics, Treatment and Handling of Rape Victims, and Nursing Care of Rape Victims. The RAKS was scored like the SKAT and each of the above five dimensions was scored separately.

Group I--Rape Myths

The rape myths group deals with acceptance or rejection of commonly held rape misconceptions. High scores (above 34) imply a rejection of misconceptions. Low scores (below 28) indicate an acceptance of popular misconceptions. The mean group score obtained for the group of nurses in this study was 34.00 (table 8).

Group II--Rapist's Characteristics

The rapist's characteristics group deals with commonly held misconceptions specifically about the rapist. A score above 17 implies a rejection of the misconceptions while a score below 14 implies acceptance. The mean group score obtained in this study was 15.63 (table 8).

Group III--Victim's Characteristics

The victim's characteristics group deals with commonly held misconceptions specifically about the victim of rape assault. A score above 13 implies rejection of the misconceptions while a score below 11 implies

TABLE 8

RAPE ATTITUDE AND KNOWLEDGE SURVEY (RAKS)
MEAN SCORE FOR TOTAL GROUP

Items	Mean	Standard Deviation
Attitude scores:		
Rape Myths	34.00	3.50
Rapist's Characteristics	15.63	2.19
Victim's Characteristics	12.16	1.98
Treatment and Handling of Victims	24.68	3.79
Nursing Care and Victims	12.16	1.74
Knowledge scores:		
Raw score	31.53	2.17

N = 19.

acceptance. The mean group score obtained in this study was 12.16 (table 8).

Group IV--Treatment and Handling of Victims

This group deals with general attitudes about present social, legal, and medical services victims receive. A score above 26 implies an orientation which view the services as acceptable. A score below 21 implies an orientation which views the services as non-acceptable. The mean group score was 24.68 (table 8).

Group V--Nursing Care and Rape Victims

This group deals with attitudes about utilizing various nursing measures in caring for rape victims. A score above 13 implies that the nursing measures were appropriate and acceptable. A score below 11 implies just the opposite. The mean group score was 12.16 (table 8).

Knowledge--Rape

Data obtained from this section of RAKS indicated that the group's mean score was 31.53. For the purposes of this study a knowledge score above 36 was identified as very adequate. A score below 28 was identified as inadequate. Seventeen (89.6 percent) subjects scored between 28 to 34 while only one (5.3 percent) subject scored below 28 and one (5.3 percent) subject scored 36. Scores ranged from 27 to 36 (table 8).

The response pattern identified in all five attitudinal groups as well as in the knowledge section may be related to the following factors. First, rape is not, according to the literature search, a discussion topic in any of the present sex education programs in nursing schools throughout the country. In a review of 220 baccalaureate nursing programs conducted by Mandetta and Woods (1976), the number of nursing schools which had sex

education courses did not include rape as a topic item. Secondly, many misconceptions regarding rape continue to prevail in today's society. Finally, there is a limited amount of nursing literature written by nurses who have been involved in analyzing and investigating the phenomenon of rape upon which the practicing nurse can base her/his nursing practice. The reduced sensitivity and reliability of the RAKS must also be considered.

Correlations within the SKAT Tool

Data were analyzed to determine the presence of significant correlations between the knowledge and attitude section of the tool. Lief and Reed (1972), the developers of the tool, reported strong correlations between the sections. The data obtained in this study do not support Lief and Reed's (1972) findings. For the purposes of this study, a significant correlation was identified as $p = 0.05$ and a highly significant correlation was identified as $p < 0.01$. Significant correlations were identified between the following areas: knowledge and sexual myths, knowledge and autoeroticism, abortion and heterosexual relations, and abortion and autoeroticism. A highly significant correlation was demonstrated between heterosexual relations and autoeroticism. The significant correlations obtained may be related to changes in society's general views toward

human sexuality since 1972, and the sample size utilized in the study which consisted of predominantly female nurses (table 9).

Correlations within the RAKS Tool

Data were analyzed to determine if a significant correlation existed between the knowledge and attitude sections of the test (table 10). Based upon the data obtained, the following significant correlations were obtained between Rape Myths and Rapist's Characteristics, Rape Myths and Victim's Characteristics, Rapist's Characteristics, Rape Myths and Victim's Characteristics, and Rapist's Characteristics and Victim's Characteristics. A highly significant relationship was obtained between Rape Myths and Treatment and Handling of Rape Victims, and Victim's Characteristics and Treatment and Handling of Rape Victims. The correlations between rape myths and both the victim's and rapist's characteristics is not surprising because all three groupings dealt with misconceptions about rape. The correlation between rape myths and treatment and handling of victims as well as victim's characteristics and treatment and handling imply, as the definition of attitudes suggests, that attitudes are indeed a response to something of social significance to the individual. Findings may also suggest that higher-order conditioning

TABLE 9

CORRELATIONS WITHIN THE SKAT TOOL

Pearson's Correlation Coefficients[a]

	Sexual Knowledge	Sexual Myths	Heterosexual Relations	Abortion	Autoeroticism
Sexual Knowledge	------	------	------	------	------
Sexual Myths	0.5327[b]	------	------	------	------
Heterosexual Relations	0.2506	0.1273	------	------	------
Abortion	0.2921	0.3608	0.4882[b]	------	------
Autoeroticism	0.4983[b]	0.2621	0.6300[c]	0.5234[b]	------

[a]Coefficients are rounded off.
[b]$p < 0.05$.
[c]$p < 0.01$.
N = 19.

TABLE 10

CORRELATIONS WITHIN THE RAKS TOOL

Pearson's Correlation Coefficients[a]

	Rape Knowledge Raw Score	Rape Myths	Rapist's Character-istics	Victim's Character-istics	Treatment and Handling of Victims	Nursing Care and Rape Victims
Rape Knowledge Raw Score	------	------	------	------	------	------
Rape Myths	0.1392	------	------	------	------	------
Rapist's Characteristics	0.3235	0.4787[b]	------	------	------	------
Victim's Characteristics	0.4055	0.5485[b]	0.5448[b]	------	------	------
Treatment and Handling of Victims	-0.0327	0.6547[c]	0.2196	0.5764[c]	------	------
Nursing Care and Rape Victims	-0.1628	-0.0968	-0.1999	-0.1177	0.0576	------

[a]Coefficients are rounded off.
[b]$p < 0.05$.
[c]$p < 0.01$
$N = 19$.

developed as identified according to the theory presented by Staats and Staats (1957).

Correlations Between Demographic Variables and Attitude, Total Knowledge Scores of SKAT and RAKS

One of the purposes identified was to identify various selected demographic data affect on nurses' attitudes and knowledge of human sexuality, rape, and care of rape victims. The data obtained are presented in the following narrative form and in table 11.

Age--Abortion scale ($p < 0.05$), Autoeroticism scale ($p < 0.05$), and Rape Myth group ($p < 0.05$)

The correlation of age with abortion, autoeroticism and rape myths may be related to and reflect the societal views taught to the subjects as they matured toward adulthood. Only within the past twenty years have sexual issues such as abortion and/or masturbatory activities been discussed openly. The phenomenon of rape has only received major societal attention as well as the attention of the scientific community in the past decade. Prior to the last fifteen to twenty years, many prevalent misconceptions regarding both human sexuality and rape existed. Even in today's society in general, and the health profession in specific, many misconceptions on the two subjects

TABLE 11

CORRELATION BETWEEN DEMOGRAPHIC VARIABLES AND SKAT AND RAKS SCORES

Kendall Tau-B Correlation Coefficients[a]

Demographic Variables	SKAT					RAKS					
	Knowledge	Attitude				Knowledge	Attitude				
	Raw Sexual Knowledge Score	Sexual Myths	Hetero-sexual Relations	Abortion	Auto-eroticism	Raw Rape Knowledge Score	Rape Myths	Rapist's Character-istics	Victim's Character-icstics	Treatment and Handling of Victims	Nursing Care of Rape Victim
Age	------	------	------	-0.4226[b]	-0.4018[b]	------	-0.4516[b]	------	------	------	------
Emergency room experience	------	------	------	-0.5766[c]	-0.4861[c]	------	------	------	------	-0.4249[b]	-0.4619[b]
Number of rape victims cared for	------	0.4807[b]	-------	------	------	------	------	------	------	------	------
Statutory rape	------	-0.4749[b]	------	------	------	------	------	------	------	------	------
Perception of self as knowledgeable-rape	------	------	------	------	------	0.5667[b]	------	------	------	------	------
Perception of self as experienced-sex	0.4034[b]	------	0.4670[b]	------	------	------	0.5508[c]	------	------	------	------
Perception of self as knowledgeable-sex	0.4313[b]	------	------	------	------	------	------	------	------	------	------

[a]Coefficients are rounded off. [b]$p < 0.05$. [c]$p < 0.01$.
N = 19.

continue to exist (Mims, Yeaworth, and Hornstein 1974; Woods and Mandetta 1975; Bernstein and Rommel 1975; Pomeroy 1977).

Emergency room experience--Abortion scale ($p < 0.01$) and Autoeroticism scale ($p < 0.01$)

Emergency room experience correlation with abortion and autoeroticism may be related to the following: (1) the limited number of times an emergency room nurse probably provides care to an abortion patient, and (2) a reflection of the subject's age. Emergency room nurses are generally involved in focusing upon immediate life-threatening situations as a result of traumatic incidents and perhaps have little opportunity to care for the abortion patient. No explanation for this phenomenon was found in the literature.

Number of rape victims cared for--Sexual Myth group ($p < 0.05$)

This correlation perhaps infers that with more frequent interaction with victims, a broader understanding of the phenomenon is developed. Woods and Mandetta (1975) suggested that perhaps exposure through first-hand experience with a phenomenon such as sexuality may broaden or liberalize the individual's attitudes toward the phenomenon. Perhaps a similar relationship exists in regard to rape.

Levels of experience with rape encounter (statuatory rape)--Sexual Myths ($p < 0.05$)

The correlation obtained may be once again related to the idea presented by Mandetta and Woods (1974) that first-hand experience broadens one's understanding and feelings toward a phenomenon. It is not surprising that actual victims of a rape encounter do not accept prevalent sexual myths. No correlation, however, was identified between level of experience with rape encounters and rape myths. Perhaps the fact that a significant correlation was not obtained between the two was due to the low reliability of the RAKS.

Perception of self as knowledgeable about rape--total raw knowledge score RAKS ($p < 0.01$)

This correlation is in conflict with the finding of McCreary-Juhasz (1967), who studied students' perceptions of the extent of their knowledge about sexuality and their actual performance on a sex knowledge test. McCreary-Juhasz (1967) indicated no relationship between the self-ratings and the actual score. The correlation relationship obtained in the study may be due to the fact that students were sample subjects in McCreary-Juhasz's (1967) study and this study utilized actual practicing nurses who were older than the student group. Perhaps it can be inferred from the

data that, since the population utilized in this study were older and possibly more familiar with self-ratings, they may have been better able to do so. Also as students, the sample populations in the McCreary-Juhasz (1967) study may have felt more inclined to rate themselves as knowledgable in order to improve their grades.

Perception of self as sexually experienced--Heterosexual Relations ($p < 0.05$)

This correlation may be related to the Mandetta and Woods (1974) suggestion that actual first-hand encounter or exposure may broaden one's understanding and acceptance of a phenomenon.

Perception of self as sexually experienced--total raw knowledge score SKAT ($p < 0.05$)

This correlation may be related to the often-listed and well-documented ideas presented by learning theorists that experience may increase one's knowledge about a phenomenon (Bigge 1976).

Perception of self as sexually experienced--Rape Myths group ($p < 0.01$)

The highly significant correlation obtained may infer that varied sexual experiences may be a liberalizing

factor which allows one to reject varied misconceptions based upon these experiences.

Perception of self as sexually knowledgeable--total raw knowledge score SKAT ($p < 0.05$)

This finding is also in conflict with the finding of McCreary-Juhasz (1967). McCreary-Juhasz utilized university students and the sample population in this study consisted of older subjects who were actively involved in practicing their professional occupations. This may have been the major cause for the difference.

Emergency room experience--treatment and handling of rape victims ($p < 0.05$) and nursing care of victim group (p 0.05)

The correlation may be related to the environment of the hospital emergency room setting and the standardized protocol utilized in providing care to rape victims. In one of the hospital emergency room settings utilized in this study, a local rape crisis center agency worked collaboratively with nurses and physicians in counseling rape victims. This probably affected the way the subjects responded particularly in regard to nursing care items.

Hypotheses

Hypothesis 1--Attitudinal relationship between human sexuality and rape

The null hypothesis was stated as: there will be no relationship between the attitudes of nurses regarding human sexuality and their attitudes regarding rape. Based on the data obtained, the hypothesis was rejected in the following areas: (1) abortion scale of SKAT and the victim characteristics group of RAKS ($p < 0.01$), (2) abortion scale of SKAT and the treatment and handling of rape victims group in RAKS ($p < 0.05$), and (3) autoeroticism scale in SKAT and the treatment and handling of rape victims group in RAKS ($p < 0.01$). The correlations obtained are somewhat surprising because no significant correlation was obtained between the sexual myth scale of SKAT and the rape myth group of RAKS. The data are presented in table 12.

The data obtained may be related to several factors. First, the sensitivity and low reliability of the instrument developed by the investigator. Secondly, the small size of the sample which consisted of predominantly female nurses may have skewed the results. Because most of the subjects were women, they may have tended to emphathize more readily with the concerns of the rape victims. Therefore, leading the subjects to accept the general measures presented and

TABLE 12

CORRELATIONS BETWEEN SKAT AND RAKS

Pearson's Correlation Coefficients[a]

RAKS	SKAT				
		Attitude			
	Knowledge Raw Score	Sexual Myths	Heterosexual Relations	Abortion	Autoeroticism
Knowledge Raw Score	0.4751[b]	-0.1319	-0.0597	0.0526	0.2419
Attitudes					
Rape Myths	0.5623[b]	0.3865	0.3255	0.4508	0.3917
Rapist's Characteristics	0.4850[b]	0.3749	-0.0553	0.0432	0.0973
Victim's Characteristics	0.5298[b]	0.3657	0.3625	0.5927[c]	0.4728[b]
Treatment and Handling of Victims	0.2871	0.4281	0.2883	0.6830[c]	0.4082[b]
Nursing Care and Rape Victims	0.1056	0.1461	0.0208	0.0300	-0.3775

[a]Coefficients are rounded off. [b]$p < 0.05$. [c]$p < 0.01$.
N = 19.

to identify abortion as an acceptable solution for victims of rape. Finally, the appearance of a strong correlation between the autoeroticism scale and the abortion scale obtained when data on correlations within SKAT were analyzed.

Hypothesis 2--Relationship between knowledge on human sexuality and knowledge on rape

The null hypothesis was stated as: there will be no relationship between the knowledge of nurses regarding human sexuality and their knowledge regarding rape. Based upon the data obtained, the null hypothesis was rejected at $p < 0.05$ level of significance. A significant correlation was demonstrated between knowledge regarding human sexuality and knowledge regarding rape. This result is perhaps not surprising when one considers the phenomenon of rape as a substructure under the broad topic of human sexuality (table 12).

Hypothesis 3--Relationship between attitudes regarding human sexuality and knowledge on rape

The null hypothesis was stated as: there will be no relationship between the attitudes of nurses regarding human sexuality and their knowledge regarding rape. Based

upon the data obtained, the hypothesis was not rejected. There was indeed no significant correlation demonstrated between attitudes on human sexuality and knowledge of rape (table 12).

Perhaps the data obtained are related to the problem surrounding correlating attitude and knowledge. Mandetta and Woods (1974) reported that there was no correlation between liberalization of students' attitudes after receiving a course in human sexuality even though the students' knowledge base improved. Tanner and Carmichael (1977) also hesitantly reported correlations between knowledge and attitude.

Hypothesis 4--Relationship between knowledge on human sexuality and attitudes regarding rape

The null hypothesis was stated as: there will be no relationship between the knowledge of nurses regarding human sexuality and their attitudes regarding rape. The null hypothesis was rejected in the following attitudinal areas: Rape myths ($p < 0.05$), rapist's characteristics ($p < 0.05$), and victim's characteristics ($p < 0.05$). The three attitudinal groups all dealt with the acceptance of misconceptions about rape. The hypothesis was accepted in the other two attitudinal groups--treatment and handling

of rape victims and nursing care of rape victims (table 12).

Summary

This chapter has presented an analysis of data collected from nineteen emergency room nurses who worked in the emergency room setting of two county hospitals in two cities in northeast Texas. The two hospitals are utilized as the primary agency in their two respective cities where rape victims receive emergency medical services. The Sexual Knowledge and Attitude Test (SKAT) developed by Harold Lief, M.D. and David Reed, Ph.D. (1972) and the Rape Attitude and Knowledge Survey (RAKS) developed by the investigator were utilized as the two measuring instruments. The SKAT was utilized to measure the nurses' attitudes and knowledge regarding human sexuality while the RAKS was utilized to measure attitudes and knowledge regarding rape and care of rape victims. Pearson's correlation coefficient and Kendall's Tau-B measure of association were utilized to measure the degree of relationship between the two sections in the two tools as well as the selected demographic variables. Descriptive analysis of the selected demographic variables was also presented. A mean group score for each of the sections of the two tools was also included in the presentation.

In Chapter V, a general review of the study and conclusions derived from the analysis of data are presented. Limitations of the study are also described. Implications for nursing practice, nursing education, continuing education, in-service hospital education, and research are also considered. The chapter concludes with recommendations for further study based upon this study's findings.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This chapter is divided into four major areas. A general review of the study and its major ideas is presented in area one. Area two describes the conclusions derived from the analysis of data. A discussion of the major limitations identified in the study is also presented in area two. Implications for nursing education, in-service hospital education, continuing education, nursing practice, and nursing research are considered in area three. The chapter concludes with recommendations for further study based upon the study's findings and the review of literature.

Summary

The problem analyzed and investigated in the study was identified as how do nurses' attitudes and knowledge regarding human sexuality affect their attitudes and knowledge regarding rape and care of rape victims. The purposes of the study were to (1) identify nurses' attitudes and knowledge of selected physiological and psychological aspects of human sexuality, (2) identify nurses' attitudes

and knowledge of selected physiological and psychological aspects of rape, (3) evaluate the adequacy of nurses' knowledge of selected physiological and psychological aspects of human sexuality and rape, (4) identify whether or not a relationship exists between nurses' attitudes and knowledge of human sexuality and their attitudes and knowledge of rape and care of rape victims, and (5) identify whether or not various selected demographic data affect nurses' attitudes and knowledge of human sexuality, rape, and care of rape victims.

A conceptual approach to human sexuality and rape was presented in the review of literature. The literature review was divided into the following four areas of discussion--sexuality, rape and its affect upon sexuality, sex education courses in nursing and medical schools in the United States, and a review of recent studies on nurses' attitudes and knowledge of certain aspects of human sexuality and rape.

An analytic survey approach, a type of nonexperimental descriptive study, was utilized as the research design for the study. The research subjects were observed without deliberate manipulations of the variables or control over the research setting.

Two county hospitals in two cities located in northeast Texas were utilized as the setting for the study. The two selected hospitals are utilized as the primary respective agencies which provide emergency medical services to all rape victims in the two cities. The population consisted of eighteen females and one male emergency room nurses (licensed vocational and registered) on the emergency room staff at the two selected agencies. A convenience sample was used. Only those who voluntarily agreed to participate served as subjects.

Two separate tools were utilized as measuring instruments. The Sexual Knowledge and Attitude Test (SKAT) developed by Lief and Reed (1972) was utilized to measure knowledge and attitudes regarding certain selected aspects of human sexuality. The Rape Attitude and Knowledge Survey (RKS) was used to measure knowledge and attitudes regarding certain selected aspects of rape. The RAKS was developed by the investigator.

The data obtained were analyzed by utilizing several methods. Frequency distributions were used to describe the demographic data. One measure of central tendency, the arithmetic mean, was used to describe the group score obtained on the attitude and knowledge sections of the two measuring tools. A correlational analysis using

Pearson's correlation coefficients and Kendall's Tau-B measure of association was utilized to examine relationship between and within each of the two tools as well as with the selected demographic variables identified. The data were presented in narrative form and in tables.

Limitations are defined as the weaknesses of the entire study as perceived by the investigator (Treece and Treece 1977). The following limitations were identified by the investigator.

1. The reliability of the instrument designed by the investigator, RAKS, was identified as extremely low by an appropriate statistical measure, the Wilcoxson's nonparametric paired t-test

2. The reliability of RAKS was not systematically studied prior to its use, even though a pilot study aided in refining the wording of items and clarifying the general directions accompanying the test

3. The sample size prevents generalizing to the entire population of emergency room nurses

4. The sample size was composed predominantly of female emergency room nurses

5. The researcher did not control various extraneous variables, such as age, length of nursing experience, and length of emergency room experience which may have

affected the outcome. These variables, however, were described and their effect upon subjects' responses were analyzed

6. The term rape was possibly not defined in the same manner by all of the participants

Conclusions

Based upon the findings of this study, the following conclusions are offered.

Significant Relationships

1. A significant relationship was demonstrated between nurses'ages, length of emergency room experiences, and levels of personal experience with sex and attitudes and knowledge of human sexuality

2. A significant relationship was demonstrated between the nurses' ages, and levels of personal experience with rape encounters and acceptance of rape myths

3. The relationship of the nurses' own perception of their personal knowledge about rape as compared with their peer group's knowledge correlated significantly with knowledge scores on rape

4. A significant statistical relationship was demonstrated between the nurses' attitudes on abortion and

autoeroticism and their attitudes on general treatment-handling of rape victims and victim's characteristics

5. A significant statistical relationship was demonstrated between the nurses' knowledge regarding human sexuality and their knowledge regarding rape

6. A significant statistical relationship was demonstrated between the nurses' knowledge regarding human sexuality and rape myths, rapist's characteristics and victim's characteristics

7. The nurses demonstrated a limited amount of knowledge per the knowledge mean score on the SKAT questionnaire. The nurses' mean average score was lower than that of the average medical student

8. The nurses' attitudes regarding the identified aspects on sexuality indicated an orientation which was somewhat conservative in character and non-accepting

9. Adequate knowledge was demonstrated by the nurses regarding rape. As a group, the nurses correctly answered approximately 80 percent of the question items on RAKS

10. The nurses did not completely reject misconceptions on human sexuality or rape

11. The nurses' attitudes regarding rapist's characteristics, nursing care of rape victims implied an

orientation toward conservativeness and acceptance of myths associated with rapists and nonacceptance of documented nursing measures

12. The nurses completely rejected misconceptions about rape victim's characteristics

13. The nurses' attitudes toward treatment and handling of rape victims indicated a somewhat liberalized or accepting orientation

Nonsignificant Relationships

1. No significant statistical relationship between the nurses' attitudes regarding human sexuality and their knowledge regarding rape was demonstrated

2. No significantly statistical relationship was identified between the nurses' knowledge regarding human sexuality and treatment and handling of rape victims and nursing care of rape victims group in the attitudes section on rape

3. No significantly statistical relationship was identified between the nurses' attitudes regarding sexual myths and rape myths

4. No significantly statistical relationships were demonstrated between the following attitudinal areas on human sexuality and rape; sexual myths and rapist's characteristics, sexual myths and victim's characteristics,

sexual myths and treatment and handling of rape victims, heterosexual relations and rape myth, heterosexual relations and rapist's characteristics, heterosexual relations and treatment and handling of rape victims, heterosexual relations and nursing care of rape victims, abortion and rape myths, abortion and rapist's characteristics, abortion and nursing care of rape victims, autoeroticism and rape myths, autoeroticism and rapist's characteristics, autoeroticism and treatment and handling of rape victims and autoeroticism and nursing care of rape victims

Incidental Findings

1. Strong significant relations were demonstrated between the following areas in SKAT: sexual knowledge and sexual myths, autoeroticism and sexual knowledge, heterosexual relations and abortion, heterosexual relations and autoeroticism, and abortion and autoeroticism

2. Strong significant relationships were demonstrated between the following areas in RAKS: rape myths and rapist's characteristics, rape myths and victim's characteristics, rapist's characteristics and victim's characteristics treatment and handling of victims and

rape myths, treatment and handling of victims and victim's characteristics

3. The nurses had not completed either of the measuring tools before or after receiving a specific course in sex education or providing care to rape victims

4. All of the nurses had provided care to rape victims during the past year

Implications

The implications from this study are directed to nursing education, continuing education, hospital in-service education, nursing practice, and nursing research.

Nursing Education

In the past nursing education and nursing educators have generally failed to disseminate to nursing students information on various aspects of varied sexual behavior patterns. Nursing students and instructors, as well, have not been allowed in some nursing programs to openly discuss feelings and attitudes regarding controversial sexual issues. Even though physiology and anatomy courses have become standard in the curricula of most nursing programs and provide basics in regard to information on the body's reproductive system, this has done little to reduce the various misconceptions that nurses maintain in

regard to sexuality and/or increase students' knowledge on the subject according to the literature search. Some nursing leaders and educators are, however, suggesting according to the review of the literature, that nurses are required and expected to provide patients with accurate information in regard to sexual issues. Rape victims and patients with sexual problems specifically require that nurses also be understanding and tolerant of their sexual behavior patterns.

In order to prepare nurses to meet the challenge and expectations of the patients, nursing education and nurse educators must provide nursing students with adequate as well as accurate information regarding varied psychological and physiological aspects of sexuality. Nursing educators must allow their students to examine their attitudes and beliefs about sexual issues in order for the students to hopefully develop a compassionate understanding of sexual problems, concerns, and behavior which may be completely foreign to them. Nursing institutions are concomitantly responsible for providing an atmosphere in which nursing educators and students can examine and discuss their feeling as well as promoting an expansion of the nursing student's knowledge base on sexuality.

Nursing educators, in order to help their students be able to adequately and effectively care for rape victims who frequently indicate sexual concerns, must, therefore, present the most recent information to their students on the two phenomena. As this study's finding indicated, most of the emergency room nurses reported that they had given care to a rape victim during the past years. The probability that the nursing student of today, as the nurse of tomorrow, will be called upon to provide care to a victim of rape continues to increase as the number of rape incidents continues to increase. The nurse of tomorrow must, therefore, be given adequate as well as accurate information and allowed to develop as tolerant attitudes as possible in order for her to be able to meet the challenge of caring for victims of rape or patients with sexual concerns. A formal sex education course which also provides a vehicle for discussing the phenomenon of rape not only appears appropriate, but also essential.

Continuing Education

A limited amount of nursing literature has been written by nurses on human sexuality and rape. Continuing nursing education could possibly help to fill the void. Some continuing education programs specifically graduate nursing programs identify that one of their main purposes

is to motivate the student to utilize research methods in order to expand the body of nursing knowledge and improve nursing practice. Perhaps more graduate nurses would be inspired to investigate sexuality and rape if they were presented as discussion topics to the students.

Continuing nursing education could also possibly help eliminate some of the prevalent misconceptions that health professionals such as nurses have on rape and human sexuality as documented in the literature search. Data obtained from this study also indicated that there was a strong correlation between increase in the nurses' ages and acceptance of rape myths as well as conservative orientations toward autoeroticism and abortion. Most students involved in graduate programs and/or other continuing education programs are generally over twenty-five. Continuing education programs could possibly provide a vehicle which would allow these nurses to broaden their knowledge base in regard to sexuality and rape as well as reduce their misconceptions.

In-Service Hospital Education

A review of the limited existing nursing literature and Donadio and White (1974) reported specifically on rape has suggested a need for improving the quality of nursing care victims of rape receive. The findings from this study

further suggest a need for practicing nurses to discuss their feelings about working with patients with sexual concerns as well as victims of rape with other nurses. The literature search has also revealed a need for the practicing nurse to continue to expand her knowledge base in regard to the two subjects. In order for the practicing nurse to continue to grow professionally, in-service hospital educators must serve as knowledgeable resource individuals. In-service seminars must allow the nurse to explore her own attitude while also providing her with knowledge upon which she can expand her nursing practice. The hospital as an institution must also continue to or begin to develop an atmosphere which is conducive toward the development of knowledgeable as well as compassionate and understanding nurses in regard to sexual problems and concerns identified by rape victims. This is essential in hospitals which are utilized as primary emergency medical agencies for victims of rape. In-service hospital educators and hospitals themselves must, therefore, consider the most effective method possible to continue to provide their staff with current information as well as an opportunity to discuss their attitudes in order to promote effective nursing care.

Nursing Practice

A review of the literature as well as the findings in this study suggest that there remains some degree of controversy regarding the nurse's role in caring for and counseling victims of rape or patients with sexual concerns. The literature suggested that the nurse is in an optimal position to have a therapeutic impact on the experience of the rape victims in the hospital setting. Some authors have reported that the nurse is also able to provide some degree of counseling to rape victims who exhibit various sexual concerns and problems. Other authors have suggested that counseling rape victims with sexual problems or concerns should be done by psychiatrists and/or other medically qualified individuals. A more unified definition of the role of the nurse in regard to verbally supporting in terms of counseling or caring for patients such as rape victims who have various sexual concerns must be identified. If the controversy persists, the practicing nurse may never be able to reach her potential for being an effective agent in helping rape victims and patients with sexual concerns.

Nursing Research

The review of literature has suggested, as well as this study's findings have indicated, a need for more

research on rape and sexuality. Because of such a limited amount of nursing research on the two subjects, the nurse of today has little upon which to support her present nursing care practices. The nurse of tomorrow is, therefore, faced with the real possibility of having nothing but medically oriented information upon which she can draw upon in regard to caring for rape victims and patients with sexual concerns.

Recommendations

From the findings of the study, as well as the review of literature, the following recommendations are suggested.

1. Conduct research that will evaluate nursing students' knowledge and attitude regarding human sexuality

2. Conduct research that will evaluate present human sexuality courses offered in nursing schools

3. Conduct research that will determine the practicing nurse's perceptions of her role in caring for patients with sexual concerns

4. Conduct research that will determine the practicing nurse's perception of her role in caring for victims of rape

5. Conduct research that will evaluate nursing students' knowledge and attitudes regarding rape and care of rape victims

6. Conduct research which will evaluate the affect of age, length of nursing experience on knowledge, and attitude on human sexuality

7. Conduct research to evaluate graduate nurses' attitudes and knowledge regarding human sexuality and rape

8. Conduct research on rape victim's perception of the role of the nurse and the adequacy of the nursing care they received

9. Conduct a similar study using a larger sample including more male emergency room nurses and utilizing a more reliable tool to measure knowledge and attitudes on rape

10. The following recommendations are in reference to future use of RAKS, the instrument developed by the investigator.

    a. Reformulate the questionnaire items utilizing the expertise and experience of nursing educators, members of the target population (emergency room nurses) and possibly rape victims themselves, as well as information obtained from the literature search.

b. Equalize the number of items in each section on attitudes by dividing the attitudinal section only into two groups--Rape Myths and Treatment and Handling of Rape Victims.

c. Base item selection in final questionnaire upon factor analysis of item response and cross-validate findings by utilizing tool in several preparatory studies

d. Elimination of items which suggest poor response splits where more than perhaps a majority (80 to 90 percent) either agree or disagree would possibly facilitate interpretation of results.

APPENDIX A

CONSENT TO ACT AS A SUBJECT FOR A RESEARCH INVESTIGATION

(The following information is to be read to or read by the subject.)

Dear Nurse,

I am Betty J. Braxter, a graduate nursing student at Texas Woman's University and I am writing a thesis on nurses' attitudes and knowledge of selected aspects of human sexuality and rape. In order to obtain this information, I am utilizing two questionnaires. Your participation would be helpful in that it could be used in teaching other health professionals about human sexuality and rape. This would hopefully lead to improving the quality of care victims of rape and patients with sexual problems receive.

Your participation in this study is both voluntary and anonymous. No record will be made of the nurses who participate. Please do not place your name, social security number, or employee number on the answer sheets. In order to correlate your response on the human sexuality test and your response on the rape test, the investigator has placed on the answer sheets an assigned code number in the right-hand corner circled in black ink. This will hopefully reduce the possibility of error in correlating your response on the two answer sheets.

Due to the subjects under investigation, any item that you, as a participant, feel is too personal, please feel free to omit. There are three potential risks to you as a participant. They include the following:

1. The possibility of embarrassment resulting from evaluating your own attitudes and knowledge of the subjects under investigation

2. The possibility of improper release of data

3. The possibility of some degree of psychological discomfort in regard to responding to items on human sexuality and rape as presented in the two questionnaires

In order to reduce the possibility of embarrassment and/or the improper release of data, no record will be made of you as a participant and no test score will be made public. Should an adverse emotional response occur, the data collection process will be discontinued. If you should suffer such a response in the hospital setting, you will be referred to a pre-selected qualified individual (clergyman, psychologist, psychiatrist) on the staff of your respective hospital for counseling service. If you should suffer any degree of psychological discomfort either in the hospital setting or your home setting in regard to responding to items on the test, please feel free to call the Dallas Rape Crisis Center at any time, day or night. The number is 521-1020 or 521-1060. You are, of course, free to withdraw from this study at any time, even after you have signed the consent sheet.

Thank you for taking time out of your busy schedule to serve as a participant.

Sincerely yours,

Betty J. Braxter, R.N.

APPENDIX B

SHORT CONSENT FORM FOR RESEARCH STUDY

I, _____, do hereby give my consent to participate in a research study on Emergency Room Nurses' Attitudes and Knowledge of Human Sexuality and Rape. The general plan of which has been explained to me including purpose of the study, anticipated benefits, risks, and potential complications. I fully understand as it has been explained to me that by notice given to the undersigned principle investigator, that I may withdraw from this research project anytime that I may elect to do so.

_____
Respondent signature

_____
Date

I hereby certify that I have given to the above individual an explanation of the study under investigation and its risks and potential complications.

_____
Investigator's signature

_____
Date

APPENDIX C

Marriage Council of Philadelphia, Inc.

affiliated with

Division of Family Study, Department of Psychiatry
The University of Pennsylvania School of Medicine
4025 Chestnut Street, Philadelphia, Pa. 19104 (215) 382-6680
2nd floor

September 26, 1978

Mrs. Betty J. Braxter
1810 Innwood Road, 423
Dallas, Texas 75235

Dear Ms. Braxter: Re: Your letter of Sept. 8, 1978

You have my permission to incorporate the SKAT in your research study. I look forward to receiving the results of your research work when it is completed.

Cordially,

Harold I. Lief

Harold I. Lief, M.D.
Professor of Psychiatry
Director, Marriage Council of Phila.

HIL:FG

APPENDIX D

GENERAL DIRECTIONS

1. Read the CODING AND GENERAL INSTRUCTIONS located on the first page of each of the two questionnaires.

2. Place completed answer sheets in the locked box located in the _____ corner of the nursing lounge area. A white sign with the words ANSWER SHEETS printed upon it has been placed on the locked box for identification purposes.

3. Place the two questionnaires in the brown folder located by the locked box. The word QUESTIONNAIRES has been printed upon the folder for identification purposes.

4. All completed answer sheets and questionnaires are to be returned within forty-eight hours after receiving them.

5. The average length of time required to complete both questionnaires is _____.

6. If you decide to take the tests in the hospital setting, please go to room _____. This area has been secured for you in order to provide more privacy.

7. If you are unable to return the questionnaire within the forty-eight hour time length, please return the questionnaires before _____ the last date for the collection of data for this research study.

8. If you should suffer any degree of psychological discomfort either in the hospital setting or your home setting, please feel free to call the Dallas Rape Crisis Center at any time day or night. The number is 521-1020 or 521-1060.

9. If you should suffer any emotional distress in the hospital setting, arrangements have been made for _____ to provide counseling services to you.

THANK YOU FOR TAKING TIME OUT OF YOUR BUSY SCHEDULE TO SERVE AS A PARTICIPANT.

APPENDIX E

SEX KNOWLEDGE AND ATTITUDE TEST (S.K.A.T.)

Used by permission of Harold I. Lief, M.D. as shown in appendix C.

CODING AND GENERAL INSTRUCTIONS

1. Pencils--Use any type of soft lead pencil. Do not use an ink or ballpoint pen.

2. All answers are to be recorded on the separate answer sheet. Do not write on the test booklet.

3. Please mark only one answer per question.

4. In answering questions concerning personal attitudes, some people give answers accepted or preferred by the society in which they live. This is often done unconsciously. Please attempt at all times to be frank in expressing your own attitudes.

IDENTIFICATION INFORMATION

I. Complete anonymity will be given to each participant. Some identification number is necessary simply for the processing of this material. The investigator has placed in the right hand corner of the answer sheet an assigned coding number. Please do not place your name, social security number, or employee number on the answer sheet. Identifying numbers are only used for matching information from this test and the RAKS.

II. Are you completing this questionnaire before or after a specific course in sex education?

A. Pre-instruction B. Post-instruction C. Neither

PART I: ATTITUDES

Please indicate your reaction to each of the following statements on sexual behavior in our culture, using the following alternatives:

A. Strongly agree
B. Agree
C. Uncertain
D. Disagree
E. Strongly disagree

Please be sure to answer every question.

1. The spread of sex education is causing a rise in premarital intercourse.

2. Mutual masturbation among boys is often a precursor of homosexual behavior.

3. Extramarital relations are almost always harmful to a marriage.

4. Abortion should be permitted whenever desired by the mother.

5. The possession of contraceptive information is often an incitement to promiscuity.

6. Relieving tension by masturbation is a healthy practice.

7. Premarital intercourse is morally undesirable.

8. Oral-genital sex play is indicative of an excessive desire for physical pleasure.

9. Parents should stop their children from masturbating.

10. Women should have coital experience prior to marriage.

11. Abortion is murder.

12. Girls should be prohibited from engaging in sexual self-stimulation.

13. All abortion laws should be repealed.

14. Strong legal measures should be taken against homosexuals.

15. Laws requiring a committee of physicians to approve an abortion should be abolished.

16. Sexual intercourse should occur only between married partners.

17. The lower-class male has a higher sex drive than others.

18. Society should offer abortion as an acceptable form of birth control.

19. Masturbation is generally unhealthy.

20. A physician has the responsibility to inform the husband or parents of any female he aborts.

21. Promiscuity is widespread on college campuses today.

22. Abortion should be disapproved of under all circumstances.

23. Men should have coital experience prior to marriage.

24. Boys should be encouraged to masturbate.

25. Abortions should not be permitted after the twentieth week of pregnancy.

26. Experiences of seeing family members in the nude arouse undue curiosity in children.

27. Premarital intercourse between consenting adults should be socially acceptable.

28. Legal abortions should be restricted to hospitals.

29. Masturbation among girls is a frequent cause of frigidity.

30. Lower-class women are typically quite sexually responsive.

31. Abortion is a greater evil than bringing an unwanted child into the world.

32. Mutual masturbation in childhood should be prohibited.

33. Virginity among unmarried girls should be encouraged in our society.

34. Extramarital sexual relations may result in a strengthening of the marriage relationship of the persons involved.

35. Masturbation is acceptable when the objective is simply the attainment of sensory enjoyment.

PART II: KNOWLEDGE

Each of the following statements can be answered either true or false. Please indicate your position on each statement using the following alternatives:

T. True F. False

Be sure to answer every question.

1. Pregnancy can occur during natural menopause (gradual cessation of menstruation).

2. Most religious and moral systems throughout the world condemn premarital intercourse.

3. Anxiety differentially affects the timing of orgasm in men and women.

4. A woman does not have the physiological capacity to have an intense an orgasm as a man.

5. There is no difference between men and women with regard to the age of maximal sex drive.

6. Social class is directly correlated with the frequency of incest.

7. The use of the condom is the most reliable of the various contraceptive methods.

8. The incidence of extramarital intercourse is constant for males between the ages of 21 and 60.

9. Nearly half of all unwed girls in America have sexual intercourse by age 19.

10. There are two kinds of physiological orgastic responses in women, one clitoral and the other vaginal.

11. Impotence is almost always a psychogenic disorder.

12. Tranvestitism (a form of cross-dressing) is usually linked to homosexual behavior.

13. There was as much premarital coitus a generation ago as there is now.

14. Sexual attitudes of children are molded by erotic literature.

15. In some successful marriages sex adjustment can be very poor.

16. Homosexuals are more likely to be exceptionally creative than heterosexuals.

17. A woman who has had a hysterectomy (removal of the uterus) can experience orgasm during sexual intercourse.

18. Homosexuality comes from learning and conditioning experiences.

19. In responsive women, non-coital stimulation tends to produce a more intensive physiological orgastic response than does coitus.

20. Those convicted of serous sex crimes ordinarily are those who began with minor sex offenses.

21. One of the immediate results of castration in the adult male is impotence.

22. The body build of most homosexuals lacks any distinguishing features.

23. Masturbation by a married person is a sign of poor marital sex adjustment.

24. Exhibitionists are latent homosexuals.

25. A woman's chances of conceiving are greatly enhanced if she has an orgasm.

26. Only a small minority of all married couples ever experience mouth-genital sex play.

27. Impotence is the most frequent cause of sterility.

28. Certain foods render the individual much more susceptible to sexual stimulation.

29. A high percentage of those who commit sexual offenses against children is made up of the children's friends and relatives.

30. A higher percentage of unmarried white teenage girls than unmarried black teenage girls in the United States have had intercoure with four or more partners.

31. The attitude of the average American male towards premarital intercourse is shaped more by his religious devoutness than by his social class.

32. In teaching their daughters female sex roles, middle-class mothers are more affected by cultural stereotypes than mothers in other social classes.

33. In most instances, the biologial sex will override the sex assigned by the child's parents.

34. The onset of secondary impotence (impotence preceded by a period of potency) is often associated with the influence of alcohol.

35. Nursing a baby usually protects the mother from becoming pregnant.

36. In our culture some homosexual behavior is a normal part of growing up.

37. Direct contact between penis and clitoris is needed to produce female orgasm during intercourse.

38. For a period of time following orgasm, women are not able to respond to further sexual stimulation.

39. In some legal jurisdictions artificial insemination by a donor may make a woman liable to suit for adultery.

40. Habitual sexual promiscuity is the consequence of an above-average sex drive.

41. Approximately one out of three adolescent boys has a homosexual experience leading to orgasm.

42. Impotence in men over 70 is nearly universal.

43. Certain conditions of mental and emotional instability are demonstrably caused by masturbation.

44. Women who have had several sex partners before marriage are more likely than others to be unfaithful after marriage.

45. The emotionally damaging consequences of a sexual offense against a child are more often attributable to the attitudes of the adults who deal with the child than to the experience itself.

46. Sexual maladjustment is the major cause of divorce.

47. Direct stimulation of the clitoris is essential to achieving orgasm in the woman.

48. Age affects the sexual behavior of men more than it does women.

49. The circumcized male has more trouble with ejaculatory control than the uncircumcized male.

50. More than a few people who are middle-aged or older practice masturbation.

51. Varied coital techniques are used most often by people in lower socioeconomic classes.

52. Individuals who commit rape have an unusually strong sex drive.

53. The rhythm method (refraining from intercourse during the six to eight days midway between menstrual periods), when used properly is just as effective as the pill in preventing conception.

54. Exhibitionists are no more likely than others to commit sexual assaults.

55. The ability to conceive may be significantly delayed after the menarche (onset of menstruation).

56. Many women erroneously consider themselves to be frigid.

57. Menopause in a woman is accompanied by a sharp and lasting reduction in sexual drive and interest.

58. The two most widely used forms of contraception around the world are the condom and withdrawal by the male (coitus interruptus).

59. People in lower socioeconomic classes have sexual intercourse more frequently than those of higher classes.

60. Pornographic materials are responsible for much of today's aberrant sexual behavior.

61. For some women, the arrival of menopause signals the beginning of a more active and satisfying sex life.

62. The sex drive of the male adolescent in our culture is stronger than that of female adolescent.

63. Lower-class couples are generally not interested in limiting the number of children they have.

64. Excessive sex play in childhood and adolescence interferes with later marital adjustment.

65. There is a trend toward more aggressive behavior by women throughout the world in courtship, sexual relations, and coitus itself.

66. Sometimes a child may have cooperated in or even provoked sexual molestation by an adult.

57. LSD usually stimulates the sex drive.

68. Seven out of ten parents desire formal sex education in the school.

69. For every female that masturbates, four males do.

70. Douching is an effective form of contraception.

71. Freshmen medical students know more about sex than other college graduates.

PART III: EXPERIENCE

It would be helpful if you would fill in the following questions. They refer to levels of experience with sex, and will aid our understanding of relationships between knowledge and attitudes. Please answer honestly, and feel free to omit any question or questions if you find them too personal.

1. How do you rate yourself in comparison with your peer group's experience in sex?

   A. Far less experienced than most
   B. Less experienced than most
   C. As experienced as most
   D. More experienced than most
   E. Far more experienced than most

2. How do you rate yourself in comparison with your peer group's knowledge about sex?

   A. Far less knowledgeable than most
   B. Less knowledgeable than most
   C. As knowledgeable as most
   D. More knowledgeable than most
   E. Far more knowledgable than most

APPENDIX F

RAPE ATTITUDE AND KNOWLEDGE SURVEY

(R. A. K. S.)

Fourth Revision

Betty Braxter

CODING AND GENERAL INSTRUCTIONS

1. Pencils - Use any type of soft lead pencil. Do not use an ink or ballpoint pen.

2. All answers are to be recorded on the separate answer sheet. Do not write on the test booklet.

3. Please mark only one answer per question.

4. In answering questions concerning personal attitudes, some people give answers accepted or preferred by the society in which they live. This is often done unconsciously. Please attempt at all times to be frank in expressing your own attitudes.

IDENTIFICATION INFORMATION

1. Complete anonymity will be given to each participant. Some identification number is necessary simply for the processing of this material. The investigator has placed in the right hand corner of the answer sheet an assigned coding number. Please do not place your name, social security number, or employee number on the answer sheet. Identifying numbers are only used for matching information from this test and the SKAT.

2. Are you completing this questionnaire before or after a specific course in providing care to rape victims?

   A. pre-instructions B. post-instructions

   C. neither

PART I: ATTITUDES

Please indicate your reaction to each of the following statements on rape using the following alternatives:

A. Strongly agree
B. Agree
C. Uncertain
D. Disagree
E. Strongly disagree

Please be sure to answer every question.

1. A woman cannot really be raped. "You can't thread a moving needle."

2. Many women dream of submitting to a strong silent heroic type rapist.

3. Husbands can be rapists.

4. "Nice girls" are less likely to be raped.

5. When a woman is being raped, she should relax and try to enjoy it.

6. Most rapes are false accusations made by women who want to get even with men.

7. Rape crisis centers should be available to all rape victims.

8. Rape is a crime of violence.

9. Rapists have higher sex drives than other men.

10. The nurse should help the victim identify the part she played in precipitating the rape.

11. Rape is really not a serious crime.

12. An increase in female sexual assertiveness is causing an increase in the number of rapes.

13. A nurse has the responsibility to give support to the rape victim especially during the pelvic examination.

14. Rape should not present a crisis situation for the normal, healthy female.

15. Rape victims should be encouraged to press charges.

16. Most rapists are not insane.

17. Health professionals should view the rape victim as high priority and treatment should be instituted immediately.

18. Rape is one type of compliment a man can pay to a woman.

19. Rape may actually serve as a romantic and stimulating adventure.

20. Regardless of the woman's personal character, her statement should be all that is needed to justify policy investigation of a reported rape.

21. Because more seriously traumatized patients are brought into the emergency room setting, the immediate treatment of rape victims should be viewed as a low priority.

22. Women who go out alone at night are asking to be raped.

23. Rape victims should receive some form of counseling only during the immediate hours and days following the assault.

24. A nurse has the responsibility to provide some form of emotional support to the victim regardless of the validity of the charge.

PART II: KNOWLEDGE

Each of the following statements can be answered either true or false. Please indicate your position on each statement using the following alternatives:

T. True F. False

Be sure to answer every question.

1. Women who are sexually assaulted generally do not report the crime because they are too fearful and ashamed.

2. One major need of the victim is to be left alone after being admitted to the emergency room.

3. The most important need the victim indicates immediately after the rape is for the assailant to be apprehended.

4. One of the primary reactions to rape which victims express is far.

5. Most rapes occur in the dark of night on a dead-end street.

6. Most rapists utilize force alone as a weapon to get the woman to submit.

7. Only a small number of rapes are committed by rapists who know their victims.

8. The largest number of both offenders and victims fall into the 15-20 age group.

9. After the rape has been committed, most victims become hysterical and are unable to think rationally.

10. Rape is a crime which mostly occurs between people of the same race.

11. As a result of being raped, some victims change their jobs, their addresses, and return home to their families.

12. Immediately following the rape assault, the victim should be helped to deal with the reality of the attack.

13. In Texas, evidence pertaining to the rape victim's past sexual activities is admissible at the trial.

14. One major need of the rape victim immediately after the attack is the need to talk with someone about the rape.

15. When a child is sexually assaulted, the victim's parents often suffer disruptions in their lifestyles as a result of the attack.

16. Bicillin 4.8 million units is usually given prophylatically to prevent veneral disease resulting from the attack.

17. A culture for gonorrhea should be taken as a part of the routine examination of a victim of rape.

18. Nausea may develop when high doses of estrogen (ethinyl estradiol) are given to prevent pregnancy from developing.

19. As a part of the routine examination, the American College of Obstetrics and Gynecologists recommends that victims receive pelvic examinations.

20. Three factors are important in the treatment of victims of rape: prevention of pregnancy, prevention of veneral disease, and documentation of any physical evidence of trauma that would be useful in court.

21. Rape victims are not very concerned about telling their families.

22. Most victims suffer some type of trauma, bruises, or lacerations as a result of the attack.

23. Rape is defined as coitus with a female without consent.

24. The greatest possibility of pregnancy resulting from rape occurs when the assault takes place midway in the menstrual cycle.

25. During the immediate hours and days following the assault, most victims' reactions do not include those of shock, disbelief, or anger.

26. One major concern of victims is the possible difficulties they might have in future sexual relationships with men.

27. After the acute phase of the crisis situation passes, victims usually return to their jobs and need no further help.

28. The speculum should not be wet prior to the pelvic examination.

29. Before the victim is able to completely resolve the crisis of rape, she has to resolve her feelings about the assailant.

30. In most cases of forcible rape, three factors are usually present: anger, power, and sexuality.

31. The angry rapist does not intent to hurt his victim.

32. During the first weeks following the rape attack, victims do not suffer a decrease in appetite or disturbances in sleep patterns.

33. Immediately following the rape, the victim may develop a fear of being alone.

34. Some rapists find pleasure and excitement in causing pain.

35. Victims often cope with the actual attack by "blocking out" the incident.

36. Immediately following the rape assault, victims may show no signs of emotional trauma such as crying. Some of the victims laugh and giggle while they wait to receive emergency treatment.

37. A man may respond to the rape of a daughter, girlfriend, or wife by becoming overprotective as a result of guilt for not having been protective enough.

38. As part of nursing care, helping a victim of rape examine alternate ways of coping with the problem is inappropriate.

39. Listening to the victim express her feelings is therapeutic.

40. "Why didn't you take a cab at this time of night? You know it's dangerous." These type of statements help the victim deal with the reality of the situation.

PART III: BACKGROUND

This information will be treated as strictly confidential and will be used for research purposes only. In no way will it be used to reveal anyone's identity. Please mark your responses on Part III of the answer sheet.

1. Age

   A. 17-21
   B. 22-26
   C. 27-31
   D. 32-36
   E. 37-41
   F. 41 and over

2. Sex

   A. Female
   B. Male

3. Ethnic origin

   A. Black
   B. White
   C. Mexican-American
   D. Other

4. Marital status

   A. Married at sometime
   B. Never married

5. Religion

   A. Catholic
   B. Protestant
   C. Jewish
   D. Other

6. Nursing experience

   A. Less than 1 year
   B. 1-5 years
   C. 6-10 years
   D. 10 years and over

7. Type of nursing school of which you are a graduate.

   A. LPN/LVN program
   B. Diploma program
   C. ADN program
   D. Baccalaureate
   E. Other: (specify) _____

8. How long have you been working in the emergency room as a full-time employee?

   A. Less than 1 year
   B. 1-5 years
   C. 6-10 years
   D. 10 years and over

9. Indicate the number of rape victims you have approximately provided nursing care to during 1978.

   A. Less than 25
   B. 25-50
   C. 51-100
   D. 100 and more

PART IV: EXPERIENCE

It would be helpful if you would fill in the following questions. They refer to levels of experience with rape and will aid in the understanding of relationships between knowledge and attitudes. Please answer honestly, and feel free to omit any question or questions if you find them to personal.

For questions 1-5 indicate how many times you have had the following encounters with rape:

A. Never B. Once C. Two-five D. Over five

1. Rape
2. Statuatory rape (rape of a female under 17)
3. Sexual molestation (noncoital sexual contact without consent)
4. Aggravated sexual abuse (victim suffers serious bodily injury associated with the sexual abuse)
5. Sexual encounter as a child

For questions 6-13, indicate whether or not any family members or friends have been raped.

A. Never B. Once C. Two-five D. Over five

E. Not applicable

6. Wife

7. Mother

8. Daughter

9. Sister

10. Aunt

11. Cousin

12. Female in-law

13. Friend

14. How do you rate yourself in comparison with your peer group's experience with rape?

    A. Far less experienced than most
    B. Less experienced than most
    C. As experienced as most
    D. More experienced than most
    E. Far more experienced than most

15. How do you rate yourself in comparison with your peer group's knowledge about rape?

    A. Far less knowledgeable than most
    B. Less knowledgeable than most
    C. As knowledgeable as most
    D. More knowledgable than most
    E. Far more knowledgeable than most

APPENDIX G

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Betty Braxter Center: Dallas

Address: 1810 Inwood Road, Room 423 Date: 12/14/78

Dallas, Texas 75235

Dear Ms. Braxter:

Your study entitled Emergency Room Nurses' Attitudes and Knowledge of Human Sexuality and Rape has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,

Estelle D. Kurtz

Chairman, Human Research Review Committee

at Dallas.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

222

HOUSTON CENTER
1130 M.S. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Dallas County Hospital District

GRANTS TO Betty Braxter

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

> Emergency Room Nurses' Attitudes and Knowledge of Human Sexuality and Rape. How do nurses' attitudes and knowledge of human sexuality affect their attitudes and knowledge of rape and care for rape victims?

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: Would like to receive a copy of the study

Date 2/1/79

Signature of Agency Personnel 2.5.79

Betty J Braxter 2/5/79
Signature of Student

Signature of Faculty Advisor 2.6.79

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.S. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Betty J. Braxter

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Emergency Room nurses' attitudes and knowledge of human sexuality and rape.

The conditions mutually agreed upon are as follows:

1. The agency (~~may~~) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (~~may~~) (may not) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date February 6, 1979

Betty J. Braxter 2/6/79
Signature of Student

Signature of Agency Personnel
Charles Quereau, Assistant Administrator

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS 76204

224

THE GRADUATE SCHOOL

April 10, 1979

Ms. Betty Jean Braxter
1810 Inwood Road #423
Dallas, Texas 75235

Dear Ms. Braxter:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Phyllis Bridges

Phyllis Bridges
Dean of the Graduate School

PB:cn

cc Mrs. Cheryl Anderson
Dr. Anne Gudmundsen
Graduate Office

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