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Rebecca R. Gonnering
Minnesota State University - Mankato

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"A Compromise to Help the Community": Rural Sexual Assault Nurse
Examiner Experiences

By

Rebecca Gonnering

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

Masters of Science

In

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"A Compromise to Help the Community": Rural Sexual Assault Nurse
Examiner Experiences

Rebecca Gonnering

This thesis has been examined and approved by the following members of the student's
committee.

Dr. Laura Harrison

Dr. Annelies Hagemester

Dr. Maria Bevacqua

Abstract

Victims of sexual assault require specialized medical care when they report to hospital emergency departments including physical examination, evidence collection, and emotional support. Sexual Assault Nurse Examiners (SANEs) are medical professionals trained to complete the examination and evidence collection in a prompt and sensitive manner. In fact, where SANE programs exist, emergency room waiting times are shorter, evidence collection improves, and revictimization from untrained staff is reduced.

Unfortunately, SANEs are not widely available, particularly in rural areas. This lack of trained examiners employed at local hospitals creates a gap in access to proper care, often resulting in long waits as hospitals try to locate an examiner, treatment from untrained staff, or a referral to another hospital. The purpose of this study was to determine SANE's perceptions of the barriers contributing to their low representation in one Midwestern rural community. In-depth semi-structured interviews were completed with six Sexual Assault Nurse Examiners.

Findings of this study suggested that Sexual Assault Nurse Examiners working in rural areas experience many of the same difficulties that Sexual Assault Nurse Examiners in urban areas experience in addition to their own unique challenges. Difficulties that rural and urban SANEs have in common include frustrations with on-call systems, difficulties with scheduling, difficulties maintaining competency and proficiency in SANE skills, and experiences of vicarious trauma. SANEs working in rural areas face unique challenges related to patient privacy as well as their own challenges related to competency. This study suggested for example, that rural SANE programs face additional challenges keeping SANEs proficient in their skills because of the low rates of sexual assault

survivors seeking SANE services in rural areas. Policy recommendations and avenues for future research are also discussed.

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Chapter 1: Introduction

According to *The White House Council on Women and Girls* 2014 report, nearly one in five women (or 22 million), are raped in their lifetimes. Men however, are also at risk. The report states that an estimated one in seventy-one (nearly 1.6 million) men are victims of rape as well. The report points out that while men experience sexual assault, women are still the overwhelming majority of sexual assault victims, while nearly all (98 percent) perpetrators are men (p. 1). Survivors, feminists, and other sexual assault advocates have long understood this reality and have worked tirelessly to build a body of work analyzing the gendered aspects of rape. Today we are starting to see the fruits of that labor as rape, and other forms of violence against women, are becoming more widely recognized as forms of gender-based violence (Green, 1999). This study examines interviews with six nurses that work with victims of gender-based violence in an effort to understand the challenges of sexual assault patient care.

The *White House Council* report is part of a continued effort by the United States federal government to fight violence against women and to provide better services to sexual assault survivors. The first major piece of federal legislation supporting anti-violence came in 1994, when the United States Congress enacted the Violence Against Women Act (VAWA). The Violence Against Women Act of 1994 was a comprehensive bill that provided funding for state and local efforts fighting all forms of gender-based violence. The bill included funding for issues such as “homicide, stalking, rape, and domestic violence” (The Office of the Vice President, 2014, p. 10) in the hopes of making streets and homes safer for women.

Since it was first passed into law in 1994, VAWA has been reauthorized three times. The most recent reauthorization, which took place in 2013, came with important changes including a new provision of funding for Sexual Assault Nurse Examiner (SANE) programs (The White House Council on Women and Girls, 2014). A Sexual Assault Nurse Examiner program is a community-based program where specially trained nurses (called SANEs) provide 24-hour-a-day access to medical care and crisis intervention to rape survivors in either a hospital or clinic setting (Campbell, Patterson & Lichty, 2005). Prior to SANE program development in the 1970s, many survivors of sexual assault suffered victim blaming and invasive questioning by police and emergency room staff. In addition to this insensitive treatment, rape victims also routinely endured examination by emergency room staff untrained in forensic evidence collection and treatment of sexual assault survivors. Sadly, many rape victims of the period reported feeling revictimized by the examination experience (Bevacqua, 2000; Littel, 2001; Mathews, 1994). Poor treatment of rape victims on the part of hospital staff and police became so well-known that feminist activists began referring to these post assault interactions as the “second rape” (Mathews, 1994, p. 11).

As these examples suggest, Sexual Assault Nurse Examiner programs began in the late 1970s in an attempt to correct the many problems associated with traditional hospital care of rape victims (Campbell, Patterson & Lichty, 2005). The first Sexual Assault Nurse Examiner program opened in Memphis, Tennessee in 1976. The second and third SANE programs opened in 1977 and 1979 (O’Connor, 2009). Today there are over six hundred SANE programs operating across the United States (Maier, 2012). Each

program specializes in providing immediate, sensitive, and compassionate care to rape victims by specially trained nurses called Sexual Assault Nurse Examiners.

Sexual Assault Nurse Examiners are “registered nurses (R.N.) who have advanced education and clinical [training] in forensic examination of sexual assault victims” (Littel, 2001, p. 1). The main component of Sexual Assault Nurse Examiners’ work focuses on the collection, preservation, and documentation of forensic evidence such as hairs, fibers, bodily fluids, and scrapings from underneath the fingernails (Ledray, 1995; Littel, 2001; Maier, 2011). This process includes photographing injuries and conducting a pelvic exam (Ledray, 1995). However, SANEs also provide emotional support to victims in crisis and may also provide treatment for the prevention of sexually transmitted infections, pregnancy, and HIV (Littel, 2001; Maier, 2012). Many SANEs also make referrals to other health professionals to help ensure patients receive comprehensive care (Maier, 2012). While the services provided by SANE nurses and SANE programs provide a crucial service to the community, many do not realize that both SANE nursing and SANE program development have their origins in feminist organizing.

Historical Context

The roots of rape consciousness can be traced back to the second wave of the feminist movement. Beginning in the mid-1960s, the liberal branch of the women’s movement began politicizing many aspects of women’s lives including pay inequality, reproductive freedom, and workplace discrimination (Bevacqua, 2000). However, it was the more radical branches of the women’s movement that first began organizing around rape and sexual assault. Radical feminist organizing around rape prevention and the

support of rape survivors quickly grew into a sub-movement called the anti-rape movement (Bevacqua, 2000; Gornick & Meyer, 1998; Mathews, 1994).

The feminist anti-rape movement¹ of the 1960s and 1970s had three main goals 1) to provide direct services to women who had been raped and to advocate for their needs as they worked with local health and criminal justice systems, 2) to teach women how to avoid and resist rape and 3) to encourage local institutions to be more responsive to women that have been raped. Rape crisis centers (RCCs) and Sexual Assault Nurse Examiner programs were two of the primary methods through which the anti-rape movement accomplished these goals (Bergen & Maier, 2011; Gornick & Meyer, 1998).

Radical feminists opened the first rape crisis centers (RCCs) and utilized a grassroots, community-orientation model of organizing (Gornick & Meyer, 1998). Guided by principles based on egalitarianism, non-hierarchical structures, and consensus building, many RCCs operated as collectives. As such, many early rape crisis centers were operated out of a member's home on a purely voluntary basis (Bevacqua, 2000). Without the use of state or government funds, RCCs offered a variety of services including hotline counseling, accompaniment to hospitals and police stations, as well as face-to-face counseling for rape survivors (Bergen & Maier, 2011; Gornick & Meyer, 1998). Although rape crisis centers provided a much-needed service to women, the primary problem of poor service delivery at hospitals was not addressed by RCCs. In an attempt to correct hospitals' treatment of rape victims, feminists and others involved in anti-rape work began developing Sexual Assault Nurse Examiner programs (Bergen & Maier, 2011; Gornick & Meyer, 1998).

¹ For a more detailed account of the anti-rape movement see chapter two.

While rape crisis centers utilized a radical feminist approach to providing services to rape survivors, SANE programs employed a contradictory approach. SANE programs actively coordinated with local police departments and hospitals to create sexual assault response teams (SARTs)—a team of advocates, law enforcement officers, prosecutors, and SANEs that work together to provide rape victims with comprehensive care. SANE nurses function as one part of a SART team (Bergen & Maier, 2011).

The contradictory approach in management between rape crisis centers and Sexual Assault Nurse Examiner programs emerged out of differences in feminist philosophy. As previously mentioned, early RCCs were operated by radical feminists who believed that women's liberation could be achieved "only by eradicating male supremacy and its institutions" (Bevacqua, 2000, p. 29). RCCs of the period were driven by a social change mission focused on eliminating rape. Radical feminists saw cooperation with mainstream institutions as useless, because they thought local institutions would interfere with their goals of eradicating patriarchy and violence against women (Bergen & Maier, 2011). SANE programs, however, operate within existing institutions (as evidenced by their use of SART teams). Instead of eradicating patriarchy and eliminating violence against women, SANE programs aim to correct the excesses of patriarchy by offering sexual assault services.

Although RCCs and SANE programs both emerged out of feminist anti-rape activism, the two have a few key differences. The main difference concerns the role of advocacy. An advocate's role is to "provide crisis intervention, to provide caring, sympathetic, emotional support for the victim, and [to] furnish the victim with options and choices" (Ledray, Faugno, & Speck, 2001, p. 92). Although it is necessary for

SANEs to support a rape victim in order to provide sensitive and respectful care during the forensic exam, SANEs are not advocates. SANEs are nurses, and as such they must remain unbiased, because they may be asked to serve in court proceedings (Ledray, Faugno & Speck, 2001).

Current Study

Research has demonstrated that SANE programs experience a myriad of difficulties including recruitment and retention of qualified staff, funding and scheduling issues, and difficulties maintaining proficiency in the skills of evidence collection and preservation (Littel, 2001; Logan, Cole & Capillo, 2007; Maier, 2012). These problems often become exacerbated in rural areas where SANE programs tend to be smaller and have less funding.

This study focuses on the work and perspectives of Sexual Assault Nurse Examiners employed in a rural area. Using interviews conducted with six SANE nurses from a hospital located in the upper Midwest, this project is an attempt to identify the barriers contributing to the low numbers of Sexual Assault Nurse Examiners in rural areas. It is my hope that future researchers may build upon this project by finding solutions to these barriers.

Before beginning however, it is necessary to define key terms related to this project. Throughout this work I use the terms *survivor* and *victim* interchangeably. Kathleen Barry (1979) states that “surviving is the other side of being a victim” (p. 39). This passage suggests that surviving a traumatic event is a journey that takes place sometime after victimization, and that has a definitive end. Barry also suggests that the term survivor, as opposed to victim, shifts the emphasis from woman’s passivity to her

agency and ability to move forward. While I appreciate the significance of Kathleen Barry's work in changing our conception of rape victims, I use both victim and survivor in this project. I do so because I recognize that those who have experienced sexual assault often use both terms. Perhaps more importantly, however, I use both victim and survivor in this research, because I believe the journey from victim to survivor is not always a linear progression (Jordan, 2013). Healing, as I have found, is an ongoing process, one that cannot be summarized by a simple evolution from victim to survivor.

It is also critically important that I define what I mean when I use the terms *sexual assault* and *rape*. The definitions of both sexual assault and rape have been heavily debated by all involved in anti-violence work including researchers, advocates, policy makers, practitioners, survivors, and feminists. Indeed, how researchers define "violence is one of the most important research decisions a methodologist will make" (DeKeseredy & Schwartz, 2011, p. 5). This is because the definitions we use to describe rape can have profound implications for "how rape is reported, treated, prevented, and even researched" (Hanser, 2005, p. 30).

In this project I use the term sexual assault as a broad term that includes many forms of unwanted sexual contact such as rape, unwanted genital touching or fondling, and even unwanted exposure to or participation in pornography. Rape is a legal term used in the United States to denote any penetration of a body orifice (mouth, vagina, or anus) with the use or threat of force or coercion, and without consent (Linden, 2011).

Throughout this project I use the terms sexual assault and rape interchangeably. I do so for two reasons. First, because rape is a form of sexual assault, and second, because those who seek SANE services may experience many kinds of sexual assault, not just rape.

Organization of Chapters

In chapter two I contextualize my research by providing a review of existing scholarship. The literature review consists of three main bodies of knowledge: feminist theories of rape, the feminist anti-rape movement, and the history and current status of SANE programs within the United States. The first section provides an overview of different feminist theories of rape as well as a discussion of rape culture. The section on the feminist anti-rape movement provides a brief overview of the historical development of the anti-rape movement as well as a discussion of the structural and legal changes generated by the movement. The third section reviews literature about the current state of SANE nursing.

The third chapter details my methodology. In it, I discuss the scope of my project and offer standpoint theory as the theoretical basis of my research. The methodology chapter also provides a detailed account of my research methods and a discussion of possible limitations present in the study. I also provide an explanation for the importance of practicing reflexivity in research and discuss my reasons for choosing this topic of study.

In chapter four I provide a detailed analysis of the themes that emerged in the interviews. Through this analysis, this chapter demonstrates the many challenges faced by Sexual Assault Nurse Examiners, and argues that SANE nursing, while growing in popularity, needs further study. Finally, chapter five concludes this project with a discussion of the importance of my findings. Here I suggest uses for my research including policy and procedural implications.

Chapter 2: Literature Review

The following literature review demonstrates that feminism has contributed greatly to society's understanding and analysis of, and struggle against, rape in the United States, and that Sexual Assault Nurse Examiner programs are a lasting and successful legacy of that struggle. Here I focus on providing an overview of feminist theories of rape, the feminist anti-rape movement and resulting policy, as well as the history and current status of SANE programs within the United States. This literature review provides both the historical and theoretical foundation for the current study. Additionally, this review aims to demonstrate that while feminist scholars have made tremendous gains in the development and implementation of SANE programs, there still remains much work to be done to improve them.

1. Feminist Theories of Sexual Assault

In order to understand the crucial role SANE programs play in the feminist struggle against sexual assault, we must first examine feminist theories of rape. This section reviews both liberal and radical feminist theories of rape. In a key step toward reconceptualizing society's understanding of rape, Susan Brownmiller (1975) rejects the notion that rape is motivated by sexual desire. Instead, Brownmiller suggests that rape be understood as violence motivated by a desire to dominate and degrade women. However, while Brownmiller's liberal feminist theory of the problem of rape aims to separate rape from normal sexual desire, some radical feminist theories suggest that all sex is rape because of the patriarchal context of heterosexual desire.

Feminist Responses to Rape

Rape as Violence

While feminist discourse concerning rape can be traced back to the first wave of the feminist movement, for the purposes of this study, I will focus on the theories of rape that developed during the second wave. One of the schools of thought concerning feminist theories of rape emerged out of the liberal feminist movement. According to Cahill (2001), liberal feminist theories of sexual assault can best be described with the statement “rape is violence not sex” (p. 2). Susan Brownmiller’s 1975 work, *Against Our Will: Men, Women, and Rape* epitomizes this liberal feminist stance on rape.

Brownmiller (1975) defines rape as “nothing more or less than a conscious process of intimidation by which *all men keep all women* in a state of fear²” (p. 15). Cahill (2001) suggests that Brownmiller’s definition of rape in *Against Our Will* serves two primary functions. The first function, according to Cahill, ensures the protection (possession) of women by men through the institution of marriage. The fear of rape, Cahill suggests, causes women to seek out marriage as a protection against rape. The second function of Brownmiller’s definition of rape is to describe women as property of the enemy during times of war. Brownmiller describes the rape of women during times of war in the following passage,

In each historic interlude a mob of men, sometimes an official militia, armed itself with an ideology that offered a moral justification—“for the public good”—to commit acts of degradation upon women. In each interlude a campaign of terror, and a goal that included the annihilation of a people, provided a license to rape. In

² Italics are in the original document.

each interlude the symbol of the mob's hatred and contempt became its exuberant destruction of *other men's property* be it furniture, cattle, or women. Further, it mattered little to the rapists...whether or not their victims were "attractive."
...[S]exual appeal, as we understand it, has little to do with the act or rape. (p. 124-125).

Thus, Brownmiller's definition succeeds by describing fear of rape as a control mechanism that limits women's participation in the public sphere. The definition also helps establish fear of rape as a process through which women become objects available for men to rape. However, the true success of Brownmiller's definition of rape comes from her ability to effectively separate rape from sexuality.

Brownmiller is able to separate rape from sexuality in the above passage by asserting that during times of war, men rape women not because of their sexual desire, but because women are viewed as the property of the male enemy. By demonstrating that men rape women independent of their victims' attractiveness, Brownmiller is able to claim that rape is not motivated by a man's desire for sex. Instead, she argues that men rape because of a desire for power and dominance over women. For Brownmiller (1975) then, rape becomes a "deliberate, hostile, violent act of degradation" (p. 391) completely separate from normal, healthy, sexual desire.

In response to liberal feminist theories of rape, and their use of the "rape is violence not sex" thesis, radical feminists offer their own theories. While the liberal feminist response is epitomized by Susan Brownmiller, it is the radical feminist theories of Andrea Dworkin and Catharine MacKinnon, and their claim that all sex is rape that exemplifies the radical feminist response to rape.

All Sex is Rape

Andrea Dworkin's (1979) work, *Pornography: Men Possessing Women* is a classic example of a radical feminist theory of rape. Similar to Susan Brownmiller's *Against Our Will*, Dworkin's work identifies the ability of men to impose fear of rape on women as a main component of the patriarchal system. However, while Brownmiller understands rape as separate from sexuality, Dworkin does not. Dworkin claims that all sex is rape because of the patriarchal context of heterosexual desire and draws her understanding of rape from an analysis of pornography.

Dworkin discovers that pornography often portrays women using degrading poses, showing them in pain, or being physically hurt. According to Dworkin this is to be expected, because men and the patriarchal culture have defined female sexuality in terms of masochism. According to the rules of patriarchy women like force, indeed they want force. Under this patriarchal definition of women's sexuality, force becomes sex and "[t]he woman who wants [heterosexual] sex wants force" (Dworkin, 1979, p. 164). Interestingly, under patriarchy, and according to the views expressed in pornography, violence becomes sex, pain becomes pleasure, not because of men, but because it is natural for women to enjoy abuse. Viewed from this perspective, "no woman, no matter how degraded she is by what she does is a victim" (Dworkin, 1979, p. 138). In short, men's use of force and women's suffering become invisible in a patriarchal society.

Although pornography is presented as a depiction of normal, healthy female sexuality, according to Dworkin, pornography actually documents several rapes. The first rape occurs when women are being photographed and another occurs every time the viewer consumes the photographs. Unfortunately, the patriarchal culture does not allow

women in pornography to be seen as victims. She points out that only women that are dead or badly beaten are allowed to be considered victims. So, because women appear to participate in pornography willingly the harm that they endure is indistinguishable and goes unacknowledged. Rape, in all its forms, becomes invisible in a patriarchal society (Dworkin, 1979).

Although Dworkin's theory of rape is important for her use of the "all sex is rape" thesis the true success of her theory is in its ability to explain why violence against women and girls goes unnoticed. Dworkin's theory critically analyzes the patriarchal culture and how women's sexuality has been manipulated as a result (Dworkin, 1979). When, as a culture, we believe that women secretly want to be raped or that they enjoy pain, it becomes easy to dismiss rape allegations as false. It is crucially important, therefore, that Sexual Assault Nurse Examiners receive training about patriarchy and gender roles in order to prevent them from reinforcing patriarchal views of victims.

Similar to Dworkin, Catharine MacKinnon also attacks the "rape as violence" thesis by examining the patriarchal context of sexual desire. As a lawyer, Catharine MacKinnon approaches her discussion of rape in her book *Toward a Feminist Theory of the State* (1989) from a legal perspective. According to MacKinnon (1989), rape under the law is defined as "intercourse with force or coercion and without consent" (p. 172). Using this generic legal definition, MacKinnon (1989) argues that because of male supremacy, this definition "assumes [a] sadomasochistic definition of sex: intercourse with force or coercion can be or become consensual" (p. 172). The problem then for MacKinnon becomes not how to distinguish normal sex from rape, but that we cannot distinguish the two. MacKinnon (1989) argues that because force is considered "normal

male sexual behavior” (p. 173) rape is within the context of normal heterosexual desire. In fact, it is the system of male supremacy and compulsory heterosexuality, through which all sex is understood, that makes a distinction between force, violence, and sexuality impossible (MacKinnon, 1989).

Cahill (2001) suggests that the radical perspectives of Dworkin and MacKinnon are flawed because of their inability to allow women to exercise sexual autonomy. However, Cahill (2001) agrees that Dworkin and MacKinnon are “right to draw links between compulsory heterosexuality and rape” (p. 37) but suggests that their theories identify the construction of heterosexual masculinity in such a way as to eliminate the possibility of female agency. However, I suggest that Dworkin and MacKinnon do not believe that *all* sex is rape, but only that heterosexual intimacy is violent. Same sex intimacy between women, as it exists outside heterosexual masculine sexuality, may not be seen as violence. I also suggest that MacKinnon’s theory of rape is useful, because it lends legitimacy to rape survivors’ experiences.

MacKinnon’s notion that we cannot distinguish between normal sex and rape is reflected in many victims’ experiences. Victims often do not know if they were raped and seek out sexual assault care in an attempt to find answers. Sexual Assault Nurse Examiners also encounter difficulties distinguishing rape from normal sexual activity. Although Sexual Assault Nurse Examiners cannot tell a victim definitively if they were raped, the presence and acceptance of violence against women makes SANE work more difficult.

Like Dworkin, Diana Russell also identifies pornography as a form of violence against women. However, Russell expands Dworkin’s attacks on pornography by

suggesting that pornography does not just resemble or represent rape, but that pornography may actually lead men to rape. Russell (2001) admits that some men that use pornography do not rape women. However, she also suggests that pornography has the power to “predispose men to want to rape, subdues some men’s internal inhibitions against acting out their desire to rape, and subdues some men’s social inhibitions against acting out their desire to rape” (p. 62). While I think it is an exaggeration to suggest that pornography causes rape, I agree with Russell’s general conclusion that pornography actively maintains rape culture³. The violent nature of pornography and the way in which pornography conflates violence with sex makes pornography a vital part of rape culture.

Radical Theories Lead to Radical Responses

Beginning in 1983, Andrea Dworkin and Catharine MacKinnon began drafting an ordinance to ban pornography in Minneapolis, Minnesota. Later the following year, their “anti-porn” ordinance was passed by the city council but quickly vetoed by then mayor, Donald Fraser. Not to be deterred however, Dworkin and MacKinnon took a revised version of their ordinance to Indianapolis, Indiana. There, the revised version was passed, signed into law, but ultimately defeated and declared unconstitutional (Bevacqua, 2000; Dugan & Hunter, 1995).

Although the ordinances were defeated, they represent a major turning point in the mainstream acceptance of rape and sexual assault. The ordinances in part described pornography as

the graphic sexually explicit subordination of women, whether in picture or words, that includes [...] women presented as dehumanized as sexual objects [...]

³ For a discussion of rape culture see the section titled Rape Culture below.

who enjoy pain or humiliation; or women are presented as sexual objects who experience sexual pleasure in being raped; or women are presented as sexual objects tied up or cut up or mutilated or bruised or physically hurt [...] in a context that makes these conditions sexual (Bevacqua, 2000, p. 179).

By framing women as sexual objects, the ordinances succeed in presenting pornography as a dehumanizing medium, one that strips women of their identity, and transforms them into empty generic symbols of the female. In this way, pornography transforms ordinary women from human beings into objects that become “rapeable.”

It is important to have an understanding of both liberal and radical feminist theories of rape, because they inform current SANE practice. The liberal feminist “rape is violence not sex” thesis dramatically transformed sexual assault care. As a result, rape survivors are seen as victims of a crime that deserves serious medical and forensic attention. Radical feminist theorizing about the patriarchal context of sexual assault has also greatly influenced SANE care. As a result, many SANEs may now understand that rape is not a private individual matter, but one that is deeply connected to the larger culture. Understanding rape as violence also allows SANEs to experience compassion for their patients and provide them with sensitive care.

Rape Culture

The problem of rape in the United States did not emerge in a vacuum. In fact, it is the very culture women live in that perpetuates this violence. Some scholars have termed the modern culture a “rape culture.” Buchwald, Fletcher, and Roth (2005) explain that rape culture is “a complex of beliefs that encourages male sexual aggression and supports violence against women” (p. xi). Bevacqua (2000) widens the scope of this definition of

rape culture to include the prevalence of sexist attitudes, victim blaming, and male privilege. One key factor of rape culture is that “both men and women assume that sexual violence is a fact of life” (Buchwald, Fletcher, & Roth, 2005, p. xi). As a result, women begin to internalize these beliefs and live in a state of fear of sexual violence. In fact, Buchwald, Fletcher, and Roth (2005) liken women’s fear of rape to a form of emotional terrorism.

In an early exploration of rape culture, Gordon and Riger (1989) explain this unique burden of female fear. “This special fear, this added burden...is a feeling women are never totally free of, and it can, from time to time, terrorize them” (p. 2). This terror limits women’s movement and participation in public space. In addition to the fear of rape women know that they are responsible for avoiding rape and will be blamed if they are victimized (Gordon & Riger, 1989). While Gordon and Riger’s work is groundbreaking for its serious examination of rape and female fear, the work falls short in two critical areas. *Female Fear* omits any serious consideration of black women’s experiences of rape and fails to identify possible solutions to rape culture.

Like other second wave feminist writing of the period, Gordon and Riger’s *Female Fear* ignores women of color. In fact, the only mention of the experiences of women of color is in the second chapter, titled *The Pervasiveness of Female Fear*. The authors state that according to their data, women of color feel the least safe when outside alone. While the authors suggest that this may be due to factors related to neighborhood location, no serious intersectional analysis is present in the work. Fortunately, black feminists correct this oversight in their scholarship.

An intersectional analysis⁴ is important when working to understand the experiences of rape victims. Failing to consider a victim's many identities and how they intersect to create a unique experience of violence may result in poor patient outcomes (Collins, 1986; Crenshaw, 1991; Davis, 1983; hooks, 1981). Considering the age, race, social class, religion, and sexual orientation of a victim for example, will allow the examiner to provide more complete care that is right for the patient.

Other scholars expand on *Female Fear* by looking for the cause of rape culture. Researchers have called into question male biases in language, the masculine gender role and male sexuality, and the influence of violent, sexist media on young boys (Benedict, 2005; Kimmel, 2005; Meidzian, 2005). In the process of theorizing the cause of rape culture, these scholars have also illuminated possibilities of change. Benedict (2005) suggests that we work to change media representations of women and girls to include images of equality and compassion. Benedict suggests, for example, that the media ought to portray victims as ordinary people instead of "whores." Benedict also suggests that the media depict sex crimes as horrible events instead of titillating spectacles. Others suggest that masculinity must be redefined to include expressions of sensitivity, nurturing, and caregiving to allow men to develop definitions of male sexuality that do not include dominance, aggression, and rape (Kimmel, 2005; Meidzian, 2005).

Rape culture is an important aspect to analyze when trying to understand why sexual assault is so prevalent. If SANEs are to treat sexual assault patients effectively they need an understanding of rape culture. Knowing how society is structured to maintain, condone, and excuse violence against women is particularly helpful when

⁴ For an explanation of intersectionality see the section titled Black Feminist Responses below.

supporting survivors. An understanding of rape culture, for example, may allow SANEs to challenge self-blame or feelings of guilt on the part of the patient.

White second wave feminists dismissed the experiences of rape and sexual assault by women of color. In response, black feminists produced their own theories of sexual assault. Black feminist theories of sexual assault expand on the work of their white feminist colleagues by adding a critical race analysis to discussions of rape. Black feminists understand the rape of black women (past and present) as a mechanism of institutionalized racial oppression. As a whole, black feminist theories of rape suggest that the rape of black women upholds the tiered system of racial hierarchy by subordinating black female bodies. In the following section, the black feminist theories of bell hooks, Angela Davis, Kimberlé Crenshaw, and Patricia Hill Collins are discussed.

Black Feminist Responses to Sexual Assault

Black feminist discussions of rape often include an analysis of black women's experiences during slavery. hooks' (1981) discussion of rape in *Ain't I a Woman: Black Women and Feminism* takes a critical look at the meaning of rape for women of color. hooks suggests that the mass rape of black women during slavery continues to have political and social meaning for women of color today. In fact, hooks suggests that the rape of black women during slavery "led to a devaluation of black womanhood that permeate[s] the psyches of all Americans and shape[s] the social status of all black women" today (hooks, 1981, p. 52). The contemporary rape of black women then, is a direct result of the racist-sexist subordination black women experienced during slavery. I

suggest that that the continued rape of black women is a physical indicator that black women continue to be devalued by the white-supremacist patriarchy.

Sexual Assault Nurse Examiners might also benefit from training related to generational trauma in order to better understand and treat women of color and their families. Generational trauma is defined as “a secondary form of trauma that results from the transfer of traumatic experiences from parents to their children” (Doucet & Rovers, 2010, p. 94). This may be particularly important for Sexual Assault Nurse Examiners working on or near a reservation, because Native American populations experience a high rate of sexual assault and may also suffer from the effects of generational trauma (The White House Council on Women and Girls, 2014).

Angela Davis also examines the history of black women’s experiences of rape during slavery in her (1983) work *Women, Race and Class*. Much like hooks, Davis identifies the rape of black women during slavery as a form of racial subordination and argues that “racism instigate[s] rape” (Davis, 1983, p. 177) of black women. This point is significant, because it moves her to a consideration of the unique burden placed on women of color. Similar to hooks’ discussion of the racist-sexist motivations of rape in the slave South, Davis also identifies how race and gender intersect to oppress women of color. Doubly oppressed by race and gender, rape is an ever-present threat to women of color, because the violence may be motivated by either identity category. The success of Davis’s work then, is the understanding that the lives of black women, and their experience of rape, must be analyzed from the intersection of race and gender. In order to end the rape of women of color Davis claims feminists must craft an intersectional approach that fights against sexist and racist oppression simultaneously (Davis, 1983).

Kimberlé Crenshaw's (1991) article, *Mapping the Margins Intersectionality, Identity Politics, and Violence Against Women of Color*, defines an intersectional approach to the analysis of black women's experiences of rape. Intersectionality theory states that each individual occupies multiple identity categories that overlap and create a unique, simultaneous experience of privilege and oppression. Crenshaw (1991) focuses on "mapping the intersections of race and gender" (p. 1244) but suggests that the intersections of other identity categories such as class, sexual orientation, age, and color also be examined. Crenshaw's analysis of black women's experiences of rape demonstrate that "women of color are differently situated in the economic, social and political worlds" (p. 1250). This unique social location creates a unique experience of rape and battering. This is particularly important to consider when trying to form SANE programs that can respond to the specific needs of communities of color. In order to help ensure SANE nurses are able to respond to the specific needs of women of color, SANEs should receive cultural competency training.

Liberal and radical feminists, as well as feminists of color, have developed their own theories of rape. They have worked tirelessly to name female fear of rape, to name our culture as a rape culture, to explain the causes of rape, and to place rape within the larger historical context of racial and gendered oppression. These theories helped shape a new social movement dedicated to the elimination of rape and sexual assault known as the anti-rape movement.

2. Feminist Anti-Rape Movement

According to Maria Bevacqua (2000) in her work titled *Rape on the Public Agenda: Feminism and the Politics of Sexual Assault*, the anti-rape movement emerged

out of the second wave of the women's movement of the mid-1960s and 1970s. Beginning around 1970, the feminist movement began politicizing issues of rape and violence against women (Bevacqua, 2000). Also around this time, the feminist debates known as the "sex wars" (p. 176) began. Bevacqua (2000) states that the "sex wars" (p. 176) can be traced back to early radical feminist challenges of violence against women in all its forms. Radical feminists who opposed pornography and sadomasochism because they were thought to degrade women were on one side of the debate, while "pro sex" (p. 176) feminists were on the other side. Feminist activists at the time took part in both anti-rape and sex wars activities and protests, and in fact, the movements are often conflated. Dianna Russell describes the connection between the anti-rape movement and the sex wars by stating that, "while [the anti-rape movement] is busy helping survivors, the billion dollar pornography industry continues to encourage increasing numbers of men to act out their rape desires" (Russell, 2001, p. 86). Thus, anti-rape efforts of the period were intimately tied to much of the anti-porn activism of the sex wars.

The anti-rape movement fits within the larger context of the sex wars because, as the above quote demonstrates, the sex wars brought discussions of "violence against women, pornography, and power to the forefront of public discourses" (Bevacqua, 2000, p. 176). The anti-rape movement began with the goal of changing both societal and state treatment of rape and rape survivors. Feminist activists were particularly successful in mobilizing the anti-rape movement and quickly achieved considerable success in the form of policy and institutional reform (Gornick & Meyer, 1998). This section reviews the historical development and structural changes garnered by the anti-rape movement.

Historical Development and Early Organizing

Nancy Mathews' (1994) work *Confronting Rape: The Feminist Anti-Rape Movement and the State* suggests that the anti-rape movement was founded on two basic principles 1) that violence against women is fundamental to women's oppression and domination and 2) that as a group, women can effect change by helping victims of violence find empowerment (Mathews, 1994, p. xii). Bevacqua (2000) expands on these principles to include the core tenant that rape is about violence not sex. Both Mathews and Bevacqua suggest that radical feminists were among the first to recognize violence against women as a widespread problem through their use of consciousness-raising groups. Consciousness-raising is a method of discussion through which women "talk freely about their frustrations and [the] restrictions they faced in their daily lives" (Harlan, 1998, p. 4). Once radical feminist groups recognized the pervasive nature of violence in women's lives, they quickly went to work organizing against it.

Attempts to protect women from attack were among the first anti-rape organizing efforts that took place. As early as 1969, the radical feminist organization Cell 16 began practicing martial arts in an effort to protect its members from sexual assault. Cell 16 distributed a poster that became popular in anti-rape circles. The poster depicted a woman kicking a man in the groin, with text that read "Disarm Rapists: Smash sexism" (Bevacqua 2000, p. 31). The popularity of self-defense grew and by 1973, martial arts were promoted by the larger women's movement as a primary method to prevent sexual assault (Bevacqua 2000).

Spread through a vast network of feminist periodicals, the anti-rape movement and related organizations continued to grow. The New York Radical Feminists (NYRF)

organized the first Speak Out against violence against women on January, 24th 1971. A conference addressing rape followed in April 1971 and a flurry of feminist theorizing about rape took off. Bay Area Women Against Rape (BAWA) organized and distributed packets of information on hitchhiking safety, as well as medical information for rape victims and advocates. The packets contained information about what one could expect at a hospital, as well as information about pregnancy, abortion, STI's and therapy (Bevacqua, 2000; Mathews, 1994).

Bevacqua (2000) also discusses Take Back the Night (TBN) as one of the most enduring examples of anti-rape activism. Through their use of consciousness-raising groups, radical feminists discovered that as a group, women fear being outside at night, and that fear of rape specifically prevented women from enjoying the freedom of going out at night. TBN was designed as a march where both women and men gather at night and take to the streets in solidarity. The march is designed to symbolically reclaim the night as a space for women. The concept of taking back the street originated in a 1971 radical feminist pamphlet titled *Stop Rape*. The text of the pamphlet reads,

Women have lost a basic civil liberty—the right to be on the street—going to a neighbors, to the store, or just for a walk...she is usually clutching her belongings and rushing for fear of potential dangers, especially rape. She can walk calmly only when she is accompanied and protected by a male (p. 71).

This excerpt demonstrates that radical feminists articulated the notion of female fear of rape four years before Susan Brownmiller's groundbreaking work. The group developed a technique called "reinstating the evening walk" (Bevacqua, 2000, p. 71) that involved a

group of women coming together to patrol the streets. Women would use this technique to offer others safe escorts and to look out for suspicious behavior (Bevacqua, 2000).

Since its development, Take Back the Night has grown into an international event and a nonprofit organization. Each year across the country hundreds of college campuses engage in a TBN march to draw attention to various forms of violence against women. TBN marches now include efforts to end sexual violence in all its forms. Although Take Back the Night no longer specifically focuses on rape, the march still draws attention to the fear women feel while outside at night (Take Back the Night Foundation, 2014) and is a lasting legacy of anti-rape organizing.

Rape Crisis Centers and the Professionalization of Rape Crisis Work

As part of their anti-rape organizing, radical feminists also developed the first rape crisis centers (RCCs) in the United States. RCCs were designed to help rape victims that had been treated unfairly by the patriarchal society. Today there are over 1,200 organizations across the United States that provide rape crisis services. A variety of other programs have also been developed in recent decades that provide education and prevention services geared toward raising awareness for sexual assault (Bergen & Maier, 2011).

According to Gornick and Meyer (1998) radical feminists were among the first to develop rape crisis centers. The first rape crisis centers opened simultaneously in cities across the nation in the spring of 1972 including Berkley, Chicago, Detroit, Washington DC, Philadelphia and Seattle. Early RCCs shared the following characteristics 1) they were organized as collectives with nonhierarchical structures 2) they provided direct

services to survivors and 3) participated in political activism aimed at changing the patriarchal society (Gornick & Meyer, 1998).

Early rape crisis centers offered a variety of services to survivors and the community. Direct services to survivors included hotline and in-person counseling, victim advocacy, and accompaniment to hospitals and police stations. They also engaged the community by passing out pamphlets and flyers about rape and sexual assault. The services early RCCs offered were not only designed to help survivors in crisis but were focused on an underlying commitment to eliminate rape and secure legislative reform for better services for survivors (Bergen & Maier, 2011).

Wary of local institutions, early RCCs operated independently from the police, hospitals, and court systems as they were seen as responsible for revictimizing rape survivors. While working independently from traditional institutions, rape crisis centers were able to affect change. They lobbied to modify sexual assault laws and increase victim rights, and in the process they raised awareness for violence against women. But, as the 1970s and 1980s progressed rape crisis centers began shifting from a grassroots organizational mode to a professionalized model dependent on funding (Mathews, 1994).

Unfortunately, many of the rape crisis services that are offered today no longer operate from the radical feminist perspective utilized by early rape crisis centers. Over time, rape crisis work has shifted away from the radical grassroots organizational model to a professionalized model. The process of professionalization resulted in the loss of the radical principles and the critical gender analysis common to early rape crisis centers (Gornick & Meyer, 1998).

As founding members of RCCs began to tire and leave after years of struggle, many centers began accepting money from state, government, and law enforcement agencies. As a result, RCCs became more professionalized in an attempt to meet the desires of funders. Instead of relying on volunteers, for example, second-generation rape crisis centers began to hire paid professionals. Second-generation rape crisis centers also became more bureaucratic as they were encouraged to develop formal policies and procedures for all employees and volunteers (Mathews, 1994). After receiving public funding, rape crisis centers also became less radical and began reducing their level of political activism.

As a result of the professionalization of rape crisis work and the collaboration with state and federal funding agencies, rape crisis centers can no longer criticize the services offered by these institutions out of fear of losing funding (Martin, 2005). The threat of losing funding also prevents many RCCs from actively engaging in protests and lobby activities. So, although current rape crisis centers still offer many of the same services traditional RCCs offered (like hotline services, in-person counseling, and accompaniment to police stations and hospitals), modern centers rarely engage in political activism (Wasco, 2004).

As this history demonstrates, RCCs began as a radical mechanism for social change, but through the process of professionalization and bureaucratization they have lost their radical edge. Relying on external funding forced many RCCs to change their model of service delivery, limit the services they provided, and the activities they were able to engage in. However, it is important to note that while professionalization of rape crisis work has its drawbacks, it also represents an important shift in society's awareness

of rape. I suggest that the professionalization of rape crisis work shows that it is valued by the economy and by society.

The effects of professionalization and bureaucratization on RCCs are important because they may provide useful lessons for Sexual Assault Nurse Examiner programs. Many Sexual Assault Nurse Examiner programs operate out of hospital emergency departments. As such, they often rely on the hospital system for funding. But, as the history of rape crisis centers suggest, relying on external funding may limit SANE programs from taking a more radical approach to service delivery. Relying on external funding can also limit what SANE programs can do because of how hospitals allot funds. Research shows for example, that SANE programs often struggle to participate in community education and outreach activities because of a lack of funding (Logan, Cole, & Capillo, 2007). If administration does not view political engagement and community education as valuable, SANE programs will not have the funds to engage in these activities.

3. History and Current Status of SANE Programs in the US

History of SANE Programs

As previously stated, the first Sexual Assault Nurse Examiner (SANE) program was established in 1976 in Memphis, Tennessee. Inspired by the feminist anti-rape movement, the program was created with the explicit purpose of correcting the failures of local hospitals. Critics and feminist anti-rape activists at the time came forward claiming that sexual assault victims received poor and often inadequate services at local emergency departments (Bergen & Maier, 2011; Campbell, Patterson & Lichty, 2005). Victims that reported to emergency departments often experienced long waits that could

last four to twelve hours (Littel, 2001; O'Connor, 2009). Patients also experienced revictimization and a result of the examination experience. SANE programs were created to address these problems and to provide victim-centered care that includes emotional support and referrals to outside services (Ledray, 1995; Littel, 2001).

By the 1990s, SANE programs had sprung up in hundreds of cities across the nation (Littel, 2001). The rapid growth of SANE programs led to the first international meeting of SANEs in 1992. The meeting was held with representatives from SANE programs across the United States and Canada. From this meeting the International Association for Forensic Nurses (IAFN) was formed which strives to advance the practice of forensic nursing. Two years later the American Nursing Association formally recognized forensic nursing as a specialty in nursing (Campbell, Patterson & Litchy, 2005). SANE programs have grown rapidly in number, and vary greatly by size, location, procedures, tools, and guiding principles. In recognition of the variety in SANE programing, researchers and advocates have worked tirelessly to produce a body of knowledge documenting, analyzing, comparing and improving SANE programs (Campbell, Townsend, Long & Kinnison, 2005; Ledray, 1995; Littel, 2001; Long, Cole, & Capillo, 2007).

In 2004, the federal government helped consolidate the vast body of knowledge about sexual assault forensic examinations into the first official set of guidelines and recommendations for SANE programs. The protocol was revised and updated in April 2013. The report titled, *A National Protocol for Sexual Assault Medical Forensic Examinations* (U.S. Dept. of Justice), summarizes the research on forensic nursing and outlines guidelines for best practices when conducting a sexual assault forensic exam.

Key recommendations for SANE programs and practitioners include 1) utilizing a coordinated SART team approach to sexual assault care 2) employing a victim-centered approach to care by giving sexual assault patients priority in emergency rooms and tailoring the exam process to the needs of the patient 3) and ensuring the patient is able to make informed decisions about whether to accept or decline a procedure (US Department of Justice, 2013).

The protocol also makes it clear that a Sexual Assault Nurse Examiner's primary responsibility is to the patient, and as such, they should address all of the patient's physical and emotional health care needs first. The second responsibility is to collect forensic evidence when appropriate (US Department of Justice, 2013). This is an important distinction to be made, because although evidence collection is important to the profession, it is ultimately the care of patients that takes precedence. The responsibilities of SANE nurses include conducting prompt examinations, providing support, crisis intervention, and advocacy, documenting exam findings, evaluating and treating injuries, properly collecting, handling, and preserving potential evidence, and providing information, treatment, and referrals for STIs, pregnancy, and follow up care. In addition, SANE nurses must also provide follow up care for the emotional needs of the client (U.S. Department of Justice, 2013).

The recommendations and best practices outlined in the protocol represent how far sexual assault care has come since the 1970s. Although Sexual Assault care and forensic nursing is relatively new, research about SANE programs have shown that they are beneficial to rape and sexual assault survivors. I also argue that the protocol

represents mainstream acceptance of sexual assault forensic care and a formal recognition of Sexual Assault Forensic Nursing.

Effectiveness of SANE Programs

Although a large portion of the empirical literature about Sexual Assault Nurse Examiner programs has been descriptive in nature, the existing research has demonstrated that Sexual Assault Nurse Examiner programs have made a tremendous impact on the quality of care provided to sexual assault survivors (Littel, 2001; O'Connor, 2009; Campbell, Patterson & Litchy, 2005). Campbell, Patterson and Litchy (2005) reviewed the effectiveness of SANE programs on five domains: psychological recovery of patients, comprehensive medical care, accurate collection and documentation of evidence, improving prosecutions, and creating community change. Results from the study suggest that SANE programs are effective in all of these areas. However, the author cautions that most published studies have “not included adequate methodological controls” (Campbell, Patterson & Litchy, 2005, p. 314) to test their effectiveness. The author also cautions that because SANE programs vary in their institutional goals making generalizations may be difficult. Despite the reservations present in this article, other researchers echo these findings.

Other research also suggests that SANE programs improve rape survivors' experiences with medical and legal personnel (Campbell, Patterson & Litchy, 2005; Littel, 2001). Patients tend to wait for shorter periods in emergency rooms and receive a higher quality of evidence collection from SANEs as compared to emergency room providers (Campbell, Patterson, Bybee, & Dworkin, 2009; Littel, 2001). SANE programs also help reduce revictimization and facilitate the healing process by humanizing the

examination experience (Fehler-Cabral, Campbell, & Patterson, 2011; Littel, 2001). SANEs accomplish this by providing “survivors with care and compassion, clear explanations of procedures, and choices” (Fehler, Campbell & Patterson, 2011, p. 3618). SANE programs that provide explanations of what will occur prior to the exam, as well as explanations of each step and any injuries that are identified help survivors feel in control during the exam. Results also suggest that when SANEs provide choices about whether to continue the exam or to complete certain parts of the exam it helps convey respect to survivors (Fehler, Campbell & Patterson, 2011).

While most of the literature about SANE nursing is positive in nature, Sameena Mulla’s 2014 work, *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention* focuses primarily on the harm sexual assault care can inflict on the patient. Set in a Baltimore hospital, she studies the practices of forensic nursing and demonstrates how it violates the patient and perpetuates experiences of revictimization. She states “if...I can characterize many nurses’ primary allegiance as being to the criminal justice system then this leaves the victim’s personal journey toward justice as a secondary priority for the forensic nurse” (p. 224). Thus, according to Mulla, SANEs revictimize sexual assault patients by focusing on the legal aspects of their work and neglecting the patient.

While it is true that SANEs collect evidence that may be used during court proceedings, I believe the characterization of SANEs as having primarily legal rather than medical priorities is false. Mulla’s characterization of SANE work is especially interesting, because it contradicts the 2013 *National Protocol for Sexual Assault Medical Forensic Examinations* (U.S. Dept. of Justice). As stated above, the report claims that

Sexual Assault Nurse Examiner's primary responsibility is to the patient. As such, SANEs primary objective is to secure the physical and emotional well-being of the patient. Mulla's work also contradicts findings that I will discuss in my analysis.

Not only are SANE programs beneficial to the patient, they have also been shown to benefit the legal system. SANE programs have been shown to increase prosecution and arrest rates of rape cases (Aiken & Speck, 1995; Littel, 2001). Research also suggests that SANE programs increase the rate of plea bargains when defendants are faced with the detailed evidence collected by Sexual Assault Nurse Examiners (Campbell, Patterson, & Bybee, 2012). Testimony from Sexual Assault Nurse Examiners has also been shown to increase conviction rates (Ledray, 1999). While the existing literature is promising, most of the research investigating how SANE program implementation effects the criminal justice system have used case study designs. Case study designs do not allow casual inferences to be made, so more research is needed in this area.

It is clear that more empirical research that tests the effectiveness of SANE programs is needed. However, the existing literature shows that Sexual Assault Nurse Examiner programs provide substantial benefits for sexual assault victims. The compassionate care that SANEs provide is emotionally beneficial to survivors. SANEs help victims feel at in control, emotionally supported, believed, and comforted (Du Mont, White, & McGregor, 2009).

Challenges Faced by SANE Programs

SANE programs experience a variety of difficulties. However, research on SANE programs demonstrates that some difficulties are more common than others. The most

common difficulties SANE programs face include emotional challenges, staffing concerns, and funding issues.

Emotional Challenges

Research by Shana L. Maier (2011) suggests that SANEs experience vicarious trauma and burn out as a result of their work with sexual assault victims. The study reveals that the majority of SANEs in her sample (51percent) discuss feelings of vicarious trauma as a result of being exposed to repeated detailed accounts of rape. Symptoms of vicarious trauma in SANEs include “crying, feeling sorry for themselves, feeling helpless, looking at the world differently, feeling frustrated, feeling preoccupied with work, wanting to resign as a SANE, and having difficulty sleeping” (Maier, 2011, p. 166). These findings are useful, because they suggest that a majority of SANEs may experience symptoms of vicarious trauma. Although the women in this study reported having good support systems in place to cope with trauma, these findings speak to the importance of having formal training on vicarious trauma and self-care for SANEs.

Maier (2011) also highlights the importance of recognizing burnout as a challenge for SANE nurses. She describes burnout as similar to vicarious trauma but more severe, because it leads individuals to contemplate leaving their work. Burnout is “the psychological statin of working with troubled populations” (Maier, 2011, p. 167). Symptoms include “depression, emotional exhaustion, reduced feelings of accomplishment, apathy, loss of compassion, and cynicism” (Maier, 2011, p. 167). In her sample, 46 percent of SANEs expressed feeling burned out at some point in their career. Causes of burnout included the inability to take time off and exposure to particularly violent sexual assault cases.

Understanding that burnout may cause some SANE nurses to consider leaving the profession is particularly important for rural SANE programs where providing sexual assault services can already be difficult. Research demonstrates that there is a global nurse shortage, and that the shortage is more acute in rural areas (Mbemba, Gagon, Pare, & Cote, 2013). It is therefore reasonable to conclude that the overall nursing shortage in rural areas manifests itself in a shortage of SANEs in rural areas. In addition to the nursing shortage, rural SANE programs are often located long distances away. Nurses and patients must travel long distances often through isolated areas in order to reach a hospital (Bergen & Maier, 2011). These concerns make it vitally important the hospitals find ways to retain the Sexual Assault Nurse Examiners currently working in rural locations. Finding ways to reduce burnout in rural SANEs may be key to rural SANE program success and longevity.

Staffing Challenges

Research by Logan, Cole, and Capillo (2007) demonstrates that SANE programs also face a variety of challenges related to staffing and scheduling. The study suggests that staffing issues like recruitment of qualified staff, retention of staff, and scheduling are among the most pressing concerns for SANE programs. It is interesting to note that burnout is listed as a contributing factor to staffing issues. In so doing, this study provides a depth of understanding to how challenges overlap and effect one another.

Understanding the interconnected nature of the changes faced by SANE programs can help future researchers solve the problems more effectively. SANEs in the study suggest that staffing concerns can be ameliorated with two simple solutions: increasing the overall number of SANE trained personnel and increasing compensation for SANE

nurses. SANE programs may find both of these solutions difficult because of their concerns related to funding.

Funding Challenges

Funding is essential to SANE program development and service delivery (Ledray, 1999; Littel, 2001). Research suggests that SANE programs may have to secure funding from a variety of sources in order to be able to support the work (Littel, 2001).

Additionally, funding issues make it difficult for SANE programs to deal effectively with other challenges. Staffing challenges become more difficult for example, because the program may not have the funds to hire, train, and compensate more examiners.

Thankfully, there is hope for SANE programs struggling with funding concerns. The third reauthorization of the Violence Against Women Act has set aside funds specifically for Sexual Assault Nurse Examiner Programs and SART teams. SANE programs are a valuable component of SART teams (White House Council on Women and Girls, 2014). Interestingly, although VAWA has dedicated funding for violence prevention and SANE programs, there is concern that VAWA may add to the struggles SANE programs experience.

Many involved in sexual assault advocacy criticize VAWA for its focus on law enforcement as the primary tool to manage violence. The Violence Against Women Act encourages a pro-arrest stance to domestic violence (Cho & Wilke, 2005). Since the passage of VAWA mandatory arrest laws—laws that require police officers to arrest an abuser—have increased. Feminists and victim advocates have been critical of mandatory arrest policies and VAWA's encouragement of their use, because they worry that mandatory arrest policies may make victims of violence less likely to seek help from

police (Miller, Iovanni & Kelly, 2011). I suggest however, that the emphasis on mandatory arrest policies is relevant to SANE services as well, because victims of sexual abuse may be reluctant to seek help at hospitals out of fear that SANEs will report the abuse to law enforcement.

Conclusion

This literature review demonstrates how both feminist theorizing and anti-rape activism came together to change the lives of rape and sexual assault survivors. Without their painstaking efforts rape and sexual assault victims might still be subject to traumatizing experiences at the hands of hospital personnel. Although the treatment of sexual assault survivors has greatly improved, much work remains to be done. This literature review has demonstrated that there is still a need for studies about SANE programs and Sexual Assault Nurse Examiners. The goal of this research is to show how Sexual Assault Nurse Examiners working in a rural environment think and feel about their work. Ultimately I aim to shed light on the particular struggles rural SANE nurses face in the hopes of finding ways to improve rural SANE nurse experiences and rural SANE service delivery.

Chapter 3: Methodology

While working as a Crisis Advocate at a women's shelter in a rural area of the Midwest, I learned of the difficulties rural SANE programs often face as a result of not having enough examiners. Coworkers told me stories about transporting rape victims to other hospitals, often hours away, because the local SANE program could not locate an examiner. I also learned that victims in my community regularly waited hours to receive the necessary care. These experiences led me to question how the numbers of SANEs could be increased in rural areas as well as how SANEs currently working in rural areas think and feel about their work. In order to answer these questions and to more fully understand the experiences and perspectives of SANEs in rural communities, I chose to conduct interviews with SANEs working at a hospital located in the rural upper Midwest.⁵

The purpose of this study is to determine Sexual Assault Nurse Examiner's perceptions of the challenges faced by SANE programs in rural communities and how these challenges may contribute to their low representation in rural areas. I hypothesized that SANE nurses encounter a number of barriers that contribute either directly or indirectly to their low representation in rural communities ranging from burnout, stress, and high workload to lack of support from hospital administration. It is my hope that gathering this data will allow future researchers to work to eliminate these barriers thereby increasing the numbers of SANEs working in rural communities.

⁵ While the city in which the hospital is located has a mid-sized population, all of the surrounding areas in the county and adjacent counties that the SANE program serves are considered rural.

Theoretical Framework

Standpoint theory is the major theoretical influence of my work, specially the work of Donna Haraway (1988) and Sandra Harding (1996). Standpoint theory is a “general approach within feminism that argues for the importance of situating knowledge in women’s experiences” (Hesse-Biber, 2014, p. 24). Harding (1996) explains that because society is stratified by varying identities like race, ethnicity, and gender some individuals find themselves on the top of the social hierarchy, while others experience marginalization. Harding also claims that the experience of being on top limits one’s ability to understand the true nature of reality. In contrast, the experience of marginalization, or the view from below, allows relationships of power to become visible. Viewed in this way, women’s (and other oppressed group’s) experiences are important because they provide researchers with new perspectives from which to create knowledge. Specifically, Harding (1996) claims that it is the experience of marginalization that creates women’s unique standpoint and provides for new and unexplored problems to be solved. Borrowing heavily from Donna Haraway’s understanding of situated knowledge, and Sandra Harding’s claim that “all knowledge attempts are socially situated” (Harding, 1996, p. 242), I believe that SANE nurses also occupy a particular social location that gives them an interesting standpoint from which to create new knowledge. Additionally, Harding’s claim that the location, experience, and lives of marginalized people can provide new starting points for knowledge lends credibility to my belief that SANEs working in rural areas have a particular situated knowledge that is useful to creating new policies, legislation, and practices related to SANE nursing (Harding, 1996).

As women, the SANEs I interviewed already occupy a marginalized location within society, but as nurses they also occupy a subordinate position within the hierarchy of the hospital in comparison to doctors and administrators. Additionally, their work providing direct care to sexual assault survivors places them in a unique position. It is the intersection of these marginalized identities (as women and as nurses that provide care to sexual assault victims) that creates a particularly unique and interesting location to be examined.

Standpoint theory helps identify the complex “insider-outsider” status Sexual Assault Nurse Examiners occupy within the health system. SANEs exist at the intersection of both the medical and legal professions. Trained in both the art of patient care and the science of evidence collection, SANEs can be understood as “outsiders within” (Collins, 1986, p. S14) the institution of medicine. Patricia Hill Collins developed the concept of the outsider within to describe and articulate the experiences of black feminist scholars within the white academy. Collins describes how her status as an intellectual affords her an insider view of the academy. However, her interlocking identities as a black woman mark her as an outsider in the largely white male world of high education. To be an outsider within then is to simultaneously occupy two locations, one that belongs and one that does not. This duality, according to Collins, is significant because it allows for the creation of new knowledge from this unique standpoint (Collins, 1986). This project is an attempt to create new knowledge based on the outsider within status of the Sexual Assault Nurse Examiner.

It is also possible that some nurses in my sample are survivors of sexual assault themselves, making them at once an insider and an outsider. It is vital to understand the

unique, multi-situated standpoint of SANEs in order to appreciate their experiences within the medico-legal system. In turn, this information will provide stakeholders with valuable information that can be used to improve procedures, services, legislation, and more.

Procedures

In order to be interviewed for this study, research participants must 1) have current licensure as a registered nurse with additional training as a SANE, and 2) be employed as a SANE in a rural area at the time of the interview. The sample included six Sexual Assault Nurse Examiners from a local hospital. Although the sample may be small, only fourteen SANEs serve the area under investigation. Therefore, the six SANEs included in the sample represent 43 percent of the total regional SANE population.

Participants were recruited through contact and snowball sampling. Flyers (Appendix 1) were shared with the Regional Manager of the SANE program who in turn passed them on to her staff of SANEs. Interested participants contacted me via email or telephone. I was also invited by the Regional Manager to attend a SANE staff meeting. During this meeting, I used my recruitment script (Appendix 2) to explain the nature of the research, asked if any SANEs were interested in being interviewed, and gathered the email and telephone information of interested individuals. Those that were interested were contacted and also asked screening questions to ensure their ability to participate in the study. Those that qualified were asked to set up an interview at a time and location of their choosing.

At the beginning of the interview I read the consent form (Appendix 3) to each participant. They were then given time to read the consent form themselves and ask

questions if needed. After all questions were answered to the participant's satisfaction, she signed the consent form. After signing the consent form, each woman was given a \$10 gift card as compensation. Next, they were asked to choose a pseudonym to use throughout the interview. I then began recording via an electronic voice recording device and began the interview. Sample interview questions include, "What kind of relationship does your SANE program have with the hospital? How does your work affect your relationships with friends, family, or intimate partners? Can you tell me a story about a time when you felt burnt out?"

Interviews lasted between 45 and 90 minutes. However, when the interview reached the 60 minute mark, I notified the participant and asked if they wished to continue the interview. Interviews that continued beyond 60 minutes did not exceed 90 minutes. Once the interview was completed, the recording was put into my password protected computer. Interviews were then transcribed verbatim and checked for accuracy. Next, I removed or changed all identifying information in the transcripts. This included removal of references made to the state or region in which the research took place, as well as changing the names of people and places. In some cases I also changed or removed words or phrases that were indicators of a unique speech pattern in an attempt to protect the women's identities. After all interview transcripts were prepared analysis began.

Interviews were analyzed using the inductive approach described by researcher Shana L. Maier in her 2013 article titled, "Sexual Assault Nurse Examiners Perceptions of the Influence of Race and Ethnicity on Victims' Responses to Rape." The inductive approach to analyzing interviews helps identify common "threads" or "themes" in each

participant's account. According to Maier, "themes are simply ideas or phrases that appear in several interviews" (2012, p. 72). Themes were identified through the process of transcription. For example, while transcribing the interviews, I noted in the margins when comments related to challenges or barriers were made. Later, after all transcripts were complete, I noticed that the comments in the margins tended to cluster around broader themes. For example, I noticed that comments about anxiety, burnout, and vicarious trauma, were all related to a broader theme of the personal impact of SANE nursing. This process allowed me to identify three themes in the interviews. The three overarching themes that emerged in the interviews including accounts of 1) the personal impact of SANE nursing, 2) colleagues' and the general public's lack of knowledge about SANE nursing and, 3) barriers specific to SANE nursing in rural locations.

Reflexivity

As a Crisis Advocate I often work with women who have been victims of sexual assault. As mentioned above, this work has put me in contact with the local hospital and provides me with an inside look at the strengths and weaknesses of its SANE program. I must be careful to practice reflexivity in order to control the ways in which these experiences may influence the research process. Reflexivity is defined as "a process by which [researchers] recognize, examine, and understand how their social background, location, and assumptions can influence the research" (Hesse-Biber, 2014, p. 3) process. According to Hesse-Biber (2014) researchers can influence their studies in several ways. The research problems they choose to investigate, the research methods they choose to use, and the ways in which researchers interpret data can all influence their work. I must

then recognize my own positionality in this research study in order to account for my personal biases and assumptions (Hesse-Biber, 2014).

First and foremost I must recognize that my personal history as a rape survivor influenced my decision to study this topic. Like many women, I have been a victim of rape and understand the lasting emotional trauma these experiences can cause. My own experiences as a sexual assault survivor and my work as an advocate for sexual assault survivors, has also shown me that healing is possible. As a crisis advocate I have been privileged to have an inside view of many women's paths to healing. Both of these experiences have instilled in me a deep desire to improve post-assault care and have led me to choose this particular topic of study.

Potential Limitations

No research study is without flaws or limitations, and this study is no exception. Here I will attempt to assess the possible limitations of the current study. One possible limitation of my research study is that I was the only person coding the data. It is important to point out that it is possible that other individuals may have coded the data differently. I am also a first time interviewer. It is possible that my inexperience with interview methodology affected the quality of the interviews. For example, most of my interviews were conducted on-site, inside the hospital cafeteria during the early morning hours. Although few people were in the cafeteria at the time of the interviews, it is possible that being interviewed at work prevented the nurses from being able to speak freely about their experiences.

It is also important to note that my work as a crisis advocate may have made it difficult for my participants to discuss their work related experiences with me. Because

the shelter where I am employed maintains a close working relationship with the local SANE program, it is possible that participants may not have wanted to share undesirable aspects of their work with me due to a desire to protect the hospital's image within the community or a desire to maintain good relations between the two agencies. In an attempt to alleviate this concern, I discussed confidentiality with each participant. I explained that all the information that was shared during the interview process would remain private and would not be discussed with anyone outside my research committee. I also explained that any identifying information such as names of people or places would be removed from the interview transcripts and would not appear in my thesis. I also anticipate concerns related to generalizability because of the small sample size utilized in this study. While it is true that it is difficult to generalize the results of a small study to the larger population, small studies provide important information about specific populations. This study provides important information about the thoughts, feelings, and functioning of SANEs working in a rural area.

Chapter 4: Results

This chapter presents the findings of my analysis of interviews I conducted with six Sexual Assault Nurse Examiners employed by a large hospital system in the rural upper Midwest. Here I discuss the unique challenges these women face regarding their work as SANE nurses as well as how they feel the hospital system effects their program. As stated in Chapter 3, due to the sensitive nature of the interviews, all names of people and places have been changed to protect the identities of the research participants. Similarly, because of the small sample (n=6) demographic information about the race, ethnicity, and ages of the women in my sample has been withheld. Also, where applicable, the code names “Spring Lake” and “Hospital Health Systems” are used for the city and hospital that are the focus of this study. At the time of each interview, all participants were employed by the same hospital system⁶ where three of the six participants held management positions within the SANE program.

The following chapter is divided into two sections. Using the accounts of the participants, section one provides a brief history of the SANE program under investigation as well an analysis of its positive and negative characteristics. The second section of this chapter presents an analysis of three overarching themes that emerged in the interviews including accounts of 1) the personal impact of SANE nursing, 2) colleagues’ and the general public’s lack of knowledge about SANE nursing and, 3) barriers specific to SANE nursing in rural locations.

⁶ While all research participants are employed by the same health system, the locations of their hospitals vary. Five of the six participants are employed at the local hospital in ‘Spring Lake’ whose SANE program is the major focus of this study. The sixth research participant is employed by and manages a second SANE program in a separate location in the same region. Although this participant manages a separate SANE program, her accounts are used here to provide depth of analysis of the health system as a whole and to better understand the struggles of rural SANE programs.

SANE Program History

2010-2014

Call calendar

According to the interviews, the SANE program in Spring Lake first started to take shape approximately five years ago when new management took over the program.⁷ Early in the program's development, a group of about 14 nurses were selected, SANE trained, and then organized into a team. It was decided that the team would utilize a voluntary call calendar where each SANE was encouraged to sign up to be on-call for a certain number of shifts per month. Unfortunately, after a few months, only a handful of SANEs regularly signed up for the call calendar. Nancy explains the call calendar in the following passage, "It was great for the first couple of months, and then the interest really tapered off, or people would do an exam or two and decide it wasn't the type of nursing for them." The women in my study suggest several reasons why the call calendar was unsuccessful. Linda, for example, suggests that the call calendar structure failed because many of the new SANE nurses experienced trauma. She explains, "Yeah, usually people get the training and they think they can do it, but they get their first case and get traumatized kind of and then don't want to do it anymore."

This quote is interesting, because it suggests that in the beginning, the program may not have had formal mechanisms in place to help new SANEs cope with the emotional impacts of working with sexual assault victims. This quote also illustrates the

⁷ The timeline of events described in this section is pieced together from the accounts of the research participants. As a result, it is difficult to establish exact dates when changes occurred, only broad time periods such as months, weeks, or years. As such, this timeline is not intended to be a definitive account of the changes this SANE program has gone through over the years. Its purpose is to give the reader a general understanding of the many changes that have taken place and how those women in the program felt about the changes.

importance of providing support mechanisms to SANEs to help promote retention and prevent SANEs from leaving the program. Judy, however, has a different perspective. She explains her experience with the call calendar in the following passage,

I like structure and like being told, “Ok, you have to put in your time. You said you’d be here for two years, every sixth weekend is your weekend. You have to put your name down five times and you’re held accountable to it.” If maybe that’s how it had been started I feel we would have been able to keep more people versus people getting away with not putting their name on.

Similar to Linda, Judy also comments that new SANEs struggled with the emotional aspects of SANE nursing and did not receive the necessary support to feel comfortable as Sexual Assault Nurse Examiners. However, for Judy, the main problem with the call calendar was that there was little accountability to the program. She expresses frustration with the fact that nurses were SANE trained but ultimately dropped out of the program without any consequences from management.

Accounts from these nurses suggest several areas for improvement. First, SANE programs utilizing a call calendar system should provide support mechanisms to SANEs to help them cope with work related stressors. This is not unexpected as previous research suggests that providing debriefing meetings for SANEs to discuss difficult cases with each other can help them cope with work related stress (Maier, 2011). Second, it is also important to ensure that SANE program managers provide clear guidelines and expectations for participation.

Nurses in my sample suggest that SANE program managers using a call calendar structure should enforce the following minimum standards of participation to help ensure

call calendars are filled and all SANEs stay engaged in the program. SANE program managers should 1) require that all SANEs sign up for a minimum of three to four on-call shifts per month and 2) require all SANEs attend 80 percent of the yearly SANE meetings. One nurse in my sample notes that because she was not required to sign a contract there was little regulation of the SANE program. They suggest that SANE program managers require all SANEs to sign a contract holding them accountable to the above requirements. They also suggest that SANE managers enforce compliance through disciplinary action. It is the hope that formalizing call calendar system structure will increase retention and participation of SANE staff.

Paging System

Seeing that the call calendar system failed to capture the needs and energies of the SANE nurses, management decided to try a different approach. After conferring with other colleagues, management decided to change the structure of the SANE program from a voluntary call calendar to a mass paging system. The idea was simple: when a patient arrived in the emergency department in need of SANE services, the hospital would send a page or text message to all SANE trained personnel. The paging system was an ideal choice at the time, because it was designed to eliminate the need for nurses to be on-call. Nancy explains, “It meant that you weren’t obligated to be on-call, so you weren’t stuck at home for eight hours waiting for a call that usually didn’t come.”

Unfortunately, when patients presented in the emergency department in need of SANE care, it was difficult to locate a SANE nurse to complete the exam, because many of the newly trained SANEs had already stopped participating in the program. Nancy expresses her feelings in the following passage,

Nobody came in. Nobody came in to do the exam. It was a failure. It was a *total* failure for us. I know that has worked for other programs, but for us it *did not* work. It just seemed like everybody was busy at the time. I mean there was [*sic*] always reasons that people didn't respond.

During this time period, the hospital resorted to transferring sexual assault patients to other locations. Patients were transferred to hospitals up to an hour and a half away from Spring Lake. It is common practice at emergency departments across the country to discourage sexual assault patients from eating, drinking, or using the bathroom for fear of losing evidence (Littel, 2001). The inability to locate an examiner then, creates unnecessary stress for the patient and added time to the process. Nancy elaborates,

They sat in our ER for an hour while we tried to find a nurse to do the exam. And then, we ended up transferring them somewhere else, and then they had the three to five hour exam. So it was really an all-day process to get the examination.

All told, patients during this time could expect the entire process including waiting, transfer, and examination to take as long as seven and a half hours. In addition to the stress associated with a long wait, transferring patients can cause further trauma and stress. Nurses in the sample consistently note that transferring patients to other locations requires that they tell their story several times to multiple people. Nurses in my sample are concerned that this adds to the trauma of the event.

When transportation to another hospital became necessary, an advocate from the local resource center was called to the hospital to help arrange for transportation or in some cases, proved the needed transportation. As a result of being unable to meet the needs of the patients in the area, Spring Lake's SANE program began to develop a

negative reputation within the community. As Nancy says, “I’m sure people have talked to one another and said, if this happens don’t even bother going to Spring Lake.” In fact, the SANE program gained the attention of the local media through an article and news story about the program’s struggle to provide sexual assault care⁸.

During the course of the interviews I discovered that many of the SANEs have strong opinions about the changes that the program has gone through in the past. One of the most surprising findings was that although the paging system was designed to alleviate the need for nurses to be on-call, in effect the paging system meant that the SANE nurses felt they were always on-call. They express concern about not knowing when a page will come and the difficulties of responding on such short notice.

Interestingly, although the SANE nurses feel discomfort with the paging system, many also do not believe the call calendar is an effective solution. Typical responses include frustrations with being on-call, difficulties with scheduling for both the calendar and paging systems, and fear or anxiety when responding to a page or text message.

Frustrations with Being On-Call

It’s difficult to be on-call. You can’t go far. Maybe there is a basketball game your niece is having, but you can’t go, because you need to be available within the hour. So it does limit what you can do. So to be on-call very frequently, plus work your own shifts, because likely these are people that also work full time, I think it got to be too much-

Chrissy

As this quote demonstrates, utilizing a call calendar is difficult, because it constrains a nurse’s ability to go about her daily activities. This quote also demonstrates

⁸ The article mentioned here was purposely excluded from the appendix in an attempt to protect the identity of the SANE program and the participants in this study.

that being on-call in addition to working scheduled shifts can present an added burden. This is not surprising as research suggests that being on-call increases nurse's stress and decreases mental wellbeing (Geiger-Brown, Trinkoff, & Rogers, 2011). A few of the SANEs express frustrations with being on-call frequently. Linda says, "I started taking more calls, because I felt bad. At the same time I was stressed out, because I couldn't do things because I was on-call."

This finding supports previous research that suggests that being on-call more than once per month can result in sleep disturbances for nurses (Geiger-Brown et al., 2011). During this time, SANE nurses were expected to be on call three to four times a month. Although I did not ask specifically about sleep deprivation in this study, Geiger-Brown et al.'s research suggests that the nurses in my study could have experienced serious sleep problems during this time. Because sleep deprivation in medical personnel has been shown to cause errors, delayed reaction time, and impaired judgment, utilizing an on-call system (calendar or paging) can have a negative impact on a nurse's full time work (Geiger-Brown, Rogers, Trinkoff, Kane et al., 2012).

For Linda, the call calendar increased her stress level, because she felt personally responsible for picking up the unfilled shifts. This quote is also instrumental in demonstrating how stress compounds and builds easily when a SANE program does not have adequate staff to fill a call calendar. Even after the call calendar system ended, however, many women still felt like they were on-call, because they didn't know when the next page would come requesting their services. Fear of being asleep when a page went out, being out of town, and not having access to childcare were common responses when asked why a SANE might not answer a page. Although the nurses did not like the

call calendar, because it limited their lives, not being able to schedule their own shifts with the paging system also created unique difficulties.

Difficulties with Scheduling

When we did do the call calendar [we had to do] three exams a month. But it was hard to get those in sometimes. It went on a first-come-first-serve basis. Sometimes people would sign up every Wednesday. Well, those two Wednesdays were the only time I could [be on-call] that month. So that was difficult too -Joyce

Difficulties with scheduling existed for both the call calendar and paging systems. As the quote above suggests, some of the women experienced difficulties finding time to be on-call. All of the SANEs in my sample worked full time equivalent workloads in nursing in addition to their responsibilities as SANE nurses. Many of the women also reported missing or not answering a page because of their hectic schedules. One drawback to the paging system was that it did not allow nurses the ability to schedule exams around their lives in the same way as the call calendar did. One participant enjoyed the call calendar for this reason, because it provided her life with stability and structure. Judy explains in the following passage,

That's why the call calendar worked so well. If I scheduled myself to be on-call [my husband] wasn't scheduled to be at work. I worked it out in advance. If I don't have it scheduled, it's much easier to say, "I'm busy."

Joyce agrees, "It's really hard when people have their schedules and their busy lives to pick up those extra shifts and to be able to respond when that page goes out." Having full lives as mothers, students, nurses, and SANEs meant that it was difficult for the women to make time for their duties as SANE nurses regardless if they were scheduled to be on-

call or not. One of the barriers to SANE nursing then, is the fact that both SANE nurses and managers are overworked.

Fear or Anxiety When Responding to a Page

Nobody picked up extra shifts, and then they [management] started losing the people who weren't doing exams. They [the SANEs] were afraid they weren't going to be competent, and they got nervous and said, "I'm done. I can't do this. I'm scared I will get called in and screw up"-Judy

As this quote from Judy demonstrates, difficulties with the scheduling policy were not caused simply by an inability to accommodate schedules or frustrations with being on-call. Difficulties with the paging system were caused by the underlying issue of competency.

Competency in nursing is defined as a nurse's ability to "perform defined behaviors proficiently by demonstrating the appropriate knowledge, skills, attitudes, and professional judgment required" (Cherry & Strong, 2014, p. 347) for a specific role. For the purposes of this study then, competency refers to a Sexual Assault Nurse Examiner's ability to execute key duties such as conducting a prompt examination while providing support and crisis intervention, evaluating and treating injuries, properly collecting, documenting, and preserving forensic evidence, as well as providing information, referrals, and follow-up care (US Department of Justice, 2013). Nurses who dropped out of the SANE program and refused to answer pages did so, at least in part, because of a lack of confidence and familiarity with the SANE role. Judy expands on the relationship between competency and anxiety in the following passage,

I just feel like either we are too timid to answer the pages or we don't get enough SANEs who feel competent in our skills. I think that is hindering us in a rural community. We don't have enough reporting to get nurses competent. I feel like if we did [have a higher reporting rate] we would have more training and more people wanting to step up to the page when it goes out. Then you don't get that overwhelming sense of what is going to happen? Do I feel competent in collecting this data? Can I write a good report? I think that always runs through my mind before I answer a page every time.

This passage is important, because it highlights the connection between low reporting rates and SANE nurse competency. For Judy, working in a rural environment with low rates of sexual assault survivors seeking SANE services and few opportunities to practice her skills causes anxiety and apprehension when responding to a page, because she is unfamiliar with the SANE role. Prior to reporting to the hospital Joyce also experiences anxiety. She explains, “[I]t is nerve-wracking too. I always think ‘Oh my gosh, what if I were to go to court or would get subpoenaed?’ I want to make sure everything is laid out correctly.” For Linda the anxiety she experiences when reporting for an exam is so pronounced that it is one of her most dreaded aspects of SANE nursing. She explains,

I think what I don't like is that I don't do this often enough. That every time I get a call and if I can come I just get nervous about it. What if I don't remember what I'm supposed to do? What if I mess up something? I think that's the most difficult part of doing this.

Although some apprehension is normal when completing an exam, feelings of anxiety may be pronounced for rural SANEs because of an inability to practice and gain a

sense of mastery of the necessary skills. The women in my sample felt confident in their full-time work as nurses but as SANEs they had misgivings about proficiency and mastery. Anxiety and low confidence in SANE skills then are two key barriers to rural SANE nursing.

Although, previous research has shown that maintaining proficiency is a common difficulty for SANE programs (Logan, Cole & Capillo, 2007) my study suggests that gaining proficiency is crucial for rural SANE programs to overcome anxieties and fears. Logan, Cole and Capillo (2007) suggest frequent training and educational opportunities for nurses to practice their skills. The managers in the sample recognize the fact that the program struggled because of a lack of confidence and proficiency in their team's skills. The new program was designed with these struggles in mind and with plans in place to help SANEs feel comfortable in their role.

2014-Present

After two attempts to find a scheduling system that fit the needs of the SANE program were unsuccessful, upper level management worked together to put in place an entirely new system that would eliminate the barriers associated with the two previous systems: limited availability of SANEs and the problems associated with being on-call. As part of the new plan, Hospital Health Systems created a separate unit in the emergency department called an observation unit. According to the interviews, the observation unit is reserved for patients who are not well enough to go home, but are not ill enough to be admitted to the hospital. The new plan requires that all nurses assigned to the observation unit be SANE trained. Then, when a patient in need of SANE services reports to the hospital an observation nurse can leave the unit to complete the exam.

This plan has generated a lot of excitement within Hospital Health Systems and within the community, because it ensures that Spring Lake's hospital will always have someone on location that is SANE trained. However, if the observation unit has a high patient load, and they are unable to complete the exam, a page will be sent out to a list of other SANE trained personnel. The hope is that the new system will eliminate long waits in the emergency room as well as patient transfers. While this system is clearly a vast improvement in terms of hospital coverage, SANEs within the program remain skeptical about the outcome. Concerns about the new observation unit revolve around two primary points. There is concern that the observation nurses may engage in victim blaming rather than providing sensitive, compassionate care because they are not self-selecting to be SANE nurses, and concern that the new system will eliminate the few passionate SANE nurses that have self-selected to assume the role.

Revictimization

A real senior nurse down there says, "Oh, I'm so glad for you guys because I would have hated to do that." They just have this negative attitude, thinking that [the patient is] always a fake, or they're trying to get attention. They'll say comments like, "I'm glad it's you not me that take those, because I would never be able to sit through those with a straight face." So now to know that those people are not volunteering to be a SANE nurse, that they are put into that position, it worries me that the patient isn't going to get the compassionate care –Judy

When management decided to incorporate observation nurses into the SANE program the emergency department was infuriated. Emergency room nurses threatened to quit, claiming that the hospital had no right to force them to do sexual assault exams.

This, coupled with the knowledge that emergency room nurses display victim blaming behavior, caused some women in the sample to question the viability of the new program structure.

As a highly specialized field, most Sexual Assault Nurse Examiners self-select to become SANE trained. Five of the six women who were interviewed stated that they chose SANE nursing as a specialty because of personal experience (either their own experiences or the experiences of friends and loved ones) with physical abuse or sexual assault. Although, to my knowledge, research has not investigated the connection between SANE nursing and personal history of abuse, research by Maier (2011) notes that a significant portion of her sample of SANEs had personal experience with abuse. I suggest that having personal experience with abuse helped create a deep personal connection to the work.

There is concern among the nurses in my sample, however, that the structure of the new SANE program will remove personal desire and connection to survivors from the equation. Now, nurses are being put into the SANE role that do not self-select to do the work. At the same time, the hospital is no longer relying on those dedicated few SANEs that began this work with a drive to care for the patient. As a result of these changes, one SANE reported feeling left out or pushed out of her role. There is also concern that the program has placed individuals that suffer from *compassion fatigue* (a gradual decline in one's compassion or ability to nurture over time as a result of exposure to events that have traumatized patients [Figley, 1995; Joinson; 1992]) and that display open signs of victim blaming in direct care of sexual assault patients.

Judy's quote at the beginning of this section showcases signs of compassion fatigue. The SANE's suggestion that she could not treat a sexual assault patient "with a straight face" demonstrates a serious lack of compassion and empathy for the patient. Similarly, the suggestion that sexual assault patients feign sexual assault in an attempt to get attention suggests that the nurse is attempting to deny the harm of the sexual assault and blame the victim.

Research suggests that denying the reality of sexual assault and blaming victims is a coping mechanism (Maier, 2011). Blaming victims for the violence they have suffered is part of the just world theory—"the idea that the world is a just place and that bad things only happen to those that deserve them" (Maier, 2011, p. 163). As women, it is reasonable that SANEs would victim-blame in an attempt to minimize their own vulnerability to sexual assault and to rationalize the violence they see on a daily basis. However, victim blaming can result in revictimization of the patient. As stated in chapter two, the term revictimization refers to "the distress, alienation, and blame that victims may experience after the assault at the hands of the criminal justice and medical system" (Bergen & Maier, 2011, p. 233). Hospital personnel revictimize sexual assault survivors by engaging in victim blaming-behavior and stigmatizing them. Revictimization may also occur as a result of hospital staff's prejudicial beliefs about rape victims. (Bergen & Maier, 2011).

Judy goes on to explain other instances of victim blaming,

They'll say, "Do you think it really happened?" just right off the bat... And then you'd come out and one of the triage nurses, who's also a SANE nurse was like, "Uh! She showed up with the guy! How could it even be real? This is just

ridiculous she's just trying to sleep with her friend's boyfriend and this is her way of getting away with it.”

This quote also demonstrates victim blaming as well as a desire to minimize and deny the sexual assault. The nurse blames the victim by suggesting she is responsible for the assault (sleeping with her friend's boyfriend), while simultaneously minimizes and denies the violence by suggesting that because she came in with a man that the sexual assault never occurred.

The new program's ability to provide 24/7 coverage is a major improvement, and should eliminate the need to transfer patients to other hospitals in the region. However, it seems contradictory to place individuals into the SANE role that do not have a genuine desire to do the work. Supporting sexual assault survivors is delicate work and requires sensitivity and compassion. The new program is designed to reduce reliance on other nurses outside the observation unit. As a result, I suggest that, the dedicated SANE nurses may feel alienated and decided to withdraw from the program. Additional consequences could include a decrease in compassionate care and revictimization of sexual assault patients if the concerns about victim blaming and compassion fatigue are not addressed.

Thematic Analysis

Theme One: Personal Impact of the Work

Interview transcripts indicate that treating rape victims impacts SANE nurses in a wide variety of ways. Personal impact is the first overarching theme that emerged from the interviews. Here I will discuss both positive and negative impacts of sexual assault

care including vicarious trauma, silence or a reluctance to talk about their profession, and a desire to help the community.

Vicarious Trauma

Although participants were not asked to reflect specifically on their experiences with vicarious trauma the subject emerged as a major theme of the interviews. Vicarious trauma is defined as a set of “psychological consequences for those exposed to other’s traumatic experiences and the ways in which one’s view of the world and other people changes as a result of this exposure” (Maier, 2011, p. 162). Three of the six interviewees display signs of vicarious trauma and an altered worldview as a result of their work. Nurses in my sample discuss their feelings of an altered worldview in relation to exposure to certain types of violence such as drug facilitated assault, sex trafficking, child sexual assault and child predators, and a heightened concern for children or grandchildren. Nancy explains,

I am concerned about just having their name on their shirt. I’m a little nervous about that. Photographs on Facebook. I’ve told my daughter, no bathtub pictures, because there are just too many people out there that are really not right.

She goes on to say, “I think there is just kind of a sense of mistrust with a lot of people. Strangers. It’s like, we don’t really know these people, so we don’t know. We *really don’t know* what a child predator looks like.”

Linda agrees that working as a SANE can change one’s perspective on the world. In the following passage she explains how being a SANE nurse has changed her view of the world and the safety of her children: “As a mother, you want to protect your children and seeing this stuff... Sometimes we live in our bubble. I’m a pretty optimistic person.

Seeing what's going on *outside*, you face the reality of how vulnerable your children are.”

Linda and Nancy both mention that working with sexual assault survivors has heightened their own concerns about the safety of their family. Their worldviews have changed in that they see the world as a more dangerous place, and are more likely to view people as potential perpetrators. Having a heightened mistrust of others affects both Linda and Nancy's home lives. Nancy discusses being more vigilant and alert while out in public,

So we were at this resort...and there was a girl there. She was pretty intoxicated and she was dancing with a lot of guys. A lot of guys. And I was very concerned for her safety. She was with a friend and I just waited for her to go to the bathroom and then I went and talked to her friend. And I just said, “I'm really concerned about your friend, and I just want to make sure she is going to be ok. Are you guys going to stick together?”

Linda expresses feelings of anxiety about her children growing older and leaving the home:

Um, I have teenagers. Every time I go [complete a SANE exam] and see a college student for example, I'm thinking “Gosh, two years and my daughter's going to be in college.” So it makes it hard. It makes it really hard to do this job... [My daughter] wants to go out of state. She lives in a kind of shelter here, and [the thought of here leaving for college] just makes you think, and gets you scared.

Linda goes on to explain how she deals with her anxiety,

[I talk] to my girls and if they have a friend I don't care, I tell them too. "No that is not ok, you should not put up with that." And my girls get annoyed. "Oh my gosh mom!" But yeah, I think we should all have a more open dialogue this our teenagers.

Seeing the world as a dangerous place has impacted how Nancy and Linda interact with others, but both women have found ways to cope. Nancy's vigilance in identifying potentially dangerous situations allow her to help vulnerable individuals. And although Linda's altered worldview creates anxiety about her daughter's future, she manages it by talking with her children about sexual assault and safety.

I did not initially expect to find signs of vicarious trauma, because of the relatively low number of sexual assault patients treated each month at the hospital. On average, the SANEs estimated that Hospital Health Systems treats zero to ten sexual assault patients a month. I assumed that their exposure to sexual assault patients was too low to result in vicarious trauma. However, as these findings suggest, vicarious trauma is not only positively correlated with a high number of sexual assault patients. It is important to note however, that the two women that exhibited the strongest signs of vicarious trauma are senior members of the SANE team and were exposed to the most sexual assault patients in my sample. This finding supports previous research that demonstrates that trauma increases based on the number of sexually abused clients one treats (Maier, 2011).

Silence and the Stigma of Sexual Assault

Throughout the interviews, several of the women admit that they rarely mention to others that they are Sexual Assault Nurse Examiners. When asked why SANE nursing

is a relatively unknown profession Linda suggests that the taboo of sexual assault keeps their work hidden from the public. She says, “[M]y guess would be is what we do; the taboo about talking about sexual assault.” This quote demonstrates that the stigma of sexual assault plays some role in the preventing the women from sharing with family, friends, and acquaintances what they do. Linda goes on to say,

Actually, when people ask me where I work I say I work on this floor [of the hospital]. When they ask what I do, I talk about what I do on the floor, but it rarely comes in conversation that I am also a SANE nurse. Yeah, I wouldn’t mention to someone, “I also do SANE exams.” Sexual assault exams, I don’t think that’s coming up in conversation.

For Linda the taboo of sexual assault keeps her silent about her work. Although she is proud of being a SANE, the taboo of sexual assault, and the stigma associated with it, prevents her from sharing her work with colleagues and acquaintances.

The women in my sample seem to only share their work as SANEs with individuals they are close with such as spouses, close family members, or friends. Kathy, for example, admitted that she has told her father that she is a SANE, but she has not told her mother. This perhaps indicates that the stigma of sexual assault is mitigated by degree of familiarity and closeness. SANEs may feel, for example, that close relatives and friends may not stigmatize them in the same way strangers might. Kathy may feel a closer bond with her father and thus feel safer in sharing her work with her father.

Joyce explains wanting to avoid talking about her work in the following passage, It’s not something that you broadcast or talk about. When people ask you what kind of nurse you are, you say, “I’m a critical care nurse.” I don’t usually bring up

the aspect that I'm a SANE...Because then you start that whole other conversation. "Oh what's that? Blah, blah, blah..."

Sexual Assault Nurse Examiners' unwillingness to discuss their work with others may also be related to a fear of stigma by association. Stigma by association is the theory that one's stigma can transfer to another person that does not share the stigmatized characteristic simply by association (Goffman, 1963). Avoiding discussing their work with a stigmatized population (rape and sexual assault survivors) may be an attempt to prevent stigma by association and the tendency for others to view them differently as a result of their work.

Desire to Help the Community

Often in the interviews, the women admit that prior to becoming a SANE they were unaware of the prevalence of sexual assault and the need for SANE services. As a result of their work, however, all of the women have developed a strong sense that being a SANE nurse is an important part of helping the community. Kathy explains,

What I like most about it is that we are able to support the victims of sexual assault in their time of need and know that they are in a crisis, and this is probably one of the worst times of their life.

Kathy supports her community not only by being a SANE, but through the act of helping survivors. By acknowledging a patient's pain, recognizing their need for help, and bearing witness to their suffering not only supports the victim but also supports the entire community of victims. Unlike in Mulla's (2014) study that suggests that SANE nurses focus primarily on the legal aspects of SANE nursing rather than patient care, SANEs in my sample view patient care as the focus of their work. The women in my

sample take pride in their ability to help patients restore their humanity by being a part of their “worst day” and treating them with compassion and respect.

All women in the sample express similar ideas about how they find it fulfilling to support victims of sexual assault. All of the women also view SANE nursing as a vital service to the community, however, each woman has a different understanding of how their work impacts the community. One participant mentioned that she is proud of the fact that she is bilingual and can help patients who speak Spanish. Managers in the sample tend to see helping the community from the perspective of supporting their team of SANEs and making sure the program runs smoothly. Linda explains her view of the role with the following, “It’s not necessarily a gain financially. Unfortunately that’s how most people do these things, you pretty much have to compromise to help the community.” For Linda, helping the community outweighs financial gain. For her, helping the community means educating her daughters and their friends about sexual assault and ways to stay safe. Like most of the women in the sample, Linda’s motivation to help sexual assault patients stems from personal experience with abuse.

Theme Two: Lack of Knowledge and Understanding about the SANE Role

The second major theme that emerged from the interviews centered on feelings that hospital staff and the general public lack an understanding of the SANE role. Participants express that the lack of knowledge about SANE nursing impacts their work in several ways. Participants felt, for example, that hospital staff has both a limited understanding of and respect for SANE nursing. They also express a desire for community outreach, so that the public can gain a better understanding of the sexual assault exam and the services SANE nurses provide.

Hospital Staff

It's not that [doctors] aren't willing to work with you or to help you, it's more that they don't know what is involved, what it is exactly that we do. I think that's where the problem is-Linda

As the quote from Linda suggests, a knowledge gap exists between SANE nurses and other hospital staff regarding sexual assault care. Linda feels that her colleagues simply do not have the knowledge necessary to understand her work as a Sexual Assault Nurse Examiner. Linda remembers how nurses outside the ER react to a patient disclosing a history of sexual assault,

When the police officer requested the exam, they [nursing staff] thought it was too long after, and they told the police, "It's too late, it's been days." The police were saying she was still able to do it. The police officer was aware but not the staff.

In this case, nurses were unaware of the proper protocol and nearly cost the patient the opportunity to have a SANE exam. Judy recounts a similar story about ER doctors and their lack of knowledge about the SANE role. She explains,

The two different ER doctors that I worked with most recently didn't know what to do as far as what their responsibility was. They were like, "What do I do? What do you need me to do?" You have to point them out. "Ok, this is the page I need you to sign, these are the meds I need to give to my patient, this is why I'm giving the patient meds, this is why I'm doing injections instead of oral meds." And they say, "Do I have to do an assessment?" You have to walk them through it.

Taken together, the experiences of both Linda and Judy showcase two problems. First, their accounts suggest that emergency room doctors and nurses may not see sexual assault care as part of their role. This finding supports previous research that suggests that emergency department staff generally regard the needs of sexual assault patients as less urgent, and are resentful when they must complete an exam because of the length of time it takes to complete an exam (Bergen & Maier, 2011; Littel, 2001). Second, their stories suggest that hospital staff's lack of knowledge and understanding about the SANE role makes SANE nursing more difficult because they must know their responsibilities and the responsibilities of emergency room physicians.

The true nature of this issue becomes visible when examined using standpoint theory. A Sexual Assault Nurse Examiner's marginalized position (as a nurse that cares for a stigmatized patient group) requires that they not only know and understand their own role in sexual assault care, but as Judy's comment illustrates, SANEs must also know the doctor's role in the process as well. This is because doctors exist at the top of the medical institution's hierarchy. As a privileged group they are afforded the ability to ignore other's work. In contrast, SANEs position of marginality requires that they know and understand all roles in sexual assault care.

When asked how to fix the educational gap, (and by extension force doctors to acknowledge SANE nursing), many nurses suggested that the entire hospital receive training about the role of SANEs and sexual assault protocols in order to provide patients with better care and to avoid these types of mistakes.

General Community

The women in my sample also believe that the general public lacks knowledge about SANE nursing. Concerns related to the public revolve around misunderstandings about the exam process and the services SANEs provide. Judy explains,

The population [the typical patient] that we get want to know, “Were they raped?” We can’t say yes or no. We can say there is bruising or cuts, or that we don’t see anything, but that doesn’t mean you were raped.

Other misconceptions include patients believing that they have to report the incident to the police in order to receive SANE services, that the hospital will call a victim’s parents, and a general lack of knowledge about other services SANE programs provide such as medication to prevent HIV, STIs and pregnancy.

The perception that the public may misunderstand the role of SANE programs is supported by previous research. Research for example, has demonstrated that victims often have never heard of the sexual assault kit and that if they have, they misunderstand its purpose. Survivors for example, may undergo a forensic exam assuming it necessary or mandatory to receive care for their injuries (Du Mont et al., 2009). Participants in my study want the public to know that survivors do not have to report the assault to the police, that the exam is optional, and that SANEs are a resource for the community. Participants for example, want the public to know that SANEs can also provide referrals to victim advocates and specialists if needed.

These results suggest that SANE nurses have a desire to add community engagement to their program service plan. The SANEs, for example, thought their program could do more to educate the community about sexual assault and sexual

violence. SANE programs then should focus on community outreach and education. As this section also suggests, SANE nurses want their coworkers and community members to know about the program. However, as mentioned in the previous section, the nurses themselves do not talk about the work. In order for community engagement to be possible, SANE nurses themselves must overcome the stigma associated with their work.

Theme Three: Barriers in Rural Locations

The third theme that emerged from the interviews revolves around barriers to working in a rural setting. Interestingly, almost all participants recognize two difficulties common to working in rural environments: difficulties maintaining competency in their skills as SANE nurses and concerns related to patient privacy. An unexpected finding was that four out of the six SANE nurses saw the rural setting of their program as having little to no impact on their work as Sexual Assault Nurse Examiners. These participants stressed the importance of working in an area with several colleges (and a high percentage of young adults) as the main environmental factor impacting their work. Although these women did not see the rural setting of their SANE program as a major influence on their work, all participants in the sample mention concerns or difficulties related to maintaining proficiency in their skills as SANE nurses. This concern was often mentioned as a result of working in a rural area with few opportunities to practice their skills.

Previous research demonstrates that SANE programs often struggle to keep SANE nurses up to date and proficient in their skills (Logan, Cole & Capillo, 2007). This study suggests that working in a rural environment, with relatively low rates of sexual assault patients seeking SANE services, exacerbates this problem because rural SANE

nurses may not get opportunities to practice their skills on a regular basis. Management of the program under investigation is aware of this difficulty and has plans to provide continued education and training opportunities to alleviate this concern.

Competency

Many of the women in the sample express concerns about maintaining their skills as SANE nurses. In the following passage Joyce explains how this difficulty impacts her work,

I think it's harder to be a SANE in a rural environment, because you don't get the volume of cases as you would in Center City County. I think it's hard to stay competent and to remember all the steps you need to do. I have to do the whole process the same way every time, but when you haven't done an exam for a few months it can be difficult to remember what you need to do.

For Joyce, living in a rural environment means that she does not get the opportunity to use her skills as a SANE nurse very often. Not having a high level of sexual assault cases may seem positive, however, research suggests that reporting rates are very low. In fact, “according to the National Crime Victimization survey, between 2005 and 2010 only 36 percent of rapes or sexual assaults were reported” (The White House Council on Women and Girls, 2014, p. 16). This statistic demonstrates that low reporting rates do not mean sexual assault has stopped. In fact, low reporting rates simply mean that survivors are not reporting the crime. Judy explains the connection between a higher reporting rate and competency,

We don't have enough reporting to get nurses competent. I feel like if we did [have a higher reporting rate] we would have more training and more people

wanting to step up to the page when it goes out. Then you don't get that overwhelming sense of what is going to happen? Do I feel competent in collecting this data? Can I write a good report? I think that always runs through my mind before I answer a page every time.

This quote demonstrates that low reporting is linked not only to a lack of confidence in their skills but also increases their feelings of anxiety. Linda describes her fear, "What if I make a mistake and the person gets off for something that they really did?" The fear of making mistakes during evidence collection was intimately tied to the issue of competency. The women explained that without a higher level of reporting, and in the absence of other training opportunities they do not get adequate opportunities to practice their skills and develop a sense of mastery.

Patient Privacy

Patient privacy was the second major concern related to working in a rural environment. The women in my sample worry that sexual assault victims in the area decide not to seek SANE services out of fear that reporting to the hospital will lead to the discovery that they are survivors of sexual assault. The fear of reporting is linked to the notion that in Spring Lake many people know each other, and perhaps the patient will run into someone they know at the hospital. This concern may be warranted since rural areas tend to have "high acquaintance density thus high levels of familiarity and a lack of anonymity" (Bergen & Maier, 2011, p. 238). Judy explains how high acquaintance density can effect a patient in a rural environment,

The word gets around in smaller communities, and I wonder if [victims] are afraid to report because they are afraid of who's going to find out. Who's their

nurse going to be? My friends all know I'm a SANE nurse, so if something happened to them would they be afraid to report, because they know I could be the one to do their assessment?

The women also mention that there is fear that they might know the patient and that knowing each other might make the patient uncomfortable. Chrissy explains,

I think the fear sometimes is that [the SANE] might know that person, because we're all from the community. And that might be uncomfortable, although, it might be comforting at the same time. I guess it depends on how they feel. As long as they can trust that we'll keep their confidentiality I think we're ok. And that we're just trying to help them.

As Chrissy's quote demonstrates, some SANEs also worry that they might know the patient. As Chrissy says the possibility of knowing the patient could be both comforting and uncomfortable for the patient. Knowing your provider, or at least being acquainted can help ease the patient's anxieties. However, familiarity could also raise concerns for the patient about confidentiality. However, as long as SANEs are able to assure the patient that their treatment is confidential, SANEs in general view familiarity as a positive aspect of rural nursing.

Participants speak about Spring Lake being "[their] little community" and a desire to keep its citizens safe. Working as a SANE in a rural community, although it presents challenges, also serves as a source of pride. The women in my sample have a sense that they play an active role in helping their community stay safe and healthy.

Conclusion

Unexpected Findings

One of the most interesting findings of the study is that the managers in the sample gave a more positive report of the SANE program (three) than SANE nurses who are not managers (three). Non-manager SANEs in the sample were much more likely to air grievances or concerns about the program. While all participants were open about the struggles the program has faced in the past, lower level SANEs express significantly more concerns about the present and future functioning of the program. This finding is not unprecedented as previous research suggests that managers and coordinators may present a biased picture of SANE programs (Logan, Cole & Capillo, 2007). In an attempt to alleviate this concern and obtain a more balanced picture of the program, I interviewed an equal number of manager and non-manager SANEs.

Another surprising finding is that few participants in my study experienced burnout in relation to their work as Sexual Assault Nurse Examiners. Although one participant expressed feeling burned out with SANE nursing in the past, most women talked about burnout only in relation to their full-time work as nurses. Most participants explained that because their program treats so few sexual assault victims, burnout was not a concern at the time of the interview.

Final Thoughts

Although this program has experienced setbacks and challenges in the past, results of this study suggest that the program is making excellent progress. In fact, many of the changes instituted by the new program follow very closely some of the recommendations mentioned in the scholarly literature. Eliminating mandatory on-call

hours and providing debriefing meetings were suggested by Maier (2011). Both of these changes will help reduce burnout potential and promote emotional wellbeing.

SANE training emergency room nurses is also mentioned in the literature as a policy recommendation (Logan, Cole & Capillo, 2007). This change will eliminate the difficulties related to on-call structures and provide full 24/7 coverage. However, results from this study suggest areas for improvement. Continued effort is needed to improve SANE nurses' sense of competency, as well as efforts to reduce compassion fatigue and vicarious trauma. Results from this study also suggest that SANEs believe continued education and training opportunities are the best ways to improve SANE programs.

Chapter 5: Conclusion

This thesis demonstrates the complex relationship that Sexual Assault Nurse Examiners have with their work and the impact it has on their lives. I argue that Sexual Assault Nurse Examiners experience a number of challenges that contribute either directly or indirectly to their low representation in rural communities. Results from this study reveal that SANE programs located in rural communities experience many of the same challenges as urban SANE programs. Many SANE programs, for example, deal with the same frustrations with on-call systems, difficulties with scheduling, maintaining competency of employees, and vicarious trauma as the program studied here. However, this study reveals that rural SANE programs have specific concerns.

Results show that the rural setting of a SANE program may cause added issues with competency, because as this study demonstrates, rural programs do not get many cases for SANEs to practice their skills. The inability to practice and maintain their skills led some of the women in my sample to feel anxious when answering a call or completing an exam, and prevented SANEs in the past from completing exams altogether. In order to relieve this concern, hospitals should provide regular training opportunities for SANEs in rural environments. Purchasing additional educational tools such as a mannequin to use during trainings and meetings is helpful. However, trainings should not be limited to practice on a model, but should also include travel to a metropolitan hospital in order to allow SANEs in rural locations to get more first-hand practice. However, providing travel to other locations and the purchase of additional training materials will require more financial support from hospital administration.

While hospital administration may not initially want to provide additional funding, it should be noted that feeling insecure about their skills was a major barrier preventing SANE nurses from responding when on-call or when receiving a page. Providing additional training is also important for SANE programs that do not utilize an on-call or paging system. Well-trained SANEs provide faster, higher quality care (Littel, 2001). Results from this study suggest that training SANEs well can also save hospitals money by limiting turnover rates, decreasing the time spent completing the exam, and limiting the time patients must spend waiting in emergency rooms.

This study also raises concerns that rural SANE programs may not be as vigilant in their fight against the emotional consequences of sexual assault care because of how few sexual assault cases they receive each month. Rural hospitals may, for example, be under the impression that because they treat as few as ten rape victims a month, secondary trauma is not a concern. Results from this study reveal that SANE nurses in rural communities experience secondary trauma despite having a relatively low sexual assault patient load. Preventative measures should be taken to avoid secondary trauma in rural SANEs. Interestingly, this study also suggests that developing new programming or relying on existing programs for trauma prevention may not be sufficient to deal with the needs of SANE nurses.

Two nurses in my sample expressed feeling stressed, however, they were unaware of any programs available to them. This is interesting, because Hospital Health Systems has several systems in place for nurses such as chaplain services and free counseling. However, the accounts of these women suggest that some SANES are unaware of the existing programs while others do not need to use them. The women that needed the

services either were unaware of existing programming or felt that the hospital needed to develop programs dedicated specifically to supporting SANE nurses.

Although the program under investigation provides SANEs with the option to debrief after a case, this was not enough for the women in the sample to feel supported. No formal trainings existed for SANEs about burnout prevention, self-care, or secondary trauma. This study reveals that it is vitally important for SANE program coordinators to provide continued education at regular intervals about a variety of topics. Suggested topics include vicarious trauma, burnout prevention, and self-care. I would also suggest that SANEs receive trainings about rape culture and rape myths in order to reduce victim blaming behaviors. Additional topics could include trainings on generational trauma and Native populations as well as cultural competency and caring for communities of color. SANE program managers and coordinators may find it useful to collaborate with faculty and staff members from local universities and rape crisis centers to provide these trainings.

Although SANE nurses have dedicated themselves to the care of sexual assault victims, the impacts of rape culture affect how they think and feel about the patients they treat. These trainings can help SANE nurses understand how societal attitudes about gender and sexuality support and condone the culture of violence against women and girls. Additionally, trainings such as these can help eliminate victim blaming behavior among nurses.

Although none of the women in my sample expressed victim blaming attitudes, there was concern that the new program structure (the observation unit) has placed others that readily employ victim blaming in the SANE role. From reviewing the literature about

Sexual Assault Nurse Examiner programs, I thought that SANE programs were immune to such problems. However, it is important to remember that the women that work as SANE nurses are a part of this culture, and as such, they are susceptible to believing or endorsing rape myths and utilizing victim blaming. This is not a personal failing of this particular SANE program. In fact, I believe many SANE programs may likewise struggle with the existence of some form of subtle victim blaming. What is important is that SANE program managers and hospital administrators take steps to educate their staff to reduce these problems. This study is important because it provides a more realistic depiction of what SANE programs struggles with than what currently exists in the literature.

The results of this study and the recommendations mentioned here can be useful to a variety of stakeholders in the anti-violence community, including Sexual Assault Nurse Examiner program directors and coordinators, hospital administrators, lawmakers, sexual assault advocates, researchers, feminists, and anti-violence activists. Sexual Assault Nurse Examiner Program directors as well as hospital administrators can use these findings to build SANE programs that are more responsive to both the victim and the SANE. This study also aids those interested in lobbying the government for more funding for SANE programs as it demonstrates how funding is essential to education and training of SANEs. Additionally, this study both supports and builds upon previous research about SANE nursing. It is my hope that this research creates a new dialogue about Sexual Assault Nurse Examiners and their role in emergency medicine.

Future research should include a more thorough study of this program and its new structure. The current study was conducted at the cusp of new changes that included

incorporating observation nurses into the SANE role. Follow-up studies should investigate how the observation nurses feel about this change. This study also raises questions about emergency room personnel's understanding of sexual assault care, specifically, a perception that sexual assault care is not emergency care, or the responsibility of emergency room personnel. Future studies should investigate emergency room personnel's thoughts and feelings about their role in sexual assault patient care.

Appendix 1:
Recruitment Flyer



**The Voices of
SANE
Nurses Matter!**

**ARE YOU A SEXUAL ASSAULT
NURSE EXAMINER?**

**ARE YOU WILLING TO BE
INTERVIEWED ABOUT YOUR
EXPERIENCES?**

If so, please contact Rebecca Gonnering,
MSU Mankato Gender & Women's Studies
graduate student at
Rebecca.gonnering@mnsu.edu or at
(507)508-0481.

The purpose of this research study is to
understand SANEs' perceptions of their work.

To qualify for participation in this research
study, you must be a trained Sexual Assault
Nurse Examiner.

This research study is approved by MSU
Mankato IRB and is conducted under the
supervision of Dr. Laura Harrison,
Assistant Professor of Gender & Women's
Studies (laura.harrison@mnsu.edu).

Appendix 2 Recruitment Script and Screening Questions

Hello: (Prospective Participant's Name)

My name is Rebecca and I am a graduate student giving potential participants information about my research study 'Navigating Barriers: Sexual Assault Nurse Examiner Experiences.' I will be conducting the interviews. Now is an opportunity for you to ask any questions and hopefully schedule an interview time and location that works best for you.

As you may know, I am a graduate student in the Gender and Women's Studies Department at Minnesota State University, Mankato. The purpose of this study is to examine Sexual Assault Nurse Examiners' perceptions of their work and the barriers contributing to the low numbers of SANE nurses in rural areas. Data will be used to better understand SANEs' experiences and to help increase the number of SANEs in rural areas.

Do you have any questions about the purpose of this study? Is it okay if I ask you a few questions to check if you met inclusion criteria? *(If potential participant agrees, at this time read them the consent form and obtain signature. Continue with screening questions.)*

1. Are you a registered nurse with training as a Sexual Assault Nurse Examiner?
2. Are you currently employed as a Sexual Assault Nurse Examiner in a rural area?

Checklist for inclusion:

1. Holds current licensure as a registered nurse with training as a SANE
2. Currently employed as a SANE in a rural area

(Inform potential participant whether or not they meet inclusion criteria. If so, continue the screening process. In not, thank them for their interest in the study.)

Your participation will involve an interview with me, Rebecca, where I will ask questions about your experiences and feelings about your work as a SANE, which should take about 1 hour. Your involvement in the study is voluntary and you may choose not to participate or to stop at any time without giving reason. Some participants may feel some emotional discomfort. I can provide you with contact information if you wish to discuss your interview in the future.

Do you have any additional questions about this research project? Would you like for me to send you a flyer and/or remind you of your interview time and location? (Schedule interview if they agree to participate). Also, please feel free to contact me, Rebecca at (507)508-0481 or Dr. Laura Harrison directly at (507)389-2077 or laura.harrison@mnsu.edu.

Appendix 3

Research Participant Consent Form

We invite you to participate in a research study involving an interview about your experiences as a Sexual Assault Nurse Examiner (SANE)!

Study Title: Navigating Barriers: Sexual Assault Nurse Examiner Experiences

Purpose of Research: The purpose of this study is to determine Sexual Assault Nurse Examiners' perceptions of the barriers that contribute to low numbers of SANEs in rural areas.

Procedures: At the beginning of the interview, the researcher, Rebecca Gonnering, will read the consent form to you. You will also have the opportunity to read this form yourself and have any questions you may have answered before the interview begins. After this, you will be asked to pick a pseudonym by which you will be referred to throughout the interview. Then, the researcher will begin recording the interview via an electronic voice recording device. The interview will not exceed 90 minutes.

Your signed consent form will be kept by the Principle Investigator, Dr. Laura Harrison, in her locked office for three (3) years after your interview date. After the three years, it will be shredded by Dr. Harrison.

Duration of Participation: Each interview is anticipated to last between 45 and 60 minutes depending on your responses to the questions. The researcher will alert you when the 60 minute mark has been reached and ask you if you wish to continue the interview for up to 90 minutes.

Potential Benefits and Risks to the Individual: You will be given the opportunity to discuss the particular stresses of the forensic nursing profession in a supportive environment. You may feel uncomfortable discussing certain questions about your profession.

Voluntary Nature of Participation: Your participation in this research study is voluntary. You have the option not to respond to any of the questions. You may stop the interview at any time by telling the researcher to end the interview. Ending the interview will not cause any penalty or loss of benefits or compensation. Participation or nonparticipation will not impact your relationship with Minnesota State University, Mankato. If you have questions about the treatment of human participants and Minnesota State University, Mankato, contact the IRB Administrator, Dr. Barry Ries, at 507-389-2321 or barry.ries@mnsu.edu.

Initial: _____

Electronic Recording Confidentiality: Your interview will be recorded using an electronic recording device. This recording will be secured on a password protected computer. Only the researcher and the Principle Investigator will have access to these recordings.

Additional Confidentiality: The recording will then be put into the researcher's computer to be transcribed by the researcher herself. The recordings will be kept on the researcher's password protected computer for three (3) years from the date of your interview and will then be deleted by the researcher. When the transcriptions are finished, they will be kept in Dr. Laura Harrison's office for three (3) years. After three (3) years, Dr. Harrison will delete all of the files.

Your personal identifying information will only be on this signed consent form. You will be referred to by your pseudonym throughout the interview and in all subsequent written information about the interviews.

Compensation: All participants will be compensated with a \$10 gift card given to them at the time of the interview.

Human Subject Statement: If you have any questions about this research project you can contact Rebecca Gonnering at Rebecca.gonnering@mnsu.edu or at 507-508-0481 or Dr. Laura Harrison at laura.harrison@mnsu.edu or at 507-389-2077.

IRB Case Number: 677063

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT. I WAS GIVEN A COPY OF THIS CONSENT FORM AT THE TIME OF MY INTERVIEW.

Participant's Signature

Date

Participant's Name

Researcher's Name

Date

Appendix 4

Interview Script

Introduction: Thank the participant for volunteering! Hand them the consent form, read it to them, and have them sign it (give them a copy to keep). After they have signed, ask them to choose a pseudonym by which they will be referred to during the interview. Then, begin recording the interview. Start with these questions:

Opening Questions:

- I am going to gather some general information first. Could you please tell me your age?
- How you identify your race or ethnicity?
- How do identify your gender?
- Including yourself, how many SANEs are there in your program?
- How many counties does your SANE program serve?
- Approximately how many sexual assault victims/survivors do you treat each month?
- Also, what was it that made you want to participate in this research study?

Research Question: What are Sexual Assault Nurse Examiners' perceptions of the barriers contributing to the low numbers of SANE nurses in rural areas?

Questions for each objective

Objective 1: To learn more about how SANEs became interested in the profession

- Can you describe when and how you first learned about SANE nursing?
- What about it made you interested in becoming a SANE nurse?
- Why did you become a SANE nurse?

Objective 2: Obtain detailed accounts of SANEs understandings of the difficulties of working as a SANE in rural areas

- How does being a SANE in a rural environment affect your work?
- Are there difficulties specific to working in a rural area? Can you tell me a story to illustrate your point?
- Do you believe your hospital is appropriately staffed with SANEs?
- Do you think SANE programs should be expanded in rural areas?

Objective 3: Obtain a detailed account of SANEs experiences of institutional/administrative pressures

- What kind of relationship does your SANE program have with the hospital? Can you give me a story to illustrate that point?
- How do you feel the hospital and its administrators view your work?
- How do others outside the program view your work?

- What could the hospital do differently to better support your work?
- Not all SANE programs are operated through hospitals. How does working within a hospital affect your work as a SANE?
- What do you enjoy about working as a SANE at your hospital? What don't you enjoy? Can you give me a story to illustrate your point?

Objective 4: Obtain detailed accounts of SANEs understandings of and experiences with burnout

- How does your work affect your relationships with friends, family, or intimate partners?
- Can you tell me a story about a time when you felt burnt out?
- What if any, support systems does your hospital have in place to prevent burnout or promote stress relief? If none, why do you think this is this the case?

Objective 5: Obtain a detailed account of what motivates SANEs to continue their work

- Prior to becoming employed as a SANE, what was your understanding of rape and sexual assault?
- How has working as a SANE changed your understanding of rape and sexual assault? Can you tell me a story to help illustrate that point?
- What motivates you to continue working as a SANE?

Final Question: I did my best to anticipate the information that would be relevant to the research study. However, being an expert in the field of forensic nursing, is there anything I left out that you would like to add?

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