Running head: NURSES' ATTITUDES TOWARDS SEX OFFENDERS

# Nurses' Attitudes towards Sex Offenders

A dissertation submitted

by

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This dissertation has been accepted for the faculty of

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## Quote

"Sometimes our light goes out, but it is blown again into instant flame by an encounter with another human being. Each of us owes the deepest thanks to those who have rekindled the inner light."

-Albert Schweitzer

## Dedication

To my professors at College of Saint Mary, for their continuous mentoring, support, and patience that guided me through this educational process. I would like to dedicate my quote to Dr. Peggy Hawkins, who is not only a mentor to faculty and students, but a leader in nursing education. And for my husband, Dr. Greg Fitzke, who never failed to express his optimism and pride in my professional endeavors. To my daughters, Keeley, Kennedy, and Delaney, no matter what challenges you face, always know I love and support you!

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To my husband, Dr. Greg Fitzke for his confidence in me and love which facilitated my completion of this dissertation. To my three daughters, Keeley, Kennedy, and Delaney, thank goodness mom is done, but may this dissertation demonstrate that learning is lifelong, hard work, and that all educational goals are achievable. And Keeley, thank you spending a Friday night with me working on my references.

Finally, I extend appreciation to my in-laws, Carl and Carolyn Fitzke, who have always provided me with unconditional loving support and generously helped with the girls.

Table of Contents

# LIST OF TABLES

TABLE PAGE

# LIST OF FIGURES

FIGURE PAGE

## Abstract

Nurses, who provide care for their patients act out of loyalty and obligation but also, adhere to a nursing code of ethics or core values and ideals. Nurses are educated to be compassionate and nonjudgmental. One's own ethical belief may be compromised when assigned patients that are known sex offenders. However, little is known about nurses' attitudes when caring for a sex offender. This descriptive study will describe how registered nurses respond to caring for sex offenders.

The sample for this study was composed of a random selection of 1,000 registered nurses from the Midwest state board of nursing registry that were mailed postcards inviting participation in an anonymous online survey. Sixty-eight respondents completed all questionnaire items.

The research questions guiding the study were 1. What are the attitudes of nurses towards sex offenders, 2. Are there differences among *social isolation, capacity to change, blame attribution*, and *deviancy* in nurses' scores, 3. Do nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender, and 4? Do nurses with specific sex offender education score differently than those without specific sex offender education?

Survey Monkey© was the online survey tool to collect data from the participants. The data were analyzed using SPSS software to perform descriptive and *t*-test analysis. Overall results from the data revealed that a majority of

nurses practice nonjudgmental care to all of their patients, regardless if the patient is a known sex offender. Further studies should be initiated to investigate nursing who actually work predominately with sex offenders and in forensic nursing.

# Nurses' Attitudes towards Sex Offenders

## CHAPTER I: INTRODUCTION

### Purpose of the Study

The purpose of this study was to explore nurses' attitudes towards sex offenders. Generally, the image of a sex offender is non-descriptive and unclear. Many offenders begin sexually abusing for a multitude of reasons. Regrettably, they do not fit in any certain discreet categories (Robertiello & Terry, 2007). Federoff & Moran (1997) found the term "sex offender" to evoke a great deal of anxiety in society. It is commonly assumed that professional nurses treat and care for all types of patients equally. The purpose of nursing includes advocating health, encouraging healing, and providing the best quality care without bias. Although nurses are educated to be compassionate and nonjudgmental, one's own ethical belief may be compromised when assigned patients that are known sex offenders. Hopper (2008) ascertained that everyone's way of thinking and opinions were easily influenced by their emotions and moral commitment. If attitudes are influenced by emotions, the stigmatizing of certain patients could occur by nurses. Nurses' attitudes have important implications for their practice, which include unbiased quality of patient care.

Little research has been conducted regarding how nurses respond when caring for a sex offender. Of further note, past research found regarding nurses' attitudes towards sex offenders have limitations. Results of this study could be

helpful and used to educate future and current nurses regarding caring for certain types of patients in their practices.

## Background and Rationale

Because of the perception of increasing sexual violence, public concerns and awareness have escalated (Brown, 1999). Despite the contention that sexual victimization is not always reported, official government statistics may not indicate a genuine number of sexual abuse incidences. In his review of child abuse, statistics, research, and resources, Hopper (2008) found that most abused and neglected children never come to the attention of government officials. Hopper (2008) disclosed that children revert to secrecy and tend to feel an intense shame, which could prevent them from disclosing the truth or seeking help. Alarmingly, the offender is not being punished and children are not seeking help.

Sixty percent of convicted sex offenders are living in the community either on parole or probation (Bureau of Justice Statistics, 2000). A further complication to the matter is that the neighborhood sex offender lacks a definitive identity or profile. It has been well documented that sex offenders comprise all ethnicity, races, ages, and socioeconomic backgrounds (Robertiello & Terry, 2007). Sex offenders can be a highly educated, trusted friend or family member. Beck, Clingermayer, Ramsey, and Travis (2004) identified in their review of sex offenders, that a majority of sexual abuse was perpetrated by an acquaintance or

family member. Of further note, sex offender notification or the sex offender registry is intended mainly to assist parents in protect their children against stranger assailants, which has been known to be a rare occurrence (Meloy, 2005).

Megan's Law was enacted by Congress to help keep track of sex offenders in the community setting (Graeber, 2004). Although Megan's Law protects the public in the community setting, sex offenders entering a healthcare setting as patients can be admitted without notice of their convictions for sexual abuses. Nevertheless, sex offender patients seeking care in healthcare settings; assumedly escape stigmatization from nurses' because their past convictions go undetected. Previous research has suggested that advanced practice nurses lacked awareness of whether sex offenders were patients in their practices (Rash & Winston, 2007). It could be argued that nurses are acculturated to be compassionate and nonjudgmental to all patients and family members seeking care. Nurses are known and educated to encompass the sick and meet the needs of others. Nursing is based upon core values and is a profession which respects human dignity, autonomy and one's own uniqueness (Clark & Aiken, 2003).

Contrary to this belief, Correy & Goren (1998) discovered that nurses traditionally stigmatized sex offenders. Undoubtedly, the attitudes of some nursing professionals can affect their patient care practices if nurses encountered known sex offenders. Kelley (1990) offered a differing opinion. Kelley's study

found nurses, protective workers, and police officers to have a positive attitude towards sex offenders. Particularly, this research used a sample of nurses, who contributed less blame and offered minimal punishment to sex offenders. In other studies, public opinions and attitudes on sex offenders are highly negative (Vallient, Furac, & Antonowicz, 1994; Corey & Goren, 1998).

Church, Wakeman, Miller, Clements, and Sun (2008) found that numerous studies acknowledged the limitation of adequately measuring attitudes specifically towards sex offenders. In their study, Church, et al., examined individuals' attitudes towards sex offenders. The primary goal of their research was to develop a reliable and valid instrument to measure the public's opinion on sex offenders. Church, et al, (2008) also found that professionals working with sex offenders did display more favorable attitudes as opposed to negative general public opinions which lacked experience with sex offenders.

The research questions of the present study are as follows:

1. What are the attitudes of nurses towards sex offenders?
2. Are there differences among *social isolation*, *capacity to change, blame attribution,* and *deviancy* in nurses' scores?
3. Do nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender?
4. Do nurses with specific sex offender education score differently than those without specific sex offender education?

## Assumptions

The underlying assumption of this study was that nurse' attitudes towards sex offenders could be understood and identified by utilizing the Community Attitudes towards Sex Offenders (CATSO) Scale (Church, et al.,) online questionnaire. It was assumed that nurses' who partake in the anonymous online survey will be open and honest with their thoughts and attitudes regarding sex offenders.

## Limitations

A delimitation of this study is that only 1,000 registered nurses will receive a postcard inviting them to participate in the online survey. This study will not account for the all registered nurses' attitudes towards sex offenders in the Midwest. A limitation to this study is that nurses knowing they are being studied on their own attitudes towards sex offenders may change or alter their opinions due to the Hawthorne Effect and that response could influence the outcome chosen to be measured.

## Definitions of Terms

The following operational definitions were used in this study:

**Nurse:** Represents a professional who is educated to care and advocate for the ill and disabled, regardless of type of patient, families, communities or practice setting (Stanhope & Lancaster, 2002).

**Attitudes:** A way a person thinks or acts (Kelley, 1990).

**Stigma:** The shame attached to something that's regarded as socially unacceptable (Lauber, Nordt, Braunschweig, & Rossler, 2005).

**Sex Offender:** Defined as person convicted of sex crimes; or that entails rape, molestation, sexual harassment and pornography. Typically, the term is associated with child molestation, but not limited to child molestation. (Robertiello & Terry, 2007).

**Sexual Assault:** Refers to inappropriate sexual contact without voluntary consent to the perpetrator (Robertiello & Terry, 2007).

**Victim:** Represents a person who has been physically or mentally harmed by a perpetrator (Kelley, 1990).

**Parole Officer:** Serves under the court system to protect and enforce a court sentence for someone criminally charged (Kelley, 1990).

**Correctional Center:** Refers to a place where a person convicted of a crime is sent for punishment and rehabilitation (Robertiello & Terry, 2007).

**Rehabilitation:** Refers to therapeutic guidance in molesters' behaviors and thoughts (Grossman, Martis, & Fichtner, 1999).

**Recidivism**: Defined as a convicted criminal re-offending (Grossman, Martis, & Fichtner, 1999).

**Treatment:** Refers to the act, manner, or method of helping someone to improve (Grossman, Martis, & Fichtner, 1999).

# Chapter II: LITERATURE REVIEW

## Historical Context

### Sex Offender History

Prior to 1994 few states required convicted sex offenders to provide to the public and local law enforcement their presence in the community and their addresses (National Center for Missing & Exploited Children, 2009). Because of the perception of increased incidences involving sexual crimes and public outcry, Congress passed the Jacob Wetterling Act in 1994, requiring all states to register sex offenders (National Center for Missing & Exploited Children). In 1996, national attention was focused on the tragic murder of a seven year old Megan Kanka by a released sex offender living in her neighborhood. Megan's Law was enacted. This federal law mandated that the public is provided the information regarding released sex offenders (National Center for Missing & Exploited Children, 2009). However, beyond that requirement, states impose their own policies and restrictions containing sex offender information that are still being challenged everyday (Salvemini, n.d.). Some basic realities that question policy makers are: most sex offenders are not in prisons, they are largely unknown to the public, sex offender statistics validate a high rate in re-offending or recidivisms, and the state system for tracking and supervising sex offenders is inundated (National Center for Missing & Exploited Children, 2009).

## Attitudes towards Sex Offenders

Sanghara and Wilson (2006) study was to determine the dangers of stereotyping a sex offender, which then could allow the perpetrator to avoid being caught. Sixty specialists involved with sex offenders (nurses, police officers, parole officers, psychologists) and 71 school teachers were the participants in this study. Three questionnaires were distributed: the Stereotypes of Sex Offenders Questionnaire; Attitudes towards Sex Offenders Scale; and Knowledge of Child Abuse Questionnaire (Sanghara & Wilson, 2006). A mediation analyses was then performed to relate the scores between the questionnaires. Overall, the results of this study showed that experienced professionals supported less negative stereotyping behavior towards sex offenders. Notably, the professionals also regarded sex offenders more positively than in light of their attitudes towards them. Experienced professional who provided therapy with sex offenders (such as, nurses, police officers, parole officers, and psychologists) had comparatively more positive attitudes then the inexperience group (for example, school teachers) who had little known interaction and less knowledge. The inexperienced group (school teachers) expressed throughout the questionnaires, little knowledge in regards to sex offenders and child abuse. Conclusions of the Sanghara and Wilson study found that in general, those with less knowledge about potential sex offenders tend to negatively stereotype more and increase their danger. The authors indicated that

more reliable information was needed regarding child sexual abuse and knowledge to help understand and avoid detrimental effects.

Nelson, Herlihy, and Oescher (2002) conducted a qualitative study investigating counselor's attitudes towards sex offenders. A total of 264 participants of the study were professional counselors who were members of the Association for Mental Health Counselors of America (AMHCA) and the International Association of Addictions and Offender Counselor (IAAOC) who answered a researcher-constructed questionnaire. A statistical significant result predicted a positive attitude with counselors towards sex offenders. The second result indicated that counselors reflected more positive attitudes than any other professionals when working with sexual predators. In conclusion, the Nelson, Herlihy, and Oescher study indicated that counselors hold a positive attitude while working with sex offenders. Possible explanations to this finding were that counselors are educated to be nonjudgmental and unbiased throughout their college program. Ultimately, this would provide good reasoning regarding why the public views sex offenders very negatively than licensed counselors. Nelson, Herlihy, and Oescher suggested additional research to explore the different treatment approaches and strategies that proved to be most effective with this type of offender.

Steed's study contradicted the findings of Nelson, Herlihy, and Oescher's 2008 study. Steed (2001) examined Secondary Traumatic Stress (STS) symptoms and the correlation between therapists closely working with sex

offenders. The Steed study had took place in Australia, used a 66-item questionnaire to measure compassion fatigue, compassion satisfaction, and burnout on a sample of 67 therapists. According to Steed (2001) this study used a five-point Likert scale, “to reflect the degree of distress, rather than the frequency, therapists have experienced” (p. 4). Results indicated that therapists working with sex offenders were found to have a negative impact and a moderate to high risk of developing compassion fatigue. Another finding indicated the therapists to be at high to moderate risk of professional burnout. New therapists were found to be more vulnerable to STS than experienced therapist. The2001 Steed study also indicated several possible reasons, to why no statistical significant were found. A main reason was the limited time frame the participants felt, while being questioned regarding their experiences working with offenders. The researcher denotes that the instructions were possibly altered from early participants who stated they thought they had a limited response and short time frame to answer questions. In conclusion, this study indicated STS for therapists while working with sex offenders. Additional education programs were implemented for all therapists to raise awareness of the occurrence of STS to be recognized and acknowledge.

Seidl, Stanton, Pillitteri, Smith, and Boehler (1993) investigated nurse’s attitudes towards dealing with the sex offenders and their victims. This descriptive study sampled 318 registered nurses attending a mandatory course for relicensure on child abuse. A questionnaire developed by four nursing

students resulted in an 84% return rate. Several research questions were asked in this study relating to nurses perceptions on dealing with the victim, the offender, and the actual abuse. The results showed nurses were less than comfortable with dealing with sexually abused children. Strong significant differences were recognized between the comforts of nurses caring for sexual abuse patients who were victims of either physical or emotional abuse. One finding indicated that the nurses were the most uncomfortable caring for the fathers in a sexually abusive situation. No statistical differences were noted using the Chi-square analyses between the nurse's demographics and their comfort level. However, the study did find a statistical difference in some types of abuse and the sex of the nurse. The Seidl, et.al, (1993) study recommended the inclusion of nursing schools to incorporate sexual abuse of victims and offenders into the curriculum of nursing study.

The Rash & Winton (2007) research study investigated advanced practice nurses' (APN) attitudes and their behaviors towards sexual perpetrators who they care for in their practice. A local APN organization sent online surveys to 300 members. Unfortunately, only 69 participates submitted their responses to the survey. The online survey comprised of 14 demographic questions and a 15-item behavioral response questions to case scenarios.

In the Rash and Winston study the researchers used a four-point Likert scale for the behavioral responses. Findings indicated that 88% of the APNs had no personal experience with sexual abuse. According to Rash & Winton a strong

agreement between the participants were seen with the following: “referring patients to an adult-only practice (N=66), instructing the staff to diligently observe for any sexual inappropriate behavior (N=64), informing the staff of the patient’s identity and inclusion on the registry (N=64), having the receptionist keep an eye on the waiting room when patient is present (N=64), prominently posting a sign stating, “children under the age of 12 are not to be left unattended” (N=64), scheduling the times when there is less likelihood of contact between the patient who is a sex offender and children (N=64), and reassuring the offender that the practice is safe and comfortable place for all patients (N=64)”(p. 300). Ambiguity was found with the sample APN in regards to their attitudes and lack of awareness among sexual offenders as patients in their practice setting. Overall, the study indicated that APN’s were unaware of sex offenders in their practice. Further research suggested using a qualitative approach to possibly detecting more data on this subject.

According to Levensen, Brannon, Fortney, and Baker (2007) public perceptions regarding sex offenders “provoke a great deal of stress” (p. 1). This study investigated the public’s perception regarding sex offenders, recidivism rates, and protection policies (Levensen, et al., 2007). The sample consisted of 193 participants in Melbourne, Florida (Levensen, et al., 2007. A questionnaire was developed and distributed while people were waiting at the Department of Motor Vehicles (DMV).

Findings of the Levensen, et. al (2007) study indicated that a majority of the DMV respondents wanted to be informed of sex offenders living in their neighborhoods. The participants indicated a strong belief of sex offenders re-offending or recidivism. Another finding indicated that the respondents were supportive of strong sentencing, treatment, and probation laws for sex offender. Lastly, females in the study indicated more fear of male sex offenders than their non-sexual offender male counterparts. Parents were also rated as being angrier towards the sex offender than non-parents in the study. The hypothesis of the study was accepted because the public had perceived attitudes and beliefs towards sex offenders.

## Ethical Dilemmas

Little research has been found to support the ethical issues in the treatment of sex offenders. Toman (2003) published a paper that focused on several ethical issues regarding the treatment choice with sex offenders and neutral therapists. This article discussed the ethical dilemma with imposing one's own thoughts and beliefs onto the convicted individual. Toman questioned the validity of proclaimed neutral therapists who work closely with sex offenders. Toman states, "he is not neutral nor value free" (p. 4). By role modeling a different way of thinking for the individual, Toman, claimed his own ethical and moral values provided a strong sense of boundaries to the offender. On further note, Toman points out that the aim of therapy is not to change the sex offender's arousal pattern, but to change their behavior to the stimulus. For instance, a

sexual offender will not be able to change their behavior into a constructive way of life until the sex offender incorporates clear values.

A study written by Schneider and Levinson (2005) divulged various different categories of ethical dilemmas related to therapist working with sexual predators. This study described many possible scenarios of dilemmas so diverse that the chance of two therapists handling the situation with the same outcome was slim. One conceding agreement unanimously supported by the authors viewed safety of others as always superseding client confidentiality and loyalty. Toman (2003) and the Schneider and Levenson (2005) studies shared similar strategies when working closely with sex offenders. Schneider and Levenson stated that if the therapists shared parts of their lives while making a case of being "genuine, modeling the successful navigation of life's inevitable problems, and offering a strategy or response that the client can relate to and perhaps incorporate into his or her journey" (p. 23). In the conclusion, Schneider and Levenson noted that sure ways to fail the patient and themselves as therapists were thinking they had all the right answers.

The Glaser (2005) research study discussed the certainty of mental health professionals practicing a unique code of ethics while treating sexual offenders, which was unlikely with other professionals (parole officers, police officers, lawyers, correctional facilities). The major salient features discussed by Glaser were establishing a therapeutic relationship, the at-risk client (related to their judgment and thought process), and client rehabilitation.

Glaser (2005) highlighted client/therapist conflict when encouraging the offender to be open and honest regarding their offenses (including any new interactions) will help the client trust the therapist. However, admitting or disclosing new information regarding offenses could self-incriminate the offender and may damage him further. According to Glaser, research has shown that treatment program techniques have decreased risk for some offenders. Although, Glaser did not want to confuse the reader by correlating the terms, treatment and punishment, there is a differences between the two terms in reference to sex offender therapy. The apparent distinctions that Glaser points out are that a treatment technique works as a form of punishment in the treatment setting. Mental health clinicians cannot ethically justify the treatment technique to be classified as therapeutic for these types of patients, when it is applied as punishment (Glaser). In his review of the sex offender literature, Glaser found that treatment programs were linked to a “problem solving court”, this enabled sex offenders to either comply with the treatment program and gain increase liberty or refusal of treatment program that will result in a stronger punishment by the court system (p. 159).

A special report written by the Methodist Church Council of Great Britain (2000) covered very important resolutions and procedures for when, or if, a sexual offender seeks to become a member of the Church (The Methodist Church of Great Britain, 2000). The church is faced not only with ethical dilemmas, but spiritual ones as well. This report pointed out that the church’s

vision and mission is to be an accepting, welcoming congregation. The Methodist Church of Great Britain states, “We have a responsibility to bring together people of diverse and sometimes conflicting experience within the same community of love” (p.16). However, when allegations of occurrences involving church members and tensions arose church members became deeply divided between the alleged perpetrator and the victim and their families. This ethical dilemma was termed by the church as resolved. However, it was decided that if this event should occur again, specialist advice, support, and assistance would be required. This would ensure the pastoral needs of all the congregation members to be dealt with and taken seriously.

## Theoretical Context

This study takes its theoretical framework from one of the earliest nursing theorist, Hildegard Peplau. Peplau’s theory focused on the interpersonal processes and therapeutic relationships that develop between the nurse and client (Townsend, 2005). Peplau described the interpersonal process as the stages of overlapping roles that the nurse and patient learn to work together and resolve problems. Overall, Peplau’s theory ascertained the importance of nurses’ abilities to understand their own behaviors and accept clients unconditionally. (Townsend, 2005).

It is clear in Koh’s (1999) article that nurses are bound to a high standard of moral conduct. On further note, the nursing code of ethics is a common theme

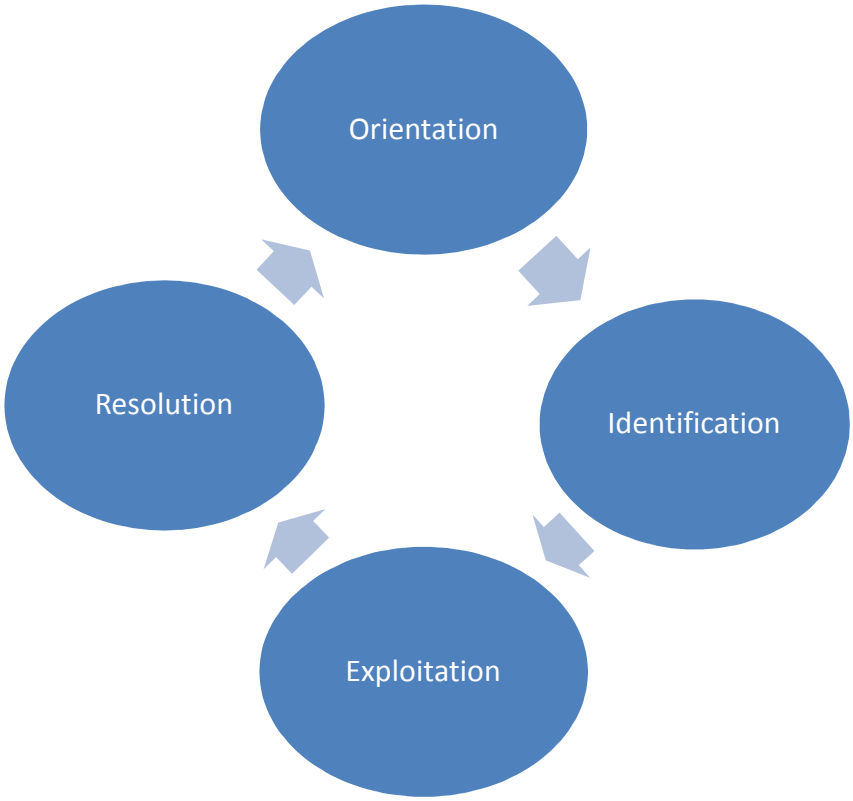
worldwide; an expected nurse's moral position is non-discrimination. The registered nurse must be respect the uniqueness of each patient and provide non-judgmental care regardless of the nature of the health problem or patient's lifestyle.

Peplau (1991) encouraged the nurse to go beyond the physical caring of a patient and meet the entire needs of the patient. This would establish a nurse-patient therapeutic relationship. Peplau (1991) described this relationship as a partnership, where the nurse has put all past judgments or opinions aside, to competently care and value the patient. Nurses demonstrate this relationship by becoming close to their patients in order to gain insight on their current medical dilemma.

Peplau (1991) established a theoretical framework correlating the team work approach of a nurse and client interpersonal relationship. She ascertained that both the nurse and patient developed during a health situation when working and learning together. In the context of nursing, Peplau (1991) maintained that: "nursing can function as a maturity force in society" (p. 159). Since illness is an event that is comprised of past experiences, but are re-enacted in the relationship of nurse-to-patient, the nurse-patient relationship is seen as an opportunity for nurses to help patients complete the unfinished psychological tasks of childhood in some degree.

# THEORECTICAL FRAMEWORK

Peplau's Four Phases of the Nurse-client Relationship (Townsend, 2005).




(Fitzke, 2009)

The four phases that Peplau designed as the nurse-patient relationship are:

- **Orientation:** Nurse and patient come together to form a union and work together on a problem (Townsend, 2005)
- **Identification:** Patient feels a sense of belonging and responds to those who meet their needs; actively participates in goal-setting (Townsend, 2005).
- **Exploitation:** Patient participates in care and takes full advantage of others who can help their needs (Townsend, 2005).
- **Resolution:** This phase occurs when all the other phases one have been completed successfully. (Townsend, 2005).

Summary

Peplau ascertained the importance of integrating the nurse-patient relationship as a partnership (Townsend, 2005). The nurse must put aside all patient differences, past behaviors, and opinions in order to care for the client as a whole. Nonjudgmental care is a professional obligation for nurses. In order to meet a healthy nurse-patient relationship, nurses must display high standards and practice a strong moral code of ethics.

# CHAPTER III: METHODS AND PROCEDURES

## Research Design

Descriptive research ascertains new meaning, describes the present, determines when it occurs, and classifies the information seized (Burns & Grove, 1999). The main outcome of a descriptive design is to make decisions or determine what others are doing in a relation to a similar situation. Polit and Beck (2008) found descriptive research as a pathway to simply explain relationships and develop effective interventions. Therefore, the present study was descriptive in nature and differentiated nurses' attitudes towards sex offenders. It investigated whether attitudes differed in response to *social isolation, capacity to change, blame attribution,* and *deviancy* in nurses' scores. It further examined if nurses who have knowingly cared for sex offenders score differently than nurses who have not knowingly cared for sex offenders. Finally, the study explored whether nurses with specific education on sex offenders score differently than those nurses without specific education on sex offenders.

The quantitative study was designed to collect online data via a questionnaire. To add to the quality of the study and the richness, a representative sample of registered nurses and the survey approach found common attitudes towards sex offenders. Gable (2000) found that ensuing survey methods provided comprehensive statements about the purpose of the study. Descriptive data were extrapolated from the participants' online responses to the devised questionnaire and then analyzed in a Statistical Package for the

Social Sciences (SPSS) for the results. The study was based on initial data and conclusions made by the researcher in furthering the understanding of nurses' attitudes towards sex offenders.

Identification of Sample

The population surveyed in this study was limited to registered nurses in Midwest. A random selection of 1,000 nurses received postcards in the mail, inviting RNs to take the online survey via Survey Monkey© with the direct link to login on the postcard. A reminder postcard also followed after several months to remind the nurses of the current study. The sample of nurses was drawn from the public records of the Nebraska State Board of Nursing. Criteria for inclusion in the study were that the heterogeneous subjects were licensed registered nurses, with varied nursing experience, variable ages, male and female, inclusion of all ethnicities, and all socio-economic backgrounds. The sample also included participants possessing a diverse educational background. Simple random sampling was obtained until 1,000 nurses were extracted from the registry.

Willingness to participate in the survey was assumed by each participant's submission to the online questionnaire. Approval was obtained from College of Saint Mary's Institutional Review Board (IRB) prior to the study. The survey did not collect names or individual identifiers. Participants were informed on the postcard that the online survey was anonymous and solely based for a doctorate student's research. There were no financial obligations or compensation awarded to the participants for partaking in this study.

## Demographics

The final part of the online questionnaire was designed to provide overall demographic data related to the respondent. No personal identification information was requested or sought. Study demographic variables included gender, age range, highest educational background achieved, personal experiences with sex offenders, and whether or not specific educational content on caring for sex offenders was previously completed. These demographics were utilized to verify the characteristics of the sample from which the responses were created.

## Description of Setting

Research participants were able to conduct and perform the online survey from their preferred setting of choice. A computer with internet access was the necessary electronic device needed to access the anonymous online questionnaire.

## Questionnaire

For this study a questionnaire was utilized to facilitate the collection of quantitative data. The Community Attitudes toward Sex Offenders Scale (CATSO) was utilized as the online questionnaire. The researchers whose materials were synthesized for this online questionnaire included Church, Wakeman, Miller, Clements, and Sun, (2008). Written permission was obtained from Dr. Church to utilize the CATSO scale as the online questionnaire tool for this study. The questionnaire consisted of 18 statements about sex offenders and

sex offenses and six demographic questions (see Appendix A for the questionnaire). Each question measured nurses' beliefs and opinions regarding sex offenders by using a six-point Likert-type scale with "1 as strongly disagreeing" and "5 as strongly agreeing". The middle portion of the six-point Likert scale was "3 as probably disagreeing". For example, one particular question was as follows: "Most sex offenders are unmarried men".

Church, et. al., (2008) found that the 18-item questionnaire produced four factors; *social isolation, capacity to change, blame attribution, and deviancy*. The researchers defined the four factors as follows: *Social isolation:* defined as isolation and evading of social contact and communication, *Capacity to change*: refers to the ability to change their character from treatment or punishment over a time period, *Blame attribution*: displacing blame unto others, to remain blameless or to accept blame, which was termed a neurotic defense mechanisms, and *Deviancy:* defined as behavior that is different from the standard or cultural norms in society. These four factors enabled the scoring system with the questions as follows: Factor 1 *(Social Isolation)*: questions 6, 7, 8, 14, and 16; Factor 2 *(Capacity to Change*): questions 1*, 2, 11, 12, and 18; Factor 3 (*Blame Attribution):* questions 4, 9*, 13*, 15, and 17; Factor 4 (*Deviancy)*: questions, 3, 5, and 10. The four factors with the asterisk marked number in relation to the questionnaire items were then reversed scored when computing the factor and total score. Total scores were computed by adding all four factors together.

According to Church, et al., (2008), a high questionnaire score denotes a more negative attitude towards sex offenders by the participant.

Church, et al., (2008) determined the tool to be reliable and valid based on the administration of the questionnaire in two phases, with the participants being undergraduate psychology students at a major southern university. Of further note, Church, et. al., (2008) discovered this prepared the direction of the 18-item questionnaire to be more reliable. Church (et. al., 2008) reported that Cronbach's alpha was utilized to determine good internal consistency for the CATSO and the factors, excluding factor 4, *deviancy.* The coefficient alphas reflecting internal consistency were reported as *Social Isolation* (0.80); *Capacity to Change* (0.80); *Blame* (0.70); *Deviancy (0*.43); and total CATSO (.74). It is likely that the CATSO can assess attitude change and investigate time (Church, et. al., 2008). The researchers advised that the CATSO scale was apposite for a larger population rather than individuals or as a clinical assessment tool. It should be noted that Church and colleagues (2008) discovered that the predictive validity of the CATSO was not addressed. However, the researchers indicated that future studies would be needed to better understand views on sex offenders (Church, et. al., 2008).

Procedure

An online survey tool, Survey Monkey.com© (1999) was used to administer the online questionnaire. With access to Survey Monkey©, the questionnaire tool was reconstructed onto the survey format. The researcher sorted the nurse

registry based on issue date of nursing license from newest to oldest. The dates were then separated into five categories; category 1, 1955-1965; category 2, 1966-1976; category 3, 1977-1987; category 4, 1988-1998; and category 5, 1999-2009. Upon further deduction from the registry, 20% of the nurses from each category were compiled to balance the age groups. Once the nurses were randomly selected from the public records, a mailed postcard sent to their listed address invited them to participate in an online survey. Participants were informed on the postcard that the online survey was anonymous and solely based for a doctorate student's research. A reminder postcard was also mailed at a later date (see Appendices D and E for both postcards). All postcards had information regarding contacting researcher via email.

Participants were asked to login with a web address to access the survey through Survey Monkey©. Once on the specified site, informed consent was included at the beginning of the questionnaire. Voluntary consent and willingness to participate in the survey were assumed by the participant's completing the questionnaire. The estimated time for completion of the survey was projected at 5-10 minutes. All data were collected online from Survey Monkey© by the researcher. No identifying codes were used to link the data to any one online response.

Statistical Tests

Statistical Package for the Social Sciences (SPSS) was the software utilized for the results. A measure of Central Tendency (Mean, Mode, and

Median) was also compared; (1) Compare mean scores of attitudes, (2) compare scores of social isolation, capacity to change, blame attribution, and deviancy (ANOVA), (3) Compare mean scores of those who have knowingly cared for sex offenders and those who have not knowingly cared for sex offenders (t-test independent), and (4) Compare mean scores of nurses with specific education and those nurses who have not had specific educational content. Reliability was tested utilizing Cronbach's alpha.

## Summary

There were 69 respondents who logged on to the online questionnaire. However, one respondent was removed due to an incomplete questionnaire. The completed questionnaire data were instilled into SPSS. Descriptive statistics and *t*-tests were utilized to determine mean differences between questionnaire items.

# CHAPTER IV: RESULTS

## Introduction

The purpose of this quantitative descriptive study was to investigate and differentiate nurses' attitudes towards sex offenders using a questionnaire of 18 statements. The questionnaire also collected data regarding nurses' practices and previous experiences with sex offenders. The Web host site, Survey Monkey©, collected and initially analyzed the data. SPSS was utilized by the researcher and a College of Saint Mary statistician for calculating results. Specifically, the research questions for this study were:

1. What are the attitudes of nurses towards sex offenders?
2. Are there differences among *social isolation, capacity to change, blame attribution*, and *deviancy* in nurses' scores?
3. Do nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender?
4. Do nurses with specific sex offender education score differently than those without specific sex offender education?

Several hypotheses that can be derived from this quantitative finding were as follows: There will be no differences among social isolation, capacity to change, blame attribution, and deviancy in nurses scores on the survey, There will be no differences on the scores of nurses who have cared for sex offender and nurses who have not cared for sex offenders, and There will be no differences on the scores of nurses who have had specific sex offender

education and those nurses who have not had specific sex offender education. The remainder of this chapter is divided into three main parts and will focus on presentation of data, data results, and summary of statistical findings. Part I is a demographic overview of respondents and includes a summary of gender, age range, highest nursing education degree, experiences caring for a sex offender in practice, and previous specific educational content in nursing practice on caring for sex offenders. Part II of the chapter will discuss each of the four research questions proposed. Part III will summarize significant findings and results. Tables and figures are used to help explain and summarize data findings. Chapter IV concludes with a summary discussion that will enhance the objective of this research.

## Part I: Sample Profile

### Demographic Overview

The sample for this research study was comprised of active registered nurses from the Nebraska State Board of Nursing public records. Postcards and reminder postcards were mailed to a random sorted collection of 1,000 nurses. A criterion for selection was to be an active registered nurse in the State of Nebraska. No exclusion criterion was utilized in the research. Per statistician, a power analysis was conducted and estimated at a 10% respondent rate. However, a total of 69 online surveys were electronically submitted. Based upon incomplete feedback, only one respondent omitted a large number of questions

on the survey and was not included in the data analysis. Nineteen surveys were returned to the researcher due to incorrect mailing addresses. Participants consent was obtained by activating the login provided on the postcard and willfully continuing the survey. A small pilot study was initiated prior to the research.

Descriptive statistics were used to summarize data and characteristics of the sample. Data analysis of descriptive statistics provided pertinent information through frequency distribution and measures of central tendency by illustrating and describing the mean, median, standard deviation, and range.

Gender

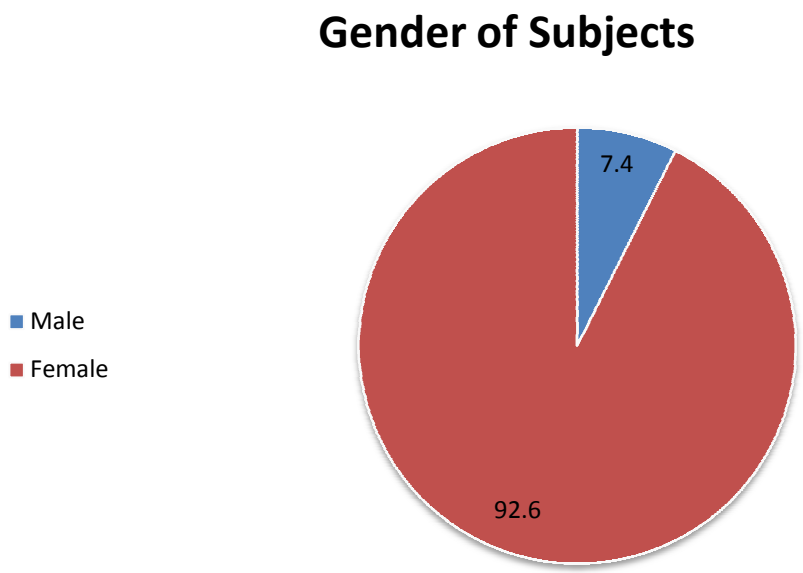
The majority of respondents were female (93%). Only seven percent of respondents were identified as males. Although, this may appear as a serendipitous finding, the disproportionate number of female responses was similar to the State of Nebraska's proportion of females dominating active practicing nurses.

Table 1

*Gender of Subjects*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Male | 5 | 7.4 | 7.4 | 7.4 |
| | Female | 63 | 92.6 | 92.6 | 100.0 |
| | Total | 68 | 100.0 | 100.0 | |

Figure 1




Educational Degree

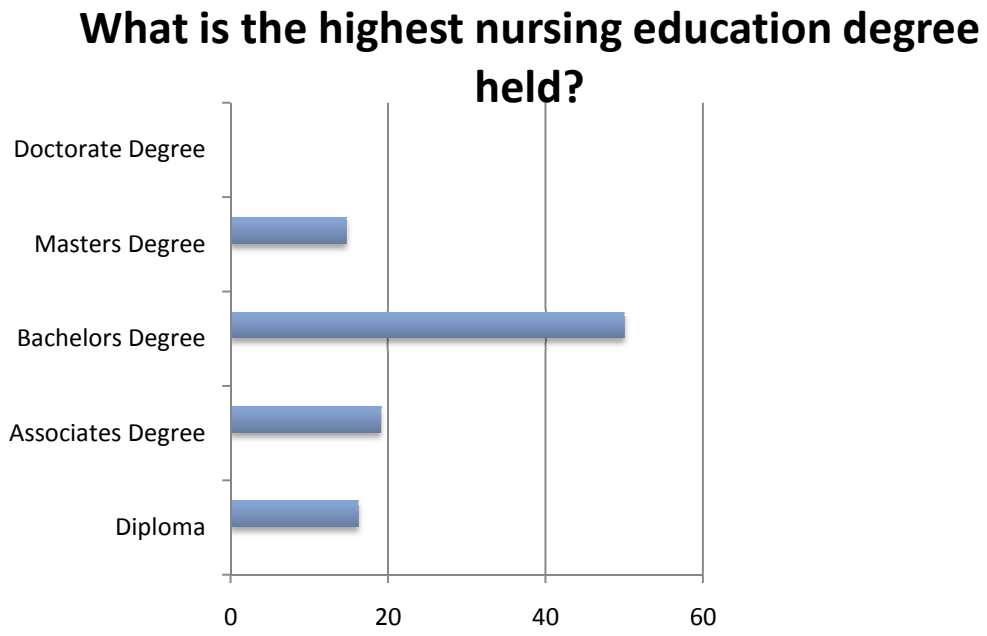
Table 2 presents the educational level reported by participants in the study. Participants were asked to identify their level of education. Based upon results from the computed data the highest nursing education degree achieved was baccalaureate-prepared registered nurses (50%). The remainder of the participants identified their degrees as having an associate degree in nursing (19%), followed by a diploma in nursing (16%). Ten participants were identified as having a master's degree in nursing (15%). Lastly, no participants were identified as doctorate-prepared nurses.

Table 2

*Highest Nursing Education*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Diploma | 11 | 16.2 | 16.2 | 16.2 |
| | Associate | 13 | 19.1 | 19.1 | 19.1 |
| | Bachelors | 34 | 50.0 | 50.0 | 35.3 |
| | Masters | 10 | 14.7 | 14.7 | 100.0 |
| | Doctorate | 0 | 0 | 0 | 0 |
| | Total | 68 | 100.0 | 100.0 | 100.0 |

Figure 2



Age Range

Table 3 presents the age distribution of study participants. The findings show the majority of participants were between ages 36 to 50 years (46%). The remainder of the respondents identified themselves between the ages of 20 to 35 years (16%) and 51 to 65 years (32%). The study identified the least amount of participants being 66 years or older (6%). The average age of a registered nurse in the State of Nebraska is reflected at 45 years (unmc.edu, 2006).

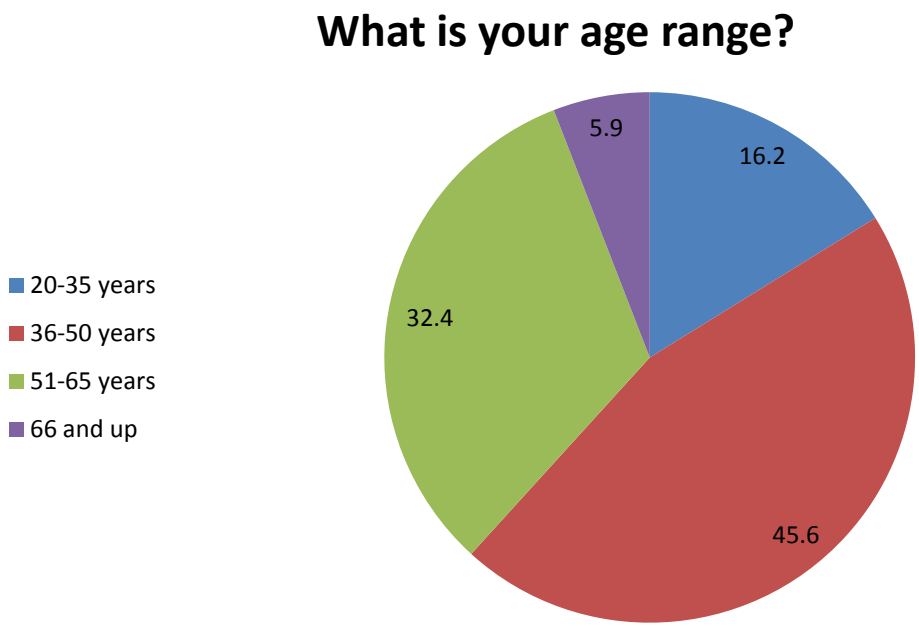
Table 3

*Age Range*

| | | Frequency | Percent | Valid percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 20-35 years | 11 | 16.2 | 16.2 | 16.2 |
| | 36-50 years | 31 | 45.6 | 45.6 | 61.8 |
| | 51-65 years | 22 | 32.4 | 32.4 | 94.1 |
| | 66 and up | 4 | 5.9 | 5.9 | 100.0 |
| | Total | 68 | 100.0 | 100.0 | |

Figure 3

Age Range




Knowingly Cared for Sex Offender

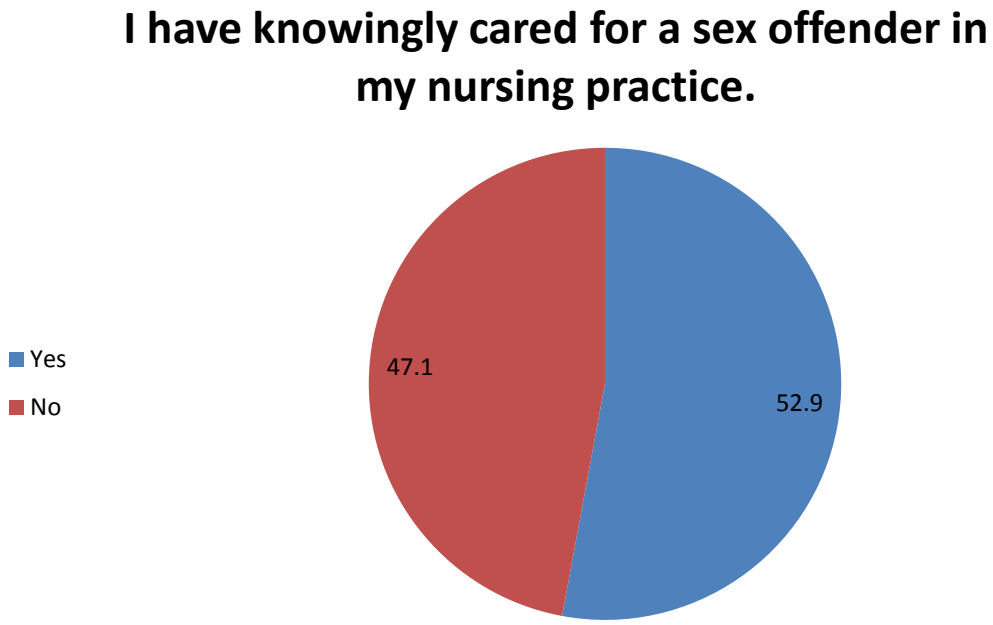
Based upon the results received most respondents had knowingly cared for a sex offender in their nursing practice (53%). Forty-seven percent acknowledged that they had not knowingly cared for a sex offender in their nursing practice. Analysis of data from a previous research study suggests that nurses do not feel comfortable working with sexual abusers, especially when it is a father who is the known perpetrator (Seidl et, al., 1993).

Table 4

*Knowingly Cared for Sex Offender*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 36 | 52.9 | 52.9 | 52.9 |
| | No | 32 | 47.1 | 47.1 | 100.0 |
| | Total | 68 | 100.0 | 100.0 | |

Figure 4




Knew Person who had Experience a Committed Sex Act

Table 5 represents participants' responses to whether they felt had stronger feelings if they knew a person who had a sex act committed on them. Nurses in this study were found to have had significantly strong feelings, when they personally knew someone who had a sex act committed on them. The

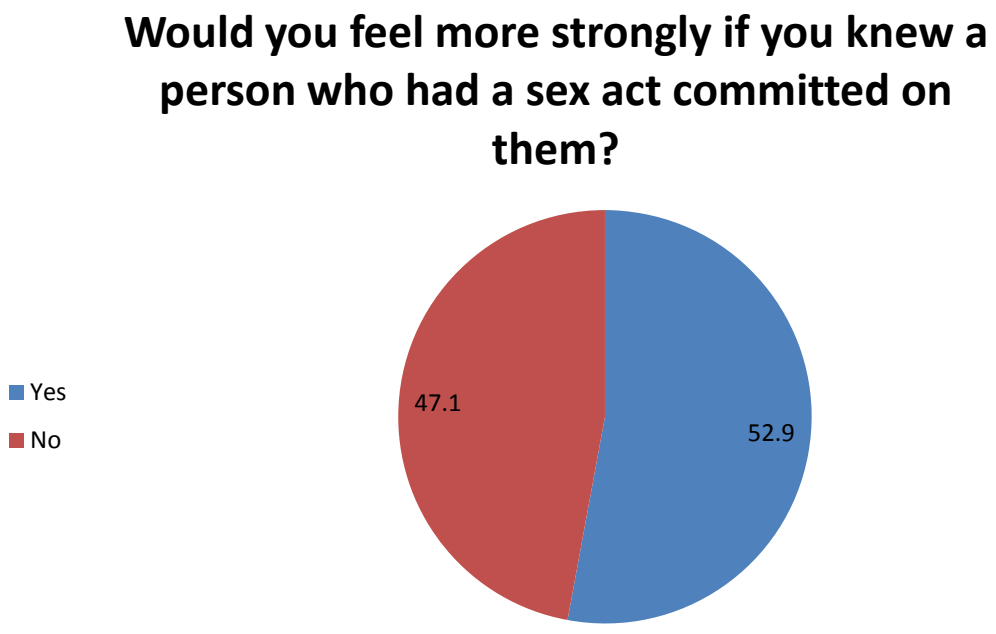
majority of the participants in the study responded “yes” (62%). Only 38% responded “no” to the question.

Table 5

Knew Person who had Experience a Committed Sex Act

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 36 | 52.9 | 52.9 | 52.9 |
| | No | 32 | 47.1 | 47.1 | 100.0 |
| | Total | 68 | 100.0 | 100.0 | |

Figure 5



Specific Educational Content

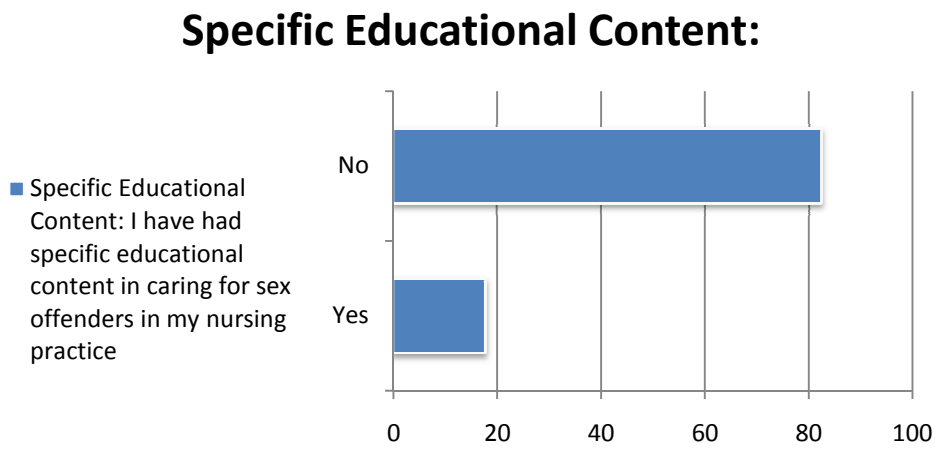
Perusal of Table 6 indicates the majority (82%) of participants had no specific educational content on caring for sex offenders in their nursing practice. Twelve participants acknowledged having specific educational content on caring for sex offenders in their nursing practice (18%).

Table 6

*Specific Educational Content*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 12 | 17.6 | 17.6 | 17.6 |
| | No | 56 | 82.4 | 82.4 | 100.0 |
| | Total | 68 | 100.0 | 100.0 | |

Figure 6



## Part II: Analysis of Research Questions

The second part of this chapter will examine the results and provide discussion for the four research questions examined and summarize the findings. Statistical significance was selected by the researcher to be p=.05. Within the 18-item questionnaire, three items were reversed scored. This action supported consistency throughout the CATSO (that is, higher scores represent more negative attitudes).The scoring was categorized as being: *Social Isolation; Capacity to Change; Blame Attribution;* and *Deviancy.* Lastly upon computing the factors, all four factors were added together to get a total score.

The research questions were as follows:

1. What are the attitudes of nurses towards sex offenders?
2. Are there differences among *social isolation, capacity to change, blame attribution,* and *deviancy* in nurses' scores?
3. Do nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender?
4. Do nurses with specific sex offender education score differently than those without specific sex offender education

### Attitudes of Nurses

Table 7 is general descriptive statistics describing the range of scores which depicts the attitudes of nurses towards sex offenders and *socially isolating* sex offenders. Church, et. al., (2008) defined *social isolation:* The withdrawal and evading of social contact and communication. Table 7 shows the minimum was 5.00, maximum 27.00, mean 12.7941, and standard deviation 3.98714.

Table 7

*Social Isolation*

| | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| *Social isolation* | 68 | 5.00 | 27.00 | 12.7941 | 3.98714 |

Table 8 graphically depicts the attitudes of nurses towards sex offenders and their *capacity to change*. Church, et. al., (2008) defines *capacity to change* as the ability to change their character from treatment or punishment over a time period. Table 8 shows the minimum was 8.00, maximum 30.00, mean 18.7206, and standard deviation 5.17123.

Table 8

Capacity to Change

| | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| *Capacity to change* | 68 | 8.00 | 30.00 | 18.7206 | 5.17123 |

Table 9 graphically depicts the attitudes of nurses towards sex offenders and their *blame attribution*. Church, et. al., (2008) refers to blame attribution as displacing blame unto others, to remain blameless or to accept blame, which was termed neurotic defense mechanisms. Table 9 show the minimum was 9.00, maximum 19.00, mean 14.2462, and standard deviation 1.85431.

Table 9

Blame Attribution

| | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| *Blame attribution* | 68 | 9.00 | 19.00 | 14.2462 | 1.85431 |

Table 10 graphically depicts the attitudes of nurses towards sex offenders and their *deviancy.* Church, et. al., (2008) defines deviancy as behavior that is different from the standard or cultural norms in society. Table 10 shows the minimum was 3.00, maximum 16.00, mean 8.3235, and standard deviation 2.39677.

Table 10

Deviancy

| | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| *Deviancy* | 68 | 3.00 | 16.00 | 8.3235 | 2.39677 |

Table 11 graphically depicts the attitudes of nurses towards sex offenders and their overall total score regarding all four factors. Table 11 shows the minimum was 30.00, maximum 75.00, mean 54.3538, and standard deviation 8.28672.

Table 11

*Total Score*

| | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| Total score | 68 | 30.00 | 75.00 | 54.3538 | 8.28672 |

Differences

Ideally a repeated measure of ANOVA would compare the sub difference of the subscales; however, the software was not available. Upon visualization of *social isolation*, mean was 12, 7941 out of 27 maximum. Upon visual deduction participants appear to score in the middle. Upon visualization of *capacity to change,* mean was 18, 7206 out of 30 maximum. Upon visual deduction, participants scored slightly over the middle. Upon visualization for *blame attribution*, mean was 14, 2462 out of 19 maximum. Upon visual deduction, participants scored over the middle range for *blame attribution*. Lastly, upon visualization of *deviancy,* mean was 8, 3235 out of 16 maximum. Upon visual deduction, participants scored right in the middle for *deviancy.*

**Caring for Sex Offenders**

Independent sample t-test analyses are a parametric procedure for testing differences in two independent groups. Independent t-test analyses were performed to determine if there were any differences between nurses who have cared for sex offenders and those nurses who have not knowingly cared for sex

offenders. Statistical significance was selected by the researcher to be p= .05. Table 12 shows there was not a statistically significant difference between *social isolation (*defined as isolation and evading of social contact and communication) scores with nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (66) = -1.71, *p* >.093].

Table 12

*Social Isolation*

| | t | df | p |
|---|---|---|---|
| Social isolation | -1.705 | 66 | .093 |

Table 13 shows the mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders and stating “yes” to the *social isolation* score, (m=12.03, *SD* =3.31) was not a significant difference from the nurses who stated, “no” in the *social isolation* score group, (m=13.70, *SD* =4.52). *Social isolation* (defined as isolation and evading of social contact and communication). The null hypothesis was accepted; thus, no statistical difference was found between nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders with *social isolation.*

Table 13

*Social Isolation*

| | | N | Mean | SD |
|---|---|---|---|---|
| Social isolation | Yes | 36 | 12.03 | 3.31 |
| | No | 32 | 13.70 | 4.52 |

Table 14 shows there was not a statistically significant difference between *capacity to change (*refers to the ability to change their character from treatment or punishment over a time period) score with nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (66) = -.558, *p* >.59].

Table 14

*Capacity to Change*

| | t | df | p |
|---|---|---|---|
| Capacity to change | -.558 | 66 | .59 |

Table 15 shows the mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders and stating “yes” to the *capacity to change (*refers to the ability to change their character from treatment or punishment over a time period) score, (m=18.40, *SD* =5.54) was not a significant difference from the nurses who stated,

"no" in the *capacity to change* score group, (m=19.10, *SD* =4.80). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders with a *capacity to change.*

Table 15

*Capacity to Change*

| | | N | Mean | SD |
|---|---|---|---|---|
| Capacity to change | Yes | 36 | 18.40 | 5.54 |
| | No | 32 | 19.10 | 4.80 |

Table 16 shows there was not a statistically significant difference between *blame attribution* (displacing blame unto others, to remain blameless or to accept blame, which was termed a neurotic defense mechanisms) scores with on nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (63) = -1.82, $p > .86$].

Table 16

*Blame Attribution*

| | t | df | p |
|---|---|---|---|
| Blame attribution | -.182 | 63 | .86 |

Table 17 shows the mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders and stating “yes” to the *blame attribution (*displacing blame unto others, to remain blameless or to accept blame, which was termed a neurotic defense mechanisms) score, (m=14.20, *SD* =1.70) was not a significant difference from the nurses who stated,” no” in the *blame attribution* score group, (m=14.30, *SD* =2.03). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders with *blame attribution.*

Table 17

*Blame attribution*

| | | N | Mean | SD |
|---|---|---|---|---|
| Blame attribution | Yes | 34 | 14.20 | 1.70 |
| | No | 31 | 14.30 | 2.03 |

Table 18 shows there was not a statistically significant difference between *deviancy (*defined as behavior that is different from the standard or cultural norms in society) scores with nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (66) = -1.10, *p* >.28].

Table 18

*Deviancy*

| | t | df | p |
|---|---|---|---|
| Deviancy | -1.10 | 66 | .28 |

Table 19 shows the mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders and stating “yes” to the *deviancy (*defined as behavior that is different from the standard or cultural norms in society) *s*core, (m=8.02, *SD* =2.60) was not a significant difference from the nurses who stated,” no” in the deviancy score group, (m=8.70, *SD* =2.17). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders with *deviancy.*

Table 19

*Deviancy*

| | | N | Mean | SD |
|---|---|---|---|---|
| Deviancy | Yes | 36 | 8.02 | 2.60 |
| | No | 32 | 8.70 | 2.17 |

Table 20 shows there was not a statistically significant difference between total score with nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (63) = -1.42, $p$ >.17].

Table 20

*Total Score*

| | t | df | p |
|---|---|---|---|
| Total score | -1.42 | 63 | .17 |

Table 21 shows the mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders and stating “yes” to the total score, (m=53.00, *SD* =7.90) was not a significant difference from the nurses who stated,” no” in the total score group, (m=55.90, *SD* =8.60). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders with all total scores and subscales.

Table 21

*Total Score*

| | | N | Mean | SD |
|---|---|---|---|---|
| Total score | Yes | 34 | 53.00 | 7.90 |
| | No | 31 | 55.90 | 8.60 |

**Specific Sex Offender Education**

Table 22 shows there was not a statistically significant difference with *social isolation* scores between nurses with specific sex offender education and those without specific sex offender education, [t (66) = .200, *p* >.84].

Table 22

*Social Isolation*

| | t | df | p |
|---|---|---|---|
| Social isolation | .200 | 63 | .84 |

Table 23 shows the mean and standard deviation of the respondents who had stated “yes “to *social isolation* for nurses with specific sex offender education and those without specific sex offender education, (m=13.00, SD=3.71). No significant difference was found with the respondents who had stated “no” in the *social isolation* score group, (m=12.80, *SD* =4.). Therefore, the null hypothesis

was not rejected and it was concluded that there was no difference in *social isolation* scores between nurses with specific sex offender education and score those without specific sex offender education.

Table 23

*Social Isolation*

| | | N | Mean | SD |
|---|---|---|---|---|
| Social Isolation | Yes | 12 | 13.00 | 3.71 |
| | No | 56 | 12.80 | 4.10 |

Table 24 shows there was a statistically significant difference between *capacity to change* scores for nurses who have had specific sex offender education and those without specific sex offender education, [t (66) = .200, $p$ <=.05].

Table 24

*Capacity to Change*

| | t | df | p |
|---|---|---|---|
| Capacity to Change | .200 | 66 | .05 |

Table 25 shows the mean and standard deviation for nurses with specific sex offender education and those without specific sex offender education. When

comparing those nurses who stated “Yes” to the *capacity to change* scores, (m=21.33, *SD* =6.30) there was a significant difference from the nurses who stated,” No” to *capacity to change* group, (m=18.20, *SD* =4.80). Therefore, the null hypothesis was rejected and it was concluded there was a difference between nurses’ *capacity to change* with specific sex offender education and those without specific sex offender education.

Table 25

*Capacity to Change*

| | | N | Mean | SD |
|---|---|---|---|---|
| Capacity to Change | Yes | 12 | 21.30 | 6.30 |
| | No | 56 | 18.17 | 4.80 |

Table 26 shows there was not a statistically significant difference with *blame attribution* scores and nurses with specific sex offender education and those nurses without specific sex offender education, [t (63) =1.21, *p*=>.22].

Table 26

*Blame Attribution*

| | t | df | p |
|---|---|---|---|
| Blame Attribution | 1.20 | 63 | .22 |

Table 27 shows the mean and standard deviation for nurses with specific sex offender education and without specific sex offender education. When compared with those who stated “Yes” to *blame attribution*, (m=14.90, *SD* =1.64) there was not a significant difference between the nurses who stated,” No” in the *blame attribution* group, (m=14.11, *SD* =1.90) Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between *blame attribution* scores for nurses with specific sex offender education and those nurses without specific sex offender educational content.

Table 27

*Blame Attribution*

| | | N | Mean | SD |
|---|---|---|---|---|
| Blame attribution | Yes | 12 | 14.90 | 1.64 |
| | No | 53 | 14.11 | 1.90 |

Table 28 shows there was not a statistically significant difference between *deviancy* scores of nurses with specific sex offender education and nurses without specific sex offender education, [t (66) =.411, *p* >.70].

Table 28

*Deviancy*

| | t | df | p |
|---|---|---|---|
| Deviancy | .411 | 66 | .70 |

Table 29 shows the *deviancy* score mean and standard deviation for nurses stating “yes” to specific sex offender education and those nurses without specific sex offender education, (m=8.60, *SD* =2.60). There was not a significant difference between *deviancy* scores for nurses who stated,” No” (m=8.30, *SD* =2.40). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between *deviancy* scores for nurses with specific sex offender education and nurses without specific sex offender education.

Table 29

*Deviancy*

| | | N | Mean | SD |
|---|---|---|---|---|
| Deviancy | Yes | 12 | 8.60 | 2.60 |
| | No | 53 | 8.30 | 2.40 |

Table 30 shows there was not a statistically significant difference between total score for nurses with specific sex offender education and those without specific sex offender education, [t (63) = 1.60, *p* >.18].

Table 30

*Total Score*

| | t | df | p |
|---|---|---|---|
| Total score | 1.60 | 63 | .18 |

Table 31 shows the total score mean and standard deviation for nurses stating “yes” to specific sex offender education and those without specific sex offender education, (m=57.80, *SD* =8.34). There was not a significant difference between total score for the nurses who stated,” No” (m=54.00, *SD* =8.20). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between total score of nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders.

Table 31

*Total Score*

| | | N | Mean | SD |
|---|---|---|---|---|
| Total score | Yes | 12 | 57.80 | 8.34 |
| | No | 53 | 54.00 | 8.20 |

Table 32 shows there was not a statistically significant difference between total score for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders [t (63) = -1.42, *p*= >.17].

Table 32

*Total Score*

| | t | df | p |
|---|---|---|---|
| Total score | -1.42 | 63 | .17 |

Table 33 shows the total score mean and standard deviation for nurses who knowingly cared for sex offenders and nurses who have not knowingly cared for sex offenders (m=53.00, *SD* =7.90).There was not a significant difference in total score from the nurses who stated," no"(m=55.90, *SD* =8.60). Therefore, the null hypothesis was not rejected and it was concluded that there was no difference between total score and all subscales for nurses who have knowingly cared for sex offenders and those nurses who have not knowingly cared for sex offenders. After table 33, the following section is a summary of chapter 4 findings.

Table 33

*Total Score*

| | | N | Mean | SD |
|---|---|---|---|---|
| Total score | Yes | 34 | 53.00 | 7.90 |
| | No | 31 | 55.90 | 8.60 |

## Results Summary

In this quantitative study, descriptive statistics depicted characteristics of respondents. The majority of respondents in the study were females (93%) and 7% were identified as males. In this study, 50% of the participants reported having a baccalaureate in nursing as the highest degree earned. The majority of respondents were between the ages of 36 to 50 years of age (46%). Most respondents reported having knowingly cared for a sex offender in their nursing practice (53%). A majority of respondents indicated having strong feelings, when they knew a person who had a sex act committed on them (63%). Most respondents had no specific educational content on caring for sex offenders in their nursing practice (82%).

While a great deal of homogeneity was seen in the findings among the respondents, behavioral response choices were representative of the literature by Nelson, Herlihy, and Oescher (2002) who discovered that counselors hold positive attitudes towards sex offenders. In the current research study, no significant findings were discovered when a nurse knowingly cared for a sex offender when compared to nurses who have not knowingly cared for a sex offender. The distribution of attitudes by nurse respondents in this study supported Peplau's theoretical framework. According to Peplau (1991) the nurse-client relationship is described as a partnership, where the nurse has put all past judgments or opinions aside, to competently care and value the patient.

The study also identified a significant finding between *capacities to change,* which was greater for nurses who had specific educational material than those who have not had specific educational content material on sex offenders. The distribution of attitudes by nurse respondents in this study supported Peplau's (1991) commitment to nurse-client partnership and collaboration.

# CHAPTER V: DISCUSSION AND SUMMARY

The purpose of this research study was to explore nurses' attitudes towards sex offenders. It is anticipated that the data will assist in developing a more complete understanding of nurses' attitudes towards sex offenders and used to educate future and current nurses regarding caring for certain types of patients in their practice. This chapter will discuss the conclusions that can be ascertained from this study and will identify areas of research needed to further the understanding of nurses' attitudes towards sex offenders. The research questions that guided this research were:

1. What are the attitudes of nurses towards sex offenders?
2. Are there differences among *social isolation, capacity to change, blame attribution*, and *deviancy* in nurses' scores?
3. Do nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender?
4. Do nurses with specific sex offender education score differently than those without specific sex offender education?

## Demographic Results

Several conclusions in connection with the sample were obtained from the data collected and presented in Chapter IV. The results of the demographic data revealed that the majority of the respondents were females (N= 63) and five were males. The majority of nurses held a baccalaureate-prepared degree (50%). The

next highest represented educational level of the respondents was the diploma in nursing (16%). The remainder of the participants identified their degrees as associate degree (19%) and master's degree (15%). No participants were identified as doctorate-prepared nurses.

The majority of participants were between the ages of 36 to 50 years (46%). According to the State of Nebraska (2004) statistics disclosed the average age of nurse was 45 years, average retirement age 62, and average age of a doctorate-prepared nurse was 53 years, which is similar to the national average of 54 years (unmc.edu, 2006).

Based upon the results of this study the majority of respondents had knowingly cared for a sex offender in their nursing practice (53%). It is interesting to note that Rash and Winton (2007) reported that out of 69 advanced practice nurses, only 5% of respondents acknowledged knowingly caring for a sex offender.

This study also revealed that nurses had significantly stronger feelings if they knew a person who had a sex act committed on them (62%). However, this major finding is unclear to the strong feelings one may have knowing a person that had a sex act committed on them. Additionally in terms of having a strong feeling, the nurses in this study were unable to differentiate strong feelings. However, behavioral response choices were representative of non-judgmental care identified in the literature (Koh, 1999). Analysis of data from a previous research study suggested that nurses do not feel comfortable working with sexual

abusers, especially when it is a father as the known perpetrator (Seidl et, al., 1993).

This study also revealed that a majority (82%) of respondents lacked specific educational content about caring for sex offenders. In their review of sex offender literature, Nelson, Herlihy, and Oescher (2002) reported that counselors who received specialized training on working with sex offenders held a more positive attitude and a feeling of being prepared while working with sex offenders. Although specific educational content may help understand sex offenders, nurses' professional obligations are committed to non-judgmental and unbiased care throughout their practice career. Such an obligation is derived from a nursing code of professional conduct that implements values and nondiscrimination towards others (See Appendix C, for Nursing Code of Ethics).

## Research Question Results

A summary of findings from the data analysis conducted in this study revealed that nurses' attitudes towards sex offenders were non-judgmental and unbiased. Peplau's (1991) theory ascertained the importance of nurses' to understand their own behaviors and accept clients unconditionally. This study supported Peplau's theoretical framework with the nurse-client relationship. No significant finding was encountered among the respondents of having a negative attitude towards sex offenders in the current study. The findings suggest that

nurses accept and upheld a strong moral position not to discriminate while caring for their patients.

No significant differences among the four subscales: *social isolation*, *capacity to change, blame attribution,* and *deviancy* in nurse's scores was indicated. These findings were viewed as a positive outcome since the participants in this study proved to be unbiased in their nursing care.

The lack of significant difference between nurses who have cared for a sex offender and a nurse who had not knowingly cared for a sex offender can be viewed as a positive outcome. The data revealed there was little difference among the nurses knowing or not knowing their patient was a sex offender. Based upon the four factors that were analyzed with the scoring process of the data, these findings may further be interpreted. Whether a nurse knew or had no prior knowledge that their patient was sex offender, *social isolation (*defined as isolation and evading of social contact and communication) was not encountered in care. The next factor, *capacity to change (*refers to the ability to change their character from treatment or punishment over a time period) also revealed no significant difference between scores for nurses who knew or had no prior knowledge that their patient was a sex offender. This positive finding is important because nurses in this study supported Peplau's theoretical framework. Nurses in this study did not indicate any *blame attribution (*displacing blame unto others, to remain blameless or to accept blame, which was termed neurotic defense mechanisms) towards sex offenders when they knowingly cared for a sex

offender. The last factor analyzed showed no significant difference among nurses regarding *deviancy (*defined as behavior that is different from the standard or cultural norms in society) among nurses when knowingly or not knowingly caring for a sex offender.

Not surprisingly, respondents identified that the *capacity to change,* is greater for those who did not have specific sex offender education than nurses who did have specific education. This positive finding is important and can be utilized in educating nurses at the beginning of their academic endeavor. Upon facilitating specific sex offender content early in nursing school curriculum, one could foreshadow that the nurses may use this education with other stigmatizing patients. The similarities between nurses regarding *social isolation, blame attribution*, and *deviancy* that had specific sex offender education and those who had not were found to show no significant findings. This finding may further be interpreted that nurses respect and accept all uniqueness and value their patients.

## Limitations of this Study

Several limitations were encountered during this study. Based upon the modest number of respondents, generalization is limited and suggests a need to obtain data from a larger, more geographically diverse sample for further studies. Secondly, participants were randomly selected from the State of Nebraska nursing registry. Additional recruitment measures might have garnered more

robust sample. Because of the homogeneity of the demographic data limitations in the ability to draw conclusions occurred in this study.

## Implications for Education

The data drawn from this study have important implications for nursing education. The hypothesis that nurses who had specific educational material on sex offenders had a greater *capacity to change* was supported in this study. Specifically, nursing schools should implement curricula that include ethical and legal dilemmas related to sex offenders. Nursing educators need to promote realistic patient scenarios and strategies that will facilitate critical thinking skills that include caring for patients who are sex offenders. Content on caring for sex offenders could be beneficial and provide future nurses with the necessary education on how to care for known sex offenders. Furthermore, this content could engage students with active learning. Nursing students could role-model scenarios that depict sex offender and demonstrate the nurse-patient non-judgmental role. Students could discuss the fundamentals of standard care and ethical practice. The results from this content could provide nurses a sense of awareness about sex offenders and the realities of the nursing profession.

## Future Research

Further research could include replicating the study on selected nurses who specifically practice in mental health or correctional facilities. In addition, further exploration of personal experiences with sexual abuse could be

investigated through the use of the questionnaire. Based upon the limited amount of research in the study of sex offenders and nursing care, more nursing research is warranted in regards to nursing care of sex offenders. This study should expand to other states in order to generate a larger sample and more diverse demographics. Lastly, exploration of other demographic characteristics such as forensic nursing and prison nursing is warranted.

## Summary

This study provided insight about the attitudes of nurses towards sex offenders. It was apparent from this study that a majority of nurses practice nonjudgmental care to all of their patients, regardless if patients were known sex offenders. The purpose of nursing is to not only promote health, but to provide the best possible quality of care. Specific educational content may prepare and educate nurses when working with sex offenders.

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# Appendices

## A. Questionnaire

**Community Attitudes toward Sex Offenders Scale (CATSO)**

(Church, Wakeman, Miller, Clements, & Sun, 2008)

Items and Scoring

Below are 18 statements about sex offenders and sex offenses. Please select the corresponding number from the rating scale given below for the answer that best describes the way you feel or what you believe. Most of the statements below are difficult to prove or verify in an absolute sense, and many are specifically about your opinion based on what you may have heard, read, or learned; thus, we are less interested in the "right" or "wrong" answers, and more interested in your beliefs and opinions regarding sex offenders. Even if you have no general knowledge about the issue, please provide an answer to each question.

| Strongly Disagree | Disagree | Probably Disagree | Probably Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior.
2. People who commit sex offenses should lose their civil rights (e.g. voting and privacy).

3. People who commit sex offenses want to have sex more often than the average person.
4. Male sex offenders should be punished more severely than female sex offenders.
5. Sexual fondling (inappropriate unwarranted touch) is not as bad as rape.
6. Sex offenders prefer to stay home alone rather than be around lots of people.
7. Most sex offenders do not have close friends.
8. Sex offenders have difficulty making friends even if they try real hard.
9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths for other crimes.
10. Sex offenders have high rates of sexual activity.
11. Trying to rehabilitate a sex offender is a waste of time.
12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.
13. Only a few sex offenders are dangerous.
14. Most sex offenders are unmarried men.
15. Someone who uses emotional control when committing a sex offense is not a bad as someone who uses physical control when committing a sex offense.
16. Most sex offenders keep to themselves.

17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.
18. Convicted sex offenders should never be released from prison.

B. Scoring

Factor 1 (Social Isolation): 6, 7, 8, 14, 16

Factor 2 (Capacity to Change) 1*, 2, 11, 12, 18

Factor 3 (Blame Attribution): 4, 9*, 13*, 15, 17

Factor 4 (Deviancy): 3, 5, 10

*These items must be reverse scored when computing factor and total scores. Add all 4 factors together to get a total score; higher scores represent more negative attitudes.

C. Demographic Questions

Nurses' Attitudes towards Sex Offenders.

(Fitzke, 2009)

At the end of the CATSO, carefully select the answers below.

The following section contains questions about you and your nursing care experiences. Please answer all questions honestly. Your responses are confidential.

1. Are you
   Male
   Female

2. What is the highest nursing education degree held?
   Diploma
   Associate degree
   Bachelor's degree
   Masters degree
   Doctorate degree

3. What is your age range?
   20-35 years
   35-50 years
   50-65 years
   65 and up

4. I have knowingly cared for a sex offender in my nursing practice.
   Yes
   No

5. Would you feel more strongly if you knew a person who had a sex act committed on them?
   Yes
   No

6. I have had specific educational content on caring for sex offenders in my nursing practice.
   Yes
   No

D. American Nurse Code of Ethics

The American Nurses Association

Code of Ethics (2009)

· The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

· The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

· The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical or illegal practice of any person.

· The nurse assumes responsibility and accountability for individual nursing judgments and actions.

· The nurse maintains competence in nursing.

· The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

- The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

- The nurse participates in the profession's efforts to implement and improve standards of nursing.

- The nurse participates in the profession's effort to establish and maintain conditions of employment conducive to high quality nursing care.

- The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

- The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

E. Postcard

**Registered Nurses,**

**You are invited to help.**

*A College of Saint Mary Doctorate Student, Molly M. Fitzke, MSN, RN appreciates your quick response.*

**Study Topic: Opinions on Nurses' Attitudes towards Sex Offenders**
**Quick Survey: Less than 10 minutes.**

**Anonymous Online Survey**

Go to this link:

# http://tinyurl.com/c2bmr3

**Questions:** **Email researcher at mfitzke28@csm.edu**
**Deadline:** **Please respond to survey by June 1, 2009**

**Thank you for your participation.**

F. Reminder Postcard


You might recall I had sent a postcard out earlier in regards to participating in a research study.

**Study □opic□** Opinions on Nurses' Attitudes towards Sex Offenders

**□uic□ Sur□ey□ □ess than □□ minutes.**

## Online Survey

Go to this link:

**http://tinyurl.com/c2bmr3**

**Questions: Email researcher at mfitzke28@csm.eduDeadline: If you choose to participate, please respond to survey by June 12, 2009. Thank you!**

G. IRB Approval Letter


April 18, 2009

College of Saint Mary

7000 Mercy Road

Omaha, NE 68106

Dear Ms. Fitzke:

Thank you for submitting the materials requested in the earlier correspondence related to your study *Nurses' Attitudes Towards Sex Offenders*. You made the required changes to the application and made the required changes to your postcard invitations.

Upon reviewing your submitted materials, you provided a Consent Form that follows the format listed in the IRB Informational Packet yet my understanding was that you were going to utilize the Online Consent Form. The "regular" format that you provided was correct and I have attached an approved date stamped copy of this document.

In order to facilitate your research, I did use your submitted Online Consent Form that was also within the packet of materials to address the changes needed. The required changes did not appear to be have made on this document, but they were extremely small changes. Since you had provided an electronic copy, I have provided a draft of this document with the changes highlighted. These changes included adding the IRB number, adding your faculty advisor's contact information and adding a statement of benefit. I utilized the statement from your "regular" Consent Form to insert the statement related to benefits.

If these adjustments drafted are acceptable, please feel free to use the attached approved Online Consent form at this time. The date stamp does not have to appear on the Online Consent Form when used with Survey Monkey or other online tools as the

graphic sometimes infers with the formatting. The date stamped copy of the Online Consent Form is provided for your records.

If you choose to revise the statement of benefits or any other information in the Online Consent Form, please just resubmit it and I will attach a new date stamp at that time. If you choose to go ahead and use one of the approved Consent Forms attached, please simply notify me as to which format you will be using so that I can note it in the IRB records.

You now have full authorization to proceed with your research and use the appropriate approved Consent Form that meets your needs. As was stated, if you wish to submit changes to the Online Consent Form for approval, it will be processed, stamped and returned for your use. The IRB number assigned to your study is IRB 08-89 and the expiration date for the completion of your research will be April 18, 2010.

If you have questions, please feel free to contact me.

Sincerely,

Dr. Melanie K. Felton

Melanie K. Felton, Ph.D.

Associate Professor

Chair, Institutional Review Board

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