

Exploring the Sexual Assault Nurse Examiner Role within the Nurse-Patient Interaction:
Making Connections to Advanced Practice Nursing Competencies

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Abstract

This project presents an integrative review of sexual assault nursing practice. The sexual assault nurse examiner (SANE) role was established to provide a comprehensive multisystem services for women who experience sexual assault (Stermac, Dunlap, & Bainbridge, 2005). Yet little is known about how SANEs negotiate their role in the nurse-patient relationship. This project employs a relational feminist theoretical perspective that informs the position of the nurse in relation to a woman in a single nurse-patient encounter. The scope of this project is limited to an adult female patient population. Four major themes emerged in the synthesis: the position of the nurse, the nurse in the process of validation, the nurse as a forensic technician, and balancing the tension between judicial interests and women-centered care. This project draws direct links between the SANE role and advanced practice nursing (APN) competencies. Practice implications, education implications, and areas for future research are drawn out from the themes and examined to enhance current SANE practice. Additionally, Peplau's (1952) *Theory of Interpersonal Relations* is used to offer theoretical connections between standards of SANE practice and a larger body of nursing knowledge. The following pages describe various aspects of the SANE role in relation to a nurse-female patient interaction.

At some point in his or her professional career, a nurse will encounter an individual who has experienced sexual assault. As healthcare professionals nurses are uniquely positioned to have a positive therapeutic effect in receiving the disclosure of sexual assault. The sexual assault nurse examiner role was born out of this perceived complimentary placement (Girardin, 2005). SANEs are mandated to provide support and medical-forensic care to women in the immediate hours after a sexual assault experience. In this context, sexual violence will be referred to as sexual assault to espouse the nurse's professional title to the reason a woman is requesting care. The International Association of Forensic Nursing (2009) supports the SANE title for nurses, midwives, nurse practitioners, and physicians that are certified to provide sexual assault care. This document examines the SANE role in relation to the nurse-patient interaction and aspects of advanced practice nursing (APN). A number of themes emerge from the literature review and are discussed for their relevance to nursing practice and advanced practice competencies; namely, the nurse in the process of validation, the nurse as a forensic technician, and tension between prosecution and women-centered care.

The intent of this project is to provide an integrative review of the literature related to the SANE role. I have examined peer-reviewed publications to understand the sexual assault nurse examiner (SANE) role in relation to advanced practice nursing (APN) competencies and the nurse-patient relationship.

The Current State of Sexually Violent Crimes

Sexual assault is defined as all incidents of unwanted sexual activity, including sexual touching and sexual attacks, regardless of the actions being attempted or completed (Brennan & Taylor-Butts, 2008; Lewis-O'Connor, 2009). Currently in

Canada the rates of sexually violent crimes against women remain steady. Brennan and Taylor-Butts (2008) findings from the 2004 Canadian General Social Survey (GSS) represent a rate of 512,200 nationwide, or 1,977 incidents per 100,000 population. Plus, the GSS confirms police sexual assault statistics at a much lower rate of 24,200 reported cases, indicating a formal report rate of 10 percent. As a significant traumatizing event, sexual assault affects every aspect of an individual's life, compromising her physical health, mental health and sense of security (Logan, Cole, & Capillo, 2007; McGregor, Du Mont, White, & Coombes, 2009). Thus, the related aftereffects of sexual assault require the attention of practicing nurses and related healthcare professionals.

Traditional Model of Sexual Assault Care

One would expect, when a woman is the victim of a crime that support is given and the crime is investigated in a thoughtful manner to not cause the individual further victimization. Unfortunately, this process is not apparent in traditional emergency department policies on investigating sexually violent crimes. Sexual assault services were only an afterthought in relation to how Emergency Department policies were implemented (Linden, 2011). It was not until 1992 that "the Joint Commissioner for the Accreditation of Healthcare Organizations made it mandatory for hospitals to develop and implement official procedures for the treatment of victims of abuse" (Fehler-Cabral, Campbell, & Patterson, 2011, p.2). This well-meaning objective lacked oversight and led to a wide array of patient care philosophies, services, and staff training. Understandably, this disjointed implementation caused blurred professional roles, underdeveloped policies, and disparities in patient care (Campbell, Patterson, & Lichty, 2005). Such

outcomes left the patient navigating a healthcare system not designed to meet her specific medical and forensic needs.

Sexual assault has been universally defined as a “broad term that includes rape, unwanted genital touching, and even forced viewing of or involvement in pornography” (Linden, 2011, p. 834). It is worth noting most definitions only account for physical attacks and injuries, but neglect the emotional affliction caused by the assault. It is evident that the clinical focus of sexual assault patient care has been biomedical rather than holistic (Campbell, Greeson, & Patterson, 2011; Girardin, 2005; Logan, Cole, & Capillo, 2007). The biomedical model, while perhaps addressing the physical needs of a person, is an inappropriate model for comprehensive patient care (Du Mont, White, & McGregor, 2009). The discipline of forensic nursing was formed at the nexus of medicine and law (Campbell, Greeson, & Patterson, 2011). However this intersection does not acknowledge nursing values and women-centered care. Therefore examining the SANE role from a nursing perspective, with particular emphasis on the nurse-patient interaction, will offer insight into the relational skills used by the nurse and the position of the woman.

Problems with emergency settings

Stermac, Dunlap, and Bainbridge (2005) state the old emergency model had critical issues with long waiting periods, time restrictions to delivering care, and a lack of staff training in forensic care. In this setting, a woman seeking care was triaged as healthy and non-urgent, which resulted in long wait times and the patient feeling neglected (Girardin, 2005). Similarly, a study conducted by the World Health Organization found 32.6 percent of healthcare workers did not consider sexual assault to

be a serious medical condition (Christofides et al., 2005). This statistic, although unsettling, is understandable in the emergency setting. As Logan, Cole, and Capillo (2007) claim, emergency departments triage according to the severity of physical injuries, which narrowly prioritizes a woman's circumstances according to a biomedical patient care model. This perspective overlooks emotional trauma and does not account for mental well-being. These types of system barriers contribute to negative experiences and may perpetuate the low disclosure rates of sexual assault (Logan, Cole, & Capillo, 2007).

Difficulties with generalist practitioners

A generalist practitioner is defined as a primary care or emergency room nurse, midwife, or physician that works at broad catchment sites and encounter women who have experienced sexual assault (Girardin, 2005). These practitioners come into this setting with varying backgrounds of experience. A recent survey in the UK found that only a quarter of medical schools provide teaching about sexual assault in the curriculum. The study stated many educators thought the topic was too specialized for general medical curriculum (Anonymous, 2007). This can lead to a discontinuity of knowledge around sexual assault policies and a lack of proficiency in forensic examination. Correct examination and forensic proficiency are vital to prosecution processes (Anonymous, 2007). Overall, only 14 to 18 percent of all reported sexual assaults are prosecuted (Campbell, Patterson, Bybee, & Dworkin, 2009). Unfortunately, one of the contributing factors to low prosecution rates is physician inconsistency in examining sexually assaulted patients (Anonymous, 2007).

In addition to this statement, Du Mont, White, and McGregor (2009) cite a study conducted in 1996 that found 86 percent of women examined by a general practitioner

were completely or partly negative about the experience. The authors go on to explain, women felt the lack of choice and distant demeanor of healthcare practitioner contributed to “secondary traumatization” by medical personnel (p.775). Secondary traumatization is described as insensitive medical interventions that contribute to adverse and unpleasant feelings in the therapeutic relationship (Campbell, et al., 2006; Patterson, Campbell, & Townsend, 2006). Also, Girardin (2005) reports, the extensive time required for examination, evidence collection, and interaction with the patient may be seen as a burden on emergency staff who have a full patient workload. Throughout the literature it is evident that generalist practitioners face challenges related to a lack of proficiency in forensic care, time restrictions, and a decreased capacity to provide women-centered care (Patterson, Campbell, & Townsend, 2006; Girardin, 2005). The SANE role was explicitly created to address these disparities (Girardin, 2005; Ledray, Faugno, & Speck, 2001).

The history of the SANE role

Prior to the rape crisis movement of the 1970s women who experienced sexual assault were often denied treatment in hospitals (Fehler-Cabral, Campbell, & Patterson, 2011). The inadequacy of generalist practitioners and emergency room policies motivated research into the service gap in sexual assault patient care (Campbell, Patterson, & Lichty, 2005). Burgess and Holmstrom’s (1973) pioneering study examined traditional sexual assault patient care practices at a Boston City Hospital Emergency Department. The study describes fragmented services divided between the emergency room physician, gynecologist, nurse, and social worker. This disjointed process referred the patient to multiple subspecialties and results in a collection of redundant details.

Burgess and Holmstrom's (1977) findings suggest nurses are uniquely positioned to have a positive therapeutic effect on a woman's *psychological* and *physical well-being*. Likewise, Campbell, Patterson, and Lichy (2005) claim during the late 1970's the nursing movement for expanded practice roles aligned well with the circulating feminist agenda raising awareness about sexual violence. The SANE role emerged from the collaborative effort of feminist activists and expanding nursing roles. The first SANE program began in 1976 in Tennessee (Girardin, 2005). Since its inception SANE programs have stood apart with a commitment to addressing the patient's *emotional needs* and *psychosocial well-being* (Campbell et al., 2006). Today, in North America, there are approximately 450 SANE programs recognized by the International Association of Forensic Nursing (IAFN) (Campbell, Patterson, & Lichy, 2005). This number continues to grow as health authorities recognize the effectiveness of SANE programs and implement SANE care models in primary and acute care settings.

Relational Feminism: The Self-in-Relation

I have selected the theoretical perspective of relational feminism as it informs the position of the nurse in the context of the therapeutic relationship. Currently, there is a gap in the literature related to how SANEs enact their role and draw upon advanced practice nursing competencies to provide holistic patient care. Relational feminism recognizes self-informed identity, positions of privilege, power dynamics, and self-reflexive practices as influential factors to any relationship (Bernstein, 1992). When dealing with the sensitive issue of sexual assault, these elements have particular relevance to the nurse-patient interaction. From this standpoint, Surrey's (1985) *Self-in-Relation Theory* of women's development grants clarity to understanding women's identity and

relational feminism in practice. The theory is founded on feminist philosophical tenets and principles of psychological development. The idea of the “self” has been prominent in feminist psychological theories since the mid 1980’s (Miller, 1984, 1986; Surrey, 1985). Traditionally, the concept of an “independent identity” or “separated self” exerted its influence on a number of social institutions including healthcare (Miller, 1984, p.6 & p.8). More recently, feminist theorists and therapists from the Stone Center at Wellesley College have proposed important sex differences in how women construct and experience the self-in-relation (Jordan, 1993; Miller, 1986; Surrey, 1985). This concept challenges traditional androcentric thinking of prominent psychological theories. Surrey (1985) claims the “self is a useful construct in describing the organization of a person’s experience and construction of reality which illuminates the purpose and directionality of her behavior” (p.1). If we only examine the self as a single independent entity, we lose sight of how our interactions shape our identity and influence how we perceive the world.

For women, the *self* is organized around being able to make and maintain relationships with others (Gilligan, 1982; Miller, 1984). The relational self is defined as an individual who forms and organizes a distinct identity in the context of important interactions and relationships (Surrey, 1985). The following qualities are associated with the feminist concept of relational self: a capacity for empathy (Surrey, 1985), relational awareness (Jordan, 1993), mutual processes of responsiveness and authenticity (Miller, 1984, 1986), and connection (Jordan, 1993). When identity is thought of as relational, then both the nurse and patient co-create the *self* in response to the other. In the context of the relationship, both the nurse and patient are able to authentically connect and negotiate position in response to each other.

The nurse-patient relationship is the core of nursing practice. The Canadian Nurses Association (2011) stipulates nurse-patient partnerships are a basic competency of practice. The partnership competency uses relational language such as “therapeutic use of self” and “interpersonal processes” intended to assist nurses in fostering therapeutic relationships (CNA, 2011, para 3). The CNA’s (2011) stance clearly articulates that registered nurses use collaborative knowledge to achieve mutually agreeable health goals. Additionally, the competencies insist the nurse-patient partnership is purposeful, respectful, and in the best interest of the patient. These statements clearly emphasize a two-way interactional model and are consistent with the *Self-in-Relation Model* where it is important to understand and be understood (Surrey, 1985). This implies ongoing awareness and responsiveness to the continuous existence of the other. Certainly, both individuals will become further defined as people as they develop within, and because of the interaction (Miller, 1984). Surrey’s (1985) model claims role flexibility and reciprocity are imperative for women’s growth in the context of the relationship. The *Theory of Self-in-Relation* assumes a *developmental* pathway; the relationship serves as an arena for growth and purpose fulfillment. This statement is predicated on the nurse and patient having a mutually agreeable agenda and distinct roles within the relationship.

From this frame of reference it is important to understand how SANEs negotiate their role within the nurse-patient relationship. What is the nurse’s position in the relationship, and what relational processes are used in the nurse-patient interaction? With these questions in mind, the literature was searched, synthesized and summarized to identify the SANE role in the context of a single nurse-patient interaction. It is intended that this literature review will derive direct connections to APN competencies and provide recommendations for SANE practice. The research question to be answered in

this project was: what is known about the sexual assault nursing role in the context of the nurse-patient relationship and APN competencies?

Methodological Approach: The Integrative Literature Review

The research method employed in this work is an integrative literature review. Integrative reviews are the “broadest type of research review methods allowing for the simultaneous inclusion of experimental and non-experimental research in order to more fully understand a phenomenon of concern” (Whittemore & Knafl, 2005, p.547). The creation and use of systematic and thoroughly researched literature reviews can provide a connection between research and evidence-based practice (Evans & Pearson, 2001). There is a range of approaches to reviewing the literature, “systematic reviews are commonly held as being the most reliable approach because of the explicit and rigorous methods” (Evans & Pearson, 2001, p.595). Unlike systematic reviews, the integrative literature review is characterized by broad inclusion of research based, theoretical, and review of practice articles (Torraco, 2005; Whittemore & Knalf, 2005). Also, an integrative literature review synthesizes publications “to define concepts, to review theories, to review evidence, and to analyze methodological issues,” rather than establish the effectiveness of an intervention (Evan & Pearson, 2001; Whittemore & Knafl, 2005, p.548). A critical aspect to the literature review concerns how quality and rigor are defined. A systematic review is scrutinized on full explication of methods, rigorous definitions, and standardization of techniques (Evans & Pearson, 2001). Such standards establish validity in the researcher’s methods and provide a comprehensive synthesis of relevant publications. In an integrative review, the subset of inclusive literature is evaluated, deconstructed, analyzed, and re-conceptualized to answer the statement

question (Torraco, 2005; Whittemore & Knafl, 2005). Integrative literature reviews synthesize evidence in nursing research to provide a new source of evidence upon which health care decisions can be based (Evans & Pearson, 2001). Rigorous systematic research is key to the advancement of nursing knowledge and evidence-based practice (Evans & Pearson, 2001). An integrative review can be used to enhance SANE nursing practice by providing a comprehensive understanding of the sexual assault nursing role in the context of the nurse-patient relationship.

Literature Search

A search of the literature using CINAHL EBSCO, PsychINFO, Pub MED, and Web of Science was conducted between September 28, 2011 and October 8, 2011. The following search terms were applied: sexual assault, sexual assault nurse examiner, nurse role, nurse-patient interaction and advance practice nurse. To avoid publication bias, the search was supplemented by a search of authors and journals that contribute to sexual assault literature, and ancestral tracing was performed on articles of interest. The search terms were limited to peer-reviewed journals between the years of 2000-2011, English language articles, and an adult female patient population. Out of the 43 articles found with this search strategy, those that related directly to the sexual assault nursing role or clinical practice were chosen as potentially relevant for integrative literature review. The use of exclusion criteria resulted in 12 articles. The excluded articles focused on: pediatric populations, sexual assaults against men, methods of prevention, perpetrator profiling, and population trends. The articles chosen were critiqued using a systematic methodology reviewing the substantive and theoretical, methodological, and ethical qualities outlined by Polit and Beck (2004). Findings from the research were synthesized

to provide a better understanding of the SANE role in relation to the nurse-patient interaction and APN competencies.

Individual Article Critique

The articles used in this integrative literature review were critiqued in accordance with Polit and Beck's (2004) *Evaluation Criteria of Research Reports*. The literature was examined using a deconstructive critique; the aim was to demonstrate the logical inconsistencies in methodology, evaluate scientific merit, and contribution to nursing's body of knowledge (Rolfe, 2008). Polit and Beck's (2004) framework served as an evaluative tool to enhance the systematic process of critique. The publications were scrutinized on three dimensions: substantive and theoretical dimensions, methodological dimensions, and ethical dimensions (Polit & Beck, 2004). First, the substantive and theoretical dimension examines the significance of the problem in terms of its contribution to nursing's body of knowledge (Polit & Beck, 2004). Within this framework the study should have appropriate conceptualizations and disciplinary orientation. Second, the methodological dimension analyzes the researchers choice of methodological decisions and the process undertaken to answer the hypothesis. Third, the ethical dimension ensures the study maintained ethical integrity with respect to participants, process, and scientific merit (Polit & Beck, 2004). Through careful selection and rigorous evaluation of the publications accepted for review, I am able to present the current state of evidence-based science, resolve conflicting reports in the evidence, and directly apply the findings to practice and policy (Rolfe, 2008; Torraco, 2005; Whittemore, 2005). The process of data synthesis occurred after the individual articles were deconstructed, critiqued, and the inclusive subset was identified.

For the purpose of including both qualitative and quantitative research, Polit and Beck (2004) was used to evaluate each article. See Appendix A for a table of the individual article critiques and Appendix B for the evaluative criteria applied in this project.

Polit and Beck (2004) provide the following broad criteria to evaluating quantitative research. First, the study problem must be manageable in terms of scope feasibility and methods used to answer the hypothesis. Second, research terms and variables must be operationalized and fully explicated. Third, the sample population must show appropriate size, heterogeneity, and external validity. Fourth, the methods of data collection align with the research methodology. Fifth, data analysis is undertaken in an auditable, methodical, and diligent way. Lastly, the findings are presented logically and contribute to professional knowledge and practice. The overarching objective in quantitative research is to fully explicate and understand variable correlations in order to generalize findings to a larger population (Polit & Beck, 2004).

The criteria for evaluating qualitative research must be paradigm specific. Ryan, Coughlan, and Cronin (2007) provide guidelines for the process of qualitative critique. First, the abstract phenomena must be clearly identified and linked to a matter of nursing interest. Second, the method of investigation must align with the employed philosophical orientation. Third, a conceptual framework is used to guide the study. Fourth, the participant's rights are protected, and the sample and setting are clearly described. Fifth, data collection and analysis are conducted methodically and clearly outlined. Sixth, the findings and interpretations are well articulated and bring forth new recommendations for practice. Unlike a quantitative approach to research, qualitative methods do not attempt

to generalize findings. Qualitative research explores individuals' experiences in order to generate new theory (Ryan, Coughlan, & Cronin, 2007).

The following sections describe the detailed synthesis of the publications found worthy of inclusion in this project.

Synthesis of the Data

After each article was critiqued, evaluated, and found worthy of inclusion, then the second phase of data synthesis commenced. According to Whitemore and Knafl (2005) "analyzing and synthesizing varied primary sources is a major challenge in undertaking an integrative review" (p.548). The process of integrative synthesis involved the following steps: data reduction, data comparison, data presentation, conclusion formation, and verification (Whitemore & Knafl, 2005). Synthesizing the literature means that the review weaves the threads of research together to focus on core issues rather than merely reporting previous literature (Torraco, 2005). Synthesis is an iterative process; it requires creativity, a conceptual framework, and intimate knowledge of the topic. The following steps guided the iterative process used in this review: data reduction, data display, and data comparison (Whitemore, 2005). First, data reduction refers to classifying topics in articles to various pre-determined subject groups. Second, data display refers to the process of putting the extracted data into some form of matrix for comparing themes (Garrard, 2007). Third, data comparison refers to re-conceptualizing the data in accordance with the relational feminist theoretical perspective (Garrard, 2007). Once this process was complete new ideas could be derived from the literature (Torraco, 2005).

This research project presents a comprehensive understanding of the SANE role in the context of the nurse-patient relationship. From this research statement, I have drawn out and explicated the recurring themes in the body of literature.

Synthesis of Findings

The articles examining the SANE role in the context of the nurse-patient relationship, included in Appendix A, were thoughtfully reviewed for this document. Collectively, the publications provided a variety of insights and themes on how SANEs enact their role. Four major themes emerged in the synthesis of the findings. The first theme, the position of the nurse, claims the SANE title was specifically chosen to reflect nursing values. A second theme, the nurse in the process of validation, examines the nursing role in providing forensic proof, as well as additional supportive nursing processes that vindicate the patient of self-blame. A third theme, the nurse as a forensic technician identifies the nurse as a forensic technician, where forensic processes are prioritized. In this theme the findings state forensic technologies have the ability to preclude the therapeutic relationship. The fourth theme, balancing the tension between judicial interests and women-centered care, discusses the need for constant negotiation between such competing interests. An overview of the findings is presented in the following pages.

Position of the Nurse

Relational feminism grants credence to the position of the nurse. The nurses' perspective is an unexamined area and remains underdeveloped because little is known about how SANEs enact their role in the therapeutic relationship. Ledray, Faugno, and Speck (2001) state the title SANE has been specifically chosen to reflect nursing values

and a nursing identity. This suggests the authors' attempt to align the professional SANE role with philosophical nursing values. Nevertheless, the current body of knowledge is primarily descriptive, articulating differences in basic operations, or types of services offered. This does not directly address how SANEs enact their role in the therapeutic relationship (Patterson, Campbell, & Townsend, 2006). A pressing need exists for more research examining SANEs clinical practice to offer insight into the dual role of the nurse and forensic examiner as two distinct components of the SANE role (Girardin, 2005). The literature suggests these two domains of practice may overlap, conflict, or coordinate in their approach to patient care (Ledray, Faugno, & Speck, 2001). If we view the nurse-patient relationship as a point of convergence between the nurse, law enforcement, and advocate groups (Campbell, Patterson, & Lichty, 2005). Then it is easy to recognize the importance of having a positive encounter with formal services when first disclosing sexual assault (Fehler-Cabral, Campbell, & Patterson, 2011). Therefore, the nurse is well-positioned to have a positive therapeutic effect in the way she receives the patient into care. Understandably, the patient may enter the relationship in a state of victimhood where fear, doubt, and vulnerability are recognizable. Victimhood is defined as loss of safety and feelings of insecurity after an assault (Campbell, Patterson, & Lichty, 2005; Girardin, 2005). Campbell et al. (2006) explain SANEs respond to victimization with increased sensitivity to the patient's emotional state, and a commitment to support. A nurse engaging with a patient under these conditions must rely on relational skills in order to acknowledge, support, and validate the patient's experience.

Under this theme the literature acknowledges nurses as well positioned to provide therapeutic care and address vulnerability. This document synthesizes relevant

publications to describe the nurse's relational role in a single relationship with a woman who experienced sexual assault.

The Nurse in the Process of Validation

Patient validation is a prominent theme throughout the sexual assault patient care literature. Processes of validation were supported from both a forensic paradigm and a nursing perspective. These two positions of validation will be discussed in the following pages.

Forensic evidence as a means of validation

First, validation in the form of "proof" is predicated on the nurse as a forensic examiner (Fehler-Cabral, Campbell, & Patterson, 2011, p.8). Proof is described as the physical findings and documented injuries that qualify as evidence of a sexual assault (Campbell, Patterson, & Lichty, 2005; Du Mont, White, & McGregor, 2009). The SANEs forensic examination may substantiate or refute an assaulted woman's claims (Campbell, Greeson, & Patterson, 2011). The literature suggests the patient population believes it is the nurse's role to find forensic evidence that relates to a patient's assault history (Campbell, Greeson, & Patterson, 2011; Ericksen et al., 2002; Fehler-Cabral, Campbell, & Patterson, 2011; Girardin, 2005).

Forensic evidence collection only entails a small part of the nurse's role, yet both the women seeking legal prosecution and law enforcement heavily prioritize it (Patterson, Campbell, & Townsend, 2006). Some authors argue the idea that a nurse finds evidentiary "proof" on a woman's body obscures the intention of the medical-forensic examination (Fehler-Cabral, Campbell, & Patterson, 2011, p.10; McGregor, Du Mont, White, & Coombes, 2009, p.776). The forensic examination is intended to document

physical findings and collect forensic samples (Girardin, 2005). The term sample is more appropriate than evidence, as it does not presuppose DNA will be found on the patient's body. Certain authors promote validation through forensic samples, objective history taking and physical findings (Campbell, Greeson, & Patterson, 2011; Girardin, 2005; Ledray, Faugno, & Speck, 2001); however, this standpoint overestimates the value of forensic samples in the patient's personal experience of seeking validation, and is not consistent with patient supportive care. Additionally, such actions may provide false hope in the pursuit of legal proceedings.

Currently, SANEs are practicing validation as proof by means of forensic samples, but neglect the relational approach to validation where the patient feels acknowledged in her position of victimhood.

Validation through the nursing process

Fehler-Cabral, Campbell, and Patterson (2011) found that patients' perceive nurses as caring and compassionate because nurses validated their experiences. This level of care and support played a critical role in helping a patient feel safe and in control of the interaction (Fehler-Cabral, Campbell, & Patterson, 2011). From this standpoint validation includes acknowledging the patient's position of victimhood. Fehler-Cabral, Campbell, and Patterson (2011) explain a nurse can help a patient transition out of victimhood through caring processes and reassuring the patient that the sexual assault was not her fault. In the selected literature for this project, validation is described as offering patient choice, respect, and fostering patient's ability to regain control (McGregor, Du Mont, White, & Coombes, 2009). Although these processes were described in the literature, there was no concrete evidence of these qualities appearing in

current SANE practices. Miller (1984) identifies that all three of these supportive strategies hinge on mutual processes of responsiveness within the nurse-patient relationship. A SANE must be sensitive to the patient's position in order to form an authentic connection (Du Mont, White, & McGregor, 2009). By providing choice, nurses demonstrate respect and grant space for an active partnership (Fehler-Cabral, Campbell, & Patterson, 2011). This personable approach plays a critical role in making the patient feel safe and to a certain extent vindicated.

Vindication is described as allowing the patient to grieve her loss and accept her position of vulnerability as a stepping-stone to healing (Fehler-Cabral, Campbell, & Patterson, 2011). From this position the nurse takes an active role in helping the patient regain control through explanation and informed decision-making. Patient choice is threaded throughout the literature as essential to both professional SANE practice and patient's sense of respect (Du Mont, White, & McGregor, 2009; Fehler-Cabral, Campbell, & Patterson, 2011; McGregor, Du Mont, White, & Coombes, 2009). McGregor et al. (2009) define patient choice as informed consent with the right to withdrawal consent at any juncture. By valuing patient choice SANEs demonstrate partnership, and in doing so empower women to overcome vulnerability.

A second aspect of patient vindication emerged as SANEs normalize the absence of evidence and injury. Campbell, Greeson, and Patterson (2011) claim through information about female anatomy SANEs help a patient understand why injury is uncommon. This normalizes the absence of injuries without disqualifying the woman's experience as sexual assault. Through explanation a nurse can help a patient qualify her experience as "rape" and refute existing rape myths (McGregor, Du Mont, White, &

Coombes, 2009). Rape myths are a widespread public belief that “rape” is only qualified as a sexually violent attack perpetrated by a stranger on a chaste woman (Masser, Lee, & McKimmie, 2010). This unrealistic qualifier is harmful and may skew a woman’s concept of what constitutes sexual assault. Therefore the nurse is well positioned in the therapeutic relationship to educate, vindicate, and refute myths.

Women’s perceptions of support in the SANE role

Supportive care is a central value in nursing practice, this concept hinges on sensitivity within the nurse-patient relationship. For instance, Campbell, Patterson, and Lichy (2005) conducted a study examining the effectiveness of SANE practice and found “at the very least, rape survivors perceive SANEs as helpful and supportive” (p.319). In a second example, Du Mont, White, and McGregor’s (2009) study examined patient perceptions of the medical-forensic exam, and found women felt they were not being judged and were provided the time and attention warranted by their circumstances. The following excerpt of from Du Mont et al. (2009) illustrates how SANEs provide patient support in the clinical setting: “[T]he nurse... was very comforting. The first thing I was told when I walked in the door [was] it’s not your fault, you may think it is, people may tell you [it is], but it’s not, that reassured me” (Interviewee 10, p.777). In a third example, Ericksen et al. (2002) examined patient experiences with SANEs and found having concrete needs met made women feel cared about. These needs were described as listening, hand holding, and being given nourishment. In the same study an interviewee remarked, “they were just very human...not clinical about it...and it was that shared humanity that meant the most to me” (Ericksen et al., 2002, p.87). In these three examples, mutual processes of responsiveness are clearly described as an aspect of

support in the SANE role (Logan, Cole, & Capillo, 2007).

When SANE programs first emerged the founding goal was to provide prompt supportive care, preserve dignity, and reduce psychological trauma (Patterson, Campbell, & Townsend, 2006). Indeed, supportive care is a central value of nursing practice. Processes of empathy, responsiveness, and connection underpin the relational feminist concept of supportive care (Jordan, 1995; Miller, 1984; Surrey, 1985). Spandler and Stickley (2011) define support as “a communicated sense of empathy, a demonstrated ‘kindness’, between individuals” (p.556). Most often, SANEs are the first formal interaction after a sexual assault. Therefore the patient’s experience of “victimhood” should be acknowledged in an empathetic manner to foster healing (Fehler-Cabral, Campbell, & Patterson, 2011, p.16). These findings suggest women feel comforted and attended to appropriately throughout the medical-forensic examination. Doane and Varcoe (2007) reaffirm this point, claiming a nurse can have a positive impact on relational engagement simply through “presencing” with a woman during her time of crisis (p.192).

The Nurse as a Forensic Technician

Without question forensic technology is part of the SANE role. The patient interaction serves as a point of contact to collect forensic samples and tend to physical injuries. Currently, forensic technologies are on the forefront of sexual assault nursing care (Du Mont, White, & McGregor, 2009; Fehler-Cabral, Campbell, & Patterson, 2011; Girardin, 2005; McGregor, Du Mont, White, & Coombes, 2009). Forensic procedures are considered scientifically rigorous and essential for legal prosecution (Campbell, Patterson, & Lichty, 2006). Yet little attention has been paid to whether forensic findings

increase prosecution rates (Du Mont, White, & McGregor, 2009). Actually, McGregor, Du Mont, White, and Coombes (2009) claim, in their review examining indicators of women-centered care, that the literature overlooks the implications of forensic technologies on the nurse-patient interaction. While this may be partially true as only two of the twelve reviewed publications mentioned implications of forensic technologies in the nurse-patient interaction. There is evidence in the two articles that SANEs question the integration of forensic technologies in the relationship. Nonetheless, it is vital to promote SANEs practice from a women-centered model of care, and properly analyze the use of forensic technologies in nursing practice (Du Mont, White, & McGregor, 2009).

The impact of forensic evidence

As a forensic technician the nurse is examining the patient's body for forensic samples (Du Mont, White, & McGregor, 2009). A forensic sample is considered a DNA specimen such as blood, semen, or an injury that corroborates the history of sexual assault (Girardin, 2005). Consequently, this procedure turns the patient's body into a crime scene to be combed over for evidence. In this context, Girardin (2005) claims SANEs have two forensic commitments: "(1) to collect evidence that would confirm or deny that the victim and suspect had sexual contact, and (2) to collect evidence that demonstrates whether findings are consistent with the history and time frame given by the victim" (p.126). Du Mont, White, and McGregor's (2009) study suggest women undergo the MFE to systematically collect legal evidence and to aid in prosecution of the case. This line of reasoning seems consistent with the original purpose of the MFE. However, Du Mont, White, and McGregor (2009) warn there is no empirical evidence to

correlate the increased routinization of forensic collection to positive criminal justice outcomes. Indeed, forensic evidence is spoken of as a necessity and valuable in court proceedings (Campbell, Greeson, & Patterson, 2011; Logan, Cole, & Capillo, 2007). However, the implications of this heavy prioritization have not been considered. The literature contains numerous references stating any nursing actions that result in evidence being lost or destroyed as unacceptable (Campbell, Patterson, & Lichty, 2005; Girardin, 2005).

The focus on forensic sample preservation may place undue value on evidence at the expense of a woman's comfort. There is evidence in the literature to suggest SANEs are critically questioning the sequence of importance between patient support and objective evidence collection (Ledray, Faugno, & Speck, 2001). Still more investigation is required to understand how SANEs balance objective science and women-centeredness in the therapeutic relationship.

Attempting to balance forensic technology

Most SANE programs evolved out of a mandate to improve forensic evidence collection and increase prosecution (Campbell, Patterson, & Lichty, 2005). The previous section discussed practice precedence on forensic evidence collection over other aspects of sexual assault care. While this is true, there is evidence in the literature to support SANEs questioning the integration of forensic technologies in the relationship. Presently, the literature shows conflicting evidence between the two issues of forensic priority and women-centeredness. For instance, Logan, Cole, and Capillo (2007) found 87.8% of SANEs describe high quality evidence collection as the greatest advantage of SANE programs over other services. In line with this thinking, Stermac, Dunlap, and

Bainbridge (2005) hail SANE programs mission “to provide an optimal standard of evidence collection... by specialized and highly trained nurse examiners” (p.126). This mission statement glorifies forensic training and ignores SANE’s professional responsibility toward promoting psychological well-being and women-centered care. Where as, Campbell, Greeson, and Patterson (2011) suggest that some SANE programs are not philosophically and functionally distinct from legal organizations, which can have negative consequences for patient care practices. Similarly, McGregor, Du Mont, White, and Coombes (2009) claim sexual assault examiners who practice woman-centered care are obligated to keep a woman’s wishes as the primary focus of care while concomitantly performing a comprehensive forensic evidence collection.

It is unclear if a practice culture of forensic precedence exists and adversely influences woman-centered care, but it is obvious it has the potential to derail the intended holistic care model of the nurse-patient relationship. These findings indicate that if the relationship shifts from woman-centered to judicial needs, the patient may endure a “dehumanizing” experience and her voice may be silenced (Fehler-Cabral, Campbell, & Patterson, 2011, p.16).

The literature identifies a tension between judicial needs and women-centered care. SANE practice seems to exist at the nexus of these two philosophies (Campbell, Patterson, & Lichty, 2005); it remains uncertain if these views are always in opposition or can coordinate to optimize comprehensive patient care. Such a position requires continuous negotiation in order to maintain a woman-centered perspective and maintain ethical nursing practice. The professional practice implication of maintaining holistic, ethical care will be discussed further in the section implication for advanced practice

nursing.

Forensic expertise

SANEs are recognized as having certified forensic expertise through the International Association of Forensic Nurses (IAFN) (Girardin, 2005; Ledray, Faugno, & Speck, 2001). Many of the reviewed studies spoke of SANEs as knowledgeable forensic experts; this affirmation of expertise reveals a power gradient between the *expert nurse* and the vulnerable patient. As an expert, MacDonald (2006) states, “nurses cannot reasonably claim that they failed to anticipate the negative consequences of their judgments and actions on others” (p.120). Nurses, who value relational practice, reflect on their connection to the patient and the potential impact of their treatment recommendations on the woman’s ability to choose her own care. SANEs base their decisions on the IAFN standards of theoretical knowledge and practice competencies (Patterson, Campbell, & Townsend, 2006). SANE training entails (1) forty hours of classroom theory (Campbell et al., 2006), (2) comprehensive instruction in evidence collection techniques and the use of specialized equipment (Girardin, 2005), (3) chain-of-custody evidence requirements (Campbell, Greeson, & Patterson, 2011), (4) expert testimony (Ledray, Faugno, & Speck, 2001), (5) injury detection and treatment (Stermac, Dunlap, & Bainbridge, 2004), (6) pregnancy and STIs screening and treatment (Patterson, Campbell, & Townsend, 2006), (7) rape trauma syndrome, and (8) crisis intervention (Campbell, Patterson, & Lichy, 2005). Collectively, these components form the body of knowledge that SANEs draw on for clinical decision-making. The responsibility for negotiating *expert knowledge* in the context of the interaction is varied for each nurse; however, mismanaged power may negatively impact the patient.

Mismanaged power is authoritative and prescriptive, which precludes women-centered partnership. Surrey (1985) recommends nurses attend to mutual processes of power and knowledge sharing in order to foster patient empowerment that follows through into action. Nurses must always draw upon ethical standards to guide their professional knowledge and promote partnership.

Balancing the Tension Between Judicial Interests and Women-Centered Care

The previous pages have discussed an inherent ethical challenge underlying the SANE role—how do SANEs balance judicial interests and women-centeredness in their practice? Patterson, Campbell, and Townsend (2006) examined SANE program philosophies, and the results suggest SANE programs that value prosecution as a primary goal provided fewer medical services for patients. The overlooked services were contraceptives, as well as STI/HIV testing and prophylaxis (Patterson, Campbell, & Townsend, 2006). These findings affirm there are potentially harmful repercussions of prioritizing prosecution over women-centered care. Additionally, two publications address the need for balance of judicial needs in relation to patient care. McGregor, Du Mont, White, and Coombes (2009) caution SANEs that the increased adoption of judicial philosophies may lead to the unintended consequence of shifting the focus away from the woman, resulting in a less holistic approach to care. Similarly, Ledray, Faugno, and Speck (2001) raise the concern that currently judicial needs overshadow the role of the nurse and give way to unqualified recommendations for the use of forensic technologies. Such statements identify conflict between two paradigms, women-centeredness and judicial needs. McGregor, Du Mont, White, and Coombes (2009) answer this practice conflict stating, “it should also be made clear that the needs of the criminal justice system

are subordinate to the sexually assaulted woman's needs and choices" (p.28). These findings highlight a significant need for teaching from a women-centered perspective in SANE training. This concern will be discussed in the context of implications for advanced practice nurse educators.

Links to Advanced Practice Nursing

MacDonald, Schreiber, and Davies (2005) claim advanced practice nursing first emerged to address physician shortages and gaps in healthcare services. Over the years, advanced nursing has been re-conceptualized as an evolving form of practice that pushes the boundaries of traditional roles to new areas of expanded scope, knowledge, and competencies. The sexual assault nursing role emerged from long-standing concerns that sexually assaulted women received a lower standard of care compared to other patients in traditional emergency settings (Patterson, Campbell, & Townsend, 2006). Girardin (2005) claims SANE training falls within the scope of basic nursing practice, as it does not require graduate education. Nonetheless, there is evidence within the literature to support that SANE nursing practice draws on advanced practice nursing (APN) competencies to provide patient care.

Hamric (2005) defines advanced practice nursing as the "application of an expanded range of practical, theoretical, and research-based competencies to phenomena experienced by patients within a specialized clinical area of the larger discipline of nursing" (p.89). Despite the fact that SANEs are not currently recognized as advanced practice nurses, Hamric's definition shows striking similarities to the scope and focus of SANE practice. In conjunction with Hamric's definition, Brown (2005) outlines five general principles common across the spectrum of advanced practice nursing roles: "(1)

use of a holistic perspective, (2) formation of partnerships with patients, (3) expert clinical thinking and skillful performance, (4) use of research evidence to guide practice, and (5) use of diverse approaches to health and illness management” (p.146). These principles of the APN role will be useful in deriving direct implications from this project for sexual assault nursing practice. Two of the APN principles were prevalent within the SANE body of literature and will be discussed in the following pages.

The use of a women-centered perspective

Considering the first of Brown’s (2005) APN principles, two prominent themes under the umbrella of holistic care were informed consent and respect for patient choice. McGregor, Du Mont, White, and Coombes (2009) provide evidentiary support in their findings that informed consent was a consistent quality of SANE practice. This concept translated into practice as the nurse thoroughly educated the patient on her options for treatment and forensic investigation; this ensured the patient understood consent and ability to alter or withdrawal consent at any time. Additionally, the nurse guaranteed confidentiality and maintained a safe non-pressured environment to bolster the patient’s autonomy and decision-making ability (Logan, Cole, & Capillo, 2007; Patterson, Campbell, & Townsend, 2006; Stermac, Dunlap, & Bainbridge, 2005). In this way, SANE philosophical tenets support clinical practice. This concept aligns well with the advance practice principle of holism as it takes into account the complexities of caring for the human condition (Brown, 2005). The patient is acknowledged in their experience of vulnerability and the nurse works to bridge any barriers to care. Thus, the nurse tends to the patient as a person and empowers through shared decision-making.

Shared decision-making is the foundation of partnerships (Brown, 2005). Brown (2005) claims if the nurse neglects shared decision-making the patient's autonomy is restricted; this is not conducive to the healing process. In order to avoid these undesirable circumstances, nurses must value informed consent and respect for patient choice as vital components of SANE practice.

Identified specialized knowledge

A second principle of Brown's (2005) APN competencies reveals the body of knowledge SANEs draw upon in their relational nursing practice. SANE clinical practice standards are governed by the International Association of Forensic Nurses (IAFN) (Patterson, Campbell, & Townsend, 2006). All reviewed publications claimed forensic expertise as a specialized body of knowledge that requires certification (Girardin, 2005). SANEs specialized knowledge is acquired from a variety of sources such as forensic theory, evidence-based research, work experience, collegial partnerships, and professional readings (Campbell, Patterson, & Lichty, 2005; Girardin, 2005). Additionally, nurses attend monthly case and policy review meetings to discuss case issues and emerging research. However, the literature reports case reviews in a limited capacity, only measuring forensic proficiency, charting, nursing interventions and treatments (Stermac, Dunlap, & Bainbridge, 2005). This limited scope may stifle the development of relational nursing practice.

The literature contains numerous references that SANEs draw upon expertise from diverse sources and adapt their practice to reflect research evidence and improve patient care. This shows a commitment to enhancing patient care policies and the proficiency of SANE practice.

It is clear the nurse-patient relationship serves as an arena for SANEs to demonstrate their knowledge and further develop their expertise. Brown's (2005) principles provide a structure by which the SANE core competencies can be measured in relation to APN standards of practice. Presently, the SANE scope of practice is guided by a holistic care perspective (McGregor, Du Mont, White, & Coombes, 2009); however, the current definition of APN necessitates graduate preparation to hold the title of advanced practice nurse (Brown, 2005). Therefore, the SANE role does not completely satisfy the criteria of APN. There is some overlap between the two domains of practice and this will serve as a strong foundation for SANEs to qualify their expertise and guide the development of their practice. While Brown's (2005) APN principles serve as one framework to measure SANE practice, it is also important to look for nursing theoretical tenets in the interpersonal processes of SANE practice.

Links to Theoretical Nursing: Peplau's Theory of Interpersonal Relations

While relational feminism is in itself a "framework," it is helpful to look at nursing theory to draw theoretical connections between standards of practice and larger body of nursing knowledge. The theoretical model examined for relevance is Peplau's (1952) *Theory of Interpersonal Relations*.

Peplau's (1952) *Theory of Interpersonal Relations* is a middle range nursing theory offering practical propositions to guide SANE practice. According to Peplau, the goal of the nurse-patient relationship is to promote health through the forward movement of personality (McCarthy & Aquino-Russell, 2009). It is through interpersonal relations between the nurse and patient that therapeutic interventions are capable of moving a patient toward health and well-being (Armstrong & Kelly, 1995). In this light, the nurse

is seen as a well-trained healthcare worker that relates authentically to promote patient well-being. From Peplau's theoretical view, the patient is viewed as a co-participant in her own health (Gastman, 1998). Peplau's theory grants some insight into two inherent tensions of the SANE role. First, nurses may experience the patient as "the other," someone distinctly different from themselves. On the other hand, nurses feel a strong attachment to this person in the therapeutic relationship (Gastman, 1998). This paradox lies at the center of ethical nursing practice. McCarthy and Aquinos-Russell (2009) remark that prior to Peplau's work patients were considered *objects* and were to be observed, rather than *subjects* to participate with in relationship. This statement coincides with the ethical conflict SANEs face in relation to forensic collection. A woman may be viewed objectively as a "crime scene" rather than subjectively as a unique person. Such an objective approach to care is not centered on the patient's needs and may be harmful to healing processes. Peplau (1997) concedes nurses require theory-based relational methods to understand personality constructs and phenomena related to patient position. For instance, Peplau's (1997) conceptualizations denote that both the nurse and patient enter the relationship with preconceptions of one another's identity. To move beyond these assumptions the nurse and patient must enter a working interaction where they reflect on their position and begin to mutually respond to each other. Such reflection allows nurses to better understand what transpires between the nurse and the patient. Responsiveness subsumes building and developing on what is already known; this is an important element to transition toward healing.

In a second example, Peplau's work claims the nurse-patient relationship serves as an arena to "correct negative thought patterns and developing a positive self system"

(Forchuk et al., 2000, p.4). Peplau supports overlapping phases of development, where the relationship moves from orientation, to working, and eventually to mutual withdrawal (Forchuk et al., 2000). This concept aligns with the previous discussed idea that SANE help patient's transition from a position of vulnerability to a place of control and empowerment. This perspective is predicated on SANEs practicing relational and holistic care. In order to fully participate in the relationship, positions and identity must be mutually understood. SANEs must clearly understand the capacity and boundaries of their role in order to authentically engage in the therapeutic relationship. A similar assertion of Peplau's theory describes the nurse in a role assisting, consulting or acting skillfully to meet patient needs (Forchuk et al., 2000). This project has outlined that such practice can only be undertaken when explicit roles and identity are negotiated within the nurse-patient relationship (McCarthy & Aquinos-Russell, 2009).

I believe Peplau's (1952) *Theory of Interpersonal Relations* draws attention to the need to abate external stressors on the therapeutic relationship and for a nurse to recognize his or her capacity to be in partnership with a patient (Armstrong & Kelly, 1995).

Summary of Findings

Four major themes emerged from my analysis of the literature. The first theme, the position of the nurse, claims the SANE title has been chosen to specifically reflect nursing values. A second theme, validation through nursing processes, examines the nursing role in providing forensic proof, as well as additional supportive nursing processes that vindicate the patient of self-blame. A third theme, the nurse as a forensic technician, reveals a forensics practice priority. In this theme the findings state forensic

technologies have the ability to preclude the therapeutic relationship. The fourth theme, balancing the tension between judicial interests and women-centered care, discusses the need for constant negotiation between such competing interests. Evidence provided by McGregor, Du Mont, White, and Coombes (2009) suggest the nurse regulates judicial needs as secondary to women-centered care practices. Collectively these findings contribute to a greater explication of the SANE role and a better understanding of the nurse in relation. All themes were examined from a relational feminist perspective, which explored relational awareness, mutual processes of responsiveness, identity, and connection within the nurse-patient relationship.

Brown's (2005) principles of APN competencies were offered as a framework to derive two important links to advanced practice nursing competencies. Additionally, Peplau's (1952) *Theory of Interpersonal Relations* provided insight into two inherent tensions of the SANE role, and connects the findings to a greater body of nursing knowledge. An integrative literature review methodology was chosen for its broad inclusion of theoretical, research, and review of practice articles. Moving into the discussion section, the nurse's involvement in validation, the method of case review, and the inherent tension between judicial needs and women-centeredness will be discussed to fully explicate direct implications for SANE practice.

Discussion

The sexual assault nurse examiner (SANE) role was established to provide support and medical-forensic care to women in the immediate hours after a sexual assault. In this project, I used a relational feminist lens to analyze the literature under a framework of processes such as mutuality, responsiveness, and attention to power. The

research question to be answered in this review was, what is known about the SANE role in relation to the nurse-patient interaction and APN competencies? The research methodology employed in this work was an integrative literature review, as this allowed for the simultaneous inclusion of experimental and non-experimental research in order to fully understand the SANE role (Whittemore & Knafl, 2005). Findings from this integrative review suggest SANEs validate the patient's experience, conduct case reviews for indicators of appropriate nursing care, and negotiate the tension between judicial needs and women-centered care. These findings will be discussed for their implications for SANE practice.

First in this project, I discovered that SANEs have a crucial role in validating the woman's experience from both forensic and nursing paradigms. Currently, SANEs rely heavily on forensic investigation to substantiate a woman's claims for future legal proceedings (Girardin, 2005). SANEs exercise good judgment in obtaining forensic samples, specifically by maintaining forensic sample integrity to confirm a woman's claims in legal proceedings (Campbell, Greeson, & Patterson, 2011). Specifically, Campbell, Patterson, and Lichty (2005) claim SANE protocols were developed so that all women who seek medical care can have the physical findings thoroughly documented for legal verification that an assault took place. Such findings support forensic sample collection as one aspect of patient validation. A second approach to patient validation was evident in the nurse's relational practice. Fehler-Cabral, Campbell, and Patterson (2011) found supportive care formed the foundation of the SANE-patient interaction, and from this standpoint the nurse is able to tend to the patient's vulnerability and move toward healing. The following excerpt corroborates this finding: "If you had any

questions, they'd answer your questions, and they would be honest and not try to hide behind euphemisms or just patronize you... and say, 'You're fine now'" (cited in Fehler-Cabral, Campbell, & Patterson, 2011, p.10). SANEs validate a patient's experience by absolving self-blame, valuing patient choice, and fostering the woman's ability to regain control of her life (Fehler-Cabral, Campbell, & Patterson, 2011; McGregor, Du Mont, White, & Coombes, 2009). Such findings show the nurse is well positioned to have a positive therapeutic affect through the use of both forensic and relational methods of validation.

The markedly different approaches to patient validation may challenge cohesive nursing care. Nonetheless, this project has revealed such practices are worth developing to benefit the patient's experience of validation and concomitantly enhance credibility in prosecution.

Second, I found that SANE programs review cases for measurable indicators of proper nursing care. In this context, appropriate care was determined by forensic proficiency, charting, nursing interventions, and treatments (Stermac, Dunlap, & Bainbridge, 2005). It is important to note that training and experience contribute to general nursing aptitude, and case review meetings serve as a forum for continuing competency (Campbell, Patterson, & Lichty, 2005). This review of practice is commendable; yet, I believe it is limited to visible indicators of patient care and overlooks relational aspects of nursing practice. For example, Ericksen et al. (2002) speak of dignity, trust, respect, and appropriate use of physical touch as essential components of holistic nursing practice. Currently, these aspects are not taken into consideration as measurable indicators of proper nursing practice. The implications of

this practice will be reviewed in the section on advanced practice nurse educator implications section.

A third finding suggests SANEs may experience role tension between forensic-judicial objectivity and subjective women-centered care. Forensic science operates from an objective position of unbiased evidence and explicit documentation (Campbell, Greeson, & Patterson, 2011). Such a stance seems in stark contrast to nursing patient-centered values. In this review, some of the earlier dated publications show a strong commitment to judicial objectivity as best practice in sexual assault nursing care (Campbell, Patterson, & Lichty, 2005, Girardin, 2005; Ledray, Faugno, & Speck, 2001). However, in the literature dated between 2007 and 2011, a transition was noted from glorifying objective forensic practices to questioning their intended use in sexual assault patient care (Du Mont, White, & McGregor, 2009; Fehler-Cabral, Campbell, & Patterson, 2011; McGregor, Du Mont, White, & Coombes, 2009). A study by Ledray, Faugno, and Speck (2001) remarked SANEs are being scrutinized in the courtroom for not being neutral, as nurses are considered patient advocates. Consequently, advocacy may imply bias and diminish the representation of the collected evidence. At the time, this criticism caused SANE programs to further distance themselves from the role of advocacy, in order to enhance forensic expertise. More recently this perspective has been overthrown, as SANEs appear unwilling to give up women-centeredness and advocacy in their patient care practices. In particular, McGregor, Du Mont, White, and Coombes (2009) confirm this stating “the importance of the woman’s wishes in guiding her involvement in the ... [healthcare] system and overriding the criminal justice agenda where the two conflict” (p.28). This indicates a shift in the literature toward women-centeredness over the needs

of the judicial system. However, these findings provide limited understanding of how this paradigm shift is being translated into everyday nursing practice. Without conducting specific research on SANE attitudes in relation to women-centeredness this implication can only be speculated.

To attain focus on women's health and well-being, the findings from this review suggest a commitment to patient-centeredness is essential in the nurse-patient relationship (McGregor, Du Mont, White, & Coombes, 2009). It is my hope this document will stimulate further discussion among a broad audience about how SANEs can incorporate principles of women-centeredness into their daily practice. Lastly, it is my intention to invite SANEs to find new and innovative ways to further develop relational capacities their practice of sexual assault care.

Several of the findings from this literature review have implications for the delivery of sexual assault care. First, SANEs must critically reflect on their role in relation to forensic technologies and strike an appropriate balance between forensic needs and nursing care. Second, a SANE should adhere to validation from a nursing paradigm, where the client is emotionally supported within the therapeutic relationship. Third, relational care methods should be discussed in case review meetings to support nurse's reflective practice. Overall, these implications offer strategies to better understand SANE relational nursing practice and the position of the nurse within the therapeutic relationship.

Relevance for advanced practice nursing

Findings from this integrative review suggest SANEs may experience role tension between forensic-judicial objectivity and subjective women-centered care. Such tension

requires SANEs to negotiate stressors on the therapeutic relationship. The need to resolve this conflict is evident, as Peplau (1997) claims the majority of nursing work transpires during interactions with patients (as cited in McCarthy & Aquino-Russell, 2009). In an effort to avoid external stressors on the therapeutic relationship, SANEs must govern judicial needs as secondary to the needs of the woman (McGregor, Du Mont, White, & Coombes, 2009). Specifically, achieving control of judicial influences on the relationship stands out as an underdeveloped area in the literature (Du Mont, White, & McGregor, 2009; Fehler-Cabral, Campbell, & Patterson, 2011; McGregor, Du Mont, White, & Coombes, 2009). When we conceptualize governance as a standard of nursing practice, we place responsibility on the nurse to develop and maintain professional boundaries. Notions of obligation, responsibility, accountability, and efficiency are as vital to nursing relationships, as are notions of compassion, responsiveness, trust, and respect (Doane & Varcoe, 2007). Such responsibilities are founded on nursing skills that reside outside bio-medical knowledge. Relationalism is a central aspect of these attributes and is consistent with nursing's ethical values (McCarthy & Aquino-Russell, 2009). This perspective orients our moral compass toward issues of everyday practice with commitments to patient centeredness and holistic care (Wright & Brajtman, 2011).

Nurses require a broader understanding of applied ethics in the therapeutic relationship (Doane & Varcoe, 2007). Rather than relying on prescribed ethical principles to dictate balance between judicial obligations and women-centered care, nurses should engage in an embodied morality enacted in every nurse-patient interaction (Doane, 2004). Fairchild (2010) reminds SANEs that the foundation of nursing practice

involves being reflectively mindful of our collective actions with engaging in caring, ethical practice.

Implications for advanced practice nursing education

It has been previously stated that SANEs acquire certification through theoretical, collegial, and clinical training. Despite this comprehensive education, the literature shows only moderate evidence of SANEs practicing from an epistemology of women-centeredness. More so, the reviewed literature offered various recommendations for future training in women-centered philosophies. One publication by McGregor, Du Mont, White, and Coombes (2009) suggests that SANEs learn common rape myths in order to refute unfounded culturally held beliefs about sexual assault. The authors believe SANEs need to be engendered to women-centeredness in order to challenge the chaste woman stereotype that serves to modify a woman's behavior to avoid sexual assault. Masser, Lee, and McKimmie (2010) add that rape myths are a form of *benevolent sexism*, which is a set of beliefs held by the common public on how women, in relation to men, should behave. This form of thinking has a way of transferring blame from the perpetrator to the victim. To counteract this practice, nurse educators should teach from a feminist epistemology to draw attention to power dynamics, positions of privilege, and patriarchal thinking that focuses attention on the woman's behavior rather than the perpetrator (Varcoe & McCormick, 2007). In order for SANEs to adopt these values they must first become familiar with these concepts through their curriculum. This presents an opportunity for advanced practice nursing educators to re-conceptualize pedagogical strategies to reflect women-centeredness. The findings from this literature review have brought forth two implications for advanced practice nursing education.

First, as previously mentioned case review meetings are used as a forum of discussion to maintain SANE competency. In line with this practice approach, nurse educators should embrace context-based learning in SANE training (Williams & Day, 2007). Similar to case review, this pedagogical approach focuses on the situation as the stimulus for learning and allows the nurse to methodically work through her clinical decisions, interventions, rationale, and reflections (Williams & Day, 2007). This teaching style will extend case study epistemology beyond a practical way of knowing and integrate new theoretical perspectives into practice (Brown & Rodney, 2007).

A second implication for SANE education is the principle based approach to ethical practice. Currently, SANEs are being taught principle-oriented ethics, which promotes prescriptive methods to addressing ethical dilemmas (Brown & Rodney, 2007). Principle-based ethics is a process-dominant method that prioritizes certain ethical variables and excludes contextual knowing (Brown & Rodney, 2007). In contrast to this approach, many educators attest “learning requires a relationship to knowledge” (Brown & Rodney, 2007, p.150). When a nurse can rationalize the connection between ethical reasoning and professional knowledge she is in a better position to make clinical judgments and understand the potential implications of her actions. Therefore, SANEs should be provided with relational ethical education that examines contextual factors, such as issues of power, and respect for the woman’s voice (Hovey & Craig, 2011). In accordance with this view, Doane (2004) states the pedagogical approach to ethical knowing must be nuanced to reflect the complexity of clinical practice. This intricate process will cultivate a stronger sense of the nurse’s moral agency and place greater emphasis on embodied ethical practice (Varcoe et al., 2004). Pedagogical strategies such

as narrative analysis, context-based learning, and the use of diverse ethical theories can improve critical analysis and the capacity for embodied ethical knowing (Varcoe & McCormick, 2007). I believe these pedagogical strategies will provide connections between SANE theoretical knowledge and clinical practice. Presently, SANE education has a well-founded practical base, which can be enhanced through feminist epistemology, context-based case review, and moral agency.

Limitations of the Findings

This integrative literature review identifies the following limitations. First, in this project, I offer relevant recommendations to guide nursing practice on a frontline level; however, governing regulations are outside the scope of this research project. The project examined the nurse's position in a single nurse-patient relationship; therefore, the findings are limited to an interpersonal level, as no attention was paid to organizational factors, such as staff retention or program funding. Third, the relational feminist perspective examined the context of the nurse-patient relationship in accordance with responsiveness, position, and power. This perspective does not address measurable biomedical processes, such as medical outcomes. Collectively, the mentioned limitations identify the scope of this integrative literature review.

Recommendations for Future Research

This project identified three areas where additional research will further develop SANE practice. First, most articles identified a need to empower the woman within the nurse-patient relationship; however, the publications did not articulate it as a nursing responsibility. Instead, the publications reported multiple barriers to empowerment, such as the law enforcement interview and the chaotic emergency department setting (Fehler-

Cabral, Campbell, & Patterson, 2011; Girardin, 2005). However, these inhibitors were depicted as either beyond nursing responsibility or out of the nurse's control. More research is required to explore the SANE's commitment to empowerment in daily nurse-patient encounters.

Second, there is a tendency to glorify forensic technology in ways that unhinge the therapeutic relationship and diminish women-centeredness. My findings suggest that there may be a disjuncture between what patients believe forensic evidence can provide and the reality of what it may deliver. To resolve this disjuncture I suggest future research investigate what SANEs understand about case law. It seems logical that SANEs require comprehensive understanding of how their nursing actions impact legal proceedings.

Overall, SANEs offer their communities an alternative model of care, one that emphasizes comprehensive, multisystem service delivery (Campbell, Patterson, & Lichy, 2005). Indeed, SANE programs have proven effective in accurate forensic evidence collection and evidence-based patient care policies (Campbell, Patterson, & Lichy, 2005; Girardin, 2005; Logan, Cole, & Capillo, 2007; Stermac, Dunlap, & Bainbridge, 2005). However, more work needs to be done to incorporate women-centeredness into future research and fully subscribe to empowering women in the healthcare process.

Summary

SANE programs were developed to meet the unique needs of women who experience sexual assault, and yet little research has been conducted to investigate how nurses negotiate this role in the therapeutic relationship (Ericksen et al., 2002). It is critical that those who provide care for women who have experienced sexual assault, do

so from a woman-centered perspective. According to Peplau (1952) a nurse can help a woman transition from vulnerability to empowerment through the use of relational skills. This all-important statement must reside at the center of every SANE-patient relationship. Relationalism provides the foundation for human healing (Armstrong & Kelly, 1995). This model of care has been shown to have positive effects in the form of reduced psychological trauma and victimization (Campbell, Greeson, & Patterson, 2011; Campbell, Patterson, & Lighty, 2005). The integrative literature review completed for this project synthesized research in this area to offer a variety of recommendations for SANEs to perpetuate a practice of women-centeredness and advanced practice nursing competencies. It is believed this project may serve as a building block for future inquiry into competing demands of the SANE role and implications on patient well-being.

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