American Academy of Nurse Practitioners

RESEARCH

Advanced practice nurse attitudes toward sex offender patients

Elizabeth Rash, PhD, ARNP, FNP-C (Assistant Professor)[1] & Mark A. Winton, PhD, LMHC, NCC (Instructor)[2]

1 College of Nursing, University of Central Florida, Orlando, Florida
2 Department of Criminal Justice and Legal Studies, University of Central Florida, Orlando, Florida

Keywords
APN attitudes; sex offenders; nursing practice; Internet survey research.

Correspondence
Elizabeth Rash, PhD, ARNP, FNP-C,
PO Box 162210, Orlando,
FL 32816-2210.
Tel: 407-823-1055; Fax: 407-823-5675;
E-mail: erash@mail.ucf.edu

Received: July 2006;
accepted: September 2006

doi:10.1111/j.1745-7599.2007.00233.x

Abstract

Purpose: To determine advanced practice nurses' (APNs') attitudes and behaviors toward patients in their practices who are registered sex offenders.
Data sources: An online survey of 300 APN members of a local APN organization asking respondents to identify the behavioral actions they were likely to agree or disagree with when faced with a scenario of realizing that a sex offender was a patient in their practice. Sixty-nine respondents submitted completed surveys.
Conclusions: There was an ambiguity of behavioral responses and no consensus among APNs on how to respond to the issue of a sex offender patient in a healthcare practice. There was also a lack of awareness of whether sex offenders were patients in their practice.
Implications for practice: The modest number of respondents and their demographic homogeneity limit the ability to draw any conclusions or generalizations from this study. While awareness of a known sex offender in a practice is unlikely to alter direct patient care, it may have an impact on office policies and procedures and should be a consideration of all involved staff, including providers, ancillary team members, and administrative personnel.

Introduction

Because of the perceptions of rising incidence of sex crimes and escalating public concerns, Congress enacted Megan's Law, requiring sex offenders to register their postconviction residency with local authorities (Graeber, 2004). Local law enforcement agencies make these registries available to the public with the expectation that this knowledge will aid in the ability of citizens to protect themselves and their families from sexual criminals (Beck, Clingermayer, Ramsey, & Travis, 2004). The constitutionality of these registries has not been determined by the Supreme Court, suggesting that they represent an area of ambiguity between protecting the public and infringing on the rights of sex offenders (Graeber).

When healthcare providers become aware that a patient in their practice is on the sex offender registry, they may be forced to make decisions about their ethical or legal obligation to this patient and to their other patients. The purpose of this study was to determine how advanced practice nurses (APNs) respond to the knowledge that a patient in their practice is a convicted sex offender and what behaviors they might initiate to protect other patients or staff in that practice.

Background

In general, the public has negative attitudes toward sex offenders; however, nurses are enculturated to be caring and empathetic. Nevertheless, certain types of patients, such as sex offenders, have also traditionally been marginalized and stigmatized by nurses (Correy & Goren, 1998). Despite this contention, in a comparison of management strategies of child sexual abuse cases among child protective workers, nurses, and police officers, Kelly (1990) found that nurses attributed less blame and recommended less severe punishment to sex offenders than police officers. Subjects with a past history of sexual victimization attributed more blame to the offender than those who had never been victimized, and a need for providers to resolve their own feelings prior to working with offenders was recommended (Kelly).

 © 2007 The Author(s)
Journal compilation © 2007 American Academy of Nurse Practitioners

In a survey of counselor attitudes toward sex offenders, Nelson, Herlihy, and Oescher (2002) found that attitudes toward sex offenders were positive. They hypothesized that individuals who choose to become counselors are predisposed to be accepting of all individuals, and this trait is then fostered in their training. Interestingly, more experienced counselors, possibly because of their experiential expertise in managing challenging situations, had more positive attitudes toward sex offenders than less experienced counselors. Despite this finding, extent of training did not impact attitudes, and the authors postulated that this was because few counselor programs address dealing with sex offenders. They noted that a feeling of being prepared to deal with sex offenders improved attitudes and suggested that specific training and resources on dealing with sex offenders be added to counselor education. Counterintuitively, those counselors who had been victims of sexual offenses had more positive attitudes toward offenders, and it was surmised that this might be because offenders are often known acquaintances and family members and the counselor may be more aware of the full range of qualities, including positive traits, that the offender might possess.

Aubrey and Dougher (1990), discussing the varied counselor responses to sex offenders, suggested that counselors potentially may be disturbed by the interactions that include open discussions of sexuality, they may feel concern as to how other providers might perceive their work with this stigmatized population, or they may be self-conscious of their insensitivity to these clients and overcompensate either positively or negatively in their interactions.

The research discussed thus far is predominantly related to counselors' attitudes. Research on nurses' attitudes toward sex offenders is limited, and while some similarities might be assumed between counselor and nursing attitudes, their roles in caring for sex offenders are likely to differ and are likely to result in dissimilar decisional behaviors.

Beck et al. (2004) proposed that offender registries were intended to increase community self-protective behaviors. These researchers separated self-protective behaviors into the domains of avoidance behaviors and defensive behaviors and then identified those behaviors within these domains that were altruistic and prevented victimization of other household members. In their study of community responses to sex offender notification, gender (female) and lower levels of education, as well as having children in the household or having household members who had been victimized resulted in greater perceived self-risk and more defensive behaviors.

While the main purpose of sex offender registries and notification is to increase self-protective behaviors, they are also intended to be for protection against anonymous offenders. However, the majority of sexual offenses are committed by family members or acquaintances (Beck et al., 2004). Recent research has found that registries have not reduced the number of sexual offenses and because of stigmatization, may have actually increased sex offender recidivism (Beck et al.).

Methodology

Members of a local APN organization were asked via an e-mail request to participate in an online questionnaire. This organization consists of APNs in an array of specialties as well as APN students. Members' e-mail addresses were provided by the organization's board. Based on this list of addresses, approximately 300 e-mails were sent. While the researchers were assured that the list had been updated within the previous 2 months, more than 50 of the e-mails were returned because of faulty e-mail addresses. A 2-week follow-up reminder e-mail was also sent. A link to the questionnaire was imbedded in each of these e-mails.

An online survey tool, Zoomerang© (n.d.) was used to develop a 29-item questionnaire that collected both demographic information (14 items) and behavioral responses (15 items) to a fictitious case scenario. The scenario was developed based on recommendations made in response to a real physician's query to the Director of Research at the Justice Resource Institute (reported in Prentky, 2005). The physician had requested guidance on what to do when he became aware that a patient in his practice was on the sex offender registry. The scenario and the range of behavioral response choices for this study were constructed by the authors based on these recommendations. Each behavioral response was followed by a four-point Likert scale ranging from 1—strongly agree to 4—strongly disagree. Participants were only able to access the survey tool once but could go back and revise their responses until they submitted the questionnaire.

Informed consent was included at the beginning of the questionnaire, and willingness to participate was assumed by the participant's submission of the questionnaire. While demographic information was included in the questionnaire, no personal identification information was requested. Approval from the researchers' university review board for the protection of human subjects was obtained for this study.

Findings

Sixty-nine members of the APN organization completed and submitted the questionnaire. The majority of these respondents were female (93%), married (73%), Caucasian (78%), had a household income of more than $75,000

(73%), held at least a master's degree (94%), and ranged in age from 20 to over 50 years. Areas of advanced practice specialization included family nurse practitioners (58%), adult nurse practitioners (21%), pediatric nurse practitioners (3%), clinical nurse specialists (2%), and those who identified themselves as other (18%). Most of these providers practiced in primary care settings (50%). In response to the number of years they had been in practice as an APN, responses ranged from students (6%) to experienced practitioners of more than 15 years (22%).

Most of the respondents had no personal experience (84%) or household member with an experience (88%) of being a victim of sexual abuse. Fifty-two percent of the respondents had at least one member in their household who was under the age of 18 years. Fifty-nine percent of respondents reported that they had professional experience in dealing with abused clients.

While a great deal of homogeneity was seen in the demographic findings, behavioral response choices were representative of the ambiguity identified in the literature (Graeber, 2004). In the analysis of the respondents' degree of agreement or disagreement with the menu of behavioral responses to the given scenario, several patterns emerged.

A majority of respondents agreed or strongly agreed with the following actions: referring the patient to an adult-only practice (62%, n = 66), instructing the staff to vigilantly observe for any sexually inappropriate behaviors (86%, n = 64), informing the staff of the patient's identity and inclusion on the registry (63%, n = 64), having the receptionist keep an eye on the waiting room when that patient is present (66%, n = 64), prominently posting a sign stating, "children under the age of 12 are not to be left unattended" (88%, n = 64), scheduling the patient at times when there is less likelihood of contact with children (67%, n = 64), reassuring the offender that the practice is a safe and comfortable place for all patients (81%, n = 64), and preparing the staff for the event that another patient recognizes the sex offender and approaches the staff with concerns and questions about the sex offender (82%, n = 62). Of these items, instructing the staff to be vigilant to observe for any sexually inappropriate behavior received the largest amount of strong agreement (47%) (see Table 1).

A majority of respondents disagreed or strongly disagreed with the following behavioral actions: having the offending patient discharged from the practice (94%, n = 67), having the patient wait in an empty exam room rather than in the waiting room (69%, n = 64), and posting a sign stating, "If we become aware that a patient in our practice is on the sex offender registry, please be assured that we will do everything we can to ensure the safety of our patients" (86%, n = 66). This last behavior ranked the highest in the strongly disagree category (26%).

Table 1 Summary of findings of sex offender in practice questionnaire

Item	Percent who strongly agreed or agreed with item
I would not tell anyone about this patient and just get them in and out of the practice as quickly as possible	45 (67)[a]
I would have this patient discharged from the practice	6 (67)
I would refer this patient to an adult-only practice	62 (66)
I would prominently post a sign stating, "If we become aware that a patient in our practice is on the sex offender registry, please be assured that we will do everything we can to ensure the safety of our patients"	14 (66)
I would instruct all staff to be vigilant to observe for any sexually inappropriate behaviors	86 (64)
I would inform all staff of the patient's identity and inclusion on the registry	63 (64)
I would have the receptionist keep an eye on the waiting room when this patient is present	66 (64)
I would prominently post a sign stating, "children under the age of 12 are not to be left unattended"	88 (64)
I would schedule this patient at times when there is less likelihood of contact with children	67 (64)
I would have this patient wait in an empty exam room rather than in the waiting room	31 (64)
I would reassure the patient that this practice is a safe and comfortable place for them and other patients	81 (64)
I would prepare the staff in case another patient recognizes the sex offender and approaches the staff with concerns or questions about the sex offender	82 (62)
I am comfortable providing health care to registered sex offenders	65 (63)
I periodically search the sex offender registry to determine if any of my patients are on the list	5 (63)

[a]Number of valid responses are given within parentheses (total n = 69).

Only 5% of respondents indicated that they periodically search the sex offender registry to determine if any of their patients are on the list. Additionally, and perhaps congruently, only 5% acknowledged an awareness of having a sex offender in their practice, 10% indicated no sex offenders in their practice, while 86% admitted that they did not know.

Discussion

The distribution of anticipated behaviors by the APN respondents demonstrated no easily identifiable pattern. Responses did not suggest a proclivity to either protect the rights of the offender to the deference of the other patients or a preponderance of behaviors that were suggestive of disregard for offender confidentiality and offender patient rights. For example, the behavior with the strongest agreement, global vigilance for any inappropriate sexual behavior, might suggest a preference for actions that do not single out or affront the offender. However, the behavior with the strongest disagreement, posting a sign indicating that in the event of a sex offender in the practice, safety would be ensured, might in contrast suggest that broad, nonspecific actions were unlikely to be chosen or desirable.

Because of the homogeneity of the sample of respondents in regard to gender, race or ethnicity, income, marital status, and education, it was impossible to determine correlations with behavioral choices. The small sample size in this study precluded use of inferential statistics; however, there appears to be no consensus among APNs on how to respond to a sex offender patient in a healthcare practice.

Limitations

The modest number of respondents and their demographic homogeneity limit the ability to draw any conclusions or generalizations from this study. Based on the structure of the questionnaire, it cannot be determined if the APN would engage in one or more than one behavior when faced with this scenario or if other behaviors not included in the questionnaire might be considered.

Conclusions and recommendations for further research

It is apparent from this study that many APNs are unaware of whether sex offenders identified on the registry are in their practices. Whether there is a false sense of safety, ambivalence regarding the concern of a sex offender in their practice or the caring nature of nursing that views patients optimistically is not known. Nevertheless, a need for further discussion among APNs and possibly training in how to respond to such scenarios might be beneficial and provide APNs with the resources necessary to deal with known sex offenders in their practices.

Further research might include expanding the inquiry to additional localities in order to increase the number and heterogeneity of respondents. In addition, because of the dearth of available research in this area, an open-ended, less restrictive questionnaire or qualitative approach might reveal more insight into this issue. Targeting APNs who work in forensic mental health or corrections institutions might provide experiential rather than hypothetical responses.

While awareness of a known sex offender in a practice is unlikely to alter direct patient care, it may have an impact on office policies and procedures and should be a consideration of all involved staff including providers, ancillary team members, and administrative personnel.

References

Aubrey, M., & Dougher, M. J. (1990). Ethical issues in outpatient group therapy with sex offenders. *Journal for Specialists in Group Work*, **15**(2), 75–82.

Beck, V. S., Clingermayer, J., Ramsey, R. J., & Travis, L. F. (2004). Community response to sex offenders. *Journal of Psychiatry and Law*, **32**, 141–168.

Correy, M. C., & Goren, B. (1998). The dark side of nursing: Impact of stigmatizing responses on patients. *Scholarly Inquiry for Nursing Practice*, **12**(2), 99–122.

Graeber, A. C. (2004). McKune v. Lile and the constriction of constitutional protections for sexual offenders. *Review of Litigation*, **23**(1), 137–176.

Kelly, S. J. (1990). Responsibility and management strategies in child sexual abuse: A comparison of child protective workers, nurses and police officers. *Child Welfare*, **69**(1), 43–47.

Nelson, M., Herlihy, B., & Oescher, J. (2002). A survey of counselor attitudes towards sex offenders. *Journal of Mental Health Counselors*, **24**(1), 51–67.

Prentky, R. (2005). Curbside Consultation. *American Family Physician*, **72**(7), 1386–1389.

Zoomerang©. (n.d.). Retrieved March 4, 2006, from http://info.zoomerang.com/