

Promoting Research Based Nursing Practice: The nurse's role in the caring encounter with women survivors of child sexual abuse

Introduction

Sexual abuse during childhood can have lasting short and long term effects on the health and wellbeing of the individual [1, 2]. The RDNS Research Unit, Centacare and Catherine House (an Adelaide based supported accommodation service) are undertaking a participatory action capacity building research project for women who have experienced child sexual abuse (CSA). These women have misused alcohol, drugs, or gambling, which has led to their homelessness. The two year study, led by Dr Anne van Loon, commenced in August 2003. Preliminary findings reveal data relevant to community nurses in their practice. Storied accounts were generated with the women who have diverse detail in their individual stories, but a readily identifiable common story which is presented here, using their own words in quotation marks.

The 'common survivor's story'

We were told throughout our lives that we were 'useless', 'good for nothing' and 'deserving of everything we got'. This was reinforced by 'betrayal' from our family and 'manipulation' from the perpetrator/s who 'dominated' us from their position of power and trust, making us feel 'powerless', 'worthless', 'ashamed', 'guilty' and 'to blame somehow'. We were 'used' and treated as 'objects' or 'meat'. When other children were developing 'the building blocks for a strong identity' and understanding that they were unique and worthwhile, able and OK; we were 'stuck' in a world that taught us 'we would never amount to anything'. But worse, we still carry the burden of 'shame' and 'guilt', 'confusion' and 'sadness' which continually diminishes our 'self-worth' and 'shatters our identity'.

We spent our childhood maintaining a shroud of 'silence and secrecy' around our perverse experiences of child sexual abuse. We coped by 'suppressing memories', 'learning to forget', 'disengaging', 'disassociating', 'isolating ourselves emotionally and relationally', 'trying to please everyone', 'trying to adapt' and accommodate our 'weird' situation because there was 'no escape anyway'. This allowed us to survive our childhood. But as we became teenagers we came 'unstuck'. We knew we 'didn't fit in'. So we 'numbed our rotten feelings' by taking alcohol, drugs and/or gambling.

For some of us self-harm and re-victimisation continued. Weak 'boundaries' made us 'an easy target' for 'predatory people', increasing our 'hopelessness and sadness'. We no longer trusted easily because 'everyone seemed to want something from us' so we chose to become 'disconnected' to protect ourselves from further 'hurt'. We had 'few dreams or hopes for the future' using addictions to 'escape', 'cope' and even 'survive'. We recognise these were 'toxic life patterns'.

When we encounter health professionals we want them to help us with 'sensitivity', 'understanding', 'respect' and 'support' so we can 'heal and grow' toward the future that was 'taken from us during childhood'. We were 'victims', but we have become 'survivors', and with

help we are daring to hope and believe we can eventually 'thrive'.

Background

Estimates of the prevalence of CSA in Australia vary between 8-60% (women) 3-29% (men) when definitions include non-contact abuse such as exposure to pornography, photography, watching, exposing, flashing. These figures decrease with narrower criteria of sexual penetration, intercourse (including digital, oral, vaginal and anal) with prevalence rates of 1.3%-28.7% (women) and 1.1% - 14.1% (men) [3, 4]. In 1996 the Australian Bureau of Statistics estimated 38% of adult females had experienced one or more incidents of physical or sexual violence [5]. Fleming's study reveals 35% of Australian women have had at least one incident of unwanted sexual contact with an adult before 18 years of age [6].

The secrecy that surrounds CSA coupled with the criminal restriction on such behaviour, silences discussion and dissuades disclosure. First-point-of contact professionals such as general practitioners, teachers, nurses, police and welfare personnel must be more aware that CSA could be the reason behind a variety of interpersonal, behavioural and psychological problems they see in adults and children [7].

The health impact of child sexual abuse

The impact of CSA pervades every aspect of the survivor's life [8]. CSA is best viewed as a risk factor for a wide range of subsequent problems. There are indications trauma during childhood may have neurobiological effects and places the child at risk of long term psychological, emotional and behavioural problems [9]. CSA acts in concert with other developmental experiences to leave the child with areas of vulnerability such as capacity for trust, intimacy, agency and sexuality. There is a well documented increased risk of alcohol and substance abuse and established links between CSA and mental illness [10, 11]. Conditions that should alert nurses to think of CSA as a possible contributing factor include, but are not limited to depression; addiction; anxiety and panic disorders; personality, compulsive and eating disorders; self-harm. Additionally, stress related health problems such as headaches, back pain, abdominal problems like irritable bowel and sexual dysfunction, [4, 11-13]. However, abuse is not a destiny and damage, if not repairable, may be ameliorated with appropriate care. Hence the potential for capacity building with women as part of the role of the health care professional.

The nursing encounter

CSA influences health encounters without either party being necessarily aware of it. Situations where survivors feel overwhelmed or have little control over their situation can trigger confusion and anxiety [14]. Such experiences are intimidating and can lead women to avoid routine preventative care. There may be

adverse effects to procedures nurses take for granted such as a full sponge, obstetric and gynaecological interventions, catheter insertion, wound dressing, pressure area care which may trigger memories that provoke anxiety for the woman who has experienced CSA.

Survivors block out details of their trauma but these memories can resurface when the women seeks to face them, or when the woman is exposed to traumatic situations that mimic the original abuse such as urinary catheter insertion or birthing. The woman may suppress memories of CSA and be unaware of why she is so uncomfortable about certain examinations [15]. Memories can even resurface for the first time when the person is older especially in early dementia, making people suddenly become anxious and fearful about being touched [16].

In encounters with health care professionals, the women participating in this study wanted to be asked about a past history of CSA. Very few women were asked. They would have appreciated opportunities to speak out when they finally felt able and ready. Being ready to disclose is another complicating matter. The woman must feel safe before she is ready. Once safety can be established, the woman will look for authentic interest of the health care professional to her story. When she finally has the courage to speak out it is likely that she can commence her healing. Storying one's account can be therapeutic. She needs to know you are listening and will do something to help her by referring her to appropriate support. This is best conveyed in your sensitive and caring attitude. Whatever the circumstances, it is detrimental to recovery if the woman is blamed for her experience, ignored, diminished or dismissed. Instead, listening means being believed, being respected and above all afforded privacy and your confidential committed action to help her find the much needed support.

In addition to offering the therapeutic benefit of being heard there are some practical suggestions. Wherever possible, allow the woman to control the interaction [17]. For example when inserting a catheter explain in detail why, how, where and how long you will examine and touch the woman [18]. Always give instructions about what to expect, the cooperation required to minimise discomfort, and remind the woman she can say stop and you will respect her request and halt the procedure. Obtain her perspective about the best management of her health and validate her opinions and feelings. Affirm her resources to manage and her cooperation. Avoid using child like endearments like 'relax sweetie' as this language may be similar to what the abuser used, instead use accurate and sensitive adult words. Always ask if you need to touch her body and describe what you are doing in plain non-emotive language using accurate words eg vagina, urethra, rather than "touch you down there" [19]. You can facilitate disclosure of CSA with non-judgemental attitudes, appropriate assessment and sensitive intervention. Privacy and confidentiality is of utmost

importance. Knowing where to refer clients who have disclosed CSA and helping them to break the silence is will assist them to move forward toward a healthier future.

CSA counselling services are available from:

the client's nearest community health centre,
Uniting Care Wesley 8202 5190; Women's Health
Statewide 8239 9600, 1800 182 098; Anglicare
8342 4005; Centacare 8210 8200; Relationships
Australia 8223 4566. There are a series of pamphlets
that can be downloaded from www.whs.sa.gov.au

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