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IMPACT OF CHILD SEXUAL ABUSE AMONG THE YOUTH; WAYS OF CARING FOR THEM.



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The information was collected from research articles. All articles were related to child sexual abuse. The purpose of the research is to discuss broadly about the subject matter. These cover the various problems that occur after sexual abuse, symptoms and causes, long and short term psychological effects, ways of helping victims, ethical considerations and derived conclusions. Aim is to create awareness, introducing possible solutions of reducing sexual violence and making recommendations. Recommendations for nurses would go to Terveystiete. Recommendations include: consequences of child sexual abuse, how to take patient's history, assessment and examination of child, ways of treatment, follow-up information, counseling and documentation. Nurses who expected to function with sexually abused children can use this information during care process, providing treatment and assessment of victim. Also it can be used as self-education material. Healthcare professionals face many problems. Recommendations can be very useful to move on in treatment process!

2 annexes are included

Annex 1: World Health Organization (WHO) sexual violence examination record

Annex 2: Recommendations for nurses

KEYWORDS: Child sexual abuse, care, impact, victims.

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1. INTRODUCTION

Sexual violence is a gross violation of children's rights that occurs in every country in the world. In 2002, the World Health Organization estimated that globally at least 150 million girls and 73 million boys under 18 years had experienced forced sexual intercourse or other forms of sexual violence involving physical contact. In several Caribbean countries, the first sexual experience of young girls is often forced; studies have shown that this was the case for 42.8% of girls below age 12. (Woody 2002.)

Child sexual abuse or child molestation can be defined as a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation. The forms of child sexual abuse include asking or pressuring the child to engage in sexual activities such as child pornography and Commercial sexual exploitation regardless of the outcome. Child sexual abuse can occur in various settings such as, formal institutions, at home, parks, pathways among others. The United Nations Children's Fund (UNICEF) stated that child marriage is the most prevalent form of sexual abuse of the girls. It is a global issue and affects both genders. Impact of child sexual abuse refers to the effect or results of sexual offences. The target group are the youth aged 16-30 years. (Woody 2002.)

Impact of child sexual abuse among the youth has resulted to various problems such as post-traumatic stress disorder, substance abuse, self-harm, suicide, sexually transmitted diseases, unwanted pregnancies, eating and sleeping disorders among others (Taylor et al. 2011).

The victimized individuals are usually deeply wounded emotionally after an assault. Our study will focus on ways of caring or helping the victims. This

particular project will focus on effects or results of childhood abuse in the adult life as well as measures of helping them cope in order to resume a normal functional life. (Black and DeBlassie 1993.)

2. LITERATURE REVIEW

2.1 EFFECTS AND EXPRESSING EMOTION

Prospective studies among adults with regard to documented memories of Child Sexual Abuse (CSA) reveal that majority of the victims remember their victimization. Scientific investigation on the accuracy of these memories has seldom been done. According to Weede et al. 2005, a study research about memory accuracy and errors was carried out on sexually abused victims. Severity of Post Traumatic Stress Disorder (PTSD) was positively associated with memory accuracy. Nonetheless, some victims nominating CSA as the most traumatic events of their lives exhibited accurate memory regardless of PTSD indicators. Memory errors were linked to less maternal support. Understanding an events traumatic impact is very important for predicting the accuracy of long term memory of the victims.

Impacts of childhood sexual assault often leads to long term effects such as depression, post-traumatic stress disorder, behavioural problems, including sexualized behaviour, poor self-esteem, academic problems and suicide. Victims of childhood sexual abuse can expect to incur higher future health care costs due to these effects, and it is not uncommon for victims to "victimize" others or become sexually promiscuous at an early age. Prostitutes and paedophiles often explain that their first sexual experience was being molested as a child. (Black and DeBlassie 1993). The sexual abusers sometimes do select their target victims. Often, they pick those who appear socially isolated, lack confidence or seem unhappy (Salter 2003.)

Causes of child molestation can be as a result of some people sexually abusing children so that they can feel the power and control, which abusers don't feel in

their relationships with other adults or in their life. Abusers are sexually attracted to other adults, but may sexually approach children when they are under stress, like losing a job or getting a divorce. (Harrison 2005.)

Childhood anxiety symptoms and disorders have long been identified as both long and short term psychological effects of CSA (Bietchman et al.1992). Other effects such as depression, anger, poor self-esteem, substance abuse and eating disorders do portray on the abused. Caregivers usually report increased anxiety and clinging behaviors among their children. (Manarino and Kohen 1986.) The sexual abusers sometimes do select their target victims. In most case, confident children are less likely to be targeted. In case they are captured, they stand a better chance to resist from their predators. In contrast, children with preexisting anxiety problems have been found to be less socially aware therefore they are more likely to be the victims of abuse. Some research findings do support that some children experiencing case-handling procedures find it significantly distressing. In addition, reaction of the victim's family after the unfortunate ordeal has a great impact on the child's mental health outcome. For instance, some of these children receive low parental support while others are blamed for the occurrence. They end up progressing very poorly (Chaffin, Wherry and Dykman 1997; Elliott and Carnes 2001.) In contrast to those who are supported by their families (Cohen and Mannarino 2000).

Most of the traumatized victims do blame themselves in such situations over which they had no control. Victims feel that they should have seen the unforeseen occurrence before it happens even though it would not have been possible. Some abusers would say to their victims that they are punishing them for their mistakes. The mistakes could have either been real or imagined. Henceforth, the victims emerge not just being damaged, but feeling that they deserved it. Children do not understand independent causations. (Spiegel et al. 2000.)

CSA has an impact on the woman's sexual well-being. CSA involving fondling alone was generally not associated with adverse sexual outcomes. However, the women who experienced sexual penetration or attempted sexual penetration were more likely to be re-victimized in adulthood, engage in unprotected sex, abstinence from sex or exhibit lower sexual esteem including fewer sexual rewards. The brutal act is regarded as a serious and widespread problem with significant implications for adult women sexual functioning. (Lemieux et al. 2008.)

Survivors of these brutal acts may end up impregnated. Some may choose to keep while others induce abortion. Pregnant survivors suffered higher distress levels with higher chances of having poor health hence increasing probability of high risked pregnancy, compared to women who suffered PTSD only. Therefore, health professionals need to recognize and address psychological state of the pregnant victims. This would help to discover their unique concerns while being monitored during prenatal period (Yampolsky 2010.)

Loss of childhood innocence and the loss of trust in persons or institutions affect children's healthy development and feelings may hit all at once—shock, sadness, vulnerability, betrayal, helplessness, anger (Woody 2002). Many children unable or unwilling disclose information about their abuse (Harrison 2005). Abused children have greater incidence of suicide attempts especially as they grow and become aware of their surrounding (Black and DeBlassie 1993).

2.2 MISINTERPRETATION

It is believed that, if a child had been sexually abused he/she would display an abnormal type of sexual behaviour. Most of these problems involve sexually harassing other kids, being sexually inappropriate with the staff, male and

female. In puberty period extreme sexual feelings might come especially if child was previously abused – a child starts to act on his/her previous experiences, which means that even with the highest supervision that you can master, there's going to be some sexual acting out among the children. (Kools et al. 2002.)

Children can exhibit sexual behaviour as a normal part of their development. Caregivers also assumed that early sexual experience led to precocious and accurate sexual knowledge. Also, it is assumed that children without limits and who acted out sexually would predictably become sex offenders in the future. Three key factors can manage child behaviour: knowledge of child development and sexual abuse, level of comfort with sexuality, liability issues. Management strategies are used to address child sexual behaviour in treatment setting is behavioural and cognitive. (Kools et al. 2002.)

Children who were sexually abused do not lose need for physical expressions of warmth and closeness. They develop a healthy sense of their sexuality and sexual identity in the context of peer interactions. These relationships provide developing body image, accommodating sexual feelings, learning socially acceptable expressions of sexuality. It would be inappropriate and rarely fruitful if you ask why they engage in this behavior. (Kools et al. 2002.)

2.3 WAYS OF HELPING OUT THE VICTIMS

Psychotherapy program is also used to treat sexual abused children. It helps to measure self-concept, anxiety and depression. Also treatment includes individual play therapy program and sex-education group therapy program. Regular follow- ups, treatment of aggression and depression are important. Some children after being treated do not improve or get worse. Optimal duration of treatment is unclear because everything depends on the child. The treatment should be based on conceptual model of the psychopathology of child sexual abuse. Other treatment program is the cognitive-behaviour therapy program which progresses in 3 phases for 6 weeks. Phase 1 - relaxation, reframing and stress management. Phase 2 - resolving, anxiety and depression (child and

parent separate). Phase 3 - application and consolidation, resolving residual problems. Parent and child should come together to raise any further problems they wish to change, and these are dealt with through externalization, reframing and relaxation, address issues relating to sexual behaviour and anger

management by behaviour therapy and cognitive therapy techniques.(Nurcombe et al. 2000.)

From the 18th week to 12 months, the following are assessed, parental psychopathology, parent's reaction after the disclosure of abuse, child's social competence and the general symptoms. The child is checked if he or she is still experiencing impulsive or aggressive sexual behavior. (Nurcombe et al. 2000.)

Group psychotherapy can be beneficial to male victims in strengthening impulse control, enhancing self-esteem and providing opportunities to participate in reality testing. The eight titles used to talk with male victims – believability; guilt and responsibility; body integrity and protection; secrecy and sharing; anger; powerlessness; other life crises, tasks, and symptoms; and court attendance. A peer group of four to ten members co-led by a male and a female therapist has been found to be the most effective model for group treatment. Age spacing among members should be closer for younger children lasting for 1 – 1.5 hours once a week. In family therapies, father's presence is crucial from the beginning. Fathers are more likely to collude with the victim in wishing to minimize the abuse or to deny a need for treatment. Therapist's role is to create a firm alliance with the parents so that they can maintain their parental roles with a sense of self-respect. Four stages common to family intervention: disclosure of abuse, family disruption, movement toward rehabilitation and the creation of "a new family". (Black and DeBlasie 1993.)

Family therapists may be involved in providing of treatment services. Family therapists should promote full understanding of all aspects of sexuality for individuals and families. They can also deal with mass media to educate in crisis intervention for persons at risk and in therapy that centers on child or adult experiences of sexual abuse. Parents and communities need help to increase

understanding of child sexual abuse and cope effectively with their desire to protect children. The most important thing is that people need guidance on how to wisely use such news events as an opportunity for providing immediate/ongoing sex education and moral guidance for youth. These therapists have much to offer when a community must deal with highly publicized sexual situations or scandals. Family therapists should use opportunities from the media to help people treat sexuality as a normal part of life. In the specific locale they may treat the children and families directly affected by the immediate situation of child sexual abuse. In addition, the media may ask family therapists to provide information about child sexual abuse for news stories to general public. Family therapists should play a significant role in providing intensive counseling for children and their families who must deal with sexual abuse or offense. Therapists can Offer brief psycho-educational programs where the goal is to provide more in-depth information, allow for interactions with the audience, expression of specific needs and encourage persons who need further help to seek counseling. (Woody 2002.)

It is useful to focus on a broad frame- work that includes three levels of prevention of health and mental health conditions. Primary-prevention efforts aim to promote health and prevent problems, such as inoculation programs, community information, awareness programs and psycho-educational programs. The second level targets persons who are at high risk for a specific health threat. The third level is to provide treatment and rehabilitation for persons already experiencing a specific illness or symptoms in order to foster a good recovery and to prevent further debilitation. (Woody 2002.)

Other method to study the abuse and neglect is analysis of imaginative literature. It may facilitate more effective care. There are two novels with experiences of sexual abused children, which are written by African American writers - *The Bluest Eye* (Morrison 1970) and *Push* (Sapphire 1996). Writing programs and storytelling projects are activities that may become a function of the child's education. (Harrison 2005.)

Child can try to write stories because it may help to break the conspiracy of silence in the surrounding. It may be better assist victims in the process of disclosure from the experience of reading such graphic novels. The abuse and neglect of children is an important concern for nurses. They are interested in the therapeutic value of writing because of advantages of this funding. Most parents do not want to harm their children, but the powerlessness, shame and brutality that are associated with abuse deprives children of their humanity. (Harrison 2005.)

General suggestions include empowering the young victim with the knowledge that he is not bad and there are choices which can be renegotiated whenever new information becomes available, normalize the child's fears and guilt, make good emotional environment. (Black and DeBlassie 1993).

The efficacy of early detection and treatment in helping young victims of sexual abuse highlights the need for professionals and parents to be knowledgeable. Helpers can organize therapeutic interviews by providing information about sexual abuse of males, some feelings and attitudes boys are likely to have about such abuse. Helpers should ask young people for general accounts of their sexual "experiences." Many males would deny having been molested (if a woman had forced them to perform sexual acts). Individual therapy with a male helper can be the most difficult and intimidating for the male sexual abuse victim, but individual work should be done in support of group treatment. (Black and DeBlassie 1993.)

When child sexual abuse becomes the focus of public discourse, parents are likely to feel forced to deal with this topic and many have a pattern of avoiding sexual discussions with their children. Those who have been victimized and their families usually get immediate counselling and their identities are protected. (Woody 2002.)

Healthcare professionals play a major role in assisting the victims. Nurses can assume a variety of non-traditional roles in facilitating the recovery of sexual

assault victims. They can function as crisis intervention counsellors, victim advocates with regard to law enforcement and medical personnel, as well as educators in relation to both the victim's significant other and to legal, medical, mental health personnel with whom the victim may interact. The nurses, who respond to the victim in a holistic manner, fulfilling a number of non-traditional roles, can promote the victim's smooth navigation of systems involved with her care. In so doing, the nurse provides continuity of care and facilitates the victim's recovery from the trauma of sexual assault by simplifying the process of treatment. (Kools and Kennedy 2002.)

2.4 ETHICAL CONSIDERATIONS AMONG HEALTHCARE PROFESSIONALS

With regard to child healthcare professionals' responsibility, the results showed that they regarded several tasks as falling within their responsibility, including motivating parents to accept help, monitoring the response to care, monitoring of high risk cases, and registration. They acknowledged their statutory responsibility to check whether a child's needs and rights are met. It is difficult to handle parents who do not want to cooperate or are resistant. (Nurcombe et al. 2000.)

It is important to pay attention to the person behind the professional. Fears (e.g., asking sensitive questions), personal values and experiences around child abuse can act as an internal barrier and should be addressed in training and supervision. (Weinbach 1987). With regard to action planning, the results showed that professionals are in need of consultation with colleagues during the complete child abuse detection process and not only in reporting alleged abuse. It is important that consultation takes place promptly and not several weeks later. (Paavilainen and Tarkka 2003.)

According to Finnish Child Welfare Act, Section 25: There is an obligation to notify the police and social welfare authorities of any suspected child sexual offenses.

3. THE TASK AND AIM OF THE PROJECT

The project's task is to discuss the causes and impact of child sexual abuse in youth, ways of caring for the victims including the nurse's role. The project aims at creating awareness and coming up with possible solutions of reducing the incident cases. Recommendations for nurses with regards to our topic will be done at Terveysnetti.

4. EMPIRICAL IMPLICATION

The main ideas of our topic were to discuss on the effects of Child Sexual Abuse especially among the youth, ways of caring for the victimized individuals, creating awareness and coming up with possible solutions of reducing this abominable act. Writing recommendations for nurses on ways of caring for the victims in hospital setting. The recommendation focuses on how the abused kids can be well taken care of and treated in hospital settings. As mentioned, nurses are expected to know the diverse effects of this brutal act, which would in turn assist them in handling such patients. They however face a difficult challenge as some of their victims may tend to be quite shy and unable to open up or express themselves. Patients it therefore a key factor to be embraced by health professional workers working in this field.

5. RECCOMENDADATIONS FOR NURSES

5.1 Consequences

There are a numerous consequences of child sexual abuse, which can be divided on two types: physical and psychological. Also, they can be seen as short-term or long-term effects.

Physical consequences include different injuries, which can be genital and non-genital. Genital injuries can include the following: unwanted pregnancy, urinary tract infections, future sexual dysfunction and infertility, genital injuries (bruises, tears and abrasions), unsafe abortion, gastrointestinal disorders (irritable bowel

syndrome, non-ulcer, Dyspepsia), menstrual irregularities, sexually transmitted infections (HIV/AIDS), redness and swelling of genitals.

Non-genital physical injuries: chronic abdominal and pelvic pain, anal or rectal trauma, bruises (fingertip, petechial, trainline), scratches from nails, lacerations, contusions, ligature marks to ankles, wrists and neck, pattern injuries (hand prints, finger marks, belt marks, bite marks), incised wounds. Incised wounds are produced by sharp edged objects whose length is greater than their depth.

Psychological effects vary considerably from person to person. Many victims experience rape trauma syndrome, which means stress response of sexually abused child. It can be shown emotionally as: crying, staying calm and very controlled, smiling and laughing, feeling guilty, angry and fear and shame. Post-traumatic stress disorder, which appears to be more common in children who got extreme physical force, who were raped by strangers and in cases where physical injuries were inflicted. Post- traumatic stress disorder symptoms can be increased or inappropriate sexual behaviour, cognitive impairment, body image concerns, loss of social competence and substance abuse. Other psychological consequences are depression, low self-esteem, anxiety, increased substance abuse, social phobias and suicidal behaviour. Long- term effect may include: fatigue, chronic headaches, nausea, sleeping and eating disturbances and menstrual pain.

In extreme cases, consequence might be - death. Mortality can result from the act of violence itself or from suicide.

5.2 Taking patient's history

Medical history assists in obtaining routine background information relating to the medical history of the abused child. This will also include medical symptoms obtained from the abuse. It should be noted that history taking is quite different from interviewing the child about allegations of sexual abuse. The caregiver, guardian or any other acquainted person to the child is the most ideal person to

obtain the history from. Older children may tend to be shy or embarrassed when questioned about matters of sexual nature. It is always a good idea to ask if they need a person present with them or not.

Taking of the child's history in such given circumstances is not such an easy task. Specific skills need to be acquired. Health workers dealing with such matters need to exhibit specialized training and proven expertise in this field.

When gathering history of a child, it is important to start with a number of general questions before moving on to the actual distressing questions. For instance what grade are you, how old are you? The questions should be as simple as possible. For example, when do you say this happened, were any threats made, when was the first time it happened, which area of your body was touched or hurt, does it hurt when going to the bathroom, among others.

5.3 Assessment and examination of children

Children should be brought to the attention of the health care professional and should not be treated at home to avoid unsuccessful ordeals. Examination is needed as soon as possible even if the contact was more than 72 hours ago and the child has no medical symptoms.

There are two aspects of gathering of information from the child: medical history and interview. Medical history helps to find out why child is being brought for care, physical and emotional symptoms, provides basis for developing a medical diagnostic impression before physical examination. Medical history involves information about abuse, health problems or symptoms that have resulted from the violence. After medical history is taken, the interview stage of assessment is done. It obtains information related to sexual abuse, its details, time, place, other description.

Consent must be received from child and caregivers to conduct a physical examination and to collect specimens. It can be problematic to get consent

because of caregiver's refusal and children's rights. In order to avoid problems, all procedures should be fully explained to child and caregivers!

Interviewing child is important and can be used for judicial purposes. Nurses must have an ability to establish rapport with children and adolescents and have capacity to maintain objectivity in the assessment process. Nurse should be extremely sensitive, understand vulnerability, try to establish neutral environment and child's developmental level, realize that children have may use terminology differently to adults, rapport with the child before beginning the interview, identify herself as a helping person, ask the child if he/she knows the reason of seeing nurse and to describe what happened (in their own words), begin with open-ended questions, establish rules for the interview (not to lie).

5.4 Treatment

This is strongly recommended when there are signs and symptoms for instance genital ulcers, highly prevalence of the disease in the community, if family members have contracted it or show symptoms of it and when parents recommended for testing.

When screening a sexually abused child for Sexually Transmitted Infections, a follow up should be done at least a week after the incidence. STI cultures are likely to be negative if tests are run quite soon after the incidence. Chances of acquiring a positive test can also be high if the child had a pre-existing STI infection. For children in pre-puberty, tests are run only when symptoms are present.

HIV testing and pregnancy tests should be done in the case where pubertal children are involved.

5.5 Follow-up care

If findings were present during the initial examination, a follow-up examination should be carried on. In serious cases, follow-up should be conducted quite often. At this time, more tests could be done for instance, blood test for HIV, syphilis and other infections the child could be prone to.

Follow-up is also carried out for psychosocial purposes ensuring appropriate counseling has been made, including adequate support for both the child and family.

5.6 Counseling

Further assessment can be conducted to ensure arising issues are addressed and dealt with appropriately. As mentioned earlier, it should focus on both the victim and the family members. Younger children may not understand implication of abuse and therefore may appear to be less distressed than older children. A supporting caretaker can be a strong determinant for a good prognosis of the child.

5.7 Documentation

Documentation should include what was said by patient, what was seen and done. Notes can be used in court as evidence, documenting the consequences of sexual violence and provide information about past and present sexual violence. Later, documentation will show to other health care providers about abuse, so they can give appropriate treatment.

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography. A sample proforma has been prepared by WHO specifically for recording consultations with victims of sexual violence. This proforma can be copied and used as it stands, or can be adapted to suit local needs and circumstances.

In sexual abuse cases, documentation should include the following: demographic information (name, age, sex), history (general medical and

gynecological history), consents obtained, results of the physical examination, tests and their results, an account of the assault, medications given/prescribed, treatment, patient's education. Documentation should be done in interests of patient's safety.

Nurse should document all pertinent information accurately, legibly and notes should not be altered. Try to make notes and diagrams during the consultation because they can be not accurate when are taken from the memory. Check what you have documented, deficiencies may cast doubts over the quality of the assessment. Write down any statements made by the victim regarding the assault. Record the extent of the physical examination conducted and all findings.

Patient records and information are strictly confidential. All patient records and specimens should be stored in a safe place. Nurses have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case.

(Baabiker and Herbert 1996), (Black and DeBlassie 1993), (Kools and Kennedy 2002), (Lemieux and Byers 2008), (Nurcombe et al. 2000), (Taylor et al. 2011), (Wilson 2010).

6. CREATING AWARENESS AND PREVENTION SEXUAL VIOLENCE

There are a number of growing educational programmes of prevention of CSA including a group based family and child taught by teachers within the school systems. Despite the alarming rates of the incidence, not all parents discuss potential dangers to their children. According to most studies, about half of all parents discuss sexual abuse with their preschool children. These parents are likely to be educated and had more personal involvement with CSA. Discussion of sexual abuse should come in the form of education about healthy sexuality for children just as it is important for parents to teach their children about traffic

or fire safety. Discussions should be adapted to the developmental and cognitive level of the child. (Maureen et al. 2008.)

Self-protection programmes should be incorporated to assist the children cope if ever faced with sexual predators. According to literatures, children who have been involved in these programmes show significant gains in knowledge and skills which may be helpful in avoiding sexual victimization. Majority of the children reported that they felt much safer after the programme. (Hébert et al. 2001.)

Some strategies of preventing CSA among children has also been discussed. Some of these measures include, teaching children to avoid speaking to strangers, reporting incidents of strangers touching them, The approach does not really deal with the actual source of the problem. In addition adults must acknowledge the potential in people to abuse children. This could be achieved through involvement in youth related services such as child care professionals can be conducted to make them aware of warning signs and preventive measures. (Rowe 2006.)

Increased public awareness could be raised through media events such as movies, talk shows, commercials in televisions. According to Wienbarch Rober,1987 public has become attuned to sexual abuse. Trials involving alleged abuse in various institutions such as daycare centers, has received widespread coverage in weekly tabloids. However, increased public awareness has not been created without its own cost and victims therefore, the public needs to consider ways of minimizing costs. (Wienbarch 1987.)

7. CONCLUSION

As previously discussed, effect of child sexual abuse results to various symptoms and disorders which can result to long term psychological effects (Bietchman et al. 1992.) including physical challenges. Caregivers usually report increased anxiety and clinging behaviors among their children (Manarino and Kohen 1986.)

Nurses on the other hand are expected to be familiar with these symptoms the victims face in order to offer them the appropriate care they need.

Necessary steps need to be taken for the care of abused. As described, medical history needs to be obtained. In the history, any symptoms relating to the case of abuse should be recorded. The information should be derived from the care giver for instance a parent. In order to obtain information of the ordeal, certain skills are needed hence specialized professionals working with the abused are best

preferred. Children can be very sensitive or shy to share the information hence certain ways need to be utilized for information to be derived. For example, asking general questions before getting into the optimal distressing discussion.

A follow up care is very vital in such situations. This is where more tests are run to establish any kind of Sexually transmitted disease that could have transpired after the act. For instance infections like syphilis, HIV virus. It also gives first-hand information if the child is getting the necessary support- whether physical or psychological. This could be achieved through a simple observation, communicating with the child and the ways he or she is expressing themselves.

Therapies and follow-up programmes are established to help the victims cope with the situation. As mentioned earlier, it can take a long period of time for one to recover. Some may never recover from these acts. The ordeal is often marked like a scar that cannot fade away. Going for therapies becomes a daily routine and part of their lives. However, most of them benefit from these programmes and are able to move on with their lives.

Nurses dealing with such cases are expected to function as intervention counselors, advocates for the victims, teachers, health personnel with whom the victims may interact with freely, and responding to the victim in a holistic manner. These gestures enhance continuity of care and victims recovery from the trauma of sexual assault. When it comes to caring for the victims in terms of helping them to move on, it is not easy. People assigned to care for them need to be very empathetic, understanding and patient. For some it may take a long time to open up about their feelings. It is much easier to attend to their needs by simply

expressing themselves. Healthcare professionals are faced with challenges which they however need to overcome and focus in helping the victims get better. From the ongoing discussion, it is certain that CSA is an issue that affects our communities. General measures have been taken to try and prevent these acts and caring for the victimized. It is not an easy task to deal with the abused as they go through various problems psychological, emotional even physical problems. It is therefore quite challenging having to help them cope with this situation. Most importantly, they should be treated and cared for in the best way possible.

7.1 IMPORTANCE OF NURSING RECOMMENDATIONS.

As discussed, CSA is very rampant, especially in the developing countries. Many naïve children are taken advantage of which leaves a permanent scar in their lives. The victims' pain is always extended to their family members and becomes a huge burden to many. Nurses play a very vital role while it comes to caring for these victims. Most of them not only experience the physical torture but also psychological problems. Nurses should be equipped with the right skills to care for these individuals as well as their closer family as discussed broadly under the topic.

7.2 ETHICAL CONSIDERATIONS

Nurses in all domain of practice bare ethical responsibilities. The responsibilities apply to their interaction with individuals, families, colleagues and employer, student nurse among others.

Focusing on CSA victims, Nurses are expected to engage in compassionate care which is expressed by body language and speech. Clinical mistakes should be avoided but in case it happens, they should admit and necessary changes should be done. Nurses should also strive to build trustworthy relationships to understand the victims needs and concern, which contributes to a clear follow up care. They should respect policies that protects and preserve victim's privacy. They should keep honest and practice integrity in all their professional interactions.

In other case scenarios, if an issue conflicts with the nurses' moral beliefs and value, they should however provide safe, compassionate competent ethical care until alternative arrangements are in place. The conflict could also be forwarded to the employer as well. Discrimination based on gender, tribe should be absolutely avoided in nursing care.

7.3 RELIABILITY

Our main research was obtained from articles from nursing journals for example Journal of Child & Adolescent Psychiatric Nursing, Australian & New Zealand Journal of Psychiatry, Scandinavian Journal of Caring Sciences among others. However few articles were outdated dating the year 1993 while most were recently dated as from 2005 . Authors utilized had years of experience in higher education and some in writing research article as well.

8. SOURCE MATERIAL

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Example of Brochure

Recommendations for nurses

How to recognize child sexual abuse (CSA)?

Physical consequences	Psychological consequences
<ol style="list-style-type: none"> <li data-bbox="344 1189 911 1592">1. Genital injuries: unwanted pregnancy, urinary tract infections, future sexual dysfunction and infertility, genital injuries (bruises, tears and abrasions), unsafe abortion, gastrointestinal disorders (irritable bowel syndrome, non-ulcer, Dyspepsia), menstrual irregularities, sexually transmitted infections (HIV/AIDS), redness and swelling of genitals <li data-bbox="344 1715 911 2000">2. Non-genital physical injuries: chronic abdominal and pelvic pain, anal or rectal trauma, bruises (fingertip, petechial, trainline), scratches from nails, lacerations, contusions, ligature marks to ankles, wrists and neck, pattern injuries (hand prints, finger marks, belt 	<ol style="list-style-type: none"> <li data-bbox="987 1189 1538 1335">1. Rape trauma syndrome: crying, staying calm and very controlled, smiling and laughing, feeling guilty, angry and fear and shame <li data-bbox="987 1458 1538 1637">2. Post-traumatic stress disorder: increased or inappropriate sexual behaviour, cognitive impairment, body image concerns, loss of social competence and substance abuse <li data-bbox="987 1760 1538 1861">3. Other: depression, low self-esteem, anxiety, social phobias and suicidal behaviour

marks, bite marks), incised wounds	4. Long-term effect: fatigue, chronic headaches, nausea, sleeping and eating disturbances and menstrual pain
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How to care for the victims in hospital settings

Taking History

- Nurse needs to have specialized training and proven expertise in this field
- Obtain background information related to medical history of abuse
- Include medical symptoms
- Obtain history from caregiver or guardian
- Ask if child needs a close person to be present with him
- Start with a number of general questions before moving on to the actual distressing questions

How to assess sexually abused child?

- Examine as soon as possible, even if no symptoms present.

- Nurse should be extremely sensitive, understand vulnerability, try to establish neutral environment and child's developmental level, realize that children have may use terminology differently to adults, identify herself as a helping person
- Begin with open-ended questions
- Medical history – information about abuse, health problems or symptoms that have resulted from the violence
- Interview stage - information related to sexual abuse, its details, time, place, other description
- Establish rules for the interview (not to lie)
- Physical examination & collection of specimen
- Look for physical signs and symptoms (diseases, genital ulcers)
- Screening for sexual transmitted infections
- HIV testing
- Pregnancy test
- Follow-up examinations (blood tests, HIV, syphilis)
- Adequate support for child and family

What should documentation include? (Annex 1: World Health Organization (WHO) examination record)

- What was said by patient, seen and done
- All information that would help in future treatment
- Hand-written notes, diagrams, body charts and photography
- Demographic information (name, age, sex)
- History (general medical and gynecological history)
- Consents obtained
- Results of the physical examination, tests and their results
- An account of the assault
- Medications given/prescribed
- Treatment
- Patient's education
- Records and information are strictly confidential
- All patient records and specimens should be stored in a safe place.

Other ways in which nurses can care for the victimized.

- Emotional Support
- Functioning as crisis intervention chancellor
- Advocates for victims
- Educators
- Responding to the victim in a holistic manner.

ANNEX 2

Research Articles

Name & Year	Aim	Research method	Participants	Results
Alexander Kristen Weede, Quas Jodi A., Goodman Gail S.,	Study examined predictors of memory accuracy and errors 12 to 21	Interview via telephone	Ten to 16 years following the original study, when	Severity of posttraumatic stress disorder (PTSD) symptomatology was positively associated

<p>Ghetti Simona., Edelstein Robin S., Redlich Allison D., Cordon Ingrid M. & Jones David</p> <p>Traumatic Impact Predicts Long-Term Memory for Documented Child Sexual Abuse</p> <p>2005</p>	<p>years after abuse ended for individuals with legal experiences resulting from documented child sexual abuse</p>	<p>Mailed questionnaires In-person interview</p>	<p>participants were adolescents and young adults. Original 217 eligible participants</p>	<p>with memory accuracy. However, individuals nominating child sexual abuse as their most traumatic life event exhibited relatively accurate memory regardless of indicators of PTSD. Predictors of memory errors were also identified</p>
<p>Babiker Gloria and Herbert Martin</p> <p>The Role of Psychological Instruments in the Assessment of Child Sexual Abuse</p> <p>1996</p>	<p>Study aims to review the different types of psychological instruments and to comment on their clinical and their research usage</p>	<p>Questionnaire</p>	<p>Sample of 369 sexually abused children</p>	<p>Clinicians are encouraged to combine the use of standardized measures with the traditional interview in their work with sexually abused children for the general purposes of research and the clinical identification of those most in need of help in these areas, and to refrain from using, in isolation, the kinds of measures</p>

Name & Year	Aim	Research method	Participants	Results
<p>Harrison E.</p> <p>Disclosing the Details of Child Sexual Abuse: Can Imaginative Literature Help Ease the Suffering.</p> <p>2005</p>	<p>The purposes of this study are to examine the lived experiences of sexually abused children in two novels by African American writers, <i>The Bluest Eye</i> (Morrison, 1970) and <i>Push</i> (Sapphire, 1996), and to determine what factors contribute to survival and healing in the abused child</p>	<p>Literary Analysis</p>	<p>2 literature books</p>	<p>Details of the event and resultant dehumanization of the children were uncovered, as well as the rescuing role of the ancestor. Writing emerged also as a therapeutic tool that facilitated disclosure and helped to promote healing</p>
<p>Kools S. and Kennedy C.</p> <p>Child sexual abuse treatment: misinterpretation and mismanagement of child sexual behaviour</p> <p>2002</p>	<p>A purposive sample of 20 registered nurses and child care workers were interviewed about their experiences working in residential treatment and their knowledge about child development and child sexual abuse and its application to practice</p>	<p>Data from interviews and field notes were analysed using dimensional analysis.</p>	<p>The purposive sample for the study was 20 residential caregivers of these children including five registered nurses and 15 child care workers</p>	<p>Caregivers had limited knowledge of the sequelae of sexually abuse. Developmentally appropriate behaviour of sexually abused children, behavioural manifestations of child sexual abuse, were often misinterpreted and mismanaged</p>

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Name & Year	Aim	Research method	Participants	Results
<p>Lemieux Suzanne R. & Byers E. Sandra</p> <p>The sexual-well being of women who have experienced sexual abuse</p> <p>2008</p>	<p>The present study examined the association between child sexual abuse (CSA) and a range of positive and negative aspects of women's sexual well-being. Also investigated the extent to which women's cognitive-affective sexual appraisals mediated these relationships</p>	<p>Studying health history of participants, in-person meetings</p>	<p>Participants were 272 female community college and university student</p>	<p>Child sexual abuse involving fondling only was generally not associated with adverse sexual outcomes. However, the women who had experienced child sexual abuse involving sexual penetration or attempted sexual penetration were (a) more likely to be sexually re-victimized in adulthood; (b) more likely to have engaged in casual sex, unprotected sex, and voluntary sexual abstinence; and (c) reported fewer sexual rewards, more sexual costs, and lower sexual self-esteem</p>
<p>Nurcombe B., Wooding S., Marrington P., Bickman L. and Roberts G.</p>	<p>To evaluate the scientific literature concerning the treatment of child sexual abuse</p>	<p>A critical review of the scientific literature</p>	<p>Sample sizes varied widely (from five to 156), as did age range (from 3 to 18</p>	<p>Only nine published research studies in which subjects were randomly assigned to an index treatment or comparison treatment</p>

<p>Child sexual abuse II: treatment</p> <p>2000</p>			<p>years) and sex of subjects (13 involved female subjects only; two included only male subjects; and 14, both sexes)</p>	<p>or no-treatment control group. The successful treatments involve group therapy combined individual and group play therapy and cognitive behavior therapy</p>
Name & Year	Aim	Research method	Participants	Results
<p>Paavilainen Eija and Tarkka Marja-Terttu</p> <p>Definition and Identification of Child Abuse by Finnish Public Health Nurses</p> <p>2003</p>	<p>The purpose of this study was to determine how public health nurses in Finland defined child abuse and how they assessed their capability to identify child abuse in the family</p>	<p>Data were collected using focused interviews developed in relation to broad topics derived from the literature on family functioning, child abuse and public health nurses' work</p>	<p>20 public health nurses who work with and care for abused children</p>	<p>The tools for identifying abuse include knowledge acquisition and interactive skills, intuition, and the capacity of the nurse to handle problematic situations. Public health nurses identified child abuse in the child's behavior and appearance and in family behaviors. Public health nurses seem to be aware of child abuse but further research is needed</p>

<p>Schols Manuela W. A., Ruiters Corine de and Öry Ferko G.</p> <p>How do public child healthcare professionals and primary school teachers identify and handle child abuse cases?</p> <p>2013</p>	<p>The aim of this qualitative study was to investigate Dutch frontline workers' child abuse detection and reporting behaviors</p>	<p>Focus group interviews were held</p> <p>The interviews were audio recorded, transcribed, and thematically analyzed according to factors of the Integrated Change model</p>	<p>16 primary school teachers and 17 public health nurses and physicians</p>	<p>Findings showed that although both groups of professionals are aware of child abuse signs and risks, they are also lacking specific knowledge. The most salient differences between the two professional groups are related to attitude and (communication) skills</p>
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Name & Year	Aim	Research method	Participants	Results
<p>Sigurdardottir Sigrun, Halldorsdottir Sigrídur and Bender Sóley S.</p> <p>Deep and almost</p>	<p>The aim of this research was to do a qualitative study of the consequences of</p>	<p>Methodological approach to answer the research question.</p>	<p>7 Icelandic men who suffered sexual abuse as children participated in the study.</p>	<p>Results showed that the men describe deep and almost unbearable suffering, affecting their entire life</p>

<p>unbearable suffering: consequences of childhood sexual abuse for men's health and well-being</p> <p>2012</p>	<p>childhood sexual abuse for Icelandic men's health and well-being</p>	<p>Totally 14 interviews were conducted, two per individual, and analysed based on the Vancouver School of Phenomenology</p>	<p>The men were in the age range of 30–55 at the time of the interviews. The abuse began for most of the men around 4–5 years of age</p>	<p>of which there is no alleviation in sight. The men have lived in repressed silence most of their lives and have come close to taking their own lives. The professionals -be alert to the possible consequences of childhood sexual abuse in their practice to reverse the damaging consequences on the health and well-being</p>
<p>Sigurdardottir Sigrun and Halldorsdottir Sigridur</p> <p>Repressed and silent suffering: consequences of childhood sexual abuse for women's health and well-being</p> <p>2013</p>	<p>The purpose of this study was to examine the consequences of childhood sexual abuse for women's health and well-being</p>	<p>The research methodology was phenomenology. Seven women with a history of childhood sexual abuse were interviewed twice with 1–6 months interval</p>	<p>7 women who were sexually abused in childhood participated in the study</p>	<p>Result of the study is that time does not heal all wounds. All have great repressed and silent suffering in all aspects of life, and the abuse is still seriously affecting them and their loved ones. It is important for health professionals to know the symptoms and consequences of childhood sexual abuse to be able to respond to adult survivors in a supportive and caring way</p>

Name & Year	Aim	Research method	Participants	Results
<p>Socolar Rebecca R.S., Raines Byron, Chen-Mok Mario, Runyan Desmond K., Green Cynthia and Paterno Steven</p> <p>Intervention to improve physician documentation and Knowledge of Child Sexual Abuse: A Randomized, Controlled Trial</p> <p>1998</p>	<p>To determine if written feedback improves the chart documentation and knowledge of physicians doing evaluations for child sexual abuse and to learn what other factors are associated with better documentation and knowledge</p>	<p>Randomized and controlled trial</p> <p>Feedback based on charts and articles were sent to randomly selected one-half of physicians during 3 month period</p>	<p>147 physicians</p>	<p>Groups improved significantly in documentation during the time period. The largest improvements in time periods were in documentation of history of child abuse, penile finding, examination and knowing Chlamydia infection. A structured medical record, female physicians, and credit in continuing medical education were associated with better documentation</p>
<p>Taylor K., Hoyt D., Whitbeck L. and Cauce A.</p> <p>The Impact of Childhood Sexual Abuse on Later Sexual Victimization among Runaway Youth</p> <p>2001</p>	<p>Aim is to investigate the impact of childhood sexual abuse on later sexual victimization among homeless and runaway youth in Seattle</p>	<p>Interviewed using a systematic sampling strategy that maximized locating homeless and runaway youth in metropolitan Seattle</p>	<p>372 young people</p>	<p>High rates of both groups were reported. Females experienced much greater rate of being sexually abused. Exposure to dysfunctional and disorganized home place youth trajectories for early independence. Street life and participation in high-risk behaviour increases the probability of sexual victimization</p>

Name & Year	Aim	Research method	Participants	Results
<p>Wilson Debra Rose</p> <p>Health Consequences of Childhood Sexual Abuse</p> <p>2010</p>	<p>This article provides a summary for</p> <p>advocacy, court testimony, assessment,</p> <p>treatment, prevention, and further research</p> <p>studies in the field of childhood sexual abuse</p>	<p>Reading and analyzing research articles</p>	<p>-</p> <p>(Research articles)</p>	<p>A literature review identifies the</p> <p>psychiatric, social, and disease disorders to</p> <p>which this population is predisposed. Adult survivors experience more depression, obesity, autoimmune disorders (irritable bowel syndrome, asthma, fibromyalgia), eating disorders, and</p>
<p>Yampolsky Lee., Lev-Wiesel Rachel.& Ben-</p>	<p>This paper is a report of a study</p>	<p>A random sample mid-</p>	<p>1835 mid-pregnant</p>	<p>Pregnant survivors of childhood sexual abuse</p>

<p>Zion Itzhak Z.</p> <p>Child sexual abuse: is it a risk factor for pregnancy?</p> <p>2010</p>	<p>of the relationship of post-traumatic stress symptoms, depression, and health status to high risk pregnancy status in survivors of childhood sexual abuse</p>	<p>pregnant Jewish women was recruited in Israel over an 18-month period in 2005–2007</p>	<p>women</p>	<p>suffered higher distress levels which heightened poor health, hence increasing the probability of high risk pregnancies compared to women who had had other than sexual abuse trauma or reported no trauma. Post traumatic stress symptoms and avoidance (a subcategory) were found to explain chronic illnesses whereas depression was found to explain gynecological problems in pregnant sexually abused survivors</p>
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GUIDE FOR NURSES

IMPACT OF CHILD SEXUAL ABUSE AMONG THE YOUTH; WAYS OF CARING FOR THEM.

Background information.

Child sexual abuse is a gross violation of children's rights that occurs in every country in the world. This majorly affects the youth in developing countries. In 2002, the World Health Organization estimated that globally at least 150 million girls and 73 million boys under 18 years had experienced forced sexual intercourse or other forms of sexual violence involving physical contact.

Child sexual abuse is form of child abuse in which an adult or older adolescent uses a child for sexual stimulation. Sexual violence has resulted to various problems such as post-traumatic stress disorder, substance abuse, self-harm, suicide, sexually transmitted diseases, unwanted pregnancies, eating and sleeping disorders among others.

Case study focused on literature review where Information was obtained from various articles based on nursing journals.

TASK AND AIM

The project's task is to discuss the causes and impact of child sexual abuse in youth and ways of caring for the victims including the nurse's role.

The project aims at creating awareness and coming up with possible solutions of reducing the incident cases.

NURSING RECCOMENDATIONS

To effectively handle the affected victims, the healthcare professionals are expected to master and understand the following tips:-

Understand the impacts of sexual violence- This includes understanding the aftermath of sexual abuse which includes both psychological and physical trauma. In most cases, it affects both the abused and the direct family.

Know-how of taking the patients history- When gathering history of a child, it is important to start with a number of general questions before moving on to the actual distressing questions. For instance what grade are you, how old are you? The questions should be as simple as possible. For example, when do you say this happened, were any threats made, when was the first time it happened, which area of your body was touched or hurt, does it hurt when going to the bathroom, among others.

Equipped with assessing and examination skills- There are two aspects of gathering of information from the child: medical history and interview. Medical history provides basis for developing a medical diagnostic impression before physical examination. It involves information about abuse, health problems or symptoms that have resulted from the violence. Afterwards, Interview stage of assessment proceeds. It obtains information related to sexual abuse, its details, time, place, other description. Consent must always be received from child and caregivers to conduct a physical examination and to collect specimens.

Giving treatment- This is strongly recommended when there are signs and symptoms for instance genital ulcers, highly prevalence of the disease in the community. When screening for Sexually Transmitted Infections, a follow up should be done at least a week after the incidence. STI cultures are likely to be negative if tests are run quite soon after the incidence.

Follow up care- Follow-up examination should be carried on if findings were present during the initial examination. Depending on the severity of the case, follow up examinations should be carried quite often. More tests could be done for instance, blood test for HIV, syphilis and other infections the child could be prone to. Follow- up is also carried out for psychosocial purposes ensuring appropriate counseling has been made, including adequate support for both the child and family.

Counseling- Further assessment can be conducted to ensure arising issues are addressed and dealt with appropriately. As mentioned earlier, it should focus on both the victim and the family members. A supporting caretaker can be a strong determinant for a good prognosis of the child.

Documentation- Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography. Documentation should include what was said by patient, what was seen and done :For instance demographic information (name, age, sex), history (general medical and gynecological history), consents obtained, results of the physical examination, tests and their results, an account of the assault, medications given/prescribed, treatment, patient's education. Nurse should document all pertinent information accurately, legibly and notes should not be altered. Nurse should document all pertinent information accurately, legibly and notes should not be altered.

ANNEX 1

Sexual violence examination record

SEXUAL VIOLENCE EXAMINATION RECORD

NAME:

DATE OF EXAMINATION:

World Health Organization SEXUAL VIOLENCE EXAMINATION RECORD¹

PATIENT DETAILS

FAMILY NAME		
GIVEN NAME(S)		
DATE OF BIRTH	AGE (in years)	SEX
ADDRESS (or other identification)		

EXAMINATION

DATE	TIME
PLACE	
HEALTH WORKER'S NAME (or identification details)	
OTHER PERSONS PRESENT DURING CONSULTATION (and relationship to patient)	

REPORT

DATE SENT	SENT TO
-----------	---------

¹ This record should be used in conjunction with the WHO *Guidelines for Medico-legal Care for Victims of Sexual Violence*, which contain much of the background information about the conduct of the examination.

CONFIDENTIAL

Notes on completing the Consent Form

Consent for an examination is a central issue in medico-legal practice. Consent is often called “Informed consent” because it is expected that the patient (or his/her parent(s) or guardian) will be “informed” of all the relevant issues to help the patient make a decision about what is best for him/her at the time.

The patient needs to understand:

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.

For example:

“I will need to ask you for details of the assault. I will need to know where your attacker’s body touched yours so I will know where to look on your body for signs of injury or for traces of evidence from your attacker.”

- That the examination will be done in circumstances of privacy and dignity. The patient will lie on an examination couch and an extensive examination will be required.
- That a genito-anal examination will require the patient to lie in a position where this area can be adequately seen with the correct lighting.

For example:

“I will ask you to lie on your back on the examination couch with a sheet draped over your knees. I will ask you to draw your knees up, keep your ankles together and flop your legs apart so that I can look carefully at your pelvic area with the help of this light.”

- That the genito-anal area will be touched by the examiner’s gloved hands to allow internal structures to be better seen. A device designed for looking inside the vagina or the female birth canal, called a speculum, may be used. A device for looking inside the anus, an anoscope, may be used.
- That specimen collection involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva. Clothing may be collected. Not all of the results of the forensic analysis may be made available to the patient.

It is crucial to inform the patient that the information told to the health worker and found on examination will be conveyed to investigators for use in the pursuit of criminal justice if the patient decides to pursue legal action or in jurisdictions with mandatory reporting requirements. This means that anything told to the health worker may not be kept private between patient and health worker, but may be discussed in an open court at some time in the future.

The patient should also be given an explanation as to how photographs may be used. Photography is useful for court purposes and should NOT include images of genital areas.

All of the above information should be provided in a language that is readily understood by the patient or his/her parent/guardian.

SEXUAL VIOLENCE EXAMINATION RECORD	NAME: DATE OF EXAMINATION:
------------------------------------	-------------------------------

CONSENT FOR A MEDICAL CONSULTATION¹

..... (*insert health worker's name*) has explained to me the procedures of examination, evidence collection and release of findings to police and/or the courts.

I (*insert patient's name*) agree to the following:

(Mark each n that applies)

- Examination, including examination of the genitalia and anus.
- Collection of specimens for medical investigations to diagnose any medical problems.
- Collection of specimens for criminal investigation.
- Photography.
- Providing a verbal and or written report to police or other investigators.
- Treatment of any identified medical conditions.

Patient's (or parent's or guardian's) signature or mark

Witness' signature

Date

¹ In cases involving children, a parent or guardian can sign on behalf of the child. Similarly, if an adult is not competent to provide consent, the next of kin or guardian should sign on his/her behalf.

MEDICAL HISTORY

1. RELEVANT MEDICAL/SURGICAL/PSYCHIATRIC HISTORY

For children include:

- relevant antenatal/postnatal and developmental history;
- history of behavioural problems (if considered relevant to allegations);
- family history.

2. RELEVANT GYNAECOLOGICAL HISTORY

First day of last normal menstrual period (DD/MM/YY):

Average number of days between menstrual periods:

Age at menarche (for children):

Was patient menstruating at the time of the assault? Yes No Not applicable

Is the patient currently pregnant? Yes No Not applicable

Pregnancy history:

Methods of contraception currently in use:

History of genital trauma, surgery or bleeding:

3. ALLERGIES

4. MEDICATIONS/IMMUNIZATION STATUS (e.g. hepatitis B, tetanus)

HISTORY OF OFFENCE

5. DETAILS FROM OTHER PARTIES (e.g. police, family, witnesses)

Details provided by (name):

6. DETAILS FROM PATIENT

Date(s) of assault (or period over which assaults occurred, number of assaults and date of last assault):

Time:

Location:

Assailant(s) (number and relationship to patient, if any):

Alcohol consumed:

Drugs consumed:

Weapons used, threats made:

Relevant details of assault:

7. CURRENT SYMPTOMS

SUMMARY OF SEXUAL ASSAULT

VAGINAL PENETRATION	<i>Assailant 1</i>	<i>Assailant 2</i>	<i>Assailant 3</i>	<i>Assailant 4</i>	<i>Assailant 5</i>
Attempted/completed?					
Ejaculated Yes/No?					

ANAL PENETRATION	<i>Assailant 1</i>	<i>Assailant 2</i>	<i>Assailant 3</i>	<i>Assailant 4</i>	<i>Assailant 5</i>
Attempted/completed?					
Ejaculated Yes/No?					

ORAL PENETRATION	<i>Assailant 1</i>	<i>Assailant 2</i>	<i>Assailant 3</i>	<i>Assailant 4</i>	<i>Assailant 5</i>
Attempted/completed?					
Ejaculated Yes/No?					

	<i>Assailant 1</i>	<i>Assailant 2</i>	<i>Assailant 3</i>	<i>Assailant 4</i>	<i>Assailant 5</i>
EJACULATED ON BODY If 'Yes' list site					
SALIVA ON BODY If 'Yes' list site					
CONDOM USED (Yes/No/?)					
LUBRICANT USED (Yes/No/?)					

OBJECTS¹ USED FOR PENETRATION	<i>Assailant 1</i>	<i>Assailant 2</i>	<i>Assailant 3</i>	<i>Assailant 4</i>	<i>Assailant 5</i>
VAGINA					
ANUS					
MOUTH					

¹ Include body parts (e.g. digits).

8. POST ASSAULT

Detail clothing worn at time of assault:

Changed clothes	Yes	No
Cleaned clothes	Yes	No
Bathed/showered	Yes	No
Had sexual intercourse	Yes	No

9. RECENT INTERCOURSE

Intercourse during the past week	Yes	No
----------------------------------	-----	----

Details (date/time/with whom):

Was condom/spermicide/lubricant used?	Yes	No
---------------------------------------	-----	----

Details:

Notes on the forensic examination

- The extent of the examination will be largely directed by the history and clinical observations. If there is any doubt, a complete external inspection is preferable.
- When describing wounds, consider: site, size, shape, surrounds, colour, contours, course, contents, age, borders and depth.
- Classify wounds:
 - Abrasion: disruption of the outer layer of the skin.
 - Bruise: an area of haemorrhage beneath the skin.
 - Laceration: splitting or tearing of tissues secondary to blunt trauma.
 - Incision: a cutting type of injury with (usually) clear, regular margins.
 - Stab: a wound of greater depth than length, produced by a sharp object.
- A speculum (or proctoscope) examination may be required for adults or post-pubertal sexually active children. Indications include:
 - genital pain;
 - bleeding;
 - foreign body (used during assault and possibly still present);
 - assaults > 24 hours earlier. In such cases, a cervical canal specimen is required.

The speculum should be warmed and lubricated with water. A bimanual examination is rarely indicated post sexual assault.

- Photography (including colposcopic photography) provides a useful addition to wound documentation. Consider the following:
 - self, police or hospital photographers may be appropriate;
 - careful labelling of film/photos is vital;
 - photography of the genital region may cause considerable embarrassment for the patient; it should only be performed when the patient provides specific consent and if it is considered essential to the case.
- Notes on methods of collecting forensic specimens are provided on pages 19–20. Advice should be sought from the forensic laboratory on any variations to this methodology.

EXAMINATION

10. PERSONS PRESENT

Name(s):

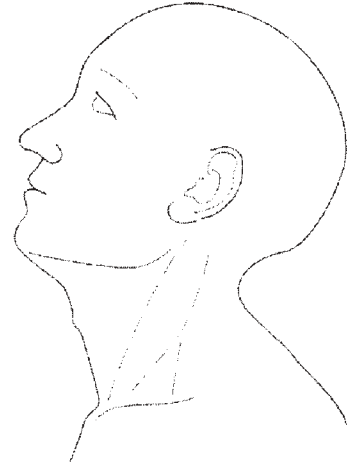
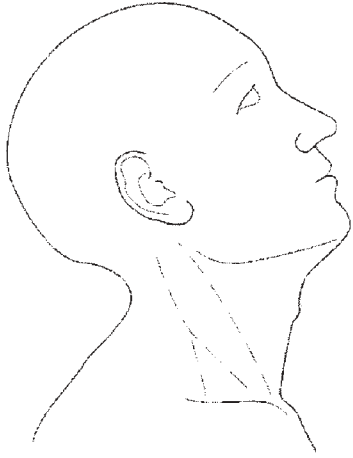
.....

.....

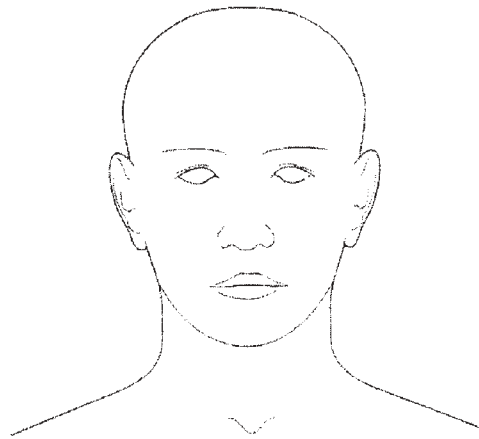
.....

11. INITIAL APPEARANCE (e. g. intellect, physical, sexual development, clothing, emotional state, effects of alcohol/drugs)

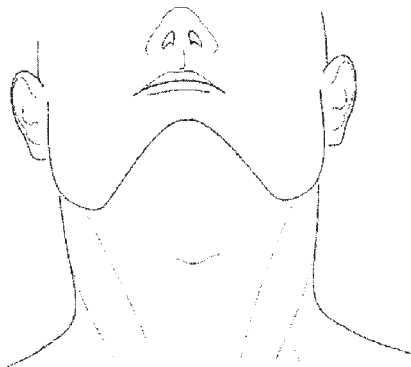
12. FINDINGS (place notes here; use body charts for diagrams)

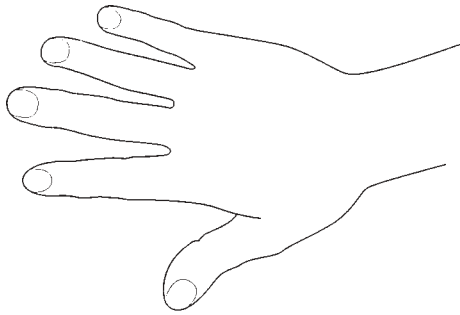


Right

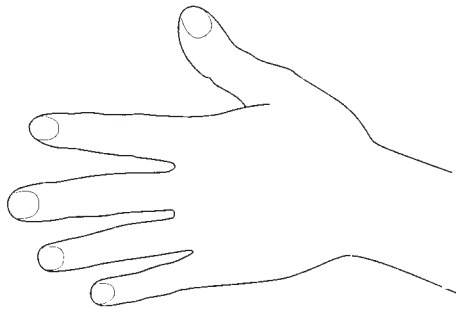
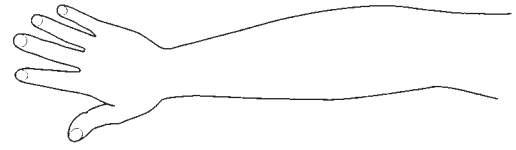


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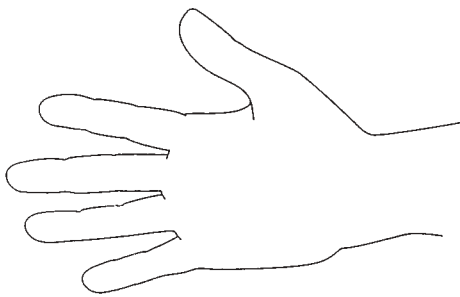
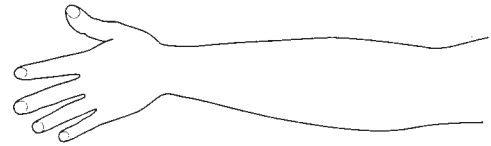




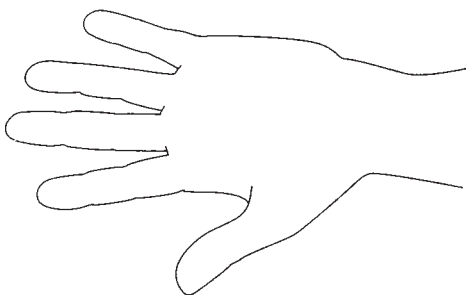
R



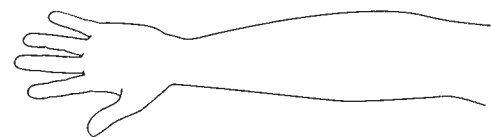
L



R

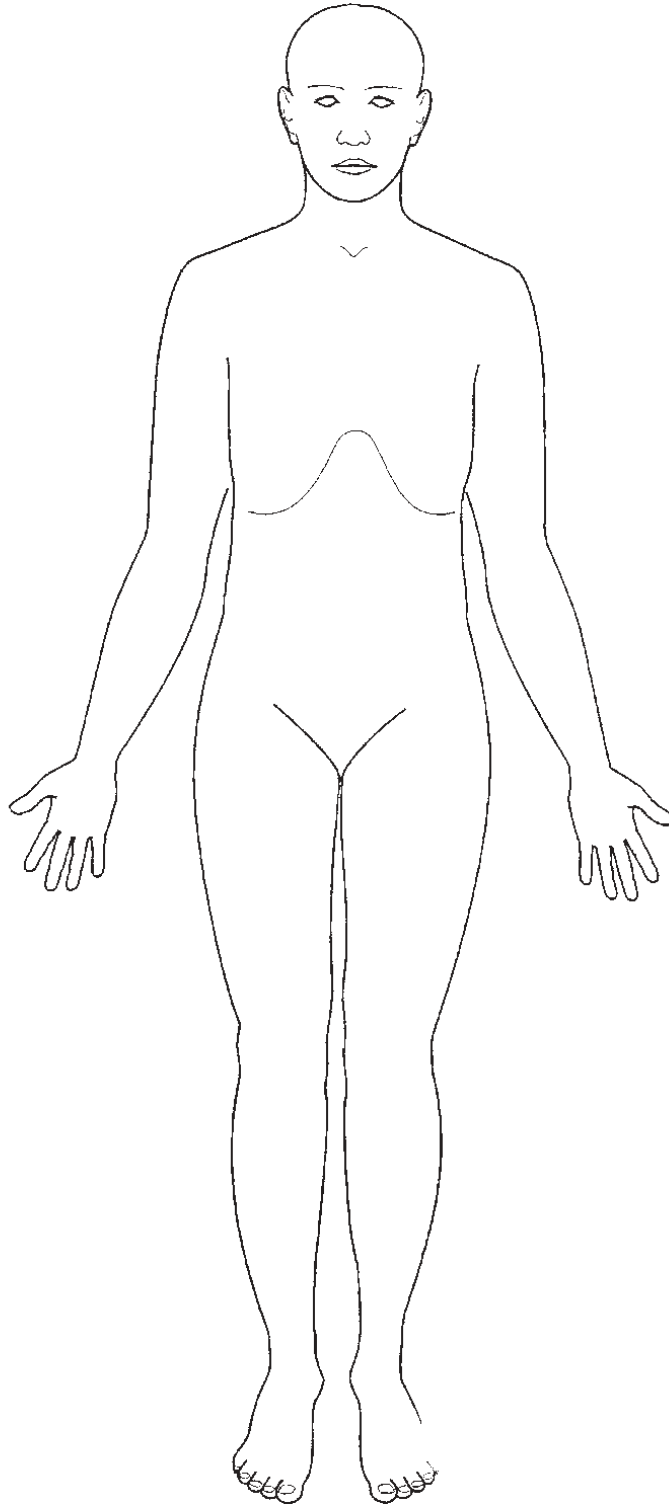


L



Right

Left

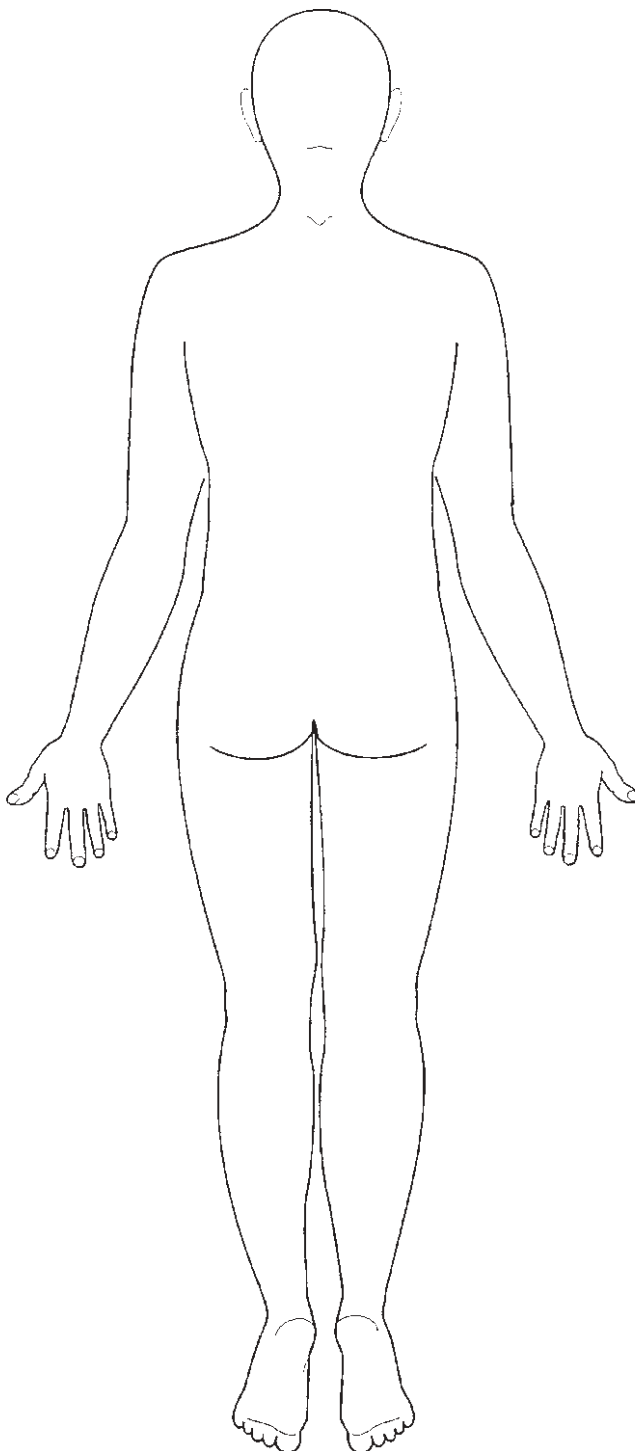


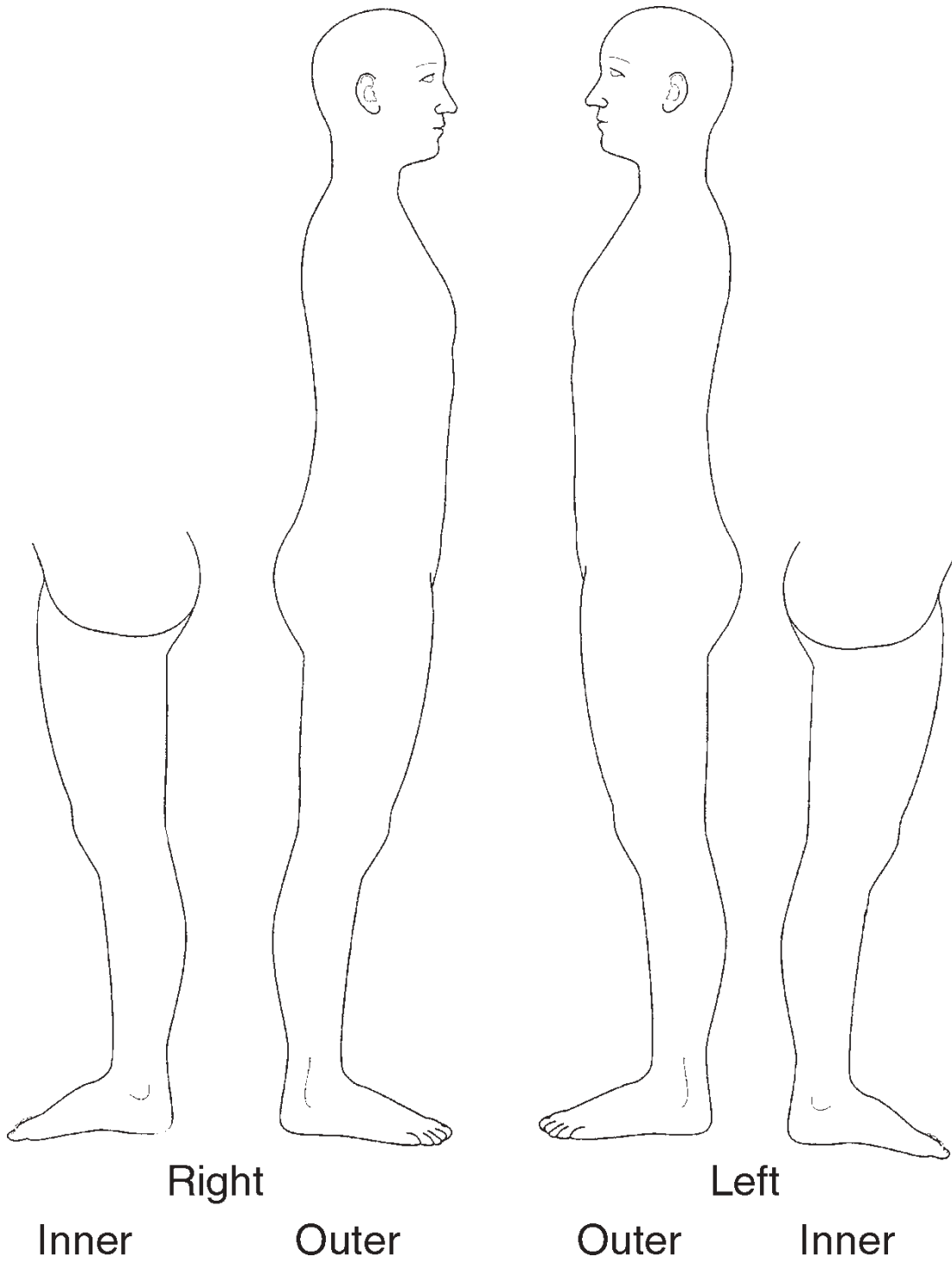
Draw in outline of breasts as required.

CONFIDENTIAL

Left

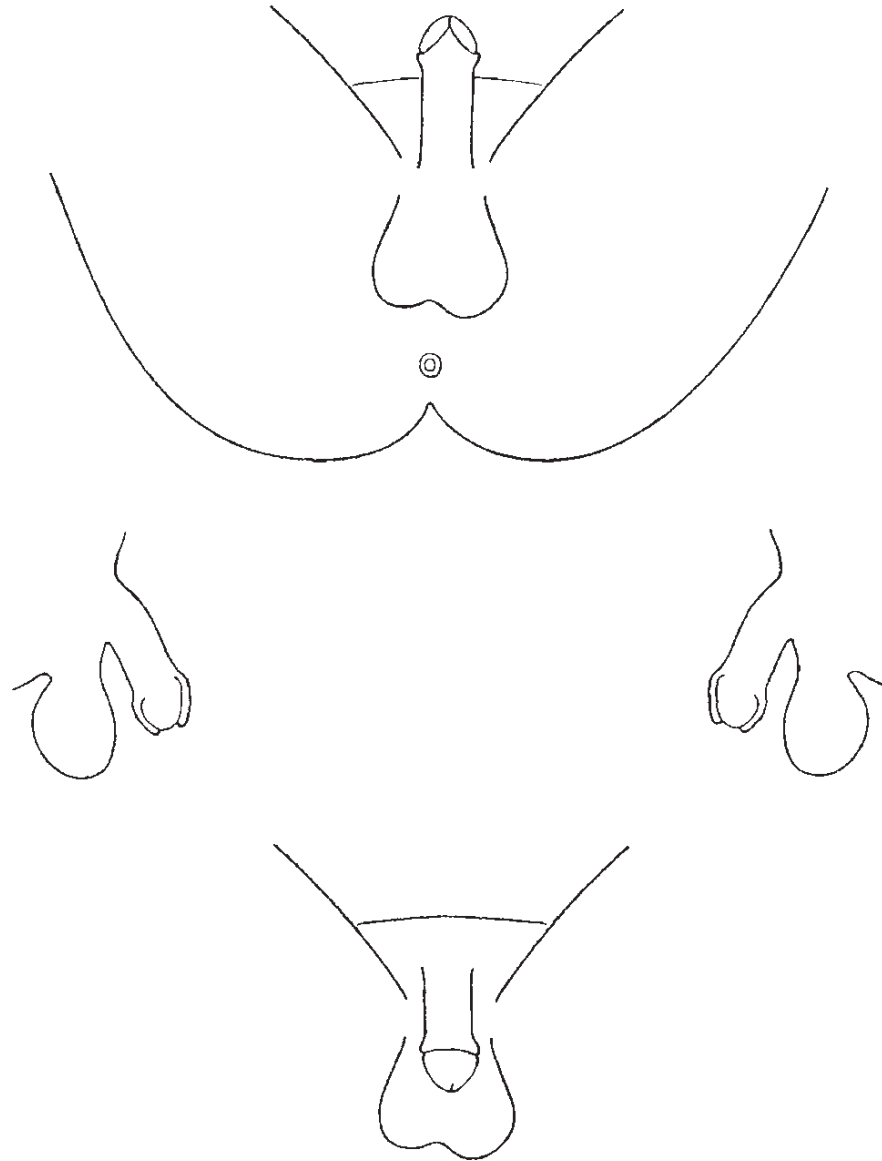
Right





Right

Left



Proctoscopy conducted

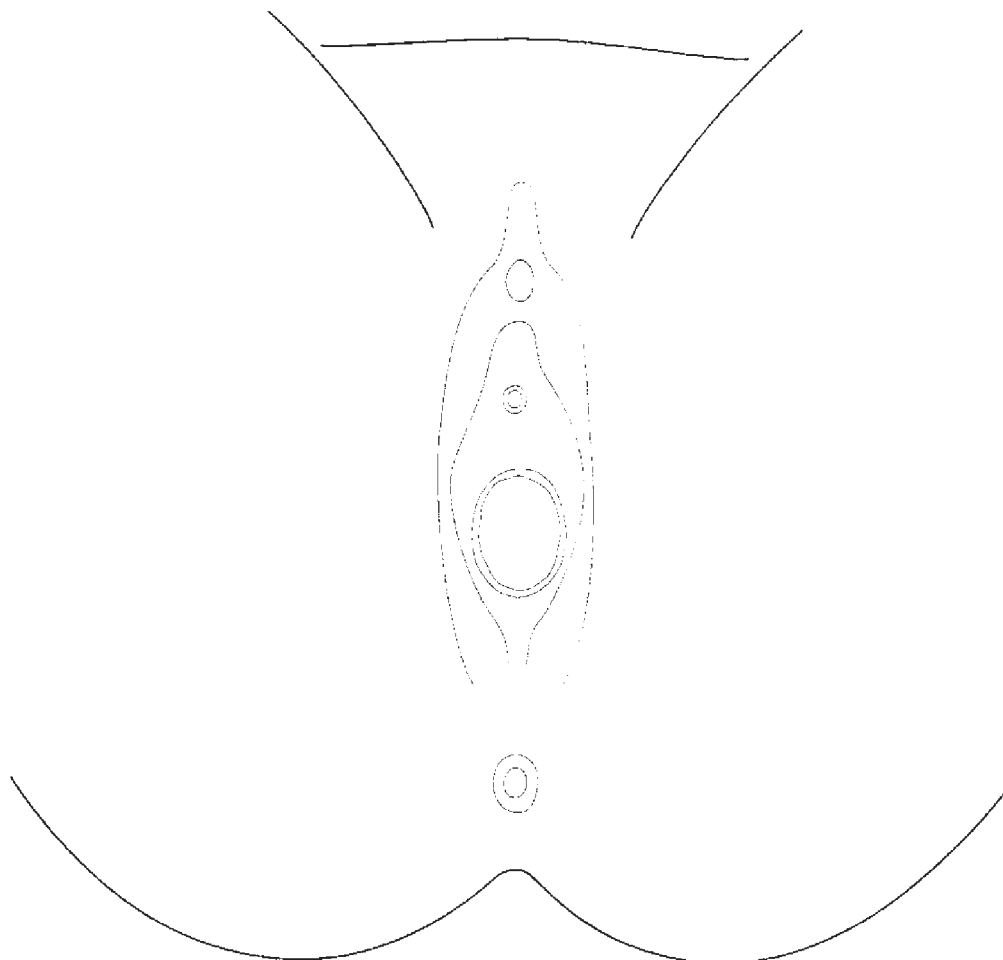
YES

NO

Findings:

Right

Left



Speculum examination conducted YES NO

Proctoscopy conducted YES NO

Findings:

OTHER DETAILS

13. PHOTOGRAPHY No Yes

By whom?

Date and time:

14. MEDICATION PROVIDED

Emergency contraception No Yes Details:

STI prophylaxis No Yes Details:

HIV prophylaxis No Yes Details:

Other No Yes Details:

15. HOSPITAL PATHOLOGY No Yes

Details:

16. FOLLOW-UP ARRANGEMENTS (e.g. medical, counselling)

17. CONTACT MADE WITH OTHER HEALTH WORKERS

Letter Yes No

Telephone call Yes No

Details:

COLLECTION OF FORENSIC SPECIMENS

Informed consent specifically for specimen collection should be obtained, and documented.

Explain that the specimens may be used for the criminal justice process should a legal action go ahead. If a report of the assault has not been made (i.e. to the police) there may still be some benefit in collecting the specimens (and holding them for a time). This should be explained to the patient.

Some results of the tests may not be available to the patient (unlike diagnostic tests done by medical practitioners).

Consult with your local laboratory regarding appropriate types and handling of specimens. For example, do not collect DNA evidentiary material if your laboratory does not perform this test.

Once collected, the specimens should not be out of the doctor's sight until handed to the police. This process is called "continuity of evidence" and is designed to avoid allegations of specimen tampering. Record the name of the police officer to whom the specimens are handed, and the date and time of transfer, on the second to last page of this proforma (page 21).

Instructions to the patient

If the patient alleges oral penetration with possible ejaculation in the mouth, drinking and toothbrushing should be postponed until oral forensic specimens are collected. If the patient is thirsty, the oral specimen can be collected prior to history taking and examination (see below).

Use words like "gather" and "collect", as opposed to "take" and "scrape". A calm demeanor is helpful.

General precautions

Wear gloves for examination and specimen collection.

All forensic swabs are **dry** to begin with and should be **dry** to end with!

Recap dried swabs and seal with a patient label, if available.

In order to find spermatozoa, the laboratory will need a slide and a swab.

The slide is used to look for sperm (the adjacent diagram shows how to plate the specimen).

The sperm are then extracted from the swab for DNA typing.

Specimens should be sealed into a bio-hazard bag.

Every specimen should be labelled with identifying data (see example).

Order of collection

Clothing

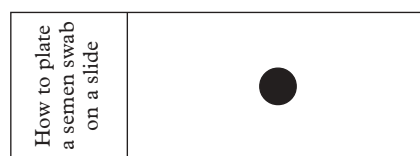
Trace evidence from the patient's clothes will not be lost if the patient is instructed to undress over a large sheet of paper (drop sheet). One way of doing this is to ask the patient to stand on a sheet of paper, behind a screen and hand out the items of clothing one by one, to be placed in individual paper bags. Note which items of clothing have been collected. Check with the police which items of clothing are required.

Drop sheet

The drop sheet could have evidence from the offender such as pubic hairs, head hairs and clothing fibres.

The drop sheet could have evidence from the scene such as sand, fibres or vegetation.

The drop sheet is folded in such a way so as to retain any evidence, placed in a paper bag and sealed with a patient label.



SAMPLE LABEL	
Name of patient	Ada Wells
Date & time of collection	01.10.02 0400 hrs
Specific type of specimen	Endocervical swab
Name of doctor	Dr A Welborn

Sanitary pad/tampon

These items should be dried and sealed in a double paper bag.

Fingernail scrapings

An allegation of the victim scratching the assailant may leave foreign DNA or fibres under the patient's fingernails. A wooden swab stick may be broken in half, one used for each hand, and the remnants placed in a sterile urine jar. Alternatively, the fingernail(s) can be cut and the clippings placed in the container.

Head hair for comparison purposes

Twenty representative hairs should be cut from over the head, placed on a piece of paper, folded as the drop sheet, sealed and bagged.

Oral swab

Spermatozoa in the mouth collect in the same places as saliva. The best reservoirs are therefore the gingival margins of the lower teeth and under the tongue. This swab should be done if there is allegation of oral penetration within the last 12–24 hours. Alternatively, have the patient rinse his/her mouth with 20–30 ml of sterile water and collect the rinsings in a sterile container.

Saliva on skin

Assailant DNA can be recovered. The double swab technique involves (a) swabbing the affected area with a swab moistened with tap water, followed by (b) swabbing with a dry swab. Both swabs should be air dried and submitted.

Semen on skin

The double swab technique can be also be used for skin where dried semen may be present. Both the first moist swab and the second dry swab should have slides made from them. Use this technique wherever ejaculation may have occurred, including the vulva and anus.

Pubic hair combing

Performed infrequently and only if foreign hair is noted on examination. Submit comb and products. Collect foreign materials with a swab stick and submit in a sterile container.

Vaginal swab

A swab taken with or without the use of a speculum, depending on patient/doctor preference.

Endocervical swab

Can be collected with the use of a speculum for direct visualization of the cervix. Use warm water to lubricate the speculum.

Anal and rectal swab

An anoscope may be used, or the anus can be swabbed under direct vision.

Victim / Assailant DNA for comparison

If there is no allegation of oral penetration, a buccal swab may be taken. Otherwise, blood will provide DNA (see below).

Blood for DNA

Should be collected into an appropriate tube.

Blood for drugs

Use a plain tube.

Urine for drugs

Instruct the patient to provide a full sterile container of urine.

FORENSIC SAMPLES

Health Worker's Copy

SAMPLES

- Clothing (bags)
- Drop sheet
- Sanitary pad/tampon

BODY EVIDENCE

- Oral swab and slide
- Foreign material on body
- Semen-like stains on body
- Semen-like material on head hair
- Semen-like material on pubic hair
- Combings of pubic hair
- Fingernail evidence
- Body swab (for saliva) (note site)
- Other (specify)

GENITO-ANAL EVIDENCE

- Foreign material
- High vaginal swab and slide
- Endocervical swab and slide
- Anal swab and slide
- Rectal swab and slide
- Other (specify)

COMPARISON SAMPLES

- Pubic hair
- Head hair
- Buccal swab for DNA
- Blood for alcohol and drugs (plain tube or fluoride/oxalate vial)
- Urine for drugs

OTHER

- Other samples (list)
-

TOTAL NO. OF SEALED BAGS

The samples listed were handed to:

Name: Rank/number:

Station/squad:

Date and time:

Signed:

FORENSIC SAMPLES

Laboratory Copy¹

Date and time collected:hours on / /

SAMPLES

- Clothing (bags)
- Drop sheet
- Sanitary pad/tampon

BODY EVIDENCE

- Oral swab and slide
- Foreign material on body
- Semen-like stains on body
- Semen-like material on head hair
- Semen-like material on pubic hair
- Combing of pubic hair
- Fingernail evidence
- Body swab (for saliva) (note site)
- Other (specify)

GENITO-ANAL EVIDENCE

- Foreign material
- High vaginal swab and slide
- Endocervical swab and slide
- Anal swab and slide
- Rectal swab and slide
- Other (specify)

COMPARISON SAMPLES

- Pubic hair
- Head hair
- Buccal swab for DNA
- Blood for alcohol and drugs (plain tube or fluoride/oxalate vial)
- Urine for drugs

OTHER

- Other samples (list)
-
-

HEALTH WORKER'S NAME:

¹ This copy to be enclosed with specimens. These should be taken to the laboratory.