



**Opinion**

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# Caring for a Child with Suspected Sexual Abuse



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## Opinion

Working in a pediatric setting is both challenging and rewarding experience. To effectively care for the pediatric patients and their families, it is vital for the pediatric nurses to demonstrate critical thinking skills, problem-solving abilities, cultural sensitivity, practical wisdom and sound clinical judgment. Caring for children with suspected sexual abuse requires sound knowledge (clinical and legal), moral decision making, therapeutic communication skills, clinical competencies, and collaborative approach to tackle the challenges posed by these difficult cases in a healthcare setting [1-3]. During my clinical experience at a pediatric setting, caring for a young girl with suspected sexual abuse was both challenging and rewarding experience. Besides abiding by the nursing process, I considered health promotive, curative and rehabilitative aspects to restore health and well-being of the child and family. In this paper, I present the case study of a young child with suspected sexual abuse and share my experience of caring for the traumatized child and her family.

## Case History of a Child with Suspected Sexual Abuse

A 4 year 9months old girl presented at the outpatient pediatric unit with the complaints of fever, abdominal pain, itching of genitalia and vaginal discharge for one month. I asked child's mother about the onset and severity of her symptoms and explored child's psychosocial history. On performing child's physical examination, a ruptured hymen and inflamed vagina were noticed. Considering the findings of physical examination, with the help of play therapy I initially developed a rapport with the child. During my communication, I tried to explore from her whether she was ever hurt or touched badly at her private parts. I came to know that each day the child travels from home to school through a school bus in which the child is being bullied by boys who is elder than her. The child also verbalized that the boys in her school bus touch at her private parts which often make her uncomfortable and due to fear she has never shared this with anyone. At this stage, child's mother was shocked and verified that the child has never told her about any such incident.

After undertaking thorough history taking and physical assessment I presented the case in front of my preceptor who was a pediatrician. On hearing the case my preceptor decided to verify the history and physical examination but found the similar findings. This was the time when the mother was prepared by both of us to suspect sexual abuse in her child. The event was quite crucial for the mother and for us being health care professionals because the diagnosis of child abuse holds several legal considerations and ethical issues.

Finally, during this visit child was diagnosed to have vulvo vaginitis, and as per request of child's mother diagnosis of "child sexual abuse" was not documented in the patient's file. During this visit child's high vaginal swab, complete blood count and blood culture and sensitivity samples were sent. As a curative measure, the child was prescribed oral antibiotics and antifungal topical application. Also, the mother was supported psychologically during this clinic visit. Hospital admission was not advised at that time. Child's high vaginal swab's report revealed positive pus cells, gram-negative cocci, gram positive cocci and beta hemolytic streptococci group F that were resistant to the prescribed antibiotics. Child's blood count revealed neutrophilia and anemia, however, the blood culture was negative.

During that week, the child was brought to the emergency department with the complaint of high-grade fever, abdominal pain, unresolved vaginal discharge and one episode of hematemesis. The child required admission at the inpatient pediatric unit. I observed that child's mother was extremely annoyed and frustrated because neither child's primary physician nor the laboratory personnel contacted her to share the abnormal reports of her child. As per mother, the previously prescribed treatment regimen did not work for the child, hence child's condition got more serious and she ended up into aggravation of symptoms.

I noticed that the child's mother lost trust on pediatricians and healthcare settings due to no follow-up call from the medical

team. At this stage, I tried to maintain my rapport with the child's mother and made her ventilate her feelings. During child's hospital admission, I noticed that the major emphasis of every physician was child's physical treatment (curative aspect) and nobody was looking after the rehabilitative and future preventive measure for this child. I further noticed that almost all attending physicians at the inpatient unit were not paying attention to exploring the perpetrator of the sexual abuse and provide anticipatory guidance to the child's parents.

### My Role as a Pediatric Nurse

During child's admission at inpatient unit, I allowed the mother to express her concerns and ventilate her feelings. Child's mother mentioned that she is experiencing confusion because she wants to prevent her child from risks of future abuse but could not think of possible perpetrator of this sexual abuse and possible ways to address this issue. At that stage, I let the mother talk to her child and think of possible changes in her daily routine. I also encouraged the mother to take her child in confidence and allow her child to express her feelings and experience. I shared a poster with the mother to provide a pictorial understanding of different forms of child abuse, neglect, and maltreatment.

On the second day when I visited the mother she mentioned that the provided material has enabled her to reflect on several aspects of her parenting. Child's mother ventilated that she could think of possible lifestyle changes that might have led to the present condition of her child. Child's mother verbalized that she has neglected her child to some extent after her miscarriage. Mother mentioned that almost 3 months back when she experienced miscarriage she decided to arrange pick and drop for school by a private school bus driver. Mother further shared that on taking her child into confidence the child has reported to her that two boys in her school bus bully her and attempt to insert a pencil in child's vagina which creates discomfort for her.

She also acknowledged that her child is picked first and dropped last by the private school bus driver who can also be a perpetrator of this sexual abuse. During that conversation, child's mother also verbalized that she has often seen her brothers-in-law who excessively hug and kiss her child, and let her sit on their lap for hours. Mother mentioned that considering family relations she often feels hesitant to take necessary actions.

In view of above, I explained the mother that now this is a right time to let her child know about "good touch" and "bad touch", as well as, to pay close attention to her child's social circle and protection from further abuse. I further encouraged the mother to be confident to hold back her child from possible causes of abuse either they are relatives or strangers.

Child's mother not only admired the suggestion but also ventilated that previously whenever she used to hear about child abuse and child neglect she used to think that this only happens with children who belong to a low income group and live in families who have low literacy rates. Mother appreciated the provided anticipatory guidance and verbalized that the teaching has made her reflect upon her parenting strategies. Furthermore, mother mentioned that now she strongly feels that she should look for any nearby school for her child, keep an eye on her child's friend circle, aware her child about good touch and bad touch, encourage her child to share her daily life situations openly without any fear of punishment, look after her child's safety needs and be more vigilant.

The above clinical case reveals that when the mother was made aware of possible types and possible sources of child abuse then she reflected on her parenting strategies and social circumstances that were increasing the susceptibility of her child for sexual abuse. Being a pediatric nurse, I realized that establishment of trusting relationship with child's parents, in-depth history taking thorough physical examination, therapeutic communication, and provision of anticipatory guidance hold magical effects on the well-being of traumatized child and family member. My role as patient's advocate, counselor, educator, and communicator enabled child's mother to reflect on their parenting strategies, identify the possible sources and perpetrator of abuse, establish a friendly relationship with her child and take necessary steps towards prevention of subsequent abuse of her child. The presented case scenario also reflected that use of holistic approach (preventive, curative and rehabilitative) is vital to care appropriately for the child with suspected sexual abuse.

To conclude, the presented clinical presentation highlights the crucial role of family-centered approach while caring for children with suspected sexual abuse. The case scenario reflects that as a part of the nursing process, it is imperative that a pediatric nurse establishes therapeutic communication to provide evidence-based, culturally sensitive, context specific and holistic care to restore the well-being of the traumatized child and family members.

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