NURSING SERVICE GUIDELINES
INPATIENT BEHAVIORAL HEALTH

Guideline: **Care of the Patient Who Has Been Sexually Abused**

Policy Number Superseded:

Responsibility: All trained Inpatient Behavioral Health staff

Purpose of Guideline: To provide a safe environment for the patient who has a history of sexual abuse. To protect the patient from further trauma and to maintain the patient's privacy.

Equipment: Grooming supplies, private room, private area for interviews.

Effective Date:
June 2024

Initial Effective Date:
March 2008

PROCEDURE	POINTS OF EMPHASIS
(1) All patients will be assessed for a history of sexual abuse. The assessment should contain as many details as possible, including dates, perpetrator, and forms of abuse. An assessment should be conducted to include patient's response and any patient needs related to abuse.	Conduct the interview in private. Use language that the patient can understand. Be understanding. Assess for suicidal ideation and self-injurious behaviors.
(2) Report physical symptoms as they arise: (a) Bleeding. (b) Swelling, pain/itching of the vagina. (c) Anus, mouth and/or throat pain. (d) Vaginal discharge. (e) Bruises and cuts. (f) Torn, stained, bloody clothing.	If the patient has never been examined for abuse, and/or it is a newly reported abuse, and these symptoms are present, contact provider immediately. For recent abuse that may need to have evidence collected, contact emergency department (ED) to determine whether a

(g) Urinary tract infections (UTIs) or sexually transmitted infections (STIs).	forensic (sexual assault nurse examiner [SANE]) examination needs to occur. Explore with ED the best way to accomplish this. During the examination reassure the patient, offer as much privacy as possible, and have additional staff present. Injuries may need to be photographed - note size, color, and location of findings. Additional testing may be ordered such as HIV testing or a consult with OB/GYN.
(3) The patient should be watched closely for sexual acting out behavior such as public disrobing, flirtatious advances toward staff and other patients, masturbation in private and/or in a public manner, and/or verbal disclosure in an inappropriate setting.	Patients with abuse histories can demonstrate poor impulse control and possess poorly defined boundaries. Traumatic sexualization often results in inappropriate sexual behaviors.
(4) The patient should be kept in a private room whenever possible if the sexual abuse was recent and/or if the patient is expressing sexual behaviors towards others. If a private room is not available, a room should be selected that allows for the greatest observation by staff and one in which the roommate will not be vulnerable.	Try to accommodate the patient's preference if possible. The patient needs could include a night light, preference of bedtime routine, and special care considerations such as grooming.
(5) Instruct the patient to bathe, groom, and conduct personal hygiene in a private area.	All staff should protect the patient's privacy as much as possible. The staff, however, should not assist the patient with grooming or other care that involves the patient disrobing, without another staff member present.

	Assignment of staff should take into consideration the gender of the abuser, whenever possible.
(6) The patient should be given an opportunity to discuss the past abuse if the patient chooses. This should be done in a private setting, away from other patients.	Forming a trusting relationship may allow the patient a feeling of safety and security, thus encouraging self-disclosure.
(7) If the patient discloses information that has not been previously reported, contact the assigned family therapist and physician to alert them as to what has been shared. Report the abuse to the appropriate county's Children's Services authority if it has not yet been reported.	Use open ended questions. Try to have a second staff member available to minimize accusations of coaching. Document accurately and objectively what is reported by the patient in the medical record. Identify inconsistencies in reported details. Provide paper for drawing if patient is having difficulty verbalizing.
(8) Let the patient know that they are safe and will be well-cared for. Offer a structured, consistent, non-punitive environment. Provide for basic needs and privacy as possible. Be sensitive. Reassure them that they did what they had to in order to survive.	Try to be objective and nonjudgmental. Self-esteem may be low, and the patient may question their worth. They may also have feelings of powerlessness, or self-betrayal.
(9) Recognize psychological symptoms of reaction to abuse: (a) Shock, disbelief. (b) Range of emotions from calm to hysterical, crying to inappropriate laughing. (c) Recurrent dreams. (d) Increased motor activity.	Many patients with an abuse history suffer from PTSD. Most acts of rape are performed by males against females. There is a greater likelihood of children with disabilities having a history of being a victim of abuse.

(e) Fears (of crowds, being alone, sexual encounters).	
(10) Encourage the patient to talk about the incident if they would like to. Listen empathetically. Staff should report possible indications of abuse for those patients who are incapable of self-reporting due to disability.	Avoid displaying shock or disgust. Individual, art and play therapy assist in the therapeutic process.

(A) References:

(1) Babatsikos, G. & Miles, D. (2015). How parents manage the risk of child sexual abuse: A grounded theory. *Journal of child sexual abuse, 24*9(1), 55-76.

(2) Bigras, N., & Briere, J. (2015). Child sexual abuse, sexual anxiety, and sexual satisfaction: The role of self-capacities. *Journal of child sexual abuse, 23,* (5), 464-483.

(3) Palo, A. D., & Gilbert, B. O. (2015). The relationship between perceptions of response to disclosure of childhood sexual abuse and later outcomes. *Journal of child sexual abuse, 24*(5), 445-463.

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