Remolding Child: Process of Nursing Practice for Sexually Abused Children

Sangtien Thamlikitkul PhD (candidate), RN*,
Jintana Yunibhand PhD, RN**, Waraporn Chaiyawat DNS, RN**

** Department of Psychiatric Nursing, Kuakarun College of Nursing, Bangkok, Thailand*
*** Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand*

Objective: *To explore and understand the nursing practice processes of psychiatric nurses for school-aged sexually abused children admitted to psychiatric wards.*
Material and Method: *Grounded theory approach. Twelve psychiatric nurses, aged between 35-59 years old, experienced with sexually abused child patients, participated in the present study. Data was collected by using in-depth interview that were tape-recorded and transcribed verbatim, line by line. It was then analyzed using grounded theory method.*
Results: *"Remolding child" was the basic social process by which psychiatric nurses provided nursing care for school-aged sexually abused children admitted to psychiatric wards. It was composed of three stages happening continuously in sequence. Each stage consisted of sub-stages that had no sequence in their occurrence and were simultaneous and reciprocal. The first stage started with establishing trust, arranging effective communication, and providing physical care. The second stage was fostering socialization, building will-power, and arranging a safe and supportive environment. The final stage was assisting living in society. Two other important characteristics of this remolding child process were working as a team and self-development.*
Conclusion: *The substantive theory derived from the study recommends new understanding in the holistic nursing practice process for school-aged sexually abused children admitted to psychiatric wards in Thailand. It can be used as a guideline to develop interventions to prevent residual effects of chronic psychiatric problems occurring in later years.*

Keywords: *Child abuse, Sexual, Nursing process, Nursing theory, Psychiatric nursing*

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Although it is well accepted that "prevention is better than cure", globally, the rate of sexually abused children is dramatically increasing[1,2]. In Thailand, child sexual abuse is no different; it has been ranked as the third most serious problem threatening Thai children[3]. The Institute of Research in Men-Women's Role and Development reports that an average of two Thai girls under 15 years of age were raped on a daily basis[4]. Sexual abuse also occurs among very young children, with the youngest victims aged only 1 year and 2 months old[5].

Approximately two-thirds of children who are victims of sexual abuse have experienced a number of negative outcomes and they were treated or admitted to psychiatric services with serious physical and psychological disturbances and social behavioral problems[6,7]. The physical problems are significant sleep disturbance and somatic complaints[7] and sexually transmitted diseases such as gonococcal infection[8] and syphilis[9]. The most common psychological reactions of sexual abuse were fear and anxiety that led to post-traumatic stress disorder[10], depression, withdrawal, and attempted suicide[11]. Various problematic behaviors were found, such as temper tantrums, conduct disorders, aggression, juvenile delinquency, and sexually deviant behavior[7,11]. Many run away from home and become involved with child prostitution rings[12]. Specifically, victims of abuse are more prone to becoming addicted to drugs, such as smoking cigarettes, using amphetamine, ecstasy, and

Correspondence to: Sangtien T, Department of Psychiatric Nursing, Kuakarun College of Nursing, Bangkok 10300, Thailand. Phone: 0-2241-6500, Fax:0-2241-1674, E-mail: Sangtien_t@yahoo.com

cocaine[13]; and having sexual problems related to unplanned pregnancies[8] and HIV infection[9,14].

Recent studies showed that both adolescents and adults who were sexually abused as child still access inpatient and outpatient psychiatric services[15]. Importantly, adults with a history of childhood sexual abuse stated that their experience in childhood, with a lack of treatment and immediate care, was a barrier to recovery[16]. Residual effects of sexual abuse were found in adulthood, with as many as five psychiatric disorders per person[17]. Not only did the consequences of child sexual abuse change their lifestyle, leading to extremely low satisfaction and quality of life[18,19], but it also resulted in huge payment for treatment and rehabilitation of sexually abused victims each year[20]. It was found that the direct cost of mental health care of those victims who required treatment was $5,800 per victim and additional health care costs associated with child sexual abuse of women was $117 per year[21]. Child victims who received early care and curative measures during the first 12-18 months after revealing the abuse, showed signs of recovery[7]. As a result, one strategy of psychiatric nurses undertaking the role of care and rehabilitation in tertiary care is to provide nursing practice for school-aged sexually abused children (SASAC) admitted for prevention of chronic illness.

Nursing practice or nursing care is an interaction process between careers and clients, to help clients improve, maintain, or recover their health, by using knowledge, clinical judgment, and the skills of nurses[22]. Generally, psychiatric nurses utilized other theories, such as bio-medical science models, the conceptual framework of Freudian thinking, interpersonal theory, behavioral theory, and humanistic theory to care for psychiatric patients[23]. In addition, psychiatric nurses used nursing processes to solve patient's problems through assessment, diagnosis, intervention, and evaluation, and chose to use various psychiatric strategies, such as psychopharmacology, psychotherapeutic management, cognitive therapy, behavioral therapy, and milieu therapy in nursing intervention[24].

From pilot studies, psychiatric nurses who worked at several hospitals of the Mental Health Department and university hospitals in Thailand shared that there are not specific patterns or models to help in the care process. Most SASAC were cared for because of their symptoms and behavior. Although some hospitals developed clinical practice guidelines for sexually abused children, it was only during the initial period and did not take into account all the psychological aspects and unexpected problems, or individual psychiatric nurse's care experiences with SASAC in psychiatric wards.

Some recent findings showed negative outcomes and disadvantages for sexually-abused child patients during the nursing practice, and some nurses experienced suffering while they were providing care in the ward. For example, whilst in hospital, some sexually abused children were not recognized or were either under or over-diagnosed[25]. In addition, psychiatric nurses showed inappropriate behavior by avoiding giving care or withdrawing care when child patients had fits of anger[26]. Some staff nurses showed disgust and resorted to punitive measures to control them[27]. Sometimes psychiatric nurses used their power in struggles against them by restricting activities[28,29] or by over medicating[29,30].

According to Day et al[31] and Fazzone[32], psychiatric nurses dealt with various issues of abused children that were both difficult and important, such as developing relationships, appropriate handling, aggressive behavior, explicit sexual acts, and abusive parents. Similar to Zeanah and Hamilton, psychiatric nurses frequently encountered the effects of sexual abuse of children. The psychiatric nurses perceived that they lacked knowledge about basic hygiene and sexual development, pregnancy and contraception, high-risk behavior, and sexually-transmitted diseases, including AIDS[33]. In addition, psychiatric nurses felt unsafe with their patients. They appeared to be particularly at risk as just over 5% of those surveyed reported being assaulted at work in the previous year[34]. Moreover, they faced many challenges in their daily care work, owing to insufficient resources, fear, and lack of training; they consequently experienced "work stress", "compassion fatigue", and "moral distress" that caused them to quit their jobs, thus exacerbating the already acute shortage of nurses in the system[35-37]. These findings indicated that psychiatric nurses faced a lack of specialist knowledge to practice nursing or to deal with the many difficulties and complexity of signs or symptoms of sexually abused children in psychiatric wards.

There is no research about nursing practice for SASAC. Only one study included interviews with psychiatric nurses about their work experience with adult survivors of childhood sexual abuse in psychiatric hospitals[35]. Four studies interviewed adult survivors of childhood sexual abuse about their healing process during hospitalization[38-41]. In Thailand, most research was of a quantitative nature related to incidences and prevalence of child sexual

abuse, and risk or cause factors of child sexual abuse[42]. One study reported only the stages modifying aggressive behavior of the abused child[43].

In the psychiatric ward, the psychiatric nurse is a vital profession that is in close proximity to SASAC 24 hours a day, from admission to discharge. From a review of various literature, De Wit and Davis[44], Gallop et al[45], Singhaphan[46], and Gillespie[47], discovered that psychiatric nurses' knowledge alone was barely sufficient; in fact, skills and work experience were required as they were directly related to the ability to provide effective nursing practice for the children. According to Benner's model, nurses who worked with their patients for more than 5 years had knowledge, skills, and enough experience to effectively care for them[48].

As a result, these experienced psychiatric nurses are very much viewed as 'insiders' because of their daily interactions. They saw SASAC' behavioral changes, understood their problems, learnt about their needs, and were able to respond effectively. The nurses gained new experience or knowledge, knew what was happening in psychiatric wards and how to deal with SASAC, and knew how to work with a multi-disciplinary team. Generally, these nurses shared their experiences and knowledge with younger staff nurses while working together, but this process took a long time. Since there is no study related to nursing practice for SASAC in a psychiatric setting, it is therefore explored how psychiatric nurses take care of SASAC on a day-to-day basis during admission.

Objective

To explore how psychiatric nurses practice nursing for SASAC who are admitted to psychiatric wards.

Material and Method

Design

The method of grounded theory was chosen to explore the work experience of psychiatric nurses who provided nursing care for SASAC. The rationale was that the understanding of the process of nursing care for SASAC during admission would emerge through psychiatric nurses' practice or experience with them. The nurses construct meanings based on their interpretations of actions and interactions with themselves and others. The goal of grounded theory method is to construct a theory that provides an understanding and explanation of identified major categories, their properties, and the relationships between them through the subject's investigation[49]. Grounded theory was chosen for the present study as it had the potential to discover new perspectives or salient variables on nursing practice for SASAC not currently identified in literature and had few adequate theories concerning a phenomenon of interest exist[50].

Ethics approval

Ethics approval to conduct the present study was obtained from the Institute of Review Board on Human Subjects Committee of the Mental Health Department.

Sample population

Initially, participants were recruited through purposive sampling at Srithanya Hospital because it was the first tertiary care center to treat and rehabilitate abused children in Thailand. Then, a snowballing word-of-mouth sampling strategy was used. Later, theoretical sampling was used to analyze variation and/or evaluate emerging categories and hypotheses about the relationship between categories, which guided further recruitment. An information sheet was given to participants and informed written consent was obtained before each interview. Participants had to be psychiatric nurses who matched certain inclusion criteria, at least a bachelor degree, more than 5 years of work experience in general psychiatric wards and providing care for SASAC in psychiatric wards for at least 1 year or in a minimum of 5 SASAC cases.

Twelve psychiatric nurses who ranged in age from 35 to 59 participated. Eleven were female and one was male. Six were married, and six were single. Three held a bachelor's degree, and eight had master's degrees. Six participants worked at Srithanya Hospital, five at Yuwaprasat Waithayopathum Child Psychiatric Hospital, and one worked at Maharat Nakorn Chiang Mai Hospital. Six participants had joined more than two training programs, five had attended only one training program, and one participant had not been on any. Two psychiatric nurses were head nurses, three were deputy-head nurses, and seven were staff nurses. Work experience in general psychiatric wards ranged from 5 to 17 years, whereas their experience in working with SASAC ranged from 1 to 6 years. The number of SASAC cases taken care of by the nurses ranged from 5 to 35 cases. These characteristics are shown in Table 1. For the present study, no participants withdrew, and all sample members volunteered to participate in the study.

Table 1. Demographic characteristics of the participants

Case	Age	Gender	Marital status	Education	Post graduate (PG) training	Numbers of working years in general ward	Working status in ward for SASAC	Numbers of years to care for SASAC	Numbers of cases to care for SASAC
1	55	Female	couple	Master degree	-PG (psychiatric nursing) -Psychodrama	15	Dep- head nurse	4	15
2	44	Female	Couple	Master degree	-	10	Staff	5	10
3	39	Female	Single	Bachelor degree	-Psychiatric nursing for children and adolescents	7	Staff	5	6
4	59	Female	Couple	Bachelor degree	-PG (psychiatric nursing)	17	Head nurse	5	18
5	50	Female	Couple	Master degree	-PG (psychiatric nursing) -Family counseling -Examining witness and testimony -Psychodrama	10	Staff	1	5
6	51	Female	Couple	Master degree	-PG (psychiatric nursing) -Psychodrama	15	Head nurse	3	6
7	50	Female	Single	Master degree	-Child counseling -Helping parents and helping their children	5	Dep- head nurse	5	5
8	38	Female	Single	Bachelor degree	-Counseling -Negotiation	6	Staff	3	6
9	35	Female	Single	Master degree	-PG (psychiatric nursing) -Psychiatric Nursing for children and adolescents	5	Staff	2	5
10	40	Male	Single	Master degree	-Observing the procedures at psychiatric ward of university hospital	10	Staff	3	6
11	48	Female	Couple	Master degree	-PG (psychiatric nursing) -Psychodrama -Counseling -Examining witness and testimony	15	Dep- head nurse	6	35
12	40	Female	Single	Master degree	-PG (psychiatric nursing) -Negotiation	10	Staff	3	6

Data collection

Data collection occurred over an 8-month period between August 2007 and March 2008. The head-nurse of the ward, which serviced sexually-abused children, was a key person in helping meet participants within the inclusion criteria. Psychiatric nurses who met eligibility criteria as participants were shown the proposal's details and its benefits to them, and were then invited to join the present study. The researcher interviewed each participant face to face after informed consent had been obtained.

The present study used mainly an in-depth interview method for collecting data. Two face-to-face taped interviews were conducted with psychiatric nurses after work hours. The researcher asked for participants' permission to take notes of important issues during the interview. The participant's appearance, interactions, visual cues, and non-verbal cues, such as movement, tone of voice and loudness were recorded in order to remember the trigger thinking and questioning processes. After each interview ended, data from the field notes was completed immediately and was compared with the transcriptions. Data collection methods with unstructured in-depth interviews were conducted and tape-recorded. Any grand tour questions were open-ended to encourage

participants to describe experiences from their own perspective. For example, one grand tour question was *"Tell me about your work experience whilst providing nursing practice for SASAC in the ward"*. Using follow-up details, another probe question was posed *"Could you tell me more about it?" "What do you mean?" etc.* The mean interview time was 1 hou0r and 30 min.

During the interview, if participants felt uncomfortable to talk about themselves or answer questions, they could stop the interview or withdraw from the study at any time. In the coding system, the identity of the psychiatric nurses and their responses were known only to the researcher. All interview data was coded without real names appearing on the transcripts. Any quote used as an exemplar was identified by a pseudonym. Tapes and transcriptions, records, and data were kept in a locked cabinet after the conclusion of the study. All data will be deleted and destroyed within 5 years of the present study.

Data analysis

Before the data was analyzed, the audiotape of each interview was listened to in its entirety, at least 3 times. Simultaneous data collection and analysis focused on the participants' descriptions of their thoughts, feelings, and behavior related to nursing care for SASAC. Analytical techniques from grounded theory, including coding, memos, and diagrams, were used[49]. Data was coded line by line. Coding is the process of labeling and grouping concepts from substantive coding to categorical coding and theoretical coding. Analytical memos were kept to reflect the researcher's thinking whilst coding data, identifying and linking categories, and determining the core variables. Diagrams were constructed showing the concepts and categories and the way they were related to one another. The modified data was repeatedly obtained and existing data reviewed. Sixteen interviews with 12 psychiatric nurses were completed. Four participants were re-interviewed to clarify/expand on issues from the first interview.

Rigor

Sandelowski[51] describes strategies to ensure that qualitative research achieves credibility, auditability, and fittingness, which are all necessary to establish methodological rigor.

Credibility or trust value occurs when findings represent the truth of the participant's experiences. *Prolonged engagement* and persistent observation was achieved throughout the eight months for the researcher to become completely familiar with the problems, and to understand the cultural context of psychiatric nurses while providing nursing care. Being within the inclusion criteria, participants were psychiatric nurses who had work experience with SASAC cases on psychiatric wards. The researcher established familiarity with all participants before the interview to be enable them to disclose their feelings, or allow them to talk easily about their personal experiences of nursing practice. Before interviews, the researcher requested that the psychiatric nurse only told of their experience in providing nursing practice to SASAC admitted to wards. *Member checks* were achieved through sharing with each participant after the verbatim transcripts were finalized.

Auditability of this study as a dissertation project, was conducted under the supervision of advisors experienced in the grounded theory method and certified as experts in psychiatric and pediatric nursing. They met regularly with the researcher to review data, data analysis, and findings.

Fittingness occurs when the findings are meaningful and applicable for persons outside the study setting and when there is a good match between the findings and the experiences of the participants. These findings were presented to three head nurses, one was recently retired and used to care for SASAC in psychiatric wards while the other two had worked with SASAC in psychiatric ward and were not participants. They concluded that the findings, *i.e.* remolding child, was true. It made sense, and corresponded closely to the realities of the psychiatric ward.

Results

Remolding child

Child remolding was a basic social process given by psychiatric nurses who had specific work experience with SASAC admitted to hospital with psychiatric consequences. It consisted of seven categories (Table 2) grouped into three continuously consecutive stages. Each stage consisted of categories that had no particular sequence in their occurrence, and these categories were reciprocal. In the first stage, the process began with establishing trust, arranging effective communication, and providing physical care. The second stage was fostering socialization, building will-power, and arranging a safe and supportive environment. The final stage was to assist living in society. These stages are shown in Fig. 1.

Table 2. Categories of remolding child

Stage 1
A. Establishing trust
Aspects:
1. Building familiarity
2. Cultivating friendship
3. Offering tangible help
4. Providing confidentiality
5. Showing respect
6. Behaving sincerely
7. Behaving consistently
B. Arranging effective communication
Aspects:
1. Using appropriate language and situations
2. Following a child's lead
3. Providing opportunity to ventilate
C. Providing physical care
Aspects:
1. Promoting personal hygiene
2. Promoting growth and development
3. Preventing injuries
4. Administering drugs
Stage 2
A. Fostering socialization
Aspects:
1. Teaching self responsibility and social rules
2. Training in self control
3. Getting rid of unwanted behavior
4. Promoting adjustment (to others)
5. Promoting avoidance of future sexual activity
B. Building will power
Aspects:
1. Generating positive self-thought
2. Instilling positive thinking
3. Inspiring hope
4. Absolving guilt
5. Facilitating forgiveness
C. Arranging safe and supportive environment
Aspects:
1. Offering safety and security in a nursing unit
2. Encouraging schooling
3. Providing dependable caregiver
4. Finding safe lodging
Stage 3
A. Assisting living in society
Aspects:
1. Providing support
2. Preventing potential problems
3. Following up on a child
4. Providing consultation

Throughout the child remolding process, psychiatric nurses worked as a team that was administrated within a nursing team, whilst also cooperating with a multi-disciplinary team. In addition, they learned about self-development during provision of the nursing care to each child. The 'working as a team' and 'self-developing' category will be later described (Fig. 1).

Stage 1

In child remolding process, after SASAC were diagnosed with a mental disorder or a behavioral problem and admitted to the psychiatric ward, participants began to enter into stage 1. Psychiatric nurses began care for SASAC by establishing trust, arranging effective communication, and providing physical care that was reciprocal.

Establishing trust

Establishing trust was the start of caring, where participants had to use much more effort in their approach, because most SASAC felt betrayed, which manifested itself as discomfort with other relationships,

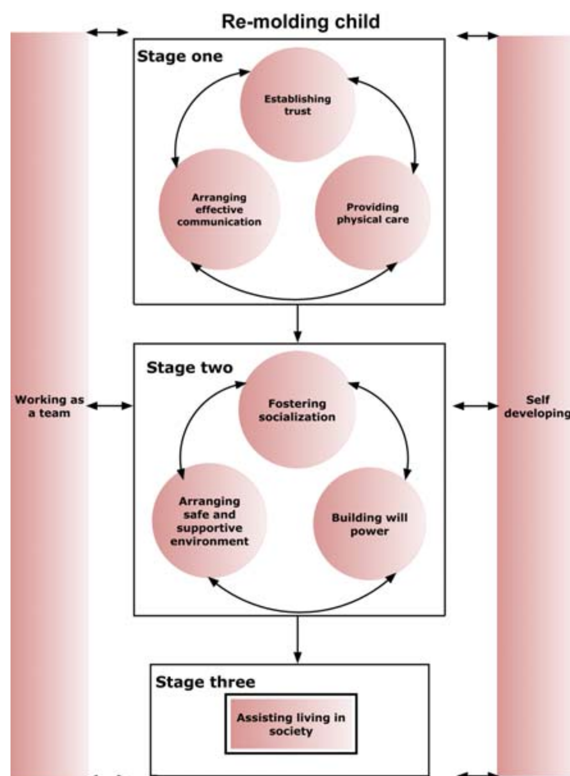

Fig. 1 Remolding child

more so than children with other psychiatric disorders. Seven aspects of *establishing trust* featured, building familiarity, cultivating friendship, offering tangible help, providing confidentiality, showing respect, behaving sincerely, and behaving consistently. These aspects were simultaneous and reciprocal.

After SASAC were admitted to the ward, all participants *built familiarity* (made themselves known) with SASAC. Several participants reported using strategies to build familiarity included smiling or gently touching the children, greeting and visiting the child, and introducing themselves. Other participants searched for ways to help SASAC to be familiar with their new location by taking them on a tour of the ward, taking time to adapt, and introducing others to them in the ward. Nurse 1 experienced a young girl who did not communicate, she said, "I tried to observe her behavior all day and found that she secretly talked to the patient-assistant who approached her on the very first day of her admission. So, initially, I used this patient-assistant as a medium to get to know her and take care of her". Similarly, nurse 8 shared, "I saw a child vent her problems with the patient-assistant, who was herself only a teenager and who worked on the day shift everyday. I often asked for the child's information from her". However, nurse 4 approached a child after assigning other friends to get to know her. In addition, she shared her experiences of a young SASAC who did not communicate, "I arranged for her to stay near nurses during my working hours. She was in my sight all the time and I also hers".

At that time, most participants gave what children liked for *cultivating friendship* (raising friendly feelings and companionship) with SASAC. Several participants realized children's nature such as wanting to play with the sandpit, dolls, games, dancing, enjoying writing or drawing; and recognizing their favorite things, such as sweets, snacks, or toys. Nurse 2 cultivated friendship by giving a pretty notebook to her. However, some participants offered to help SASAC by always showing concern and attention to them. Nurse 4 used invitations to play fun activities together, or invitations to eat lunch together.

After that, most participants *offered tangible help* (relevantly giving or responding with things needed) to SASAC. Regularly, SASAC told no one what they needed, so that participants observed or investigated what the physical and psychological needs of each SASAC were. Sometimes, each SASAC needed different things, and participants responded to SASAC based on their own ideas. Nurse 7 said, "I gave a notebook to her after I knew the child wanted it to write in and let out her thoughts and feelings. Or, when the child said she did not want to repeatedly talk about her story to others, I took action upon that by reporting it to the multi-team, nursing team, and administrators, so that they would not continually ask her over and over again. Or sometimes, she was afraid of injury from the abuser, so I arranged for a guard to walk around the ward, and I restricted people visiting her by having them screened by a nurse first. Moreover, I allowed only her elder sister to be in her company". In addition, she shared that if nurses gave or responded SASAC by keeping their word, they were impressed by the nurses and realized that they were ready to be helpers.

Importantly, most SASAC thought of the abusive events as shameful and keep them secret. Participants *provided confidentiality* (arranging or choosing places of privacy, a closed room, a private room, or a quiet room) in which to easily talk about SASAC's personal history or to disclose their secrets. Five participants (nurse 1, 3, 4, 6, and 8) mentioned the atmosphere that children disclosed their secrets to nurses during taking a shower or using the toilet, or when talking with the child before bedtime.

The final three aspects were that of showing respect, behaving sincerely, and behaving consistently that were formed into a group of special characteristics of the participants. Participants *showed respect* (accepting them as a human who had rights and freedom equal to others, although they were still a child) to SASAC. Most always requested children's permission or advised them before they were about to do something. Nurse 6 told, "I asked for the child's permission before getting her friend to join in before a psychodrama group". Nurse 2 said, "After I gave a pretty diary to the child, she handed it to me. I asked the child whether she would allow me to read it…she said yes".

At the same time, participants *behaved sincerely* (showing honesty and good intentions in helping) to SASAC. Furthermore, they provided only the facts and avoided lying to them. The nurses would neither promise things that could not be done, nor talk about things that they did not really know. Nurse 12 shared, "My method was that I did not tell anyone in the team at the beginning, I kept the child's personal topics a secret to gain the trust of the child and until I was sure that the child's data was true or correct. Once the data was verified and the child became familiar with and trusted me, I would ask the child to allow me to

disclose the data to the team for the purpose of getting the best rehabilitation results. In this way, I did not betray her trust".

In addition, most participants *behaved consistently* (frequently showing or acting the same way towards SASAC every time) to SASAC for achieving new perspectives to nurses. Most nurses always came at the appointed time, greeted the child at every meeting, and talked with the child everyday. Nurse 4 said, "I often participated with children in all daily activities, such as showering, dressing, playing, studying, eating". However, nurse 5 shared, "I was patient, quiet, and always showed a warm manner or a stable mood to him, even if he always slapped the table in front of me".

Arranging effective communication

Generally, most children were too young to understand complex vocabulary or the meaning of sexual oppression, and SASAC's language development was disturbed such as speechlessness, murmuring, stammering, shouting, and scolding. Communication helped nurses know SASAC' needs or problems and helped to properly release their tension. Three aspects of *arranging effective communication* were using appropriate language and situations, following the child's lead, and providing an opportunity to ventilate.

Initially, participants learned of the nature of SASAC and their cognitive ability by observing their verbal and non-verbal language and trying to understand any overt and covert behavior. Participants *used appropriate language and situations* (arranging or adopting easy language and situations to communicate) with SASAC through playing, drawing, or writing. Several participants used suitable language appropriate with the child's age and IQ, such as simple vocabulary, short expressions, clear speech, and simple concise sentences. Nurse 1 said, "I arranged for a girl to learn communication by watching her friends speak, or speaking after I had spoken, or being in a situation to speak with a peer group". Nurse 4 mentioned, "I told of the reasons for staying in the ward, it stimulated her to ask about and negotiate her length of stay in hospital. It was an easy way to communicate together".

Alongside communication, participants *followed child lead* (giving a chance for SASAC to talk freely about any topics they were interested in, paid great attention to what the child said and held child-centered talks). It made participants increasingly understand SASAC's feelings and thoughts. Nurse 7 said "I knew that this child loved her father and her younger twin. I gave her freedom of speech. She could tell me anything that made her happy. If I judged her by my own standards, I might have felt that she had a really tough life, but to her, this fact did not bother her much. She's quite pleased with being able to survive, to live, to eat, to go to school, to take care of her father, and to spend time with her twin. This was good enough for her". During talks with SASAC, nurses neither showed curiosity nor set to get the prepared topics for the conversation.

Sometimes, SASAC kept and repressed their moods, or showed negative responses, such as speechlessness, making noises, using impolite language, or slapping the table. Nurses *provided opportunity to ventilate* (arranging a chance or channel to suitably express or ventilate thoughts, needs, mood or unhappiness; or encouraging release of tension in their minds) to SASAC. Nurse 3 shared one such strategy for the child to ventilate, "I sought for the way that one child who could not write would be able to vent or express what she needed. One day, while I was playing with a puppet doll with her, she responded using the doll. I used the puppet doll as a ventilator for her events by using a pseudonym name". Moreover, both nurse 2 and nurse 7 encouraged SASAC to ventilate by writing in their notebooks. Nurse 6 arranged a child to ventilate through a psychodrama group. During these ventilation exercises, if these reactions were investigated and were not dangerous to the SASAC or anyone else, nurses let them to continue. Most found that SASAC would get better after being allowed the opportunity to ventilate.

Providing physical care

Physical care was a routine care that responded to the basic needs of child patients. Most SASAC were neglected by their parents/caregivers, and so usually lacked self-interest in physical hygiene. *Providing physical care* was defined as an action taken by psychiatric nurses to promote personal hygiene, promote growth and development, prevent injuries, and administer drugs.

Most SASAC lacked anyone to teach them how to wash themselves. After evaluating the abilities of self-care, participants *promoted personal hygiene* (correctly teaching or helping SASAC to have abilities and skills of self-hygiene care and other cleanliness) to SASAC according to their age. If the child cases were unable to manage, the participants did everything for them or they assigned patient-assistants to help. In

certain cases, participants partially helped, and divided training into stages, teaching each stage step-by-step. However, where the child could manage, participants encouraged or monitored SASAC to do so, and followed-up their results. Nurse 1 said, "There was one girl who had poor hygiene skills. I taught her everything, such as showering, shampooing, tooth brushing, changing clothes, caring for herself after using the toilet. I also taught her to wash underwear, clean the dishes, and clean the toilets".

Most SASAC lacked food, leading to poor nutrition, but some ate too much, causing them to be over-weight. Participants *promoted growth and development* (arranging rich nutrition; balance of eating healthy food, of sleeping to enable growth, and of burning energy in routine activities and in exercise according to their ages) to SASAC. Nurse 11 shared, "After I evaluated his physical development and found his growth was low, I requested supplementary food from the nutritionist for him". Moreover, nurse 12 told, "I did not forget to ask her about menstruation period. If it was absent, I would be at ease. I would report to the doctor to clarify this problem by conducting urine pregnancy tests".

Flashbacks were an SASAC' sign, often triggered by sights, sounds, smells, behavior, or specific locations. Some participants experienced powerlessness, feinting and moments of semi-consciousness. They *prevented injuries* (ensuring against any dangers) to SASAC lives by arranging for the child to be near to a nurse; assigning the child to be part of the patient-assistant's follow-up procedures. Nurse 1 shared, "I told a child that when she saw something scary or felt shocked, she should get hold of something before falling down and should slowly fall down and lie on the floor. I learned that I should not carry her on to her bed during moments of unconsciousness, but did so if the situation was evaluated as not being dangerous. I did not forget to protect her life by observing the breathing".

Most participants shared that psychiatric drugs were important for the recovery of SASAC who were admitted. They *administered drugs* (effectively preparing, using or giving medicine through 5 right's methods and knowledge of psycho-pharmacology). Nurse 10 shared, "A child had more euphoria in spite of getting some mood-stabilizing drugs. I studied more about the half-life of drugs; excretion of drugs I reported to doctors to adjust the effective doses of treatment. I observed side effects of over-reactions and prevented interactions to other drugs. I intermittently took her blood to examine lithium, electrolytes, and creatinine levels".

Stage 2

After SASAC were able to pass a majority of aspects in the first stage of remolding, psychiatric nurses took care of SASAC by fostering socialization, building will-power, and arranging a safe and supportive environment.

Fostering socialization

Most psychiatric nurses found that SASAC lacked someone who taught and guided them. They did not know what was right or wrong, or what they should or should not do, which meant it was difficult to adjust living back in society. Psychiatric nurses and teams tried to teach SASAC about life skills for living in society or in a particular community. *Fostering socialization* was actions of psychiatric nurses that included teaching self-responsibility and social rules, training in self-control, getting rid of unwanted behavior, promoting adjustment to others and promoting avoidance of future sexual activity.

Most SASAC learned to do as they liked and to respond to their needs with unacceptable methods of society. Most participants *taught self-responsibility and social rules* (teaching to accompany others in society and to understand personal rights and self-duty) to SASAC. At first, most participants taught discipline or responsibility through daily activities on a timetable, assigning some duties in accordance with age and ability. Moreover, nurse 1 told, "After SASAC were admitted, I taught them to keep the rules of the ward, such as not harming friends, not picking up other's property without permission. If they could do it, I spoke praise to them". In addition, nurse 4 taught them to practice the rules of society, such as queuing, playing gently with friends, not being sarcastic, not laughing at others in a group, and not scolding others. In addition, nurse 6 taught a girl to be courteous or considerate of other's feeling, "After a girl came back to the ward, she showed her clothes that her father had bought her during her home visit. I taught her to not make trouble for her father, by reducing her demands and being satisfied with what she had".

Most SASAC showed severe anger and uncontrolled emotions. As a result, SASAC made trouble for others during daily activities with friends. Participants taught *training self-control* (teaching and practicing to have the skills to deal with their anger

and methods to calm down) methods to SASAC. Methods used included encouraging the child to talk and think by themselves before doing something, counting numbers, avoiding things/people that aroused them, walking away from situations, and assigning self-analysis written work. Sometimes, SASAC experienced fear during flashbacks, nurse 1 taught a child to shake her head, and taught her close friend nearby to call her names and to shake her back to consciousness. During training, nurse 7 shared, “After a child showed aggressive behavior, I asked her, what had happened, and whether she needed help in controlling herself. She decided to use writing to ventilate her anger and this was reflected in her handwriting. At the beginning, she wrote 5 pages but later only 2 pages. I praised the child and said ‘Now you can control yourself better. Now you can see that you do not have to get angry”.

SASAC lacked someone to teach them and so they had more opportunities to perform various behavioral problems or show unacceptable/unwanted behavior, such as aggression, lying, stealing, or quarreling. Participants *got rid of unwanted behavior* (changing, reducing or preventing unacceptable behavior and manners to that which was acceptable in society) of SASAC. Most participants used strategies to teach the child to know what actions were acceptable and unacceptable, to closely monitor SASAC’ unwanted behavior. Sometimes, punishment and rewards were used to change their unwanted behavior. Nurse 1 stated, “I taught a girl who stole others’ belongings in the ward not to pick up other’s possessions without permission because it was bad and illegal. She not only had to return the things to their rightful owners, but she was also fined by having to give her own things to the person from whom she had stolen. Another way to solve the problem of theft was to re-adjust the environment by arranging a locker for everyone, or to instruct SASAC to keep valuable things in the locker and keeping their own key with them at all times”.

Most SASAC felt low self-esteem; they often had isolated themselves from society. Participants *promoted adjustment to others* (helping or arranging to participate or to do any social activities with others) to SASAC. Most participants arranged for them to join with others in many different social activities whilst in the ward, such as playing sports, singing and dancing contests, joining a field trip, paying respect to the Buddha image, and making merit during Thai festivals. Nurse 5 and nurse 6 arranged SASAC to learn strategies to be compatible to others by training them to face disappointments and things they disliked, or training them to listen to other people’s reasons. For example, nurse 4 taught a child to patiently wait to do something; she shared, “When I was busy, I would evaluate what the child wanted to talk about. If it was not an urgent matter, I determined not to discuss the matter with the child straight away. This was the way to teach the child to learn to wait until the next appointed time, and also to prevent her from becoming too self-willed”. When they could not deal with their problems, they sometimes harmed themselves. SASAC shaped their thoughts and judgments by looking to those who they knew loved or helped them, and who could point out ways to solve problems, and make contingency contracts to prevent self-harm in the future.

Some SASAC felt good about sex because they got comfort and convenience as a payback after the abuse. Participants *promoted avoiding future sexual activity* (trying to change their sex values or misunderstandings about sex) to SASAC by explaining what were good jobs, telling the children of their duties, praising the children if they persevered with their work, and suggesting that they did not have sex during childhood to prevent STDs and AIDS. Nurse 1 also taught SASAC to say “no”, or found helpers or new strategies when someone approached them for sex again through a group. Nurse 6 told, “I talked with a girl about the norms of society and Thai customs. I discussed with her many issues such as appropriate dressing, showing themselves to the opposite sex, and going out at night. I taught and explained to her how to have safe sex and how to take care of herself, if she was in situation where she could not avoid sex”.

Building will-power

Several SASAC felt bitter with their lives and felt guilt and shame. They might blame themselves or have low self-esteem resulting in low life expectancy. Nurses built-up psychological power and strengthened the positive self-concept of SASAC. *Building will-power* was defined as an action of psychiatric nurses that was composed of generating positive self-thought, instilling positive thinking, inspiring hope, absolving guilt, and facilitating forgiveness.

Most SASAC who perceived their ‘self’ to be unequal to others developed an inferiority complex. Participants *generated positive self-thought* (promoting good perception/ideal of self) to SASAC.

Nurse 6 told, "I taught a girl that all people had good and bad points. I encouraged her to search for her own good and bad points". Sometimes the nurses would point these out to the SASAC. Nurse 7 shared, "I sought a child's good points to praise and found that she was a grateful person. I used it as a reward and told her that this goodness would help protect her. I also pointed out to her that when something happens, everyone comes to help her". In addition, nurse 1 said, "I assigned a girl to decorate a board with the patient-assistants because she had good ideas and beautiful handwriting. She was happy with her own results and with helping others. I discovered that she had several abilities of singing and playing music, I informed the CPCR so as she could study music at the weekends". Nurse 10 assigned SASAC to make benefits for others such as taking care of the younger children, or being the leader of a group.

SASAC who faced troubles or past events from the abuser felt angry, hurt, unhappy, or pessimistic towards others. Participants *instilled positive thinking* (establishing optimism and encourage self) to SASAC by arranging to actually analyze situations and self, asking them to think of their situations from other's view points, or arranging to share several ideas for each situation. Nurse 7 said, "After the child and I talked to each other, the child had a chance to analyze events. She did not believe that her father would hit her instead of her father's friend. But once she thought it over again, she said that it was a good thing, because her father could not fight with his younger friend". These new thoughts helped SASAC to have more happiness.

Most SASAC felt useless and hopeless, these participants helped SASAC to *inspire hope* (stirring up sense confidence and the value of life expectancy in themselves to live) by encouragement, asking them to search for self-hope, persuading them to set reasonable goals, and by promoting plans to bring about hope. In addition, they suggested to parents that children should be encouraged to hope and reach their goals through love and support. Nurses promoted both parents and children to have good attitudes and relationships together. Nurse 6 stated, "I told the child that after bad events have passed, it's just like having had a bad dream and that she still has a chance to experience good things in her life. I tried to foster the good attitude that the child and her mother have towards each other. I told the mother to push her child forward, whilst understanding and encouraging her".

With SASAC who felt shame and guilt that led to self-blame and self-harm, participants *absolved guilt* (reducing or removing guilty feeling) by asking them to talk about any guilty feelings, giving them a chance to express their guilty feelings, making sure that they understood that abuse was an unusual event and had now passed, and by soothing and assuring them that they were not wrong. Nurse 7 encouraged, "It is not her fault. However, she can learn from this event that there are both good and bad people in this world, and it will help make her stronger and smarter. Although, now she is good, she should be careful too".

Even though SASAC' other symptoms and problems were improved, unfortunate feelings of anger towards the abuser remained. Participants *facilitated forgiving* (preparing and searching for suitable strategies to help reduce feelings of revenge, or to help purify the child's mind) by using the teachings of the Buddha, such as kindheartedness and forgiveness. Nurse 7 reported, "In this case, I knew that the abuser might be put into jail for only a short time before being set free. I prepared the child to face this truth. I used the Buddha's teachings, and afterwards the child accepted that the abuser had been sufficiently punished, by being condemned as a bad man and being unable to make a living in the area, and by having to move to somewhere else". These helped promote peaceful and happier lives.

Arranging a safe and supportive environment

Some SASAC were aggressive, whilst other children had depression or thoughts of self-harm. Both these positive and negative symptoms had an affect on their lives and those around them in the ward. Being therapists for SASAC, psychiatric nurses discovered strategies or provided safe environments for them. *Arranging safe and supportive environment* was an action of psychiatric nurses that included offering safety and security in a nursing unit, encouraging schooling, providing dependable caregivers, and finding safe lodgings.

Most SASAC had hallucinations, flashbacks, or feared that someone would harm them, so participants *offered safety and security in a nursing unit* (arranging safe places for them to live) to them. For the safety of others around SASAC in the ward, nurse 1, 2, 4 and 7 mentioned that they paid close attention, arranged ways to release tension, and modified the ward's physical construction such as removing sharp weapons, replacing mirrored windows, and setting-up

CCTV (Closed Circuit Television), and assigning someone to keep watch on the CCTV monitor, or used safety standards within the ward and hospital. For SASAC' *safety and security,* nurse 1, 6, and 7 shared that they helped SASAC who were insecure from psychiatric symptoms by informing them when someone was coming into the ward; assuring them of locked iron doors, staff in wards, and security guards in front of the hospital to protect them.

SASAC who were admitted to wards for several months lacked the chance of social awareness, language, and cognitive development. Participants *encouraged schooling* (preparing readiness to learn according to their ages) to SASAC. Nurse 1, 2, 3, and 4 taught young SASAC or SASAC who lacked the chance to go to school by practicing eye-hand coordination, through throwing and catching balls, or teaching writing and reading; teaching academic subjects such as Mathematics, Science and Thai.

Most SASAC wanted someone who understood them and who could support them when they had problems**.** Participants *provided dependable caregiver* (searching for someone who was a suitable caregiver) for SASAC. Nurse1, 4, 6, and 7 searched for someone to be a key person of SASAC, to take action as the new caregiver, protectors, or supporters. Most dependable caregivers were relatives, non-relatives, teachers, staff of non-government organizations (NGOs), and government organizations (GO). Moreover, nurse 1, 6, and 7 prepared new caregivers to become acquainted with the child by arranging for them to meet or join in activities together.

Some SASAC had low IQ, were of passive personality, slow learners, or wanderers, and were too young to take care of themselves. Participants *found safe lodgings and school*s (searching for new safe houses and safe schools for preventing re-abuse or other danger) for SASAC. Nurse 1 shared, "When I visited a girl's house, I explored her livelihood and environment. After I talked with her father and step mother to evaluate child-parents' relationships and attitude, I consulted with my multi-disciplinary team by telling them that the girl's father was a salesman who travelled out of town frequently and that the stepmother was too young to take care of the girl, motorcycle riders who were previous abusers lived near her house. Thus, the team moved her to Lopburi's boarding school". As a result, SASAC were referred to safe and suitable settings for the characteristics and abilities of each child, helping them to adapt easily and study academic subjects.

Stage 3

After SASAC's behavioral problems, or severe signs and symptoms, had been reduced or improved, psychiatric nurses prepared them to return to home and live in society.

Going back to society

In order to solve the child's complex problems and prevent future reoccurrence of sexual abuse, the nursing and multi-disciplinary team was very important in helping to optimize their lives. Participants assisted SASAC to *go back to society* by providing support, preventing potential problems, following-up on the child, and providing consultation during hospitalization and after discharge.

Most SASAC were repeatedly admitted to wards because they could not adapt to living in new settings or their own houses. Participants *provided support* (giving help to successfully adjust with others) to SASAC. Nurse 6, 8, 9, and 10 arranged SASAC to visit home in the first few days, sometimes having activities together with the family at weekends. The participant searched for new SASAC' problems or evaluated their abilities when they participated with others or carried out social activities. If these problems were found early, it was easier to solve them prior to discharge. In addition, nurse 1 shared, "In discharge cases, if only one child is referred to a new lodging, that child can't usually stay there. I would wait until another discharge case for a new lodging came up, and let them leave together. If a child has a friend, then the child is not too lonely". In addition, nurse 6 supported the child's mother to have the skills to take care of her child and said, "After I talked with the girl I found that she disliked her mother being so fussy, so, I encouraged her mother to speak positively with her". Moreover, nurse 1 said, "I gave a child's reports to a new caregiver of any behavioral improvements, or residual signs and symptoms, to assist in better understanding the child's case. The caregiver was trained to administer medication, and I suggested tactics to deal with times when she was uncontrollable".

When having low IQ, being too young, being lonely, or lacking someone to watch them, participants *prevented potential problems* (attempting to reduce risk problems in the future) for the SASAC. Nurse 10 said, "I tried to talk with the child to discover her history. I found that she felt lonely in the house by herself because her mother worked in a bar at night. Often, she went away to her friends. I asked her to find out what her hobbies were, and cheered her up with

her favorite hobbies. I suggested to her to make use of her time carefully in order to reduce loneliness and prevent her escape from the house". In addition, nurse 1 mentioned, "This case is MR child. The last time, I tried to refer her to a safe setting, but she always escaped from the house to have sex. So, I invited the grandparents to talk about her sexual behavior and suggested to them that a doctor should sterilize the child".

Most participants believed that SASAC were too immature to manage all their problems and furthermore, that the caregiver's level of education and parenting skills were limited. Nowadays, the health care providers in the community are insufficient to provide adequate care. As a result, participants *followed-up on the child* (paying attention to each case and updating their information) for offering help and suggestions early on. Nurse 1, 4, 6, and 10 followed-up them by calling to talk with the children or to talk with the parents; and asking staff of organizations after meeting in conference.

Participants explained the severe problems or behavior upon discharge that caregivers might face whilst taking care of the child. For SASAC and their parents/caregivers who could deal with these problems at their home, participants *provided consultation* (being a consultant to give some suggestions to care for SASAC). Nurse 2 shared, "Before sending a child back home, I usually give my contact number to the child and the parents, so that they can call for advice or help. One child called me from time to time, asking about going for job interviews and seeking advice on how to dress, act, and answer questions". Nurse 8 said to the parents/caregivers who could not handle their children, that they could call to the ward at any time to solve any urgent problems, and suggested they make an appointment at OPD, or drop by the ward if necessary. Moreover, nurse 1 reported, "Before sending a child to a place within our network, I will try to find support for that place. For example, I tell the teacher of the boarding school that I am glad to give help at any time if there is a problem".

Each sub-stage of the remolding child process occurred simultaneously with working as a team and self-developing. Finally, the researcher concisely explored working as a team and self-developing to better understand the remolding child process.

Working as a team

In remolding child, psychiatric nurses who care for SASAC worked both within a nursing team and with the multi-disciplinary team. In the nursing team, the head-nurse of the ward assigned some nurses who held a master's degree, or who had work experience of more than 5 years, to be the primary nurse or case manager to care for them. Moreover, she assigned patient-assistants to be responsible for the routine care of SASAC and to assist nurses as observers, followers, and reporters of the children's behavior and symptoms. For effective operation of the nursing team, the head-nurse empowered staff nurses by encouraging staff to look for new nursing procedures, motivating them, giving suggestions, and helping them to solve complex problems. In addition, all staff nurses helped to develop patient-assistant's ideas, taught tactics of work, and enriched skills for taking care of SASAC.

In working with the nursing team, psychiatric nurses acquired data from many different sources such as senders, caregiver, or SASAC after being trusted. They assessed the real needs of the child through observing, discovering, asking, and listening prior to helping. Within the nursing team, psychiatric nurses prioritized problems and planned to solve both the short and long-term issues through sharing data/ideas, group discussion, making decisions. If the child's problems had not improved, psychiatric nurses met to newly assess or adjust goals or care.

In the multi-disciplinary team, psychiatric nurses took the role of cooperator by preparing the child's information, sharing new data, sending for special requests, following-up results, arranging meetings, making decisions within the multi-disciplinary team, and continuing to help after discharge.

Self-developing

While working with SASAC, psychiatric nurses applied knowledge from education, training, or personal experiences, but they also learnt from practical experience on the ward. Some psychiatric nurses mentioned that SASAC were their teachers who enabled them to provide good nursing care in future cases. For example, nurses were careful not to get trapped in situations, such as being in a room while a child was shouting. They learnt methods to remain safe from experience of previous cases, especially related to violence, by moving fire extinguishers to a safer setting, or by locking and leaving situations after evaluating that they were unsafe. These practical techniques were shared and learned with colleagues within the nursing team that helped nurses to update their knowledge and collate the effective strategies of nursing.

Whilst taking care of SASAC, psychiatric nurses were sometimes themselves faced with severe symptoms and negative moods, such as being scolded, being harmed, feeling angry during police's investigations or questioning of the child in court. The nurses tried to control themselves and had to remind themselves of their professional role in the situation.

Other than learning by themselves, psychiatric nurses developed minds through their attention to help and support both the children and their caregivers. Moreover, psychiatric nurses were concerned about SASAC' minds by automatically protecting the benefits/rights of the child, following the child's progress, negotiating with police about trauma caused during questioning of the child, negotiating with the public prosecutor to become a friend during court appearances. The nurses have awareness towards the nursing profession by creating public awareness about the child's trauma.

Discussion

Findings from the present study provide various insights into practice for SASAC through interviewing psychiatric nurses who have had direct experience. Child remolding is similar to caring of Lininger[52], in that remolding child is a nursing process responding to SASAC' needs and problems. In addition, it is a holistic care process like Bertalanffy's general system theory[24], not only with physical care to reduce serious psychiatric symptoms, but psychological care also to foster socialization, build will-power, arrange safe and supportive environments, and social care to assist return to society. In addition, nurses do not forget to care for the father, mother, or other relatives who have been distressed with the child's behavior.

Findings from Kelly[53] and Jirapa[54] show that care for sexually-abused children is most effective with a multi-disciplinary team approach. Similarly, the child remolding is a nursing care process that occurs simultaneously with multi-disciplinary teams, through "working as a team" to give help or respond to the complex needs of SASAC. In order to ultimately benefit SASAC, psychiatric nurses who work with multi-disciplinary team must have good relationship with team members.

Moreover, Cohen and Mannarino[55] and Tremblay, Hebert, and Piche[56] suggested that the effective outcome of treatment of the child is dependent on parental support. Similarly, Harper, Stalker, Palmer and Gadbois[57] reported experiences of adults abused as children, in that they are not improved after discharge because of lack of subsequent follow-up and emotional support from family members. The family is now seen as one of the most significant supports[58]. Those finding are similar to the present study, in that the parent or caregiver's support was found to be highly important in helping SASAC. Psychiatric nurses provide suitable or dependable caregivers with inspiration and hope. The nurses may indirectly help caregivers to care for their children post-discharge through helping them to be strong, healthy, empowered. Psychiatric nurses are ready to provide support and consultation to caregiver, and add strength to their available network.

For the present study, most participants described experiences of nurse-client relationships as similar to those, which Peplau emphasized in Interpersonal Relations Model[59], in that it was necessary to firstly establish a relationship for clients to trust nurses. With remolding child, participants established trust with SASAC by building familiarity, cultivating friendship, providing confidentiality, offering tangible help, behaving consistently, and showing respect with no particular set sequence, they occur concurrently and reciprocally. However, Peplau stated that nurses passed through four phases of the nurse-client relationship, such as orientation phase, identification phase, exploitation phase, and resolution or terminal phase.

In remolding child, the roles of psychiatric nurse are not different to Peplau's six major roles of nurse-patient relationship composed of stranger, resource, teaching, counseling, surrogate, and leadership roles. *In stranger role*, psychiatric nurses start to make approaches to build familiarity and to make themselves known to SASAC through greeting, smiling, touching, or talking. *In resource role*, the nurses also give information, knowledge, and answers to SASAC and caregivers during remolding child process. *In teaching role*, the nurses both teach and train SASAC about daily activities, self-discipline, and self-responsibility, social rules, social norms, and schooling; and even provide suggestions and training for caregivers. *In counseling role*, the nurses talk with SASAC everyday and give them a chance to talk about their everyday problems or troubles. *In surrogate role*, these nurses act as listener, speaker, or mediator for the child, especially when they felt hurt, afraid, or dare not speak. *In active leadership*, the nurses may be either leaders of nursing teams or primary nurses

who display the leadership of staff nurses and patient-assistants of SASAC.

The 'remolding child' related to Maslow's theory that included only fourth hierarchy of needs, such as physical survival, safety and security, social, and self-esteem needs[60]. Most SASAC are ignored by their parents and family, they lack response to their needs. With physical survival need, psychiatric nurses, as vital health care providers, respond by providing physical care, such as food and medicine, and ensuring that they have well-balanced amounts of sleep, exercise, and play. In safety and security need, nurses respond by arranging a safe and supportive environment, introducing the child to members of staff, helping to cultivate friends, and orientating SASAC to the ward. Before discharge, psychiatric nurses search for safe lodgings or homes for their patients, in an effort to ensure that re-abuse does not occur. In social need, SASAC need to love and be loved. Therefore, psychiatric nurses start establishing relationships of building trust, monitoring their patients' desires; promoting a sense of belonging by showing a keen interest or concern for their welfare; initially accepting some levels of negative behavior; and helping to promote mother-child relationships. In self-esteem need, a great number of SASAC have aggression, antisocial behavior, or delinquency, and this is related to low self-esteem[61]. Psychiatric nurses promote self-esteem by building patients' will have power like King's nursing theory[24] through generating positive self-thought and fostering an understanding of self.

On the other hand, most processes of remolding child are particular and delicate to developing children's competency. Psychiatric nurses experience that most SASAC show aggressive or sexually deviant behavior, lying, stealing, or attempting to escape from house that lack external and internal self-controls or someone to look after them. Schaefer and Lamm stated that socialization is the most important process occurring between the ages of one and ten, but people continue to learn re-socialization throughout their lives, *i.e.* the process of learning new norms, values, attitudes, and behavior[62]. According to Rotter, it was suggested that people are controlled to act with either external or internal factors of the locus of control theory[63]. In the remolding process, nurses encourage and foster the child to learn culture, norms, and practices of a particular group; including the rules, values, and expectations of family, group, or the nation. SASAC are molded or fostered through learning and behavioral theory[24] by re-shaping unwanted behavior, taught to have responsibility for themselves and others, taught to abide by social rules or norms and adjust any misunderstandings they may have, and trained to have the ability of self-control to assist living in society by using rewards and punishments. Initially, nurses help SASAC to practice self-control by using external factors such as rules of the ward and the norms of their peer group. Afterwards, nurses train or empower SASAC to control themselves to act rationally.

Some nursing strategies of caring for SASAC in remolding child, and adult patients with a history of childhood sexual abuse, are similar. Irwin[35] stressed nursing care for adult patients during hospitalization, slowly building relationships and trust, observing patient's behavior in daily activities, evaluating patient's readiness before helping them, and planning with the patient prior to discharge. Draucker[38], Symes[39], Lawson[40], and Schachter[41] indicated that the healing processes of adult survivors of childhood sexual abuse during hospitalization included facilitating activities, encouraging getting rid of shame and guilt, and adequate preparation before discharge.

Limitation

A limitation of the present study was that the researcher used only in-depth interviews, because SASAC cases were not permanently admitted to psychiatric wards. Therefore, the researcher was not able to observe or interview SASAC whilst conducting the research. During the in-depth interview process with the psychiatric nurses, any results may be limited to the participants' emotional status, cognitive maturity, and honesty. Psychiatric nurses working with SASAC represented a small group, and participants of this study comprised only 12 psychiatric nurses.

Implication

In this finding, the remolding child process is a new understanding related to nursing practices that came from interviewing psychiatric nurses who have experience in working with SASAC. This remolding process may help novices or inexperienced psychiatric nurses to know and understand more about the nursing practice process for SASAC. In addition, it may be used as a guideline in caring for SASAC admitted to psychiatric wards, saving time, energy, and cost.

The novices or inexperienced psychiatric nurses knew and understood more about the useful tactics. *Firstly*, in building familiarity, nurses would

never directly ask SASAC about their abusive situations or habitual negative behavior because they might feel uncomfortable or unsafe. *Secondly*, the researcher noticed that SASAC often disclose abusive events whilst they are bathing in a washroom and the psychiatric nurses are waiting for them outside; or talking before sleep. Psychiatric nurses are now aware that they should bring the child to bathe alone, or offer a short talk or tell a tale before going to bed. *Thirdly*, the nurses may also use small gifts, candy, or toys to help build friendships with children in this group. *Fourthly*, if a male psychiatric nurse is caring for a female SASAC, the nurse should build relationships by explaining the goals of the therapeutic care after the child has already established trust with female nurses. *Lastly*, when faced with negative moods as a result of providing nursing care, nurses should remove themselves from the situation and request that another team member take over the SASAC case.

In the future, the level of education and training of psychiatric nurses facilitates nursing practice for SASAC; however, the nursing curriculum of the bachelor's degree course gives little precedence to the topic of violence. In nursing education, educators should devote more teachings hours to the subject of dealing with violence, and develop basic nursing competency for SASAC and families by providing a specialist course of care for abused children.

Next, this research could be extended to adolescents or adults with childhood sexual abuse who are admitted to psychiatric wards, to compare the similarities and differences of results, or to generate the process of nursing practice in other aged groups. Other than studying the nursing practice process of SASAC by interviewing psychiatric nurses, the next research should investigate it from the SASAC's or caregiver's perspectives to get a more complete view of care. Not only should psychiatric nurses be interviewed, but also several other professions within the multi-disciplinary team to compile views of all those involved in helping sexually abused children. Moreover, additional research should study the two processes as conditions of remolding, 'working as a team' and 'developing personal self'. From data analysis and notification, future research should explore under what conditions are secrets kept, and what methods might be employed to encourage SASAC disclose abusive events.

However, the "remolding child" is a substantive model derived from data, so it is necessary for repeated testing to add credibility, before it can be developed into interventions to reduce the residual symptoms of chronic psychiatric problems in later life.

Conclusion

The remolding child, the holistic care process, was integrated from multi-theories and psychiatric nurse's personal experiences that they applied to practice for SASAC and their families. It composed 11 categories divided into three stages that happened continuously in sequence. Each stage consisted of sub-stages that had no sequence in their occurrence, and these sub-stages were simultaneous and reciprocal. In remolding child process, the first stage started with establishing trust, arranging effective communication, and providing physical care. The second stage was fostering socialization, building will-power, and arranging a safe and supportive environment. The final stage was assisting living in society. Working as a team, and self-developing, were two other important characteristics of the remolding child process. The remolding child process may prevent chronic illness being transferred to adolescence and adulthood.

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References

1. Masuku S. Prevention is better than cure addressing violent crime, Addressing violent crime in South Africa. SA Crime Quarterly 2002; 2: 5-12.
2. Murray CJL, Lopez AD. Quantifying the burden of disease and injury attributable to ten major risk factors. In, Murray CJL, Lopez AD, editors. The global burden of disease, a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA, Harvard University Press; 1996, 8-9.
3. Thangkananurak W. Surveillance of child problems in 2004. Senate Journal 2004; 12: 4-6.
4. Hutaphat B. Providing services of government organizations and non-government organizations related to violence problems in the family. Nonthaburi, Sukhothai Thammathirat Open

University; 2002, 67-9.
5. Chaisuparasameekul S. Physically and sexually abused children, A retrospective 7 year study. Nonthaburi, National Child Health Institution, Ministry of Public Health; 2005, 105-7.
6. Allers, CT, Benjack, KJ, Allers, NT. Unresolved childhood sexual abuse, Are older adults affected? J Couns Dev 1992; 71: 14-7.
7. Kendall-Tackett KA, Williams LM, Finkelhor D. Impact of sexual abuse on children, a review and synthesis of recent empirical studies. Psychol Bull 1993; 113: 164-80.
8. Boonma M, Bhoopat T, Treratwerapong T, Jintanadilog A. Physical effects of sexually abused children and adolescents at Taksin Hospital. J Med Assoc Thai 2007; 90: 2608-15.
9. Vitavasini C. Sexually transmitted diseases in sexually abused children. Thai Police Med J 2003; 29: 12-8.
10. Trangkasombat U. Child sexual abuse, a report on 16 cases. Chula Med J 1992; 36: 583-91.
11. Calam R, Horne L, Glasgow D, Cox A. Psychological disturbance and child sexual abuse, a follow-up study. Child Abuse Negl 1998; 22: 901-13.
12. Techakasem P, Kolkijkovin V. Runaway youths and correlating factors, study in Thailand. J Med Assoc Thai 2006; 89: 212-6.
13. Flinn SK. Child Sexual Abuse I: An Overview [Online]. 1995 [cited 2009 Feb 17], [3 screens]. Available from: URL:http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsabuse1.htm
14. Brown K. Children who were sexually abused were more disturbed than their peers after 5 years. Evid Based Nurs 1998; 1: 84.
15. Goodman LA, Rosenberg SD, Mueser KT, Drake RE. Physical and sexual assault history in women with serious mental illness, prevalence, correlates, treatment, and future research directions. Schizophr Bull 1997; 23: 685-96.
16. Harper K, Stalker CA, Palmer S, Gadbois S. Adults traumatized by child abuse, What survivors need from community-based mental health professionals. J Ment Health 2007; 17: 361-74.
17. Allers, CT, Benjack, KJ, Allers, NT. Unresolved childhood sexual abuse, Are older adults affected? J Couns Dev 1992; 71: 14-7.
18. Cecen AR. Child sexual abuse, prevalence, effects and school based prevention. Int J Hum Sci 2007; 4: 238-58.
19. Kolko DJ, Moser JT, Weldy SR. Behavioral/emotional indicators of sexual abuse in child psychiatric inpatients, a controlled comparison with physical abuse. Child Abuse Negl 1988; 12: 529-41.
20. Fromm S. Total estimated cost of child abuse and neglect in the United States, Statistical evidence. Chicago, IL, Prevent Child Abuse America; 2001, 2.
21. Ching-Tung W, John H. Total estimated cost of child abuse and neglect in the United States, Statistical evidence. Chicago, IL, Prevent Child Abuse America; 2007, 4-5.
22. Meleis AI. Theoretical nursing, development and progress. 4th ed. London, J. B. Lippincott; 1997, 252-5.
23. Boonthong T, Sittimongkhon Y. Theory based in psychiatric nursing. In: Boonthong T, editor. Mental health promotion and psychiatric nursing: Unit 1-7. Nonthaburi: Sukhothai Thammathirat Open University Printing; 2001: 56.
24. Schwecke LH. Violence and nursing. In: Keltner N, Schwecke LH, Bostrom CE, editor. Psychiatric nursing. 4th ed. St Louis (MO): Mosby Year Book; 2003: 118-22.
25. Savell S. Child sexual abuse, are health care providers looking the other way? J Forensic Nurs 2005; 1: 78-81, 85.
26. Goodwin J, Attias R, McCarty T, Chandler S, Romanik R. Reporting by adult psychiatric patients of childhood sexual abuse. Am J Psychiatry 1988; 145: 1183-4.
27. Kohan MJ, Pothier P, Norbeck JS. Hospitalized children with history of sexual abuse, incidence and care issues. Am J Orthopsychiatry 1987; 57: 258-64.
28. Gallop R, McCay E, Guha M, Khan P. The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. Health Care Women Int 1999; 20: 401-16.
29. O'Brien L, Cole R. Mental health nursing practice in acute psychiatric close-observation areas. Int J Ment Health Nurs 2004; 13: 89-99.
30. Jennings A. On being invisible in the mental health system. J Ment Health Adm 1994; 21: 374-87.
31. Day A, Thurlow K, Woolliscroft J. Working with childhood sexual abuse, a survey of mental health professionals. Child Abuse Negl 2003; 27: 191-8.
32. Fazzone PA. Caring for abused and neglected children on inpatient child psychiatric units, a cross-sectional ethnography [Dissertation in Doctor of Nursing Science]. Chicago, Illinois, Rush University; 1991, 121-30.

33. Zeanah PD, Hamilton ML. Staff perceptions of sexuality-related problems and behaviors of psychiatrically hospitalized children and adolescents. Child Psychiatry Hum Dev 1998; 29: 49-64.
34. Budd T. Violence at work, findings from the British crime survey. London, Home Office; 1999, 222-4.
35. Irwin F. Working with an adult survivor of childhood sexual abuse. Mental Health Care 1997; 3, 98-100.
36. Sabin-Farrell R, Turpin G. Vicarious traumatization, implications for the mental health of health workers? Clin Psychol Rev 2003; 23: 449-80.
37. Long A, Smyth A. The role of mental health nursing in the prevention of child sexual abuse and the therapeutic care of survivors. J Psychiatr Ment Health Nurs 1998; 5: 129-36.
38. Draucker CB. The healing process of female adult incest survivors, constructing a personal residence. Image J Nurs Sch 1992; 24: 4-8.
39. Symes L. Arriving at readiness to recover emotionally after sexual assault. Arch Psychiatr Nurs 2000; 14: 30-8.
40. Lawson L. Becoming a success story, how boys who have molested children talk about treatment. J Psychiatr Ment Health Nurs 2003; 10: 259-68.
41. Schachter CL, Radomsky NA, Stalker CA, Teram E. Women survivors of child sexual abuse. How can health professionals promote healing? Can Fam Physician 2004; 50: 405-12.
42. Chinlumprasert N. The development of violence research database and the synthesis of research on violence issues in Thai society. Nonthaburi, Health Systems Research Institute; 2003, 101-6.
43. Natesuwan J. Shaping behaviors, a case study of child abuse. Nonthaburi, Srithanya Hospital; 2003, 35-7.
44. de Wit K, Davis K. Nurses' knowledge and learning experiences in relation to the effects of domestic abuse on the mental health of children and adolescents. Contemp Nurse 2004; 16: 214-27.
45. Gallop R, McCay E, Austin W, Bayer M, Peternelj-Taylor C. A survey of psychiatric nurses regarding working with clients who have a history of sexual abuse. J Am Psychiatr Nurses Assoc 1998; 4: 9-17.
46. Singhaphan, S. Staff medical practice for protection of the rights of abused children [Thesis in master degree of administration of medical law and public health]. Bangkok, Mahidol University; 1999, 89-93.
47. Gillespie FJ. Child sexual abuse. 2, Techniques for helping adult survivors. Br J Nurs 1993; 2: 313-5.
48. Benner P. From novice to expert, Excellence and power in clinical nursing practice. Menlo Park, Addison-Wesley; 1984, 35-6.
49. Strauss A, Corbin J. Basis of qualitative research technique and procedure for developing grounded theory. London, Sage; 1990, 32-5.
50. Stern PN. Grounded theory methodology, its uses and processes. Image (IN) 1980; 12: 20-3.
51. Sandelowski M. The problem of rigor in qualitative research. ANS Adv Nurs Sci 1986; 8: 27-37.
52. Leininger MM. Culture care diversity and universality, a theory of nursing. New York, National League of Nursing Press; 1991, 35.
53. Kelly R. Caring for sexually abused children. Nurs N Z 2001; 7: 14-6.
54. Jirapa C. Multi-disciplinary team practice in helping sexually abused children, case study on The Centre for Co-ordination and Protection of Childs Rights in Chiang Mai. Bangkok, Thammasart University; 1998, 120-1.
55. Cohen JA, Mannarino AP. A treatment outcome study for sexually abused preschool children, initial findings. J Am Acad Child Adolesc Psychiatry 1996; 35: 42-50.
56. Tremblay C, Hebert M, Piche C. Coping strategies and social support as mediators of consequences in child sexual abuse victims. Child Abuse Negl 1999; 23: 929-45.
57. Harper K, Stalker CA, Palmer S, Gadbois S. Adults traumatized by child abuse, What survivors need from community-based mental health professionals. J Ment Health 2007; 17: 361-74.
58. Mohr WK. Rethinking professional attitudes in mental health settings. Qual Health Res 2000; 10: 595-611.
59. Peplau HE. Interpersonal relations, a theoretical framework for application in nursing practice. Nurs Sci Q 1992; 5: 13-8.
60. Maslow AH. A Theory of human motivation. Psychol Rev 1943; 50: 370-96.
61. Donnellan MB, Trzesniewski KH, Robins RW, Moffitt TE, Caspi A. Low self-esteem is related to aggression, antisocial behavior, and delinquency. Psychol Sci 2005; 16: 328-35.
62. Schaefer RT, Lamm RP. Sociology, A brief introduction. New York, McGrew-Hill; 1994, 69-76.
63. Rotter JB. Generalized expectancies for internal versus external control of reinforcement. Psychol Monogr 1966; 80: 1-28.

การหล่อหลอมเด็ก: กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ

แสงเทียน ธรรมลิขิตกุล, จินตนา ยูนิพันธ์, วราภรณ์ ชัยวัฒน์

วัตถุประสงค์: *เพื่อศึกษากระบวนการที่อธิบายของการปฏิบัติการพยาบาลสำหรับเด็กวัยเรียนที่เข้ารับการรักษาในหอผู้ป่วยจิตเวชเนื่องจากถูกทารุณกรรมทางเพศ*

วัสดุและวิธีการ: *วิธีการวิจัยเชิงคุณภาพ ชนิดการสร้างทฤษฎีจากข้อมูลพื้นฐาน ผู้ให้ข้อมูล คือ พยาบาลจิตเวชที่มีประสบการณ์การดูแลเด็กที่ถูกทารุณกรรมทางเพศ อายุระหว่าง 35-59 ปี จำนวน 12 คน เก็บข้อมูลโดยการสัมภาษณ์เชิงลึก การบันทึกเทป ถอดความแบบคำต่อคำ และวิเคราะห์ข้อมูลตามวิธีการสร้างทฤษฎีจากข้อมูลพื้นฐาน*

ผลการศึกษา: *"การหล่อหลอมเด็ก" เป็นกระบวนการที่พยาบาลจิตเวชใช้ในการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศที่เข้ารับการรักษาในหอผู้ป่วยจิตเวช กระบวนการนี้ประกอบด้วย 3 ขั้นตอนที่เกิดขึ้นเป็นลำดับอย่างต่อเนื่อง ในส่วนของแต่ละขั้นประกอบด้วยขั้นย่อยๆ ซึ่งไม่มีลำดับการเกิดที่แน่นอน รวมทั้งสามารถเกิดขึ้นพร้อม ๆ กัน หรือ เกิดย้อนไปมาได้ ขั้นตอนของกระบวนการหล่อหลอมเด็กประกอบด้วย ขั้นที่หนึ่ง การสร้างความไว้วางใจ การจัดให้มีการสื่อสารที่มีประสิทธิภาพ และการดูแลด้านร่างกาย ขั้นที่สองประกอบด้วย การพัฒนาการปรับตัวให้เข้ากับสังคม การสร้างพลังใจ และการจัดสิ่งแวดล้อมที่เกื้อกูลและให้ปลอดภัย ขั้นที่สามเป็น การช่วยเหลือการดำรงชีวิตในสังคม ส่วนการทำงานเป็นทีมและการพัฒนาตนเองของพยาบาลจิตเวช เป็นลักษณะสำคัญอีกสองประการของกระบวนการหล่อหลอมเด็กที่เกิดขึ้นพร้อมกัน*

สรุป: *ทฤษฎีเชิงสาระที่ได้จากการศึกษาครั้งนี้ ทำให้เกิดความรู้ความเข้าใจกระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศที่เข้ารับการรักษาในหอผู้ป่วยจิตเวชในประเทศไทยได้อย่างลึกซึ้ง ความรู้นี้สามารถใช้เป็นแนวทางในการพัฒนาการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ เข้ารับการรักษาในหอผู้ป่วยจิตเวชได้*