การหล่อหลอมเด็ก: กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ

นาง แสงเทียน ธรรมลิขิตกุล

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาพยาบาลศาสตรดุษฎีบัณฑิต
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REMOLDING CHILD: PROCESS OF NURSING PRACTICE FOR SEXUALLY ABUSED CHILDREN

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A Dissertation Submitted in Partial Fulfillment of the Requirements

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นางแสงเทียน ธรรมลิขิตกุล: การหล่อหลอมเด็ก: กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ. (REMOLDING CHILD: PROCESS OF NURSING PRACTICE FOR SEXUALLY ABUSED CHILDREN) อ. ที่ปรึกษา: รศ. ดร. จินตนา ยูนิพันธุ์, อ.ที่ปรึกษาร่วม: รศ. ดร. วราภรณ์ ชัยวัฒน์, 152 หน้า.

กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ เป็นกลวิธีที่จะป้องกันมิให้เด็กเหล่านี้ป่วยเรื้อรัง แต่กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศมีลักษณะอย่างไรยังขาดรายงานการศึกษาและทฤษฎีที่เหมาะสมมาอธิบาย การศึกษาในครั้งนี้มีวัตถุประสงค์ เพื่อศึกษากระบวนการของการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศที่เข้ารับการรักษาในหอผู้ป่วยจิตเวช โดยวิธีการวิจัยเชิงคุณภาพ ชนิดการสร้างทฤษฎีจากข้อมูลพื้นฐาน ผู้ให้ข้อมูลที่สำคัญคือพยาบาลจิตเวชที่มีประสบการณ์การดูแลเด็กที่ถูกทารุณกรรมทางเพศ อายุระหว่าง 35-59 ปี จำนวน 12 คนเก็บข้อมูลโดยการสัมภาษณ์เชิงลึก การบันทึกเทป ถอดความแบบคำต่อคำ วิเคราะห์ข้อมูลตามวิธีการสร้างทฤษฎีจากข้อมูลพื้นฐาน

ผลการศึกษาพบว่า "การหล่อหลอมเด็ก" เป็นกระบวนการที่พยาบาลจิตเวชใช้ในการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ ที่เข้ารับการรักษาในหอผู้ป่วยจิตเวช กระบวนการนี้ประกอบด้วย 3 ขั้นตอนที่เกิดขึ้นเป็นลำดับอย่างต่อเนื่องในแต่ละขั้นประกอบด้วยขั้นย่อยๆ ซึ่งไม่มีลำดับการเกิดที่แน่นอน รวมทั้งสามารถเกิดขึ้นพร้อมๆกันหรือเกิดย้อนไปมาได้ ขั้นตอนของกระบวนการหล่อหลอมเด็กประกอบด้วย ขั้นที่หนึ่ง การสร้างความไว้วางใจ การจัดให้มีการสื่อสารที่มีประสิทธิภาพ และการดูแลด้านร่างกาย ขั้นที่สองประกอบด้วย การพัฒนาการปรับตัวให้เข้ากับสังคม การสร้างพลังใจ และการจัดสิ่งแวดล้อมให้ปลอดภัยและเกื้อกูล ขั้นที่สาม เป็นการช่วยเหลือการดำรงชีวิตในสังคม การทำงานเป็นทีมและการพัฒนาตนเองของพยาบาลจิตเวช เป็นลักษณะสำคัญอีกสองประการของกระบวนการหล่อหลอมเด็กนี้

ทฤษฎีเชิงสาระที่ได้จากการศึกษาครั้งนี้ ทำให้เกิดความรู้ความเข้าใจกระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ เข้ามารักษาตัวในหอผู้ป่วยจิตเวชในประเทศไทยได้อย่างลึกซึ้ง ความรู้นี้สามารถใช้เป็นแนวทางในการพัฒนาการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศเข้ารับการรักษาในหอผู้ป่วยจิตเวชได้

สาขาวิชา.....พยาบาลศาสตร์.....
ปีการศึกษา.....2550.....

ลายมือชื่อนิสิต.....
ลายมือชื่ออาจารย์ที่ปรึกษา.....
ลายมือชื่ออาจารย์ที่ปรึกษาร่วม.....

4677977636: MAJOR NURSING SCIENCE
KEY WORDS: NURSING PRACTICE/SEXUALLY ABUSED CHILDREN

SANGTIEN THAMLIKITKUL: REMOLDING CHILD: PROCESS OF NURSING PRACTICE FOR SEXUALLY ABUSED CHILDREN. THESIS ADVISOR: ASSOC. PROF. JINTANA YUNIBHAND, Ph.D., ASSOC. PROF. WARAPORN CHAIYAWAT, D.N.S., 152 pp.

The process of the nursing practice for sexually abused child patients is a pivotal strategy to prevent them from chronic illness. However, theory related to the nursing practice for sexually abused children was currently unknown. The purpose of this study was to explore how psychiatric nurses practiced nursing for school-aged sexually abused children who were admitted to psychiatric wards. A grounded theory approach was used in the study. Twelve psychiatric nurses who had experience in providing nursing care for sexually abused child patients, aged between 35-59 years old, were participants of this study. Data was collected by in-depth interview, tape- recorded, and transcribed verbatim, line by line. Data were analyzed using grounded theory method.

The findings indicated that, "remolding child" was the basic social process by which psychiatric nurses provide nursing practice for sexually abused children admitted to psychiatric wards. The process of remolding child was composed of 3 stages that was happened continuously in sequence. Each stage consisted of sub-stages that had no sequences in their occurrence, and these sub-stages were simultaneous and reciprocal. In remolding child process, the first stage was started with establishing trusts, 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 this remolding child process.

This substantive theory recommends a new insight, new knowledge and understanding into the nursing practice process for sexually abused children admitted to psychiatric wards in Thailand. It can be used as a guideline to develop interventions to prevent the residual symptoms of chronic psychiatric problems occurring in later years.

Field of study.....Nursing Science..... Student's signature Sangtien Thamlikitkul
Academic year.....2007..... Advisor's signature Jintana Yunibhand
Co-advisor's signature Waraporn Chaiyawat

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Evidence of child sexual abuse in Thailand is given daily in the newspapers, movies, television, and radio news reports. Most sexually abused children suffer with trauma and the serious consequences throughout their entire lives. Sexually abused children need competent therapists to assist with their healing process. As a nurse educator in nursing college, I have had the opportunity to talk with and observe psychiatric nurses working with school-age sexually abused child patients, and found that nursing care for sexually abused children is a complex phenomenon. As a result, it inspires me to find a strategy to help school-age sexually abused child patients by exploring psychiatric nurses' knowledge and experience within the work environment of psychiatric wards.

Completion of this dissertation is due to the assistance of some very special people. First of all, I am deeply grateful to the psychiatric nurses who participated in this study. They willingly and enthusiastically took part in the research, and their courage and self-disclosure in talking about the suffering and their techniques for dealing with it, made this study a truly meaningful and moving experience.

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CHAPTER I

INTRODUCTION

Background of the study

According to the World Health Organization, the global rate of child sexual abuse has continued to rise exponentially (World Health Organization [WHO], 2002). Although it is well accepted that "prevention of child sexual abuse is better than cure," evidence of child sexual abuse in Thailand has continued to rise (Child Protection and Child Rights Foundation, [CPCR], 2007). Child sexual abuse has featured prominently in the Thai media and is ranked as the third most serious problem for children (Thangkananurak, 2004). The Institute of Research in Men-Women's Role and Development, reports that Thai girls under 15 years of age were raped at an average of 2 girls per day (Hutaphat, 2001). Trends of child sexual abuse also occur in younger children, with the youngest sexually abused child victims being only 1 year and 2 months old (Chaisuparasameekul, 2005).

The consequence of child sexual abuse impacts directly on the child in the short term, and also in the long term as they become adult. Initially, emotional or behavioral indications of disturbance are indicated, commonly sleep disturbance, somatic complaints, poor self-esteem, and learning disabilities, conduct disorders, and temper tantrums leading to major mental illnesses or deviant problems. Over time, fears, post-traumatic stress disorder, anxiety, depression, attempted suicide, conduct disorders, behavior problems such as sexualized behavior, aggression, juvenile delinquency, and substance abuse, frequently occur as symptoms in the child victims (Calam, et al., 1998; Kendall-Tackett, et al., 1993). Lastly, sexually abused children may have a tendency to abscond from home, become involved with

child prostitution rings, be more prone to drug addictions such as smoking cigarettes, using amphetamines, ecstasy and cocaine, and be at greater risk of HIV infection, and unplanned pregnancies (Dekker, et al., 1990; Miller, & JoAnn, 1999; Swanston, et al., 2003; Techakasem, & Kolkijkovin, 2006). These consequences affected the child victims leading to extremely low quality of life and satisfaction (Cecen, 2007; Kolko, et al., 2005).

Approximately two thirds of child victims, who have the various symptoms, seek help from medical services and enter psychiatric institutions with a mental illness during their lives (Allers, Benjack, & Allers, 1992; Kendall-Tackett, et al., 1993). As an example, data from The Center of Care and Rehabilitation of Child Abuse, of Thai sexually abused child patients admitted to psychiatric wards, shows that sexually abused Thai child patients under 15 years old in the last 6 months of 2000 was 9 children; in 2001 it was 23 children; in 2002, 19 children; in 2003, 12 children; in 2004, 24 children; in 2005, 22 children; in 2006, 8 children; and in 2007, 14 children (Srithanya, 2007). According to Yuwaprasat Waithayopathum Child Psychiatric Hospital, sexually abused child patient statistics showed 1 case in 2005; in 2006, 3 cases; and in 2007, 2 cases (Yuwaprasat Waithayopathum, 2007). The largest group of sexually abused children admitted on psychiatric wards is aged between 10-15 years old (Chiang Mai Co-Ordination Centre for the Protection of Child Rights, 2003; Ford Foundation, 2003; Srithanya, 2007).

In tertiary hospitals, psychiatric nurses are vital professionals who are directly responsible for the care and rehabilitation of people with short and long term mental health problems (World Health Organization [WHO], 1956). But Kendall-Tackett, et al. (1993) synthesized 45 studies of sexually abused children, found that the victimized children showed recovery during the first 12-18 months of revealing the abuse. Thus, of those sexually abused

children who lacked caregiver's support and adequate medical and available nursing practice in the initial period, symptoms were residual and transformed into long-term consequences in adulthood (Perry, & Azad, 1999; Dominguez, Nelke, & Perry, 2001). Unfortunately, Katerndahl, Burge & Kellogg (2005) found that of these adult survivors who had mental illness, some had as many as five mental disorders. Most importantly, treatment and rehabilitation over the long term rarely has a good prognosis and these adult survivors do not have the life-style in their society as they had before.

For preventing the transfer of chronic illness from adolescence to adulthood, the researcher focused only on school-aged children. The reasoning being that, school-aged children begin to have abilities and an understanding of many concepts, and the world around them continues to grow, all of which can be communicated to the psychiatric nurses. During school-age years, a child moves from playing alone to having multiple friends and social groups. A very important part of growing up is the ability to interact with others and learn social skills (Fabes, & Martin, 2001). On average, self-esteem is relatively high in childhood however it may decline during adolescence (Robins, & Trzesniewski, 2005). Almost all children who are victims of sexual abuse feel guilt, and are ashamed to socialize with others; they disable relationships, and have lower self esteem. Vincent, et al. (1997) reported that adolescents, still upset with the consequences of sexual abuse which happened during childhood, tend towards multiple suicide attempts and eventually lead to completed suicides. Thus, psychiatric nurses have a key role to play in helping, supporting, and treating sexually abused school-age patients.

In psychiatric wards, nurses who had close-up contact with sexually abused children, 24 hours a day, had many interactions as the continual professional relationship, occurring

between a nurse capable of giving care and a patient in need of care, to change or improve the patient's health situation developed (Meleis, 1997). These psychiatric nurses are the main contact for the client from admission to discharge, so they see changes in behavior; understand their clients' problems; and learn of their special needs. At the same time, psychiatric nurses aspired to provide holistic care and treatment of the person as a whole (Mohr, 2003). Psychiatric nurses who provided effectively nursing practice used nursing theory relevance with nursing process made clinical judgments through assessment, diagnosis, intervention, and evaluation of the nursing practice (American Nurses Association [ANA], 1980). In addition, psychiatric nurses used the psychotherapeutic management for sexually abused children that comprises multiple strategies: (a) nurse-patient relationship; (b) therapeutic communication; (c) counseling; (d) group therapy; (e) milieu therapy; and (g) psychopharmacology (Keltner, Schwecke, & Bostrom, 2003).

However, De Wit and Davis (2004), Gallop et al. (1998), Singhaphan (1999), and Gillespie (1993) discovered that psychiatric nurses' knowledge alone is not enough, but that skills and work experience are directly related to the ability to provide effective nursing practice for sexually abused child patients. In recent findings, there are many difficulties and complexities of signs or symptoms of sexually abused children in psychiatric wards that these psychiatric nurses face and deal with (Fazzone, 1991; Day, Thurlow, & Woolliscroft, 2003).

Firstly, psychiatric nurses face difficulties in dealing with sexual behavior of sexually abused child patients in many forms, such as seductive sexual behavior with staff, sex play with other patients, sex content in conversation and masturbation (Fazzone, 1991, Kohan, Pothier & Norbeck, 1987). Traumatic sexualisation comes from the conditional learning

related to the sexual behavior of the abuser, and is inappropriate for the sexually abused child's developmental levels, causing misconceptions about real love, sex, and sexual norms. The sexual play-acting behavior that sexually abused children display, appear in many forms, such as: excessive masturbation, touching another child's genitals or breasts, soliciting or offering sexual acts to other children or staff on the unit, or openly displaying their genitals or breasts. Sexually abused children may act out sexually with the opposite gender or the same gender in psychiatric settings.

On the other hand, persistent sexual abuse of children continuously creates negative emotions and memories. These problems influence the development of their sexual identities, and may lead to either a lack of intimacy in relationships or increased arousal sensations (Finkelhor & Browne, 1985). These sexually abused children may repress sexualized behaviors, or avoid talking about their sexual stories. Following the norms of Thai society, sexuality is not openly discussed in public or with others, especially if the abuser is a family member.

Secondly, it is difficult for psychiatric nurses who have had to deal with the powerlessness that occurs as a result of abusers invading children's bodies, as well as their personal and private space, against their wishes, using force or trickery to involve them. As a result children live a life of fear, if the abuse continues over time. Children perceive themselves as "victims" with nothing in life to live for. In this way, they may identify with the abuser later (Finkelhor & Browne, 1985), particularly those involved with Satanism and ritualistic cults where patients are reluctant to change their faith or beliefs (Fazzone, 1991). Severe aggressive behavior is often seen in sexually abused children, who seem ready to explode at anytime in wards, because of imbalanced neurotransmitters, and a lack of

appropriate prior socialization from the family, resulting in the child's inability to co-habit with other children. Other child patients in wards, who are unable to protect themselves, will be vulnerable to the sexually abused children's impulsive and often violent behavior.

Thirdly, it is difficult to deal with the self-mutilation and suicidal behavior of sexually abused children. Stigmatization is the result of abusers blaming and denigrating children, pressuring children into secrecy and projecting guilt and shame into their minds. The child's self-esteem is lowered and damaged from learning that no one accepts and loves him/her as a unique human being, or that no attachment can occur without sex. Children feel like damaged goods, different from everyone else. Because of the effects of psychological stress to imbalanced neurotransmitters in their brains, the sexually abused children may lack self-control in suicidal behavior (Meston & Heiman, 1998, Moffitt, 2002). Some children adopt self-destructive behavior, and some attempt or commit suicide (Finkelhor, & Browne, 1985). In treating depression, it may take four weeks or more for anti-depressant drugs to effectively control a child's behavior (Reist, et al., 1989).

Fourthly, it is difficult to deal with establishing a relationship of trust with sexually abused children. Feelings of betrayal are the result of abusers manipulating children's trust and vulnerability; disregarding the well-being of children; leading them to believe that all adults are the same, and that therefore none can be trusted to provide care and protection. Betrayal is also felt because of lack of support and protection from parents (Finkelhor & Browne, 1985). Sexually abused child patients not only mistrust everyone, but they also feel strange when faced with new surroundings, new people, new sights, and new rules in psychiatric settings.

Lastly, there is the difficulty of psychiatric nurses dealing with abusive parents who are either against, or uncooperative, in caring for sexually abused children, and with non-abusive parents who are in denial, or suffering from loss and grief from their inability to protect their children. Some staff felt discomfort with, and were angry to, the abusive parents, making it difficult to establish relationships them (Kohan, Pothier, & Norbeck, 1987; Fazzone, 1991). Furthermore, psychiatric nurses approached parents for initiation of a plan to ensure future safety when sexually abused child patients returned home (Lipovsky, et al., 1998). These nurses have to deal with the transferal of their own emotions upon the parents.

Looking at all of these difficulties, there is no research/theory that describes how to provide efficient nursing practice to solve the problems of school-age sexually abused children. Only five studies appear to have been carried out in psychiatric hospitals relating to the experiences of psychiatric nurses, focusing on adult survivors of childhood sexual abuse. Irwin (1997), a clinical nurse specialist in a psychiatric setting, reported on the nursing care of psychiatric nurses who cared for women with a history of childhood sexual abuse. The report showed that staff nurses observed behavior while attending to their other daily activities and evaluated clients readiness, or that staff nurses slowly began to build relationships with the patients until the patient trusted the nurse, whereupon nurses began helping them; and lastly, that staff nurses and patients planned for the eventual discharge, together. On the other hand, the studies were related to the healing process of adult survivors who received treatment and care in hospitals. In the results, the caring of psychiatric nurses may be that of helping to facilitate patients, encouraging them to rid themselves of shame and guilt, getting patients prepared for discharge, and creating the relationship of trust (Draucker, 1992; Symes, 2000;

Lawson, 2003; Schachter, et al., 2004). The type of therapy was indicated by the patient such as their stage of healing, state of readiness and pace of recovery (Long, & Smyth, 1998).

Only one study mentioned caring from the caregiver's perspective, of sexually abused survivors. Jennings (1994) provided a case study of her daughter's sexual abuse as a child and subsequent experiences as a chronically mentally ill client in the mental health system. Information from 17 years worth of mental health records and anecdotal accounts are used to illustrate the effects of the abuse, attempts to reach out for help, and the system's failure to respond through lack of support, self-awareness, and psychiatric nurses basing their nursing practice only on bio-medical model. The patients were often re-traumatized and had their personal rights violated during the nursing practices. This highlights that there may be other specific forms of knowledge or theory that can be applied in the nursing practice for sexually abused patients.

In Thailand, child sexual abuse has recently gained the attention of researchers. There is no research about nursing practice for school-aged sexually abused children. Most research is of a quantitative nature relating to incidences and prevalence of child sexual abuse, risk factors or causes related to child sexual abuse, socio-psychological status of sexually abused children and the promoting of primary school students' self-protection from sexual abuse. The research also showed the workings of multidisciplinary teams to help sexually abused children; nurses and physician's attitude to child sexual abuse; counseling and psychotherapy methods to reduce anxiety of the sexually abused child; strategies for helping adolescence who have been raped; the psychological effects of victims raped and the need for help from the legal system or medical services (Chinlumprasert, 2003).

Lacking a body of knowledge of nursing practice may lead to dangers or disadvantages to sexually abused child patients. Psychiatric nurses may cause potential harm if the signs and symptoms of sexual abuse in a child are not recognized or if the problem is either under or over-diagnosed (Savell, 2005). In addition, psychiatric nurses may show inappropriate behavior to sexually abused child patients such as avoiding their patients or withdrawing care when these child patients have fits of furious anger (McCarty, 1988). Some staff nurses show disgust and give out punitive measures to control sexually abused child patients (Kohan, Pothier & Norbeck, 1987), they use their power in struggles against them by restricting activities (Gallop, et al., 1999; O'Brien & Cole, 2004), or over-medicating patients (Jennings, 1994; O'Brien & Cole, 2004). Including, psychiatric nurses may also be in danger themselves. Health care professionals appear to be at particular risk as just over 5% of those surveyed had been assaulted at work during the previous year (Budd, 1999). Findings indicated that psychiatric nurses faced many challenges in their daily care work, with insufficient resources, fear, and lack of ongoing education; they have consequently experienced "work stress," "compassion fatigue," and "moral distress" which could lead them quitting their jobs, thus exacerbating the acute shortage of nurses in the system (Farrell & Turpin, 2003; Irwin, 1997; Long & Smyth, 1998).

Although psychiatric nurses have a nursing process at work or know that what psychotherapeutic managements there are, and are using knowledge from studying, they are still faced with difficulty in providing nursing practice. Thus, there is a need to explore whether the provision of nursing practice for sexually abused child patients is similar to that of adult survivors, or not. The researcher wanted to discover what other problems happened in psychiatric wards and how were they dealt with; or indeed the reasons and beliefs behind

the nursing care; what are the roles of psychiatric nurses; how do psychiatric nurses manage their roles during the nursing practice of sexually abused child patients. Furthermore, how each psychiatric nurse dealt with their own psychological distress whilst working with sexually abused child patients in psychiatric wards; how psychiatric nurses contacted nursing teams or cooperated with multidisciplinary teams to help sexually abused child patients.

A naturalistic use of the inquiry paradigm to reasonably explore a process of nursing practice for school age sexually abused children is suitable to acquire additional knowledge for psychiatric nursing. Psychiatric nurses who are experts are viewed as insiders who stayed with patients 24 hours a day, knew for certain and understood the problems of the school-aged sexually abused child. In particular, expert psychiatric nurses are regarded as highly knowledgeable and subjective in the details of nursing practice, the social process between nurses and patients, and everyday occurrences in psychiatric wards.

Generally, the expert psychiatric nurses will share experiences or knowledge that operates from a deep understanding of the overall situation with other staff nurses. Individual psychiatric nurses have reacted to situations and created interpretations through personal experience on the ward. However, no studies explain the continuum of psychiatric nurses' nursing practice for school-aged sexually abused children during treatment in psychiatric wards. To fill these gaps, there is a need to understand the social processes of nursing practice for school-aged sexually abused children admitted to psychiatric wards. The grounded theory is a selected approach to explain in this study.

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Purpose of the study

The purpose of this study was to explore how psychiatric nurses provided the nursing practice for school age sexually abused children who were admitted to psychiatric wards.

Research question

How do psychiatric nurses provide nursing practice for school age sexually abused children admitted to psychiatric wards in Thailand?

Scope of the study

Participants will include psychiatric nurses who have cared for sexually abused children who have been sexually abused by intra-familial members or extra-familial members and admitted to a psychiatric ward. School-age sexually abused child patients who have been diagnosed by psychiatrists, using a diagnostic and statistical manual of mental disorders (DSM-V 5th Edition), with psycho-pathological disorders which are short-term consequences or possible risk behavior such as psychotic disorders, depression, post traumatic stress syndrome (PTSS) or post traumatic stress disorders (PTSD), aggressive behavior, sexual play-acting, self-mutilation or attempted suicides. The psychiatric wards provide in-patient services over the tertiary hospitals for treatment, rehabilitation, and prevention of re-victimization. The team is divided into two. The first team, a nursing team, is composed of a head-nurse, a deputy head-nurse, staff nurses, and patient-assistants. The second team, the multidisciplinary team, consists of psychiatrists, psychiatric nurses, social workers, psychologists, occupational therapists, staff of non-governmental organizations (NGO), police officers, the courts, physical trainers, and a specialist educator.

Definitions of term

For the purpose of this study, the following definitions were utilized:

The nursing practice referred to an interaction process of psychiatric nurses as a provider of nursing care both bio-psycho-social dimensions to school age sexually abused children which occurs professionally in psychiatric wards. The interaction process also included relationships between nurses and nursing teams or nurses and multidisciplinary teams; and relationships between nurses and school age sexually abused children' caregivers. These interactions are everyday experiences that have happened in the period of time from admission to discharge.

Sexually abused children refers to child victims of sexual abuse are aged 6-12 year olds expressing acute signs or symptoms of mental disorders and problematic behaviors and are diagnosed by psychiatrists using Diagnostic and Statistical Manual of Mental Disorders, the Fifth Edition (DSM-V) in classifications such as anxiety disorder, dissociative disorder, depression, post traumatic stress disorders (PTSD), impulse-control disorder, eating disorder, sleep disorder, personality disorder, sexual acting-out, self-mutilation and attempted suicide (American Psychiatric Association, 2000). This mental illness is a consequence of sexual abuse that occurs with child victims inability in copings after be sexual abused in younger childhood. They are admitted to psychiatric wards for treatment and rehabilitation.

Significance of the study

Findings from this study may help correct deficiencies in current nursing practices for school age sexually abused children who have been admitted into psychiatric wards.

Findings may be used to help improve the nursing care that school age sexually abused children receive by providing an increased understanding and awareness of personal problems and a proper response to their needs. This may assist school age sexually abused children to fully recover from their mental illness and give them the best chance for optimal health. Treatment at an early stage will lead to recovery and the well-being and healthy lifestyle of the children. Providing good nursing care can reduce the cost of treatment in the short term and long term and save staff time and energy by shortening the term of admittance in hospitals. Results from this study may also lead to more administrator understanding of psychiatric nurses, and nurses who work with school age sexually abused children who are sometimes in danger and who suffer from stress, burnout and distress. Furthermore, this finding may be developed so that there are more effective interventions which will better facilitate nursing care for all school age sexually abused children.

CHAPTER II

REVIEW OF LITERATURE

This literature review is divided into three sections. The first part looks at the child sexual abuse, the second part considers psychiatric nursing services and psychiatric nurses who care for sexually abused children in psychiatric settings, the third part looks at the nursing practice of psychiatric nurses for sexually abused children in psychiatric settings, and the fourth part looks at the overview of grounded theory.

Child sexual abuse

The present situation regarding child sexual abuse

According to the World Health Organization, the global rate of child sexual abuse has continued to rise exponentially (World Health Organization [WHO], 2002). Although, a U.S. survey of youth and caretakers suggested that 320,400 children were sexually abused or assaulted in 1999, 88,656 children were still sexually abused in 2002 quotes (Finkelhor, Douglas, and Sedlak, 2005). The National Society for the Prevention of Cruelty to Children in the UK estimated that over 6600 children under the age of 16 years are sexually abused each year (National Society for the Prevention of Cruelty to Children [NSPCC], 1990). In Canada, prevalence rates for child sexual abuse have doubled, ranging from 11.1% to 22% for girls, and 3.9% to 10% for boys (Schachter, et al., 2004).

Thai children bear the full brunt of broken families, their parents' poverty and weakened family relations. Family problems appear to have become more intense and complex during 2002. According to the Slum Infant Foundation, there are 1,866 children in the newly born-5years old age group, under its care. There were 25 children afflicted with family violence and 182 children coming from broken families. The Office to 'Monitor and Combat Trafficking in Persons' of U.S. Department of State reported that Thailand has been ranked on the "tier 2 watch list" as a source, place of transit, and destination country, for persons trafficked for sexual exploitation and forced labor (Thai Asia Foundation, 2004). Some 75 percent of Thai men in one survey actually admitted to using child prostitutes (Jehovah, 1993).

In Thailand, child sexual abuse has featured prominently in the Thai media and it is ranked as the third most serious problem for children (Thangkananurak, 2004). For example, from 1998 to 1999, sexually abused children who were referred to Child Protection and Child Right Foundation had increased from 53.66% to 74.07% (Child Protection and Child Right Foundation [CPCR], 2000). Child Protection and Child Right Foundation reported that sexually abused Thai children had risen by approximately 100-110 new cases every year from 2000 to 2003 (CPCR, 2003). According to the Child Rights Protection Center, the trend of sexually abused children has continued on an upward path from 3 cases in 1983, to 101 cases in 2002. In 2003, Chiang Mai Co-Ordination Centre for the Protection of Child Rights Statistics found that the total number of sexually abused child victims amounted to 211 cases (199 girls and 12 boys), (Chiang Mai Co-Ordination Centre for the Protection of Child Rights, 2003).

Childhood sexual abuse, as a prominent phenomenon of Thailand, is found that intra-familial was more than extra-familial. Boonmongkul, et al. (2003), who studied situations of child sexual abuse in five newspapers, from 1997 to 1999, found that most of the abusers were members of the child's family. And Wateviboon (1996) reported that most abusers were the biological father, stepfather, relatives, or caretaker. Importantly, both Thai abusers and victims of sexual abuse were younger than in studies conducted in the past. And most of the victims were still female children.

In Thailand, there are multi-risk factors of child sexual abuse. For example, the sexually abused child victims are very young, and communication or understanding is limited. They are not able to say that these events occurred. Most Thai children have timid characteristics and cope with their problems by keeping things secret, repressing the urge to acknowledge or report parents with deviant behavior (Nitirat, 1997). Included within this group are those children who are ignored, lack emotional attachment and whose parents have minimal parenting knowledge and parenting skills, or who live in disorganized or dysfunctional families. Examples of these include low income families, unemployed families, single-parent families, and parents suffering from alcoholism, drug addiction or marital conflicts (Poorsakul, et al., 1999; Wateviboon, 1996; Wongsansri, et al, 2000). Additionally, there is the power inequality between men and women, our patriarchal society, social condemnation (Chinlumprasert, 2005), cultural and traditional barriers requiring respect to be given to elders, an inability to criticize inappropriate parenting, and ineffective law enforcement (Gilligan & Akhtar, 2006; Louwsakulporn, 1999; Thangkananuruk, 1992; Thitimontri, 1994). All of which combined, create the high risks that are associated with continuing child sexual abuse.

Definitions of child sexual abuse

Child sexual abuse (CSA) is defined variously; some definitions emphasize the activities of the abusers to their child victims; others emphasize the characteristics of the abusers. Terms that have been used interchangeably with child sexual abuse are sexual assault, sexual maltreatment, child rape, and incest (Russell, 1988). Holz (1994, p. 13) has broadly defined child sexual abuse as, "any sexual activity between a child less than the age of 18years and a person of power, usually two or more years older, and who has authority over the child." Simkin (1994, p. 20) defined child sexual abuse as having any kind of imposed sexual activity under the age of 18 years old. It is usually performed on a child, male or female, by an older person, male or female, having some power or authority on the child. Sexually abused children are any persons under the age of 18 years old who are involved with any inappropriate sexual behavior instigated by an adult, male or female, family member or otherwise, or a substantially older child and a child under 18 years, whose purpose is to sexually arouse the children whereby the child's health or welfare is harmed or threatened (Wallace, 1995).

Sexual abuse, according to the definition used by the World Health Organization, is attempted or actual fondling of a child's genitals, intercourse, incest, rape, sodomy, or exhibitionism, and occurs when a child is used for a sexual purpose by an adult or adolescent. It involves exposing a child to any sexual activity or behavior. Sexual abuse most often involves fondling, and may include inviting a child to touch or be touched sexually.

Sexual exploitation occurs when any adult uses a child for personal benefit, such as using a child for labor, cheating them, child's wages, commercial sexual exploitation through juvenile prostitution, or the production of pornographic materials (WHO, 1999: p. 8).

Finkelhor and Korbin (1998, p. 3) defined sexual abuse as “any sexual contact between an adult and a sexually immature child for the purposes of the adult’s sexual gratification; or any sexual contact with a child made by the use of force, threat, or deceit, to secure the child’s participation; or sexual contact to which a child is incapable of consenting by virtue of age or power differentials and the nature of the relationship with the adult.”

The work of health professionals with sexually abused child patients falls under the Thai Act of protection for children in 2003 (CPCR, 2003). Most professionals depend on a definition of sexually abused children under the Thai act that, “sexually abused children are any persons under 18 years old who have experienced any sexual behavior from older people, both male and female, regardless of whether the child was willing or not, that is dangerous to the children’s physical and psychological state and is against good morality in society.” These sexual activities are, for example, a) sexual intercourse; b) oral sex or anal sex; c) rape; d) exhibitionism; e) fondling; f) touching; g) pornography; h) exploitation; and i) prostitution. The offenders or abusers were either members of the family or people outside of the family and they were committed for the sexual gratification of the abusers, and the term applies whether the children participated by consent or not (Department of Mental Health in Thailand [DMHT], 2003).

Types of child sexual abuse

Forms of sexual abuse are classified in to two types: extra-familial and intra-familial.

Extra-familial sexual abuse refers to exploitative sexual contact with perpetrators who may be known to the child, such as neighbors, babysitters, teachers, acquaintances or those unknown to a child such as strangers.

Intra-familial sexual abuse (incest) is any sexual contact occurring between the perpetrators such as a parent, older sibling, extended family member, or relatives and the victim, in which the perpetrator violated a position of trust or authority, with the first occurrence of sexual contact taking place when the victim was less than 18 years old (Ellenson, 1986; Wallace, 1995). Besides, Urbancic (1993) defined incest perpetrators broadly as blood relatives, and surrogate relative-stepfathers, mother's boyfriends, and close family friends who may have assumed caretaker roles instead of the father or mother, and whom were trusted.

Psychological reactions of sexually abused child patients

The emotional patterns of sexually abused children are described by many authors. According to Summit (1983) the Child Sexual Abuse Accommodation Syndrome, from synthesizing research and testing over a period of four years in practice, composed five stages:

Two stages define basic childhood vulnerability:

a) secrecy: victims may be confused, scared, ambivalent, feel guilty with something that is bad and therefore requires silence and secrecy,

b) helplessness: adults' power and authority to threaten victims, and victims' dependence on the adult abuser for food, shelter, and clothing.

The other three stages are contingent upon sexual assault:

c) entrapment and accommodation: from the inevitability of repeated abusive episodes over a long period of time, victims may "accommodate" the abuse by denying feelings, withdrawing, denying what is happening, dissociating from the abuse,

d) delayed and unconvincing disclosure: victims may be making decisions in disclosing their trust in someone, or keeping a secret out of fear and lack of confidence that someone will believe them, and lastly

e) recantation: victims may recant or change their accounts because they are fearful for the loss of peace in their life, worried about personal security, their familiar environment, friends or family.

Similarly, Finkelhor, and Browne (1985) carried out extensive research in the area of child sexual abuse, and findings showed several common themes from the dynamics of abuse, psychological impact and behavioral problems included in the "Traumatic Dynamics Model of Child Sexual Abuse." This model is grouped into four categories:

a) Traumatic sexualization: the result of abusers rewards to children for inappropriate sexual behavior, to their developmental levels, exchanging attention and affection for sex, and transmitting misconceptions about love and sex. As a result of these dynamics and confused sexual identities, victims may also show signs of precociousness or avoidance of sexual behavior.

b) Stigmatization: the results of abusers blaming children, pressuring them into secrecy, and projecting guilt and shame into their minds; these dynamics can affect internalization of negative feelings, low self-esteem, pain through the use of drugs, self-destructive behavior or suicide.

c) Betrayal: the results of abusers damaging children's trust, leading children to believe that all adults are the same, including their parents lack of support and protection; the results manifesting as grief, isolation, and discomfort with other relationships.

d) Powerlessness: the result of abusers invasion of children's bodies and private space by the use of force or trickery. This is a deep-rooted psychological wound and can lead to somatic complaints, running away, overt aggressive behavior, bullying and sometimes becoming an abuser themselves.

Other than understanding about the behavior and emotional patterns of sexually abused children, psychiatric nurses can also learn about the disclosure process of incest child victims for 'good patient approach'. Tower (1993) established five stages or phases of incest progression between children and abusers as family members:

a) The engagement phase: a perpetrator has an opportunity to discuss sex with a child without the supervision of any other adult until that child is entrapped or threatened by force.

b) The sexual interaction phase: the perpetrator has been involved in actual sexual contact: the child is nude, fondled, forced to perform oral sex, or experiences actual penetration.

c) The secrecy phase: the perpetrator convinces the child to remain silent about the acts by using more threats, bribes, or games for an extended period of incest time.

d) The disclosure phase: a child's disclosure may occur accidentally during a visit to a physician or when the perpetrator is observed in the act of sex. Intentional disclosure remains hidden until maturity, due to the authority or power of the perpetrator.

e) The suppression phase: the caretaker's attempts to force the victim to recant accusations of abuse after the child's disclosure or discovery of abuse.

Psychiatric nurses should be aware of the physical and psychological responses to a child who has been raped. Burgess and Holmstrom (1973) defined Rape Trauma Syndrome (RTS) as an acute stress reaction composed of somatic and psychological responses, behavior common to a life-threatening situation such as rape. Rape Trauma Syndrome is divided into two stages:

a) The acute reaction phase, which usually evokes severe feelings of shock or disbelief and displays of somatic symptoms.

b) The re-organization phase, occurring about 2-3 weeks after the rape and manifesting as displays of motor activity, nightmares and trauma-phobia.

Psychiatric services and psychiatric nurses

In Thailand, health services, both general hospitals and mental hospitals, are classified into five levels according to the level of care they provide. For example, Self-Care level in the family, Primary Health Care level in the village, Primary Care level in a Tambon, Secondary Care level within a district, and provincial Tertiary Care level (Department of Mental Health in Thailand [DMHT], 2003). The majority of mental hospitals are under the authority of DMHT in each region, other psychiatric services are in university hospitals and hospitals depending on the government ministry. The mental health and psychiatric services carry out mental health promotion, prevention of mental health problems, therapeutic care and rehabilitation of psychiatric patients.

Sexually abused child patients with serious psychological disorders and/or problematic behavior manifestations are referred from OSCC (One Stop Crisis Center) of

hospitals in primary or secondary care and referred to tertiary care level where there are serviced inpatient psychiatric wards (DMHT, 2003). These wards are in regional hospitals, general hospitals, university hospitals and psychiatric hospitals in Thailand, and offer specialized treatment and rehabilitation care in bio-psycho-social dimensions and the promotion & prevention of re-abuse.

Although the proportion of the population to that of Thai psychiatric nurses each year has decreased, the numbers of psychiatric nurses are not enough to deal with the increase in psychiatric patients. This is worrying, particularly when child sexual abuse is not being controlled and the treatment of child victims is necessary to prevent to chronic illnesses. The International Council of Nurses announced there were 121 members against violence and dedicated to helping child victims (International Council of Nurses [ICN], 2001). The Thai government proclaimed that the problem of child sexual abuse was being addressed quickly. In Thailand's 2004 National Agenda, it was stated that child victims were being responded to, and their needs and necessary support for recovery and reducing stigma was helping them to return to their communities (Thai Asia Foundation, 2004). For responding to this policy regarding sexual abuse towards children in Thailand, psychiatric nurses should be aware of their roles and participate with utmost responsibility in caring for sexually abused child patients.

Although numbers of psychiatric nurses have increased each year, the ratio of the population to 1 psychiatric nurse is high, around 35,000: 1 (DMHT, 2007). In 2007, the child population below the age of 15 years was 14,604,000 children. This proportion reveals the imbalance in effective health care service and highlights the shortage of psychiatric

nurses, which should be given urgent attention. If this imbalance is not addressed, sexually abused child patients may not gain sufficient or satisfactory nursing care.

According to Benner (1984) each nurse has five progressive stages of experience: a novice stage, an advanced beginner stage, a stage of competency, a stage of proficiency, and an expert stage. Benner defines expert nurses as the ones who in the course of their work have collected enormous experience in working with patients in the same or similar situations over periods of more than five years. In the execution of their nursing practice, nurses are not limited by any rules, guidelines or maxims, but instead have an intuitive grasp of each situation and accurately zero-in on the problem without wasting time in the consideration of a wide range of unfruitful, alternative diagnoses and solutions. The expert nurse operates from a deep understanding of the overall situation. The nurse's performance is flexible and highly proficient.

Nursing practice for sexually abused child patients in psychiatric wards

Definitions of nursing practice

There are many words such as *nursing practice*, *nursing*, *nursing care*, *care*, and *caring*, used in the nursing profession. *Nursing practice* is the actual provision of nursing care (Medical, 2002). Leininger (1991, p.35) stated that *care/caring* is *nursing*, and *nursing* is *caring*. Sometimes, *caring* is viewed as the core of nursing. Mackintosh (2000) reviewed literature and found that *nursing* and *care* are both interchangeable and symbiotic concepts. The meaning of what nursing really is in each country is different, and these meanings are often changed by medical science as the role of the nurse has changed. Leininger (1981b) discovered that since Florence Nightingale’s days, the nursing profession has consistently

used the term *care* in their literature. Sometimes, the term *care* is often linked as a suffix to *nursing* (Clarke, & Wheeler, 1992).

When examining *nursing, nursing care, care, and caring,* it becomes necessary to identify their definitions before studying. In generally, *nursing* is viewed as the tasks performed or the care provided by a nurse (Medical, 2002), or refers to the work of caring for the sick, the injured or infirm (Worldnet, 2001). So, caring is viewed as series of helping activities/actions. In nursing science, Leininger (1981) postulates that caring and culture are inextricably linked, and means that human caring is actions and activities directed towards assisting, supporting, or enabling another individual or group with evident or anticipated needs, to ameliorate or improve a human condition or way of life, or to face death. McFarlane (1976) defines caring as series of helping activities. Similarly, Orem (1980) defined caring as a therapeutic intervention, and Roach (1984) refers to caring as the human mode of being. Watson (1985) takes caring to be a moral imperative, a value and an attitude, that becomes a will, an intention, or a commitment, and which manifests itself in concrete acts. Zarzycka and lusarska (2007) described the essence of nursing care as providing care, communicating, supporting, helping, assisting, accompanying and managing. Sappington (2004) identified that caring is touching, listening, bringing order and beauty, respect, safety, nurturance, compassion and commitment. In addition, caring is the process of helping. Caring is the process of helping another to grow and that a knowledge of oneself and others, must exist (Mayerhoff, 1971). Peplau (1952) and Parse (1987) mention caring as an interpersonal relationship. The caring process pertains to relationship(s) whether it is one to one, one to several, or several to several (Bevis, 1989).

In this study, the term *"nursing practice," "nursing," "nursing care," "care," or "caring"* are used in the same context, as 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.

Psychiatric nursing

Psychiatric nurses are concerned with evaluating the individual differences of each patient and recognizing them as a whole person who has different physical, psychological, social, and spiritual needs (Smuts, 1926). Taylor (1994) stated the general principle of psychiatric nursing for psychiatric nurses, was that they respect each sexually abused child patient as a whole, who is unique and has a strong belief in their capabilities. Psychiatric nurses identify sexually abused child patients' needs and promote the strengths of each of them.

Due to the various and acute signs and symptoms of sexually abused child patients, psychiatric nurses face many challenges whilst working with their patients. One of the difficulties faced with sexually abused child patients in the hospital, was the lack of a theoretical base in working practices for nurses (Berry, et al., 1993). With this lack of theory in psychiatric nursing, psychiatric nurses have to borrow from many other theories, bio-medical science models, the conceptual framework of Freudian thinking, interpersonal theory, behavioral theory, and also humanistic theory (Boonthong and Sittimongkhon, 2001). Additionally, these psychiatric nurses may integrate other disciplines such as neuropsychiatry, pharmacology, sexology, and developmental psychology, with the principle of psychiatric nursing, to cover the problems of sexually abused child patients. Psychiatric

nurses use many varied techniques and therapeutic methods in the nursing process, and other psychotherapeutic management tools such as nurse-patient relationship, therapeutic communication, counseling group therapies, milieu therapy, and psychopharmacology, are employed in providing holistic care and a client-centered approach.

Psychiatric nurse-patient relationship

Although, Hildegard Peplau published the Interpersonal Relations Model in 1952, the model still remains relevant for psychiatric and mental health nursing today. Peplau described nursing as a therapeutic interpersonal process to understand one's own behavior, to help others identify difficulties, and to apply principles of human relations to the problems that arise at all levels of experience. The nurse-patient relationship may be dynamic and flexible since the professional contact with the patient changes over time. Peplau's Interpersonal Relations Model comprised four phases of relationship: orientation phase, identification phase, exploitation phase, and resolution phase.

During the orientation phase of relationship, the nurse and patient first meet and come to know each other as people and respective expectations and roles are understood. The patient at this time needs to recognize and understand their difficulty and need for help, be assisted to plan how to use the professional services offered, and harness the energy derived from their needs (Peplau, 1952, p 19). It may be expected that the patient will test limits in order to establish the integrity of the nurse. The tasks of this phase are to build trust, rapport, establish a therapeutic environment, assess the patient's strengths and weaknesses and establish a mode of communication acceptable to both patient and nurse

(Shives, 1994, p 91). When the patient can begin to identify problems, the relationship progresses to the working phase.

During the working phase or identification phase of relationship, trust begins to develop and the patient begins to respond selectively to persons who seem to offer help. The patient begins to identify with the nurse and identify problems which can be worked on. The meaning behind the feelings and behavior of the nurse and patient are explored. Peplau (1952, p31) states that when a nurse permits patients to express what they feel, and they continue to receive all of the nursing that is needed, then patients can undergo illness as an experience that reorients feelings and strengthens positive forces in their personality. The tasks of this phase are to develop clarity regarding the patient's preconceptions and expectations of nurses and nursing, to develop acceptance of each other, to explore feelings, identify problems and respond to people who can offer help. In particular the nurse assists in the expression of needs and feelings, assists during stress, shows acceptance and provides information. The nurse and patient may make plans for the future, but the implementation of the plan signifies the beginning of the exploitation phase of the working relationship.

During the exploitation phase of relationship, “the patient realistically exploits all of the services available to them on the basis of self interest and need” (Peplau, 1952: 37). The nurse assists the patient in their efforts to strike a balance between the needs for dependence and independence. The plan of action is implemented and evaluated. “The patient may display a change in manner of communicating, as new skills in interpersonal relationships and problem solving are developed” (Forchuk & Brown, 1989: 32). The nurse continues to assess and assists in meeting new needs as they emerge.

During the resolution phase of relationship, **"**there is the gradual freeing from identification with persons who are helping, and the generation and strengthening of the ability to stand alone, eventually leading to the mutual termination of the relationship" (Peplau, 1952: 39). The patient abandons old needs and aspires to new goals. She or he continues to apply new problem solving skills and maintains changes in styles of communication and interaction. Resolution includes planning for alternative sources of support, problem prevention, and the patient's integration of the illness experience.

The limitations of the use of this model are almost exclusively related to the processes of disease, in which the patient presents limitations for communication, such as in cases of comatose states.

The roles which nurses assume during this relationship influence the results of the patients and the responsibility of the nurse, to professionally use his/her interpersonal abilities to allow the relationship to mature. Each role is designed to aid the patient in achieving specific therapeutic objectives and include: being a stranger, a resource person, a teacher, a technique, a substitute, or an advisor.

As mentioned, the nurse may assume different roles within the relationship. The first role assumed by both the nurse and patient is that of strangers. This role requires respect and positive interest on the part of the nurse. The nurse may function then as a resource person, providing specific answers to questions usually formulated with relation to a larger problem. As a teacher, the nurse assists the patient as a learner to grow and learn from experiences. "As a leader, the nurse may assist the patient as follower in a democratically implemented nursing process" (Stuart and Sundeen, 1987: 46). The nurse may be cast into surrogate roles by patients based on their significant past relationships.

Considerable importance is also assigned to the role of the nurse as counselor, which is viewed as helping the patient integrate the facts and feelings associated with an episode of illness, into his or her total life experience. “Nurses may assume many other roles, but in the context of the interpersonal relationship, all aim to assist the patient to meet the goals of therapy, need satisfaction and growth” (Stuart and Sundeen, 1987: 45).

Long and Smyth (1998) stated that nurse-patient relationships may be the most important thing to gaining trust. Psychiatric nurses should develop a working relationship with the patient in everyday care. Stability and consistency, coupled with knowledge that the nurse will observe boundaries, helps to generate trust. Good interpersonal relationships are weaved from unconditional acceptance, positive regard, patient growth and the power of rapport (Fazzone, 1991). Irwin (1997) suggests that patients should be in conditions of responsibility within the community, before developing relationships with others.

A child’s character related to nursing practice for sexually abused child patients

Genders and ages of sexually abused child patients

Male victims need to be looked at separately from females, as there are some differences in the nature of the abuse. Boys are usually victimized by someone of their own sex, whereas girls are usually abused by a male. Boys are also more likely than females to be abused by a stranger. The male victim of sexual abuse is more likely to turn his rage outward in the form of aggressive and anti-social behavior. He is even more intolerant of his helplessness than that of the female victim, and more likely to rationalize that he is exploiting the relationship for his own benefit (Beitchman, 1991).

Mental health professionals, who care for sexually abused children, rarely make studies about sexual abuse in male patients. Staff did not feel sufficient need to inquire about sexual abuse in male patients after their training, and they were generally using ineffective and unsystematic methods of inquiry when they did interview male patients (Lab, Feigenbaumb, and Silvac, 2000). The younger victim is less aware of the meaning of the abuse, and may suffer less than the older victim, because the older child is more confused, ashamed, angry, and depressed over the experience (Veltcamp and Miller, 1994)

Sexual abuse conditions of sexually abused child patients

The greater the duration and frequency of the abuse, the more severe will be the initial effect on the child (Gillespie, 1993). The use of force against CSA victims, creates the most traumatic cases (Finkelhor, 1979). A series of reports have been consistent in finding force, or the threat of force, as a strong predictor of a negative outcome. Research findings indicate that sexual abuse involving penetration, such as intercourse or oral-genital contact, results in greater trauma or harm (Veltcamp and Miller, 1994).

Relationships between abuser and sexually abused child patients

An offender, as a member of the same family, such as father-daughter, stepfather-daughter, brother-sister, is associated with greater distress to the victims than other offenders (Cry, Wright, McDuff et al., 2002; Rudd and Herzberger, 1999; Terr, 1991). The reactions of families, when their children are sexually abused by members within the family are different compared to abuse that originates outside of the family. In intra-familial sexual abuse, abusive parents do not cooperate and may act violently towards psychiatric nurses. In

extra-familial sexual abuse, parents will blame themselves and blame each other. Some of them have murderous anger and exert aggressive control over their children. These parents need information on how to care for their children, and need to learn to cooperate with psychiatric nurses. In their dealings with abusive parents and other offenders, psychiatric nurses will sometimes exhibit anger towards them and maybe other members in family. The evidence suggests that, parental attitudes towards the child and toward the child's role in the event, are important determinants of the long-term impact of child sexual abuse (Beitchman, 1992).

Cultural barriers to the disclosure of sexually abused child patients

Before providing nursing care to sexually abused child patients, psychiatric nurses should understand the influence of Thai culture on sexually abused child patients. In Thai society, sex is a taboo subject that is not openly discussed in public or with others (Nimkannon, 2006). Thus, sexually abused child patients may be blamed by a society as "bad girls" who like to show alluring manners to men. In Thai socialization, sexually abused child patients are in conflict with socialized teachings such as remaining a virgin, (*rak nuan sa-nguan tua*), and mistaken references by abusers such as showing respect to elders and following their advice (*pu-yai, choui-phang*). There are also the Buddhist teachings which require one to be grateful or thankful, or to be honest to one's father, mother, and relatives (*kha tun yu-khata va tee*) and bring great merit to a child as a consequence (*dai-boon*) (Suvannathat, Bhanthumnavin, Bhuapirom et al., 1985; Thangkananuruk, 1992). Moreover, child rearing in Thai society, both past and present, lacks the promotion of child curiosity, includes many prohibitions, and uses fear tactics (Soonthornthada, 1998). Additionally,

these child victims are humble and don't want to make a nuisance of themselves (*kreng-jai*) when they have problems and often simply express the phrase "no problem" or "it does not matter" (*mai-pen-rai*) (Suvannathat, Bhanthumnavin, Bhuapirom et al., 1985). Stemming form these cultural influences, Asian women in the community are not brave enough to make the decision to divulge their sexual abuse stories, to express their feelings, thoughts, or needs, because of shame or embarrassment (Gilligan and Akhtar, 2005). The influence of Thai culture means that sexually abused child patients have more conflict, shame, and feelings of guilty, which cause negative psychological symptoms (Arata, 1998; DiPietro, Runyan, and Fredrickson, 1997; Kaufman, 1996; Sas, 1993; Sjoberg and Lindblad, 2002). These are barriers to building relationships between psychiatric nurses and sexually abused children. Psychiatric nurses should show concern and try to reduce these negative feelings whilst providing nursing care for sexually abused child patients.

Guilt and shame of disclosure of sexually abused child patients

Guilt is a cause of negative psychological symptoms. Although child victims of incest may have more guilt than children of extra-familial sexual abuse, because of feelings of responsibility towards their family, shame is a central issue for most women who were sexually abused in both categories. The shame grows and develops into a sense low self esteem or feelings of inferiority, which impacts upon their psychopathology (Kaufman, 1996). In addition, the shame of the secret they are keeping inside, exacerbates the feeling of self blame. Once this shame is internalized, it damages the interpersonal bridge with outsiders (Kaufman, 1992). Feiring, Taska, and Lewis (1996) reported that sexual abuse leads to shame through the mediation of cognitive attribution, and poor adjustment. A child's

shame for the abuse is related to an increased psychological distress, including more depressive and post traumatic stress symptoms, lower self esteem, and eroticism (Feiring, Taska, and Lewis, 1998).

Coping strategies /social supports to sexually abused child patients

In mental mechanisms, sexually abused children often use denial, repression, suppression, rationalization, and dissociation, and the feeling of being trapped in a "no-win" situation (Leitenberg, 1992; Keltner, Schwecke, and Bostrom, 2003: 561). McCarty, et al. (1999) reported that "Thai children showed more than twice as much covert coping as American children for stressors involving adult authority figures." Thai children attempted to adjust to stress by isolating themselves, leading to severe mental illness. In social support, support from family and friends was found to moderate the association between CSA experiences, sexually abused children who lacked this support become more traumatic (Veltcamp and Miller, 1994, Murthi and Espelage, 2005, Rosenthal, et al., 2003). According to Cohen and Mannarino (2000) who studied predictors of treatment outcome in sexually abused children, it was found that parental support of the child were strong predictors of treatment outcome. In addition, Tremblay, et al. (1999) found that coping strategies (β =.34) and social support (β =.36) were important mediators of the adaptation of children following child sexual abuse. Bal, et al. (2005) found that post-disclosure trauma symptomatology (β =.45) and a lack of initial crisis support (β = -.26) were two predictors of ongoing trauma symptoms 6 months later, and lead to trauma symptomatology in adolescence.

Nurse's characteristics in nursing care for sexually abused child patients

Sexual abuse history of nurses

Gallop, et al. (1995) compared the psychological well-being of nurses, who were sexually abused as children, with those who were not abused, and found that the abused nurses had significantly higher distress scores and lower self esteem scores.

Education, experience, and resources of nurses

De Wit & Davis (2004) explored nurses' present understanding and experiences of learning about, and caring for child victims of domestic abuse, by using semi-structured in-depth interviews. It was reported that three major categories: education, resources, and the nurses' role, emerged together with nurses' own ability. Boonyanurak, et al., (2002) investigated The Human Caring Meaning Questionnaire (HCMQ) in Thai nurses' behavior with regard to human caring, and found that educational background showed significant differences. Nurses who held a master's degree had the highest scores of HCMQ, followed by a bachelor's degree, with the lowest scores of HCMQ being achieved by those who had followed only a two-year program. Arthur, et al. (2004) examined caring practices and demographic features and found that The Care Attribute Questionnaires (CAQ) increased significantly with position, age and years of experience. Singhaphan (1999) reported that knowledge, position and experience in working were important. Day, et al. (2003) surveyed mental health professionals working with childhood sexual abuse, and found that staff with less experience were more likely to feel supported. Berry, et al. (1993) found that psychiatric nurses dealing with sexually abused children needed strong support and supervision systems to enable them to cope with the feelings of helplessness and sadness that can arise. Also

health visitors needed a supervisor to act as a confidante when dealing with sexual abuse (Scott, 1997).

Emotions and feelings of nurses

Boutcher and Gallop (1996) examined psychiatric nurses' attitudes towards sexual assault/rape and incest. The results indicated that their beliefs were not hostile towards rape victims and that they did not support or promote the crime of rape; the offender carried the most blame in the crime of incest, followed by blame of the society, situational blame, and victim blame. Health professionals perceived that younger child victims obtain some enjoyment, but that it was not the children who were responsible for the initial sexual contact (Eisenberg, et al., 1987).

Not only general nurses felt inadequately educated about violence, but psychiatric nurses also felt difficulty and discomfort in caring for sexually abused children, which negatively affected the nursing care (Breakey, Wolf, & Nicholas, 2001). Problems of staff fear, anger, frustration, anxiety, and shock or surprise, in response to a child's intense and extensive sexual play acting, meant that there was often a feeling of anger felt towards the abusive parent (Kohan, Pothier and Norbeck, 1987). McCarty (1988) found that it was difficult to remain consistent and reliable at times when a patient who had been sexually abused was angry. Nurses did not want to be with these patients. Working in areas of child sexual abuse can, and usually does, cause the nurse distress and possible feelings of inadequacy (Long & Smyth, 1998, Irwin, 1997). Psychiatric nurses faced with difficult working conditions and negative attitudes, may respond by giving poor nursing care. Staff nurses who showed inappropriate behavior towards sexually abused children, did so by

avoiding or withdrawing from an encounter or situation with such a patient, or reacted with disgust, introduced punitive measures, engaged in power struggles and/or restricted activities. Staff also tended to be overprotective with these sexually abused children (Kohan, Pothier & Norbeck, 1987). Ganzarain and Buchele (1986) discuss counter transference experiences such as rage, disbelief, revulsion, rescue fantasies, feelings of attraction and defensive fears, when dealing with incest survivors. Counter transference issues can commonly become a hindrance to therapy and these personal feelings and negative attitudes interfere with the development of a trusting relationship with the abusing parents (Fazzone, 1991). Berry, Drury, Prendeville, Ranganathan, and Sumner (1993) found that nurses, dealing with people who had been sexually abused as children, need strong support and supervision systems to enable them to cope with the feelings of helplessness and sadness that can arise.

Environmental and organization conditions

Therapeutic milieu is set an environmental unit for promoting recovery, safety and quality of life, which is the most effective treatment for these cases. Kohan, Pothier and Norbeck (1987) found that it was difficult to maintain a therapeutic and safe milieu because amongst these patients, there was an increased occurrence of self-mutilation, suicidal and overt sexual behavior. Davenport (2002) mentioned that the wards must act as a safe container for both patients and staff. The environment should conform to the recommendations of safety, first. All staff need to be trained in the management of violence and in ‘breakaway’ techniques. Nurses require training in many areas of violence and restraint. In particular, training in the safe restraint of a violent patient using a three-person team where the ward is locked. From the experience of a relative, Jennings (1994) reflected

that psychiatric nurses were not fully aware of the problems and had a tendency to deny what the patient was saying or indicating. Sometimes nurses would threaten the patient with strict restraint or seclusion, suspension of activities, or even overmedication.

Therapeutic intervention for sexually abused child patients

Horowitz, Putnum, Noll, and Trickett (1997) describes the naturalistic therapy experiences of 81 sexually abused girls, aged between 6 to 16 years old, and the relationship of these experiences to demographic factors, abuse experiences, psychopathology, and family functioning. Results indicated strong effects for abuse experiences and child psychopathology in the total amount of therapy received. Long and Smyth (1998) suggested that group therapy is of fundamental importance and helps the healing process of patients, particularly when patients reach the stage of maturation or readiness. The type of therapy may be indicated by the patient, their stage of healing, state of readiness and pace of recovery.

The effective approaches for sexually abused children are addressed in the treatment of sexually abused child patients and include (a) group therapy for improving self-esteem and reducing symptoms scores (Kridler, 2005), improving the adaptive function (Kruczek, 1999), improving self-esteem and life expectation and reducing depression (Khotchaphalayuk, 1998); (b) individual psychotherapy; (c) a milieu management for treatment traumatized youngsters (Lawson, 1998); (d) art therapy for the treatment of post-traumatic response in the healing process (Glaister, 2000); (e) cognitive behavior therapy to assist the healing process of child sexual abuse (Jansiri, et al., 1997); (f) Rogerian individual counseling for reducing anxiety in sexually abused girls (Rungruangsiripan, 1999); (g) combined group psycho-

therapy and cognitive-behavioral therapy for treatment of sexually abused adolescent and pre-school children (Jansiri, et al.,1997; Panyayong, 1994), or individual/group play therapy and cognitive behavior therapy (Nurcombe, et al., 2000; Putnam, 2003).

Literature related to nursing practice for sexually abused child patients

In recent times, there has been little research or study of nursing or caring for groups of sexually abused children, especially in psychiatric wards. However, two pieces of research found that caring, was the activity of nurses to patient, in dealing with negative symptoms or behavior of sexually abused child patients, such as aggression, inappropriate sexual behavior; or dealings with parents. Psychiatric nurses managed aggressive behavior and verbalization of violent thoughts that were being directed at themselves and others (Kohan, Pothier & Norbeck, 1987). Adequate staffing, proper training, a reward consequence system, structure and consistency in the milieu, and a lengthy patient stay, all helped to overcome the difficulties in the management of aggressive behavior (Fazzone, 1991). Moreover, it was observed that various kinds of sexual play acting behavior took many forms, such as seductive behavior with staff, sex play with others, sex content in conversation, and masturbation (Fazzone, 1991; Kohan, Pothier & Norbeck, 1987). Setting boundaries with children about touch, separating children who persisted in sexual play acting, providing constant surveillance of children, are all related to ways of dealing with sexually abused children (Fazzone, 1991). When dealing with Satanism and ritualistic cults, and the difficulty in changing children's' faiths or beliefs, the sharing of thoughts and feelings with patients, helps nursing staff particularly when working in small groups (Fazzone, 1991).

Although it is a female adult's perspective, nurses can understand sexually abused child patients well, and this may lead to the provision of good alternatives and modifications in psychiatric settings. Gallop, McCay, Guha, and Khan (1999) reported the experiences of 10 women with childhood sexual abuse who were hospitalized in psychiatric settings, restrained, and given forced medication. The experience of psychiatric hospitalization may represent an event that re-enacts the experience of trauma. The results suggest that, from the perspective of these women, the experience of restraint engendered traumatic emotional reactions such as fear, anxiety, and rage, and in no way was it viewed as therapeutic, even years later. Women felt powerless and unheard. The women wanted nurses who were empathic and responsive to their human needs as clients, but they felt nurses did not want to hear about the abuse or their internal distress.

Furthermore, some staff reported difficulty in establishing relationships with abusive parents due to discomfort and anger (Kohan, Pothier & Norbeck, 1987). Lipovsky et al. (1998) described a formal approach for the abuse clarification process in the treatment of intra-familial child abuse and found that there were four main components: clarification of the abusive behavior, offender assumption of responsibility for the abuse, offender expression of awareness of the impact of the abuse on the child victim and it's family, and initiation of a plan to ensure future safety. Redner and Herder (1992) reported that case management services can become the central means of effecting a necessary change in treatment. Nurses are in a case management role, in effecting appropriate treatment for persons with severe and persistent mental illness who have a history of childhood sexual trauma.

Nurse caring for sexually abused child victims was studied from patient perspectives. In a grounded-theory approach, Schachter et al (2004) explored how health professionals can practice in ways that are sensitive to adult women survivors of child sexual abuse by carrying out semi structured in-depth interviews of 27 women survivors of childhood sexual abuse in small and midsize cities in Ontario and Saskatchewan. A crucial theme was the need to feel safe when consulting any health professional. Participants described specific ways for clinicians to facilitate the feeling of safety. Disclosure of abuse history was another key theme; analysis revealed no one “right way” to inquire about it. The mental health professionals who worked with child sexual abuse were concerned with managing many strategies and a milieu environment. Draucker (1999) described the therapy experiences and self-perceived psychotherapeutic needs of 33 women who survived sexual assault. With regard to professional services, the participants were mostly concerned about the quality of the therapeutic relationship and advised clinicians to appreciate the strengths and resources women bring to their own recovery. The participants' specific psychotherapeutic needs were influenced by the pervasiveness of the violence in their lives.

Lawson’s (2003) interviews of boys treatment experiences that had been successful, found that the boys practiced by talking to people they trusted, listened to what people said, and used what people said to help them do what was right. Godbay and Hutchinson (1996) understood the healing process of incest survivors and found that there were seven phases: (1) reappearing, (2) revivifying, (3) resuscitating, (4) renovating, (5) regenerating, (6) reanimating, and (7) reincarnating.

There was a research project conducted that studied caring in a hospital setting, but it was caring for survivors of childhood sexual abuse in an emergency room of a medical

practice. Van Loon, Ba, and Karlik (2004) studied care for female survivors of child sexual abuse in emergency departments found that emergency nurses were: increasing staff awareness of the impact of child sexual abuse; creating a culture of privacy and confidentiality that promoted safe disclosure; advocating sensitive responses; promoting client driven interactions/interventions that allowed women to control potentially intrusive procedures; examining personal qualities of staff that assisted the client; and providing literature, websites and referral protocols, together with identifying professional support and self-help resources. Although this research may shed some light on the ways and procedures of nursing care in hospitals, it also highlights that it is not only the sole responsibility of psychiatric nurses. Jenny & Roesler (2003) suggested that medical care alone might not be able to solve their health problems, and in fact physicians should screen for a history of childhood trauma during health maintenance visits. They should also encourage open communication with patients about emotional as well as physical problems, be familiar with the resources available in the community, where adult survivors of sexual abuse can be referred for treatment, and never forget to consider childhood trauma as a complicating factor when dealing with cases of chronic, unexplainable pain or other inexplicable symptoms.

According to research that studied caring in a hospital setting, there was a small study based in the community such as, Burgess (2003) who suggested the four phases of treatment for community members who can assist in the recovery of victims of child sexual abuse. In essence, the four stages of treatment were to assess the acknowledgement of the child and family members; to establish safety and build a sense of competency and self-esteem in the child; to process the various therapies to reduce the trauma; and to go beyond the trauma to the current normative developmental tasks. Alike Khantikul (1997) studied the procedures of

developing the process of helping sexually abused children in 30 Thai professional workers including: social worker, psychiatrist, pediatrician, gynecologist, forensic medical officer, forensic psychiatrist, pediatric psychiatrist, and the police, by using The Delphi Technique. The findings showed that a multidisciplinary approach is necessary for the child victims' protection. There are five procedures as follows: the procedure of investigation, the court procedure, the diagnosis assessment in physical health, mental health and treatment intervention, the protection of the safety of the child, and the procedure of dealing with the offender. Although in this study guide of those working in the child sexual abuse field, the psychiatric nurse group is not included.

Overview of grounded theory

Grounded theory is a qualitative research approach. The major difference between this methodology and other approaches to qualitative research is its aim of developing theory (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Grounded theory is based on the systematically generating of theory from data that itself is systematically obtained from social research. Thus the grounded theory method offers a rigorous, orderly guide to theory development that at each stage is closely integrated with a methodology of social research. Generating theory and doing social research are two parts of the same process (Glaser, 1978).

Grounded theory has its roots in the social sciences, specially, in the symbolic interaction tradition of social psychology and sociology (Glaser & Strauss, 1967; Chenitz & Swanson, 1986). It was originally developed in the 1960s by two sociologists: Anselm Strauss and Barney Glaser. Anselm Strauss was a social psychologist that came from the

University of Chicago (Baker, et al., 1992; Stern, & Covan, 2001), where the philosophy in symbolic interactionism had influenced him (Stern, & Covan, 2001). Barney Glaser in contrast received his training at Columbia University and was influenced by quantitative analytic methods with Lazarsfeld, who generated a name for himself in the field of quantitative statistics. Before developing their method of grounded theory, both Glaser and Strauss joined the faculty of the nursing doctoral program at the University of California, San Francisco (Stern, 1985). These appointments led to the introduction of grounded theory to nursing students.

Grounded theorists believe that there is a socially constructed reality and that truth emerges from the interpretation and analysis (Strauss and Corbin, 1998). Grounded theory methodology involves all reasoning techniques including induction, deduction, and verification. The theory induced from the grounded theory procedure is conceptual dense, which refers to the richness of concept development and concept relationships embedded in great familiarity with, the repeated checking of, associated data. Glaser (1987) and Strauss (1987) suggest that the researcher taking a grounded theory approach must practice "theoretical sensitivity." This involved thinking about the data in terms of theory and applying theoretical insight to the work.

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses data and decides what data next and where to find them, in order to develop theory as it emerges (Glaser and Strauss, 1967). The aim of theoretical sampling is to maximize the number of opportunities to compare events and incidents to determine how a category varies in term of its properties and dimensions (Strauss and Corbin, 1998). It is used until each categories reaches theoretical saturation that is

indicated by dense description of the category occurring along with variation and process, by having no new data added into the category, and by finding that the relationship between categories are integrated and validated (Jeon, 2004).

Data analysis

Constant comparison method

According to the grounded theory method (Glaser & Strauss, 1967; Strauss & Corbin, 1998), data will be analyzed using the constant comparative method wherein each line, phrase, sentence, and paragraph from the transcribed interviews and field notes will be read to decide what concepts the data reflect and to code the data. Each code will be compared to all other codes (Stern, 1980). Comparisons for similarities, differences, and general patterns will be made. Questions will be raised regarding unclear or missing data so that the researcher could explore such areas during the other interview. This process also helps the researcher gain insight into interviewing techniques and biases. The constant comparative method of analysis (Strauss & Corbin, 1998) will be used until core categories or basis social process (BSP) emerge. Two analytic procedures, making comparisons and asking questions, will be carried out. Memos and diagramming will be done also in conjunction with the coding process. Details related to analysis and coding procedures: open, axial, and selective, are as follows (Glaser, & Strauss, 1967; Strauss, & Corbin, 1998).

Coding and categorizing data

Three levels of coding procedures: open, axial, and selective, will be used (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Level 1 open coding: According to Corbin & Strauss (1998), open coding refers to the level 1 coding process through which concepts are identified and their properties and dimensions are discovered in data. Open coding in this study will begin with the process of labeling many individual phenomena after audio-tapes have been transcribed verbatim by the researcher. The data will be read and analyzed, initially using line-by-line coding, to break down the data (Charmaz, 2000). As the researcher becomes more familiar with the data and the concepts and categories are identified, coding can be done by sentence and, at times, by paragraph, in accordance with Strauss and Corbin (1990).

If a new concept or category is identified, the researcher will revert to line-by-line coding. Line-by-line coding during the initial period of data collection forces the researcher to concentrate on the data and avoid undue influence from preconceived beliefs about the field of inquiry (Charmaz, 2000). In line by line coding, the researcher reads all raw data and starts to label words or codes the informants use, then these codes are further moved to a more abstract level called “categories. In time, a number of individually labeled concepts are clustered around a related theme. The individual concepts are gathered together to form more powerful and abstract categories.

Level 2 axial coding: Strauss and Corbin (1998) describes axial coding as the process of relating categories to their subcategories linking a category at the level of properties and dimensions” (p. 123). The focus of axial coding is to create a model that details the specific conditions that give rise to a phenomenon’s occurrence. In this technique, the data are put back together in a different way, through categorizing the data and making links between a category and its subcategories (Irurita, 1996). Concepts are elevated to provisional categories. A category is a classification of concepts, arising through a process of constant

comparative analysis, grouping or clustering concepts together in a higher order, more abstract concept (Strauss and Corbin, 1990). The process requires inductive and deductive thinking, asking questions, and proposing and making comparisons with the data.

Level 3 selective coding: Selective coding is built upon the foundation of the previous open and axial coding efforts. The process of selective coding, also known as Level III coding, aims to identify a core or overarching category, and attempts to establish links between this and other categories (Charmaz, 2000).

Selective coding is “the process of integrating and refining the theory included selecting the central or core category, systematically relating it to other categories, validating those relationships, and filling in categories. Theoretical coding will be used to uncover the categories relation to one another, for example, conditions, strategies, and consequences. Strauss and Corbin (1998) stated that this central or core category should have the analytic power to “pull the other categories together to form an explanatory whole” and “should be able to account for considerable variation with categories” (p. 146). During this level of coding, theoretical saturation should be reached. This means that no new properties, dimensions, or relationships emerged during analysis. Identifying the “story” is a key aspect in formulating the grounded theory.

Data collection, coding and analyses were continued until theoretical saturation will be achieved. According to Strauss and Corbin (1998) theoretical saturation means that: (1) no new or relevant data seem to emerge regarding a category; (2) the category development is dense; and (3) the relationships between categories are well established and validated.

Memos and diagramming

In addition to coding and sampling, a major tool in data analysis is the use of memos and diagrams, which provide a history of the data analysis and help develop the theory. Memos are analytical notes the researcher writes to herself or himself as the researcher is collecting and analyzing data. The researcher starts to write memos when ideas are generated during the process of coding and comparing categories. It helps determine gaps in the researcher's thinking process, raises data to a conceptual rather than descriptive level, and presents hypotheses about connections between categories and their properties. In addition, it help integrate clusters to generate theory (Glaser, 1978; Strauss, & Corbin, 1998) by sorting these memos about categories and theoretical relationships, the core variable or basic social psychological process (BSP) will emerge.

Logic diagrams (Strauss & Corbin, 1998), the researcher in reflecting on and understanding the relationships between and among emerging categories. In the beginning, the researcher may make diagrams that are mere scribbles of arrows and words, using these sketchy diagrams to search for what is missing from the emerging theory (Schreiber, 2001). At each stage, the researcher may draw a series of diagrams, each as an approximation of what the researcher is attempting to capture in the theory. By drawing and re-drawing diagrams, the researcher can stand back and conceptualize the full theory, which can then be checked against data.

CHAPTER III

METHODOLOGY

The methodology issues and concerns are addressed in this chapter. First, the design of the study is discussed. Next, the participants and setting, the subject recruitment, instrumentation, and protection of human subjects are defined. Then, the processes of data collection methods and data analysis are described. Finally, the controls in the research procedures are explained.

Research design

The design of this study is the grounded theory approach. According to Stern (1980) this approach is appropriate for studying areas of human behavior and social life where little research has been done and salient variables have not been identified, or few adequate theories concerning a phenomenon of interest exist. Moreover, Chenitz and Swanson (1986) discuss grounded theory design and state that grounded theory is based on a discovery model of theory development. The purpose of grounded theory is to account for or explain phenomena in the social world, or to develop a substantive study. Grounded theory is a method used to guide sampling, data collection, analysis and verification in this study (Glaser, 1978).

As no research is known about nursing care for sexually abused child patients, grounded theory methodology is well-suited to explicate the social and psychological process through psychiatric nurses' experiences of working with school-aged sexually abused

children in psychiatric wards in Thailand. The study aims to explain the process of nursing practice for school-aged sexually abused children during treatment in psychiatric wards from the perspective and experiences of psychiatric nurses in Thailand. Researchers need to know how to care for school-aged sexually abused children in nursing practices.

Participants and settings

After the researcher discovered which hospitals serviced sexually abused child patients, it was discovered that there were three types of hospitals: the psychiatric hospitals of DMHT; the university hospitals that serviced inpatient psychiatric care; and the hospitals of Department of Medical Science (DMS) that serviced inpatient psychiatric care. But the researcher was limited on data collecting time and approving IRB from each hospital. The researcher chose only psychiatric hospitals of DMHT that had five hospitals: Srithanya Hospital, Yuwaprasat Waithayopathum Child Psychiatric Hospital, Nakornratchasrima Psychiatric Hospital, Suansaranroum Hospital, and Institute of Promoting Children's Development in the North Region. Cases of sexually abused child patients at Nakornratchasrima Psychiatric Hospital and Suansaranroum Hospital were less than 5 cases. Nowadays, Institute of Promoting Children's Development in the North Region does not service inpatient wards, but refer cases to the Maharat Nakorn Chiang Mai hospital.

Therefore, in this study, the participants were psychiatric nurses who were working with sexually abused child patients in psychiatric wards at Srithanya hospital, Yuwaprasat Waithayopathum child psychiatric hospital in center region; and the Maharat Nakorn Chiang Mai hospital in the north of Thailand.

The researcher's reasoning behind choosing these hospitals was that Srithanya Hospital was the first tertiary care center of treatment and rehabilitation of mentally ill patients of all ages in Tiwanoon, Nonthaburi province, approximately 1.5 kilometers from Bangkok. The hospital services patients and caregivers both OPD and IPD with 1,430 beds (DMHT, 2003). Hence, most school-aged sexually abused children from many One Stop Crisis Centers (OSCCs), university hospitals and general hospitals of Thailand were referred to Srithanya Hospital for treatment and rehabilitation both physical, psychological and socially because of its reputation as the first center specifically built as a safe house for child abuse in 2000. In addition, the researcher was a nursing instructor at Kuakarun College of Nursing and supervised nursing students in psychiatric practice at Sritanya Hospital. Thus, the setting was a conveniently short trip away and helped the researcher easily approach psychiatric nurses at the commencement of the research process.

The second hospital, Yuwaprasat Waithayopathum Psychiatric Hospital, situated on Sukhumvit road, Paknam district, in Samutprakan province had serviced only autistic children, both Out Patient Department (OPD) and In-Patient Department (IPD) and other child psychiatric patients. These child psychiatric patients were admitted on a child psychiatric ward recently and the hospital had only had these services for just three years.

The third placement, the researcher used personal relationships to ask for a psychiatric nurse's cooperation, in particular from one who worked with school-aged sexually abused children in the Maharat Nakorn Chiang Mai hospital and interviewed this participant at her home. Maharat Nakorn Chiang Mai Hospital was the university hospital that had serviced both OPD and IPD psychiatric cases. In the north of the region, most school-aged sexually abused children were referred to the Maharat Nakorn Chiang Mai hospital.

As a result of child sexual abuse being a new phenomenon, a number of school-aged sexually abused children were admitted to hospitals throughout Thailand and there is little chance that psychiatric nurses provided nursing practice for them, in many cases. In addition, some psychiatric nurses who had experience were now retired. In the beginning, the researcher selected preliminary sampling by a purposive sampling that the initial inclusion criteria were psychiatric nurses who had at least a bachelor degree; had work experience in general psychiatric wards for more than 5 years; had worked with school-aged sexually abused children in psychiatric wards for at least 1 year; and had experience of providing nursing care to at least 5 school-aged sexually abused child cases. After the first interview, the researcher used a snowball technique from the second case to the sixth case. After beginning to analyze data from six participants, the researcher used the theoretical sampling form particularly in the steps in which categories emerged.

Twelve Thai psychiatric nurses agreed to participate in the study. The demographic characteristics of psychiatric nurses are shown in Table 1. The psychiatric nurses ranged in age from 35 to 59 years old. Five participants were 35-40 years old, four participants were 41-50 years old, and three participants were 51-59 years old. The average age of the participants was 45.75 years old. Eleven were female and only one was a male psychiatric nurse. In marital status, six of the participants were in partnerships and the other six participants were single. With regard to educational qualifications, two thirds of the participants graduated at master's degree level. Relating to staff training, one participant gained only the post-graduate training of psychiatric nursing, six participants gained both the post-graduate training of psychiatric nursing and other training**,** and four participants gained various training such as family counseling, examining witness/testimony, psychodrama,

psychiatric nursing for children and adolescents, counseling, negotiation, and observing procedures at a psychiatric ward of a university hospital. Only one participant did not have any additional training.

In seniority within the ward, two psychiatric nurses were head nurses, three psychiatric nurses were deputy-head nurses, and seven were staff nurses being team leaders and members of teams. The staff's experience of working in general psychiatric wards ranged from 5 to17 years. Four participants had the most experience, working from between 15 years and 17 years. Four participants had experience in working for 10 years. Four participants had 5-7 years work experience with general psychiatric patients. The average experience in working in general wards was 10.42 years.

The staff's experience of working with school-aged sexually abused children ranged from 1 to 6 years. Only one participant had worked with school-aged sexually abused children for 6 years. Four participants had worked with school-aged sexually abused children for 5 years. Six participants provided nursing care for 2-4 years. Only one participant had just one year's experience. The average experience in working with school-aged sexually abused children was 3.75 years. The number of school-aged sexually abused children taken care of by psychiatric nurses ranged from 5 to 35 cases. Only one participant had provided nursing care to 35 cases, two participants had cared for 15-18 school-aged sexually abused children, six participants had experience of 6-10 cases, three participants provided nursing care to 5 cases. The average number of cases cared for by the participants was 10.25 cases.

Table 1: Demographic characteristics of the participants

Case	Age	Gender	Marital status	Education	Post graduate Training	Working status in ward	Years of working in general ward	Years of care for School age sexually abused children	Numbers of case cared for
1	55	female	couple	Master degree	-PG (psychiatric nursing) -Psychodrama	Dep-head nurse	15	4	15
2	44	female	couple	Bachelor Degree	-	Staff	10	5	10
3	39	female	single	Bachelor degree	-Psychiatric nursing for children and adolescents	Staff	7	5	6
4	59	female	couple	Bachelor degree	-PG (psychiatric nursing)	Head nurse	17	5	18
5	50	female	couple	Master degree	-PG (psychiatric nursing) -Family counseling -Examining witness/testimony -Psychodrama	Staff	10	1	5
6	51	female	couple	Master degree	-PG (psychiatric nursing) -Psychodrama	Head nurse	15	3	6
7	50	female	single	Master degree	-Child counseling -Helping parents and helping their children	Dep-head nurse	5	5	5
8	38	female	single	Bachelor degree	-Counseling -Negotiation	Staff	6	3	6
9	35	female	single	Master degree	-PG (psychiatric nursing) -Psychiatric Nursing for children and adolescents	Staff	5	2	5
10	40	male	single	Master degree	-Observing the procedures at psychiatric ward of university hospital	Staff	10	3	6
11	48	female	couple	Master degree	-PG (psychiatric nursing) -Psychodrama -Counseling -Examining witness/testimony	Dep-head nurse	15	6	35
12	40	female	single	Master degree	-PG (psychiatric nursing) -Negotiation	Staff	10	3	6

Subject recruitment

After the researcher discovered which psychiatric hospitals of DMHT serviced sexually abused child patients, two hospitals were identified as follows: Srithanya Hospital, Yuwaprasat Waithayopathum Child Psychiatric Hospital. The researcher requested the Nursing Faculty of Chulalongkorn University to approach these hospitals, all of which enthusiastically granted permission to be included in the study (Appendix A.). The researcher sent the proposal (Thai version) and letters for requesting permission to study (Thai version) to the head-nurse of each hospital. The researcher presented the proposal to IRB's committee of the hospital.

Initially, the researcher contacted psychiatric nurses who were head-nurses of wards as the key person to help to meet the criteria of "clinical expert" for school-aged sexually abused children. The researcher, after making introductions, established a one-to-one relationship of trust with participants and showed the proposals and aims of this study together with its benefits. The researcher invited nurses to be participants of the study through direct oral contact, telephone calls or letters, as was deemed most convenient. Then, after participants expressed their intention to participate in this study, the researcher made an appointment to interview them and informed participants about the scope of content of the interview. The information sheets and consent forms (in Thai) were written by the potential participants (see English form in Appendix B, Thai form in Appendix C). A signed copy was given to the participants at their first interview. However, no participants withdrew; all sample members were volunteers and freely agreed to participate in the study.

Protection of human subjects

The research proposal with interview guide and consent form was submitted for review, and approval was granted from the Institute of Review Board on Human Subjects committee at the department of mental health (Thai version illustrated in Appendix D). The principles of beneficence, respect for human dignity and justice to the participants were carefully considered. For protection of confidentiality, the researcher gave a complete description of this study to psychiatric nurses who met the criteria of participants. The individual psychiatric nurses were given opportunities to agree or disagree to participate in the study. The participants who agreed were informed of the purpose of the study, the potential risk, and the protection of confidentiality as the rights of the participants (see English form in Appendix E, see Thai form in Appendix F). Then, the participants were asked to sign a consent form (Appendix C) and were provided with a copy of it. An appointment time was made before an in-depth interview began. To confirm availability, the researcher made a phone call before the appointment times and on the day of the interview itself.

Risk to psychiatric nurses were considered low as they were already telling of their own experiences during the interview process, and the researcher was contactable 24-hours a day if problems surfaced due to issues raised in the interviews. Due to dialogues in this interview that were related to sexual play-acting, aggressive behavior and other psychotic symptoms of school-aged sexually abused children, the researcher reserves the right of privacy not to mention the school-aged sexually abused children by name, but has replaced them with “this case” or “that case” during the interview. In order to prevent any stigma towards the sexually abused children and to ensure safety for psychiatric nurses, settings in

this study were either the private rooms of psychiatric wards or places the participants selected that were free from interruptions and distractions.

During interviewing, if participants felt uncomfortable to talk about themselves or they were not able to answer the questions, the participants could say “stop” to the researcher or they could withdraw from the study at any time. At the end of the interview, the researcher asked participants about their need to share any experiences or feelings. During data collection, all participants were asked for permission to record and transcribe the interviews. In a coding system, the identity of the psychiatric nurses and responses were known only to me. All interview data was coded without the real names appearing on the transcripts. Any quote used as an exemplar was only identified by a pseudonym. Tapes and transcriptions, records, and data were kept in a locked cabinet and destroyed after the conclusion of the study 5 years ago. The data in the computer was destroyed and all files and all records were deleted.

Instrumentation

In this grounded theory study, the researcher was considered the instrument (Chenitz & Swanson, 1986). The researcher played a major role in the process of inquiry to get the qualified data and the corrected analysis. Thus, these abilities of the researcher were developed prior to the study.

The researcher had been a lecturer or nursing teacher of psychiatric nursing for 16 years at The Kaukarun College of Nursing. In psychiatric nursing practice, the researcher was a supervisor of nursing students practicing in psychiatric wards. The researcher had taken a class in counselor training at the Kaukarun College of Nursing and had studied cross-cultural sensitivity training

while serving as a master's degree student in developmental psychology (Appendix G). The researcher studied a qualitative course for 3 credits in the Faculty of Nursing at Chulalongkorn University in Thailand and took a class in qualitative research for 3 credits in the Faculty of Nursing at Indiana University-Purdue University in Indianapolis. The researcher had conducted practice interviews on four psychiatric nurses who had worked with school-aged sexually abused children in psychiatric wards in Thailand. From these practice interviews, the researcher was able to assess the interview questions and the researcher was able to improve interviewing skills from feedback given by the 4 practice interviewees and from advisors who had experience in qualitative methodology before carrying out the next interviews.

As a result of previous experience from the researcher in contacting both psychiatric patients and psychiatric nurses; trial interviews, and advisor's reflections, the researcher had in-depth practical knowledge of interviewing and non-participant observation. The researcher studied grounded theory in-depth through self-study into the research process where the data is gathered, interpreted, and presented. In addition advisors were able to supervise the researcher in conducting a naturalistic inquiry and the researcher achieved a state of "theoretical sensitivity" throughout the research processes.

Data collection

In order to assure the quality of the data, the researcher used in-depth interview methods for collecting data because this method gained information from its source by exploring participants' experiences in context from the respondent's own words (Bowling, 1997; Marshall & Roseman, 1999). After gaining psychiatric nurses or participants consent

forms, a demographic data form and semi-structured face to face interviews were applied to collect data with each of the psychiatric nurses. All interviews were tape recorded and transcribed verbatim. A small number of observations and field notes had been taken of the quality or accuracy of the data collected. During each interview, the researcher had field notes on the important issues, interactions occurring, non-verbal cues such as movements, tone of sound, loudness, and visual cues. The data from field notes was completed immediately following the interview. The researcher also took notes during the interviews, and later compared the notes to the transcriptions. Nine interviews were conducted in-depth at private rooms of psychiatric wards after work, and two interviews at participant's homes. Participants were able to talk freely and to answer the questions. The researcher encouraged the participants to relate their working experiences as to how psychiatric nurses provided nursing care for school-aged sexually abused children on psychiatric wards. Each interview was between 90-120 minutes. Four participants were interviewed in-depth twice. The duration of data collection was eight months from August 2007 to March 2008.

The data collection process consisted of two phases. In the beginning, the first and second participants were selected by criterion: psychiatric nurses who had at least a bachelor degree; had work experience in general psychiatric wards for more than 5 years; had worked with school-aged sexually abused children in psychiatric wards for at least 1 year; and had experience to provide nursing care to at least 5 cases of school-aged sexually abused children by asking the head nurse of wards who knew staff nurses that met the necessary criteria. For the next participants, the researcher used a snowballing approach by asking psychiatric nurses who had been interviewed before. The snowballed psychiatric nurses were screened in inclusion criteria. In-depth interviews were often only loosely structured in order to allow

the participant a free rein to expand on the topics in question. An interview guide was prepared for the researcher who used it as a direction in the in-depth interviews. The researcher asked broad and open-ended questions following the interview guide (see English form in Appendix H, see Thai form in Appendix I) to try to ascertain the work experiences with school-aged sexually abused children. After data analysis began, the next data collection and interviews were guided by the emerging data, and a theoretical sampling technique was used. After the sixth interview, the researcher understood more clearly the phenomena of the nursing care process. Questioning to the next participants regarding their experiences of providing each nursing care, the sequences of nursing care, and the relationships of each nursing care was applied. There was no new emerging data in the ninth, tenth, eleventh, and twelfth interviews. In the tenth and eleventh interviews, a comparative of nursing care process emerged between gender differences of psychiatric nurses and of school-aged sexually abused children. In the twelfth interview, the substantive model was confirmed in a final check that there was no new emerging data. The researcher determined that the data was saturated.

The interview guide consisted of demographic data, a grand tour question, and probe questions using follow-up details. Initially, the researcher greeted the participant and asked about demographic data. The participants were invited or asked broadly with an open-ended grand tour question that tried to elicit experiences in, and the conditions under, nursing care for school-aged sexually abused children. The researcher had the flexibility to follow the informant's ideas or viewpoints. As an example of a few grand tour questions: *"Tell me about your working experience whilst providing nursing practice for school-aged sexually abused children in a ward."* Probe questions were used to encourage the participant to tell

more of his/her experience: *"How do you deal with that situation?" "Could you tell me more about it?" "What do you mean?" etc.* (Appendix H). At the end of each interview, the researcher said "Thank you very much" and thanked them for the interview. The researcher asked permission to contact them again in order to complete and verify the data. Later, the data of the initial interviews emerged leading to a review of the questions or an appraisal of new questions that needed to be asked in order to explore further.

During interviews, the researcher asked for participant's permission to take notes of some important issues; including, the general appearance and non-verbal behaviors of participants. After each interview ended, the researcher additionally wrote up the events, actions, and interactions in order to remember the trigger thinking processes.

Data analysis

Data in each participant to be analyzed was collected from the transcribed taped interviews by the researcher. This data was re-checked against the transcripts and by asking my colleague to listen to the tape recordings, to ensure that there was an agreement of more than 90% throughout the process of conducting the research. In each transcript, if it was less than 80% harmonious , it was re-checked by a third person and thoroughly debated. Constant comparative analysis was utilized to analyze the data concurrently with participants. Data was analyzed by using the method where in each line, phrase, sentence, and paragraph from the transcribed interviews and field notes, were read to decide what concepts the data reflected and then the data was coded. Each code to then be compared with all other codes (Stern, 1980). Comparisons for similarities, differences and general patterns were made through coding process until core categories or basis social processes (BSP) emerged

(Strauss & Corbin, 1998). Questions were raised regarding unclear or missing data so that the researcher could explore such areas during other interviews. This process also helped the researcher gain insight into interviewing techniques and biases. Two analytical procedures, making comparisons and asking questions, were carried out. Memos and diagramming were done also in conjunction with the coding process.

Coding process

Coding is the process for reducing raw data into concepts that related to categories. In this study, the coding process was guided by Strauss and Corbin (1998), which was composed of open coding, axial coding, and selective coding, as follows:

Open coding

The open coding generated conceptual labels, concepts from the raw data for developing. In this open coding, the researcher began with reading the data transcribed verbatim, first, line by line, then paragraph by paragraph. The researcher broke down the data into small meaningful phrases/pieces of events or nursing practice phenomena and started to label key words or to code or identify the informants used. Using open coding, several hundred codes were generated during data analysis for this study. Then, similar events were grouped together to form the same name or category and different events were separated to other groups. These codes were further moved to a more abstract level from comparing each new extracted phrase from data to previous ones. These abstract codes were called "concepts/categories" that ensured description of all the data. Whilst opening the code, the researcher stopped coding to memo new thoughts, questions, or details related to that data.

Each memo was identified by a participant number as well as the line number from the transcript to facilitate returning to the full passage.

Axial coding

While open coding splits data into concepts and categories, axial coding was used to help discover categories by comparing similarity and difference. Axial coding is a process whereby the data is put back together in new ways after coding. It was coding that occurred around the axis of category at the level of properties and dimensions to form more precise and complete explanation about phenomena (Strauss and Corbin, 1998). It was a process where the researcher tested new connections related to linking categories and their subcategories. These categories tended to be more abstract than initial coding. Each memo represented an idea that the researcher had about each category. At the end of the axial process, the researcher had developed 7 categories and a list of properties for each of these categories. The researcher started to produce theoretical sampling in the new interviews after hypotheses in this study were formed and needed to be tested.

Selective coding

Selective coding is “the process of integrating and refining the theory”, including selecting the central or core category, systematically relating core category to other categories, validating those relationships, and filling in categories. Selective coding was built upon the foundation of the previous open and axial coding efforts. The process of selective coding was aimed to identify a core or overarching category, and attempts to establish links

between this and other categories. Memos were a way to capture the insight that accompanied the process of being submerged in open and axial coding. The categories of establishing trust, arranging effective communication, physical care, developing skills, building will power, arranging safe and supportive environment, and assisting living back in society consisted of a core category called re-moulding child, representing the basic social process (BPS) experienced by psychiatric nurses toward sexually abused child patients while providing nursing practice from admission to discharge.

A relationship of a category to all other categories was found that was simultaneous and a reciprocal cycle that was started with establishing trust, arranging effective communication, and providing physical care. Then, this effect led to an interchangeable cycle of developing skills, building will power, and arranging safe and supportive environment. Lastly, its result was related to assisting living back in society as the end of the process. Theoretical saturation meant that no new or relevant data seemed to emerge regarding a category; the category development was dense; and the relationships between categories were well established and validated.

Memos and diagramming

In addition to coding and sampling, a major tool in data analysis was the use of memos and diagrams, which provided a history of the data analysis and helped to develop the theory. Memos were notes that the researcher wrote personally to record and explicate the theory. Writing memos helped the researcher develop theoretical sensitivity and thinking. Memos consisted of a memo as a memory aid, a personnel memo, coding memo, theoretical memo etc. to utilize through the data collection and analysis. The researcher started to write

memos when ideas were generated during the process of coding and comparing categories. It helped determine gaps in the researcher's thinking process, raised data to a conceptual rather than descriptive level, and presented hypotheses about connections between categories and their properties. In addition, it helped integrate clusters to generate theory (Strauss, & Corbin, 1998). By sorting these memos by categories and theoretical relationships, the core variable or basic social psychological process (BSP) emerged.

Logic diagrams (Strauss & Corbin, 1998) helped the researcher in reflecting and understanding the relationships between and among emerging categories. In the beginning, the researcher made diagrams that were mere scribbles of arrows and words, using these sketchy diagrams to search for what was missing from the emerging theory. At each stage, the researcher drew a series of diagrams, each as an approximation of what the researcher was attempting to capture in the theory. By drawing and re-drawing diagrams, the researcher could stand back and conceptualize the full theory, which could then be checked against the data.

Control in the research procedure

In the qualitative inquiry, trustworthiness referred to a conceptual soundness from which the value of the research could be judged (Marshall and Rossman, 1995). In general, trustworthiness was bolstered by the amount of time spent in the field with the data, the triangulation of data, alertness to the subjective lenses and subsequent biases that the qualitative researcher brought to the study and mapping what worked within the boundaries and limitations of the study (Denzin, 1978; Lincoln and Guba, 1985). Trustworthiness was also strengthened by exploring negative cases that illuminated more varied and sophisticated

expressions of the phenomenon (Glaser, 1978). Trustworthiness was illuminated by the concepts of Lincoln and Guba (1985). According to Lincoln and Guba (1985), trustworthiness was achieved by the satisfactory attainment of four constructs that relate to credibility, transferability, dependability, and confirmability.

Credibility

In this study, credibility was established by the multi-methods such as appropriate selection of participants and on studying methods, prolonged engagement, and member or participant checks. The researcher selected appropriate participants to address. The participants were psychiatric nurses who had human experience in general psychiatric wards for more than 5 years and in psychiatric wards for at least 1 year to provide nursing practice for school-aged sexually abused children of at least 5 cases. During interviews, the researcher spoke of the scope of the interview to the psychiatric nurses by requesting only their direct experience of providing nursing practice to 6-12 years old sexually abused child patients admitted to wards. In addition, the researcher used adequate and sufficient data collection methods such as in-depth interviews, and field notes in order to understand the nurses' individual experiences, whereupon the conclusion of the findings depended on the empirical data.

Prolonged engagement and persistent observation was achieved throughout the eight months to become completely familiar with the problem and to deal with personal and external distortion in psychiatric wards. In order to gain multiple realities and the true value of nursing practice processes for school-aged sexually abused children, and to understand the cultural context of psychiatric nurses while providing nursing practice, the researcher

established familiarity with all participants. For example, the researcher greeted each participant when they met together and talked very generally about the topics, so as to put them at ease. Moreover, the researcher explained the purposes of the study before the interview so that they could become familiar with the aims of the research study. Then, the researcher encouraged participants' sense of ownership of the study so that they became participants in the full sense of the word, enabling them to talk easily about personal experiences of nursing practice. Both in-depth interviews and observations about the experiences of psychiatric nurses regarding nursing practice procedures were used to gather information.

Participant or member checks were achieved through sharing with each participant, after the verbatim transcript of the individual interview, to double check or verify the real meaning of some of the data. In this study, the researcher returned a second time to authenticate the meaning of dialogues of three of the participants. To increase credibility, the researcher then had explore these cases thoroughly enough to understand the differences and incorporate them into the model, which provided the flexibility and variation needed to strengthen the model of nursing care for sexually abused child patients aged 6-12 years old (Strauss, & Corbin, 1998).

Transferability or generalizability

Transferability or generalizability referred to the theoretical parameters of the research (Marshall, & Rossman, 1995), and to the applicability of one set of findings to another setting (Guba, & Lincoln, 1981). Transferability has also been labeled "fittingness". In grounded theory, transferability was accomplished through a set of empirically grounded

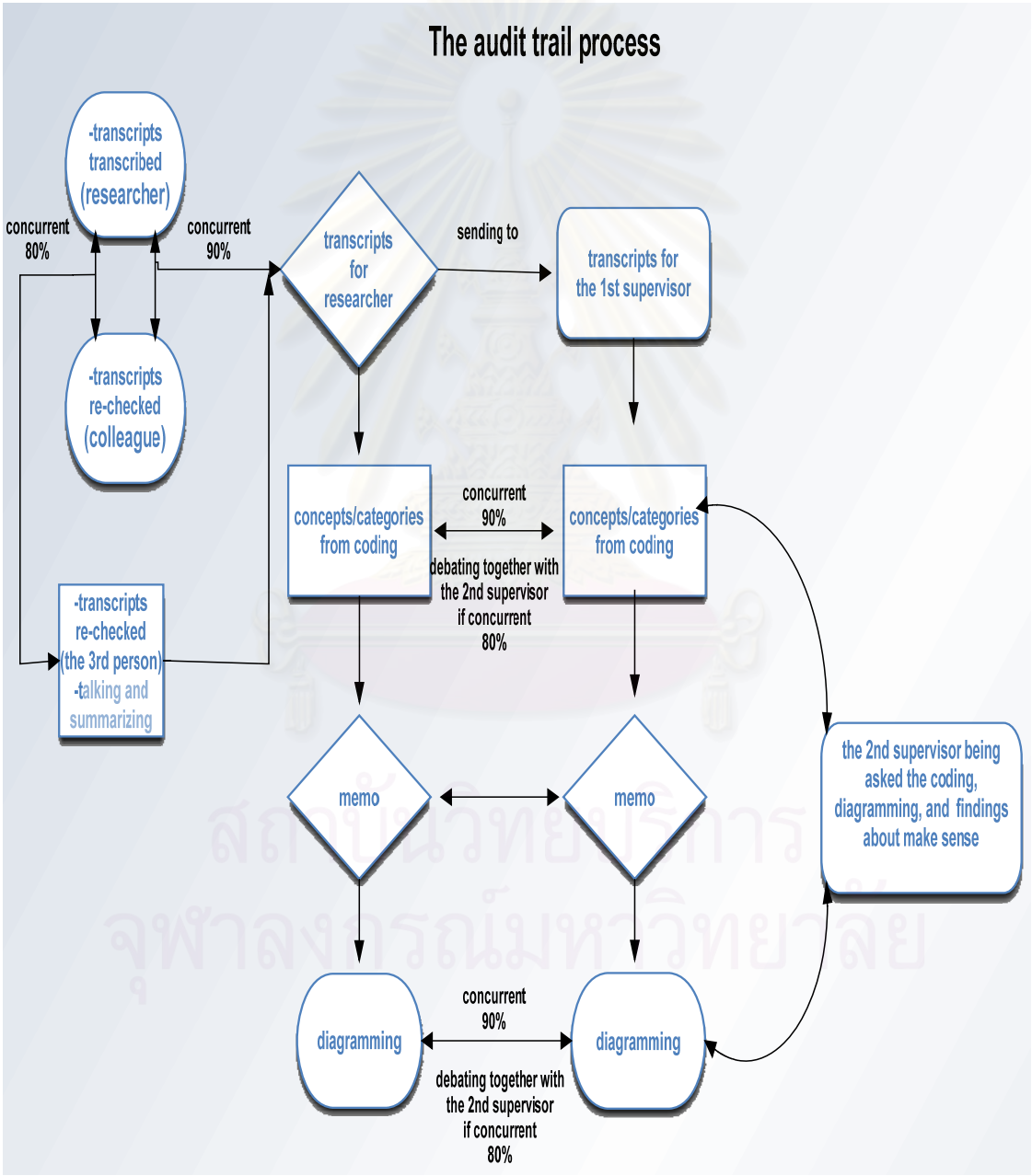
hypotheses. Therefore, transferability in this current study was strengthened by providing rich, thick slices of data to make transferability judgments possible on the part of potential appliers. In grounded theory, transferability was achieved to confirm a set of grounded hypotheses. In this study, the researcher showed the detailed description during data collection such as that of the sampling techniques, the reasonable characteristics of the sample, the possible range and variation through theoretical sampling to test a set of grounded hypotheses, and the relationship of the findings to an already developed framework.

Dependability and confirmability

Dependability referred to the stability of the findings over time, and confirmability examined the "objectivity" of the research; that was, that another researcher could confirm the study when presented with the same data or neutrality of the data. Both dependability and confirmability were accomplished by using an audit trail. An audit trail provided the necessary materials to confirm the research. Two supervisors assisted, the first being a nursing researcher experienced in pediatric nursing and qualitative data analysis, followed the audit trail (raw data derived from audiotapes, verbatim transcripts, researcher field notes from the interviews and observations, and coding and memos from each round of interviews); the second supervisor who was an expert in psychiatric nursing, queried the meaning and sense of each category, subcategory and core category, and then debated the findings between the pediatric supervisor and the researcher. A thorough investigation into how the researcher analyzed the data, starting with the transcriptions and ending with the

substantive theory was made. Inter-subjective agreement between the two supervisors and the researcher was judged (see Figure 1).

Figure 1 The audit trail process



CHAPTER IV

FINDINGS

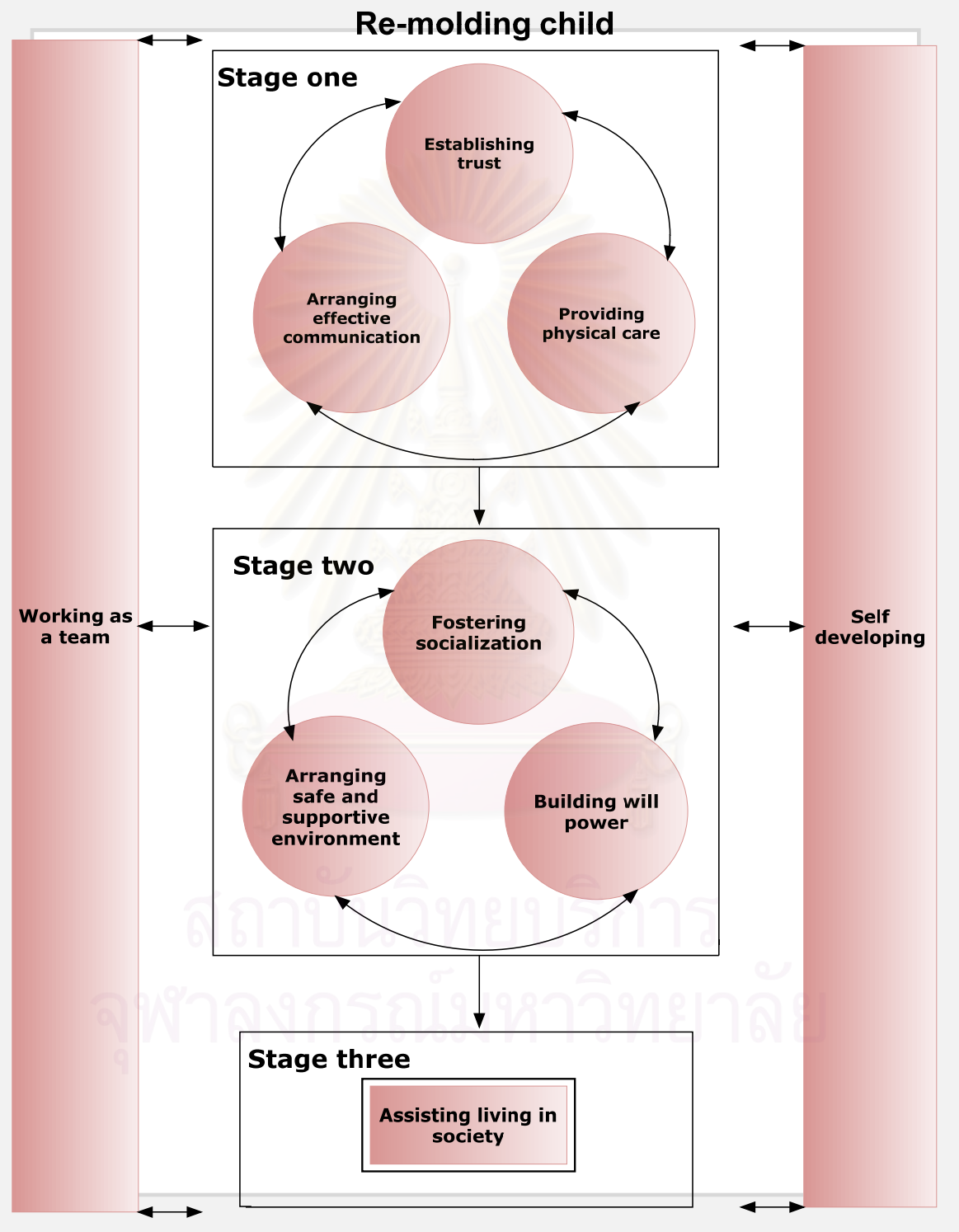
In this chapter, the findings of the study are addressed. The findings that emerged from the data collected in interviews with 12 psychiatric nurses indicated the basic social process that has been named the remolding child. Throughout this chapter, direct quotes from psychiatric nurses are presented for substantiation and illumination. These direct quotations are cited verbatim with no corrections or changes to preserve the flavor and reality of the statements. To insure confidentiality, no names, aliases, or initials are used.

Remolding child

The remolding was the basic social process given by psychiatric nurses who were experts by way of inclusion criteria, for school-aged sexually abused children admitted to hospital with psychiatric symptoms and/or behavioral problems. It was a process of reshaping child's thought and behaviors, adjusting child's environment as well as providing support after discharge. The remolding child process consisted of 3 continuously consecutive stages. Each stage consisted of sub-stages that had no particular sequence in their occurrence, and these sub-stages were reciprocal. In remolding child process, the first stage was started with establishing relationships, 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 Figure 2.

In this process, psychiatric nurses provided care for not only the abused child but also the child's families. Throughout the remolding child process, psychiatric nurses worked, and were administrated within a nursing team, whilst also cooperating with a multi-disciplinary team. During provision of the nursing care to these children, psychiatric nurses gained self awareness. They were understood of their roles and were able to provide a better care for each child. The working as a team and self developing category will be later described.

Figure 2 Remolding child



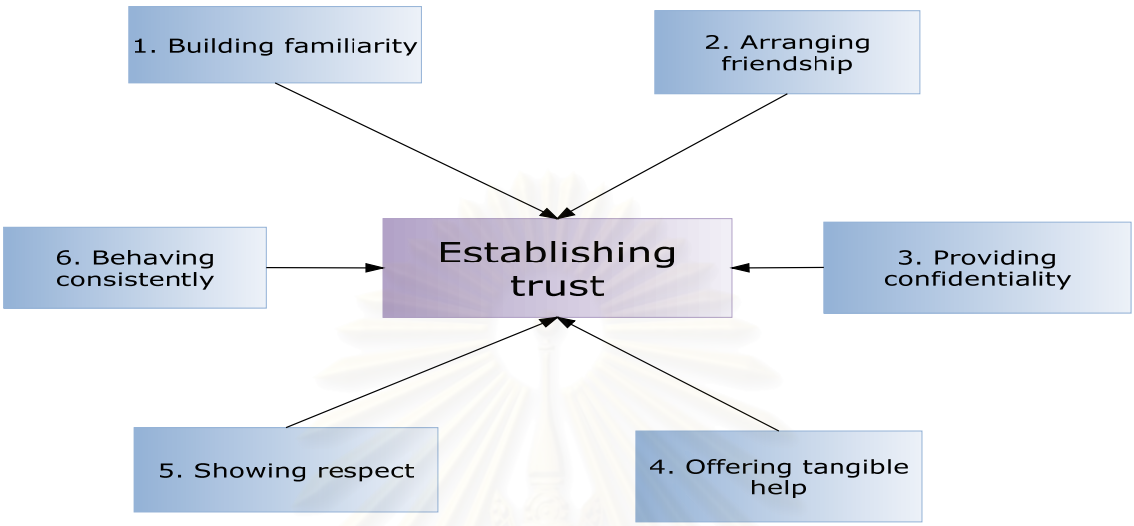
In remolding child process, the first stage was started with establishing relationships, arranging effective communication, and providing physical care.

Stage 1

1. Establishing trust: Most child patients who were sexually abused, whether that abuser lived in the family house or not, believed that all adults were the same and none could be trusted to provide care or protect them. The severity of mistrust depended on children's experiences, such as the number of times the abuse occurred, the styles of abuse, and the relationship of the child to the abuser. As a result, building relationships with these children was more difficult than with other psychiatric children. Psychiatric nurses had to use much more effort and a variety of nursing strategies in order to gain trust from these children. Gaining trust made nurses to be able to identify each child's problem, and to obtain significant information necessary for planning an effective nursing care such as the child's abusive experience.

Establishing trust was defined as an action of psychiatric nurses to attempt to approach child, to make a child trust nurses which was included building familiarity, arranging friendship, providing confidentiality, offering tangible help, showing respect, and behaving consistently (see in Figure 3).

Figure 3 Sub-categories of establishing trust



1.1 Building familiarity: In sexually abused child patients, psychiatric nurses were unfamiliar people and ward environment was a strange place. After school-aged sexually abused children were admitted, psychiatric nurses arranged for them to become acquainted with their new surroundings and relaxed with the unfamiliar persons or strangers around them. The first step in building familiarity was assessing how the child respond to other persons. Nurses collected this information by approaching the child. They may smile at or ask easy questions such as the child's name. Response of these children can vary from no response at all to attacking the approaching person. Reactions of child provided valued information for nurses in selecting strategies to build familiarity to each child.

If the child showed no violence, psychiatric nurses began to introduce themselves and to introduce other staff members and other children to the child; this included arranging the child to introduce themselves to others (arranging effective communication).

Then, psychiatric nurses took the child on a ward tour to make the child familiarity wit new environment. Nurses also tried to make frequent short visit to the child each day. They often expressed greetings and smiles toward the child, touched them a bit, or talking about general topic with the child. Psychiatric nurses avoided to ask about the abusive situations because it was the sensitive and shame issue that should not talk with someone met for the first time. Psychiatric nurses built familiarity with the child to reduce the fear of living in a new and unfamiliar place, and to reduce the anxiety from be separated from their family.

> *"In initially, I introduce myself, and ask the child's name to evaluate the child's response to interpersonal relationships." #4 p6/180-183*

Sometimes, some school-aged sexually abused children did not want to stay in the hospital, and asked or negotiated with the nurses about the length of time they would have to stay there. This helped to strengthen familiarity to the nurses because they had more time to see the nurse's appearance and expression, as well as heard their voices.

> "*Some school age sexually abused children took long time, more than 3 hours to accept to be in ward. I introduce them to know places and other friends. I will tell a bit of information in one time. Persuading them to shortly talk, taking time to be familiar with new place, giving reasons of admission. "# 4 p5/149-155*

Quite often, the children responded to the nurse's first approach by making a noise, using impolite language, or slapping the table. If the child's reaction was not dangerous to anyone, not life threatening, or merely a tension release, nurse allowed them to do as they wanted and came back to approach the child later. Nurses tended to arrange the new child in close proximity to the nurses, so both the child and nurses could see and observe each other behaviors. Sometimes, nurses had to repeat this process many times, and

constantly try to re-approach the child. This meant that nurses had to have a strong sense of endurance throughout the nursing process (self developing).

> *"In uncontrolled emotional case, after I get in, child makes outcry, not obey. Sometime, I must let to make a noise, or have swearing sharply, if no dangers. Waiting until calming down, I enter to talk with child again." #4 p6/163-168*

1.2 Arranging friendship: Psychiatric nurses used the things that a child likes, such as snacks/candy/toys/painting books/pretty diaries to build closeness with child. After the child had learnt this closeness through repetition many times, eventually the child felt that nurses were good persons to have friendship. The child complied nurse know some information of child. Child allowed the nurse to read her diary.

> *"Child goes with elder sister to my room. In my working room, there are sweets, snacks, I give them to the child and let them eat during talking. I talk with her and elder sister in general stories in their live. I also give a small toy to her. She wants a notebook to write. I talk with child in everyday. I tell child, if there is some trouble to come in and we will talk together in this room."*
> *#7 p12-13/347-353*

> *"After that 1 week, child has written dairy, child brings it to nurse. I ask child. Can I read it? Child said it's OK" #002p4/102-105*

Moreover, psychiatric nurses showed interests and concerns in the child by inviting the child to talk, taking time with the child, asking of the child's feelings, listening, talking, or offering to play fun activities together. As a result, the child could develop a sense of friendship with the nurse. Importantly, psychiatric nurses always were honest with the child, they provided only the facts and avoided lying to them. In addition, psychiatric nurses did not promise what could not be done, nor talk about something that they did not really

know. Furthermore, nurses explained the aims of meeting, causes of talking together, for the child to understand and realize the nurse's honest intention. This resulted in greater companionship. With these activities the child could develop friendship with nurse. Arranging friendship like this was an important aspect of gaining trust from the child.

> *"I tell child at first time that reason of talking together for you get better. I will help you, what you think that it suffers you. Please tell me. …. If you have some unhappiness, you can see me."#007p11/301-302,352-353*

> *"A boy thinks that we know everything related to him. We said that sometime I don't know in every issues. I want to know what things you speak from your voices." #002p12/356-358*

1.3 Providing confidentiality: Most sexually abused child patients had secrets, especially secret about their abused experience. Nurse need to provide these children privacy when talking about their secrets. Nurses assured that they and the child were in private room when discussing the child's personal issues. Nurses also tried to, opened private time with the child. For example, spending a few minutes with the child before bedtime or standing outside the bathroom while the child was taking a shown. Most of the time, the children themselves started telling their secret during this time. In addition, psychiatric nurse always showed the children that they would keep their promise about not disclosing the children's secret before receiving permission from the children. Providing confidentiality is one of the important activities of psychiatric nurse in gaining trust from the sexually abused children. Evidence of gaining trust children's disclosed their secret. However this did not occur in the encounters. Nurses needed to show the children their efforts in providing them confidentiality.

"This child trusts me, easily. I thinks that I explains at the beginning that I will keep a secret. ……We will talk with child in close setting that is fine to talk and has kept a secret."#7 p11/301-306

"We will quietly talk with child during 10 bathroom minutes, the child doesn't want to tell in a room where there are many people. I will talk with child, one by one, while child takes a bath." #8 p4/123-125

"In my style, I don't tell anyone in team, I keep topics talked as a secret, until I am sure my data be trust or correct, or it is a time for need team's helps. I will permit child to tell topics talked to team for helping child, completely." #12 p5/117-175

1.4 Offering tangible help: School-aged sexually abused children often kept their needs, and their signs and symptoms to themselves. Psychiatric nurses could respond only to the relevant needs of the child through watching their behavior or by asking what they required, including through telling their needs after trusting nurses. After knowing what child's needs, psychiatric nurses planned to respond to child in all needs that lead to occur easily trust.

"Child wants a notebook to write, I gave it for her....I manage by child needs such as she doesn't want to talk about her story to the other, again and again. I reported child's needs to multi-team, nursing team, and administrators.…...She fear to be injured from abuser. I give a guard comes to walk around ward, or I limit someone getting visit her by being screened from nurse, before. I permit elder sister living to be friend during admission." #7 p13/354-359

"We keep observation what child wants. If we give assistance with at child wants, child will trust us fast." #4 p9/276-280

1.5 Showing respect: Psychiatric nurses recognized school-aged sexually abused child as a human with equal rights to those of all others. Psychiatric nurses showed respect to these children by preserving child's right. Nurses always asked permission from child when there were other members to join with nurse-child talking, or asking for permission to intrude child's privacy such as reading the child's diary that the child herself offered.

> *"Before having an empty chair group to ventilate, I permit child that there is a friend being in room during a group. ….She said that OK." #6 p25/796-797*

> *"I have given a pretty diary to child. After she writes, she gets it to me. I ask child. Do you permit me to read. She said OK." #2 p4/101-104*

> *"I ask child. Do you want to disclose? Child tells that she writes diary book because she wants the others read and not ask her again and again. ….Before discharge, I permit child that disclose her child's feeling in un-named diary book to others for being advantages to other child." #7 p19/505-507, 533-536*

In addition, nurses accepted child's decision, when children became intimate with a particular nurse, that nurse let themselves be chosen as someone who was trusted by the child. Besides, nurses always accepted child's potential that each child had individual differences to develop such as some child did not speak with anyone, psychiatric nurses had to understand that the child was separated from their family, or the child was ill. If it was not serious, the nurse would let the child do it.

> *"In uncontrolled emotional case, after we get in, child makes outcry, not obey. Sometime, we must let to make a noise, or have swearing sharply. If no dangers, we let child do. #4 p6/163-165*

> *"Everyone speaks self name, on queue, but…..it is arriving to child, child doesn't speak and stiff stand. Never mind, oh! today if child doesn't speak." #1 p5/ 150-160*

1.6 Behaving consistently:, Psychiatric nurses kept their approach consistent and always came at the appointed time. Psychiatric nurses showed stability, warmth, and a secure sense of self, while talking with school-aged sexually abused children. Often, the children became moody, angry, or ill-mannered. Psychiatric nurses would then tell the child that they would talk with them at another time; they did not respond to the child with violence or show that they were bored with the bad behavior. The psychiatric nurses approached the child with calmness and talked everyday.

> *"We were stable and talked with child in everyday. Although child is moody, we don't show the boring manners. But we made a good things to child."#5 p19-20/ 607-610*

2. Arranging effective communication: Arranging effective communication was defined as an action of psychiatric nurses to arrange or discover methods to have effective nurse-child communication that included using appropriate language, using appropriate media, following child lead, providing opportunity to ventilate (see in Figure 4).

Regularly, school age sexually abused children often had communicative problems because of mistrust to talk, or being inability to talk. Most of school age sexually abused child patients who were ignored, or lacked of encouragement form parents were disturbed or delayed on language development from speechless, murmur, repeating one's word, shouting, scolding. Psychiatric nurses faced with communicative problems to child. Thus, arranging effective communication was the initial helps for school age sexually abused children to tell self needs and to communicate with others in daily living. Psychiatric nurses used specific

knowledge about child development and speech training to apply in nursing practice. Psychiatric nurses and nursing team practiced the same patterns to train children.

Figure 4 Sub-categories of arranging effective communication

2.1 Using appropriate language: Most of school age sexually abused children were limited to be young to describe self events or to understand meaning of sexual oppression. Some school age sexually abused children did not have understanding of advanced vocabulary; or they lacked of someone to participate with; or they were ignored to stay with home. Psychiatric nurses learned child's nature and cognitive ability; or observed the child's non verbal language and found out meaning of strange behaviors for choosing or arranging suitably language styles with each child such as using easy vocabulary; clear speeches and short words; simple and concise sentences word. Psychiatric nurses arranged child to learn both indirectly and directly by seeing friends speaking, teaching to speak repeatedly after nurse, arranging to be in situation to speak, or urging child to speak.

"When child can not control herself, I don't speak loudly or don't react to child. But, I will speak with child to understand with clear word, simple word, speaking shortly." #4 p9/281-285

"If relationships isn't happened, child doesn't speak with nurses. But I will greet child, Are you hungry?, Do you have friends? Whom you know? How about your food?" #4 p10/291-294

"Every time changing to new activities, child will be quiet, has stiff standing. Child will not tell what child dislikes or what child likes. …..We must observe and learn meaning of these behaviors." #1 p4/102-105, 110-112

2.2 Using appropriate media: If child patients did not speak with anyone, psychiatric nurses tried to observe child's behaviors in all day whom child contacted with. Psychiatric nurses and team discovered several things or methods that lead to ventilation and communication between the nurse and the child by communicating through trusted persons at the beginning of admission such as some nurse, the patient-assistant met for the first time, the patient-assistant looking like a younger or older sister, or through other children, or through playing and through writing for providing other nursing practice to child. In nursing team, these special strategies were shared with other nursing members, and used it in providing nursing practice.

"A child doesn't speak for many weeks, I have observed that there is one patient-assistant enters approach a child at the beginning of admission. The child will hide to speak shortly, softly with her. If nurses get in to talk, child doesn't talk with nurse. The child doesn't cooperate if nurses give eating, bathing. I provide nursing care through this patient-assistant." #1 p1/28-36

"Sometimes, child goes to let off her problems with a patient-assistant. There is the teen-aged patient-assistant in ward. The patient-assistant who is trusted has more relationships with child than us due to she works on day shift in everyday. Psychiatric nurses are changed in all day-evening-night shifts and are off duty in sometimes. But she will tell the new data disclosed to psychiatric nurses." #8 p8/255-260

2.3 Following child lead: During talking with school age sexually abused children, psychiatric nurses did not show curiosity; they allowed the child to freely talk about different things and general topics, and then they followed by the conversation on the child's interests. No frame of topics for the talk was implemented and nurses avoided asking about abusive events or past behavior. If child started to trust nurse, child began to increasingly talk about self story.

"But……I will talk with a child following by child's feeling at that time. What is the trouble by child's perception? What is child's hurt /sadness that child wants to tell me ? I will take a child is stood to talk. It depends upon what is a child want to tell. Looking like child tell self story and child will tell continually. ….I don't have the issue in a hand or ask following by topics." #7 p11-12/306, 308-311, 319-320

From following child lead, nurses had more understanding to child about child's thinking that was different to nurse's views. Psychiatric nurses were aware to not practiced nursing care on based nurse perspectives. This findings helped nurses responded pertinently on child.

"If I get a standard to measure child's trouble, I may decide that child has the most trouble. But child satisfies only food for eat, thing to use, going to school and playing with friends, and taking care for father.….That leads me know what attitude child fell to father; what make child endure." #7 p12/329-339

2.4 Providing opportunity to ventilate: Due to communication was the basis for many different types of learning, but psychiatric nurse faced with problems that school age sexually abused children refusing to talk. Psychiatric nurses believed that nurses did not know child's needs or signs, if they did not communicate. Moreover, psychiatric nurses had experienced that child patients got better after ventilating. Thus, psychiatric nurses try to teach school age sexually abused children to communicate for ventilation or tell self's needs or unhappiness to others. It was applied to psychiatric nurses gave a chance or channel to child to express or release self's mood, self's thought, self's tensions to outside by talking with child, sharing feeling in group, asking child in group, writing dairy book, playing with child, acting in psychodrama group, seeing or listening friend's telling self desires.

> *"We teach child to tell self desires such as "I don't like it," or "I don't take it" We will give child introduces herself in every group activities. We set every children tell their self names before getting food, child will do like other friends by using peer group."#1 p2-3/60-67*

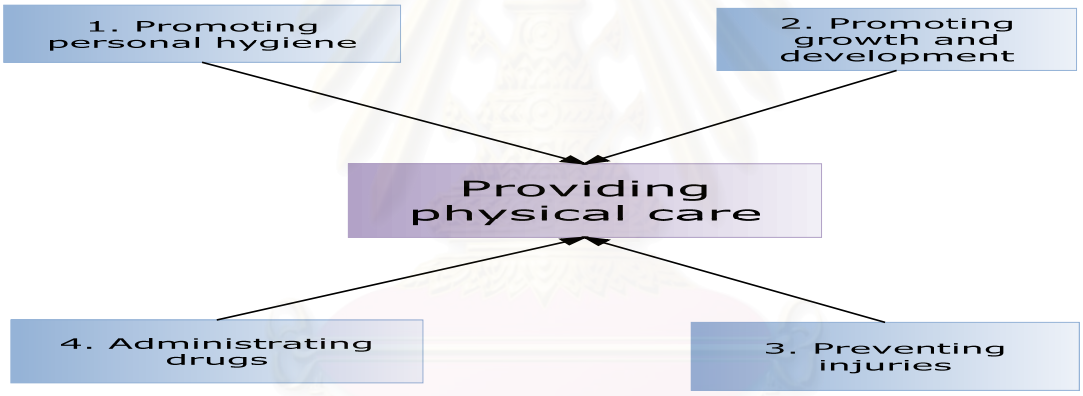
> *"As if, child can't explain self-needs, or knows less vocabulary. Sometimes, we give child sits and listens others in the group. Child will see the elder friends tell their stories in group. We arrange child is in group in everyday." #1 p5/139-145*

> *"Child has plentiful something in mind, but whom child has talked with was little. I find out how to ventilate something inner mind. I give a notebook to child to write." #7 p17/478-480*

> *"When I talks about the abuse, suddenly, a child doesn't speak anything, and walk out. I seek the way that child ventilates something off. The child can't write. In one day, during I play with her by using a puppet doll. I see!... She speaks, as if she wants to show. I try to use the puppet as a teller the events by pseudonym." #3 p1/20-26*

3. Providing physical care: It was directly responsibility to psychiatric nurses provided physical care, as a routine care because physical care was the responding to basic needs of patients. Some school age sexually abused children were neglected by their parents/caregivers, and were lacking of self interest to body cleanness. Providing physical care was defined as an action of psychiatric nurses to promoting personal hygiene, promoting growth and development, preventing injuries, administrating drugs (see in Figure 5).

Figure 5 Sub-categories of providing physical care



3.1 Promoting personal hygiene: Psychiatric nurses assessed the cleanliness of the children's body and their ability to clean themselves. Plans were made to teach them to do daily activities by schedule or training each stage everyday until they were successful at doing it by themselves. Daily routines that were trained were cleansing dishes, shower, shampooing, brushing teeth, cleaning after using toilet, changing cloth, washing under-ware. Extremely, psychiatric nurses used many techniques: if child could not do for herself, nurses cleaned for her. If child could do it, the children were encouraged what to do. At least,

psychiatric nurses eventually let the child carry out the cleaning by themselves, nurses only monitored child after doing it. Sometimes, psychiatric nurses assigned patient-assistants to assist teaching/training, or to monitor child to keep to the routine schedule.

> *"In beginning of admission, after physical evaluation found poor hygiene, we look after about child' health status and self cleaning" #4 p3/92-95*

> *"When a child arrives, we must teach child that in general, person must take care self-cleaning. We will teach newly, as though, each a family is different. This case lives with only elder sister. All day she may not take a bath, or no brushing. After arriving in ward, she doesn't know what she should do at present. …Except teaching self-cleaning, we also teach washing." #1 p8-9/215-258*

> *"We will give patient-assistants cooperates with us helps to see child. We set a schedule time of training to patient-assistants such as rubbing the body, brushing the teeth are trained for 4 weeks." #1 p10/229-302*

3.2 Promoting growth and development: Some school age sexually abused children lacked of nutrition and encouragement, their physical growth were delayed. But, some school age sexually abused children had been overeating or had dieted. Thus, psychiatric nurses promoted school age sexually abused children's body to grow up and to have the muscle strength or muscle coordination appropriated with their ages by arranging the balance of eating food, sleeping and exercise routines. The exercise was a stimulus to help them become alert before getting in group therapy. Psychiatric nurses taught school age sexually abused children to care hygiene during menstruation, and followed up the menstruation period lacked for urine examine.

"I will ask girl about a menstruation period. When is the last your a menstruation period? Because if it is absent, we will send urine exam for pregnancy." #12 p6/206-208

"There are musical activities, swimming, basketball, fitness and games that are training strength of the muscle, coordination of the muscle for getting relax in the morning, getting alert fully to do other group next. #8 p7/212-215

3.3 Preventing injuries: Some school age sexually abused children experienced unconsciousness and fell down because of their psychiatric problems After the episode, Initially, psychiatric nurses provided care to child at the scene instead of caring the child to bed to avoid more physical injuries. Nurses also set several strategies to prevent future injuries such as assigned child being nearly nurse; arranging child to be in patient-assistants' follow up; teaching child to have self protection by holding something before falling down, falling slowly down on floor. Additionally, during child's unconscious, nurses also protected child's life by observing child's breathing and arranging first aid to child.

"Unexpectedly, child fell down suddenly. Child told that child is shot. We tell child that child gets hold of something before falling down and fall slowly down and lie on floor. After evaluating the situation that is no danger, we do not carry child on bed while being unconscious. We tell child that " #1 p33/1037-1044

3.4 Administrating drugs: Every school age sexually abused children were admitted, they needed psychiatric medicine. Therefore, it was on duty of psychiatric nurses to took medicine to patient with 5 right methods. Nurses should have well knowledge of psycho-pharmacology. Nurse had to observe action of medicine to child's symptoms for

adjusting doses for suitably controlling child's symptoms. Sometimes, these children took many drugs, these actions were interfered together, it may be in over actions or under actions. Nurse should take blood examine for drug level.

> *"Child begins to not answer, not smile, being sad down obviously. Child has a bipolar, sometime depression, or sometime mania, for a moment, she is quiet. .....At this period, we always have talked with a doctor, we report that this child laughs too, and laugh unreasonably. The doctor adjusts medicine level, adds new medicine. There are a symptomatic observation and re-checking medicine level in blood." #10 p6/172-175*

After school age sexually abused child patients passed stage 1, psychiatric nurses and team discuss and judged/decided together to enter to stage 2. Within the child's outcomes, school age sexually abused child patients started to be familiar with nurses, staffs, friends and complied to do activities. These children were able to communicate to nurse with non-verbal or verbal and had more concentrate and understanding vocabularies. Including, these child patients had abilities to do daily activities by themselves.

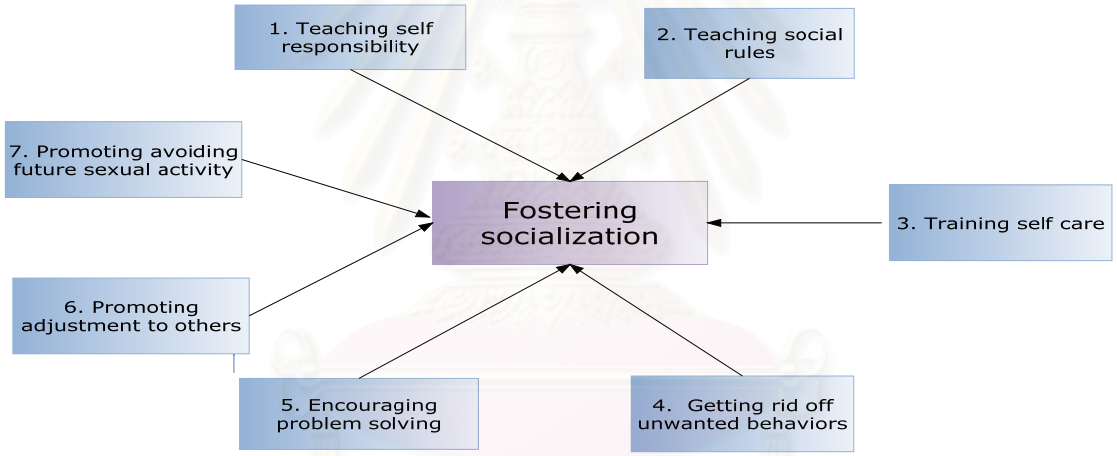
The second stage was fostering socialization, building will-power, and arranging a safe and supportive environment.

Stage 2

4. Fostering socialization: Fostering socialization was an action of psychiatric nurses that included teaching self responsibility, teaching social rules, training self care, getting rid off unwanted behaviors, encouraging problem solving, promoting adjustment to others, promoting avoiding future sexual activity (see in Figure 6).

Many school-aged sexually abused children were abused for a long time, they loss ability to adjust to society. They did not know what was right or wrong; or what a child should or shouldn't do. As a result, these children had various behavioral problems or showed unaccepted/unwanted behavior that were at odds with society. Psychiatric nurses and team helped together to teach the child to have skills required for functioning successfully in society or in a particular community.

Figure 6 Sub-categories of fostering socialization



4.1 Teaching self responsibility: Some school-aged sexually lacked someone to teach them how to do things themselves, have self discipline, or have responsibility for their own actions. Psychiatric nurses taught them to do daily activities at scheduled times, or assigned some duties to the child according to age and abilities. If a child made a mistake, the child was taught to accept it. Child patients were taught to prevent theft by keeping every thing in their own locker, or to solve mistakes such as returning something picked up,

repaying something back to the owner, or washing bed-sheets themselves, after enuresis. The child was taught not to make trouble for others and were taught to reduce their own demands and shown how to save money. In nursing teams, psychiatric nurses helped to find out strategies and to foster child patients to have a sense of self responsibility.

> *" We teach to have self-thought, self- responsibility in doing the daily routines. We assign duty by age. …..This case is younger. We assign child is an assistance of elder patients such as child will wait to pick a broom, or prepare to pick a bowl to clean floor. Although, it is a little job, we must give child doing by her duty." #1 p7/211-213, 215-222*

> *"We train to piss before sleeping, and awake child to rise to piss after sleeping around two weeks. After two week ago, we give child rises by self. If child had piss pour, we will assign to wash sheet by self" #1 p11/329-334*

> *"After shopping with father, child tells that father buys both clothes, dress. We teach child that you don't have more demands, you should know the value of money" #6 p33/1042-1043*

4.2 Teaching social rules: From lacking necessary teaching, psychiatric nurses gave children new teachings about personal rights, such as one's own rights and the rights of others, self responsibility to others; about rules of the ward and rules in society such as not harming friends, not picking up other's property without permission, queuing; rules of doing activities with others when playing with friends or entering in a group activity. School-aged sexually abused children learnt and accepted social behavior taught by nurses, such as not being sarcastic, not laughing at others in a group, learning to wait to do something, learning to listen to other's reasoning. If there were problems in a ward, child patients as members of the ward participated to solve their problems, or formulated a set of rules for the ward together. Importantly, nurses taught and warned children about practicing good social

manners such as dressing adequately, accepted behavior with the opposite sex, not going home very late at night, not scolding others, and not playing strongly with friends.

> *"As my feeling, we will let child learns to wait to talk in next appointed time, if we were busy, we will evaluate that talking topic did not hasten. We will deny child for preventing to be self-willed." #004/p11-12/L349-356*

> *"We make agreement with child that in ward if something is lost and is met at someone. That person will return to owner and is fined in self part." #1 p8/236-239*

> *"I tell child who steals other's properties that child will return things to owner. We try to manage in other way such as each person doesn't pick the valuable things with self, but keep them in a self-locker. We arrange the place/ the situation doesn't pick things easily." #1 p15/463-471*

4.3 Training self care: Most school-aged sexually abused children had various psychiatric symptoms such as powerlessness, flashbacks, hallucinations; and behavioral problems such as aggression and uncontrolled emotions. As a result, child patients were quick to be unable to control their behaviors which made trouble to others in society. Psychiatric nurses taught and trained the sexually abused children until they had basic skills and understanding and to knew techniques for self-control, anger management, and individual symptoms that may arise during daily activities. Psychiatric nurses realized that the process had many steps and it took time with training, but that a child was able to eventually take care of themselves. Psychiatric nurses arranged for the child to have self-analysis by writing in a book, or talking in psycho-therapy groups. These child patients were taught to avoid people coming in by counting numbers, running away, getting in to the rest room; telling someone close up to coach the child before expressing symptoms, and shaking the body for pulling back conscious. After a bout of lacking self control, psychiatric nurses

asked the child how they felt, what actions child should do and how to cope the next time. During training, psychiatric nurses gave support; used positive reinforcement such as praise, clapping; and cheered up the child to successfully do things.

> *"We train the skill to stop the self aggressive behavior. Shaping both speech and threaten if other child doesn't do by child. We try to use varied procedure, at last using cognitive therapy, child nods that ❞ #1 p21/661-665, 672-676*

> *"We teach anger management for knowing how stop self. If the event is severe, child can't stop self, we will get in to coach, being closely as one to one." #1 p20/595-596*

4.4 Getting rid off unwanted behaviors: From lacking someone to teach children, they had more opportunities to perform unwanted behavior in society such as aggressive behavior, lying, stealing, quarreling, self harm. Psychiatric nurses taught children about behavior that was unaccepted in society. Nurses desreased unwanted behavior by talking about causes of actions, making contracts to not do unwanted behavior; negotiating with a child to reach the accepted point, deviating to have new interests such as joining in activity groups, monitoring child, shaping a child's behavior by using peer or group power or using rewards after good behavior, modifying environments such as to hardly pick up something, or to keep valuables in one's locker, to pick-up sharp weapons; and by arranging physical training for release of tension.

> *"Child has more aggression, we will catch child to separate for child calm down. After that, we will talk with child. She said that it is very angry, it scolds me. We must keep watching whom she dislikes. We arrange litigant stay away. We learn what meaning of their staring. We always monitor child, and change their interests to read cartoons." #8p7-8/228-246*

4.5 Encouraging problem solving: Most school-aged sexually abused children did not know how to solve their problems by themselves. Psychiatric nurses believed that after discharge, if children could solve their problems first, they would have more be able to adjust to society. Psychiatric nurses used individual talks to encourage school age sexually abused children to have more skills at solving problems by asking/discussing to find the source of problems and find strategies to solve them, asking them to think about how to do things, discussing with the child about the consequences of doing and not doing things. Sometime, these children could not solve their own problems. Nurses told them that they were still loved and that they still had people upon whom they could depend. Nurses made agreements with children that they shouldn't harm themselves through self mutilation..

> *"After I asks child how is she feels to be sexual abused, she tells that it is merely the something that come in and then it passes by " #7 p20/587-589*

> *"If you don't like with mother's actions, you should tell her to know." #2 p2/36*

4.6 Promoting adjustment to others: Most school age sexually abused children had isolation from society. Psychiatric nurses promoted the child to adapt in their daily living, to live with others by encouraging friendship and playing with friends, taking the child to join social activities such as taking the child to walk in a small park, leading the child to pay respects to the Buddha, going to make merit on Thai festivals, or going on a field trip. Moreover, psychiatric nurses urged the child to listen to friends and others if they wanted to go to market fairs, psychiatric nurses gave reasons that the place might be too crowded and unsafe, but nurses took the child to walk in a small park instead. Psychiatric nurses and teams observed a child's response during their relationships with others and

evaluated how the child adjusted to others. Including times when children were trying a home visit, psychiatric nurses called on the child at home, or checked with the child when they came back to hospital to see how they were adjusting to the new conditions.

> *"We have our reasons, but child has her reason. We will quietly talk , we can not decide who correct. If it was not dangerous or more trouble, we negotiate to quickly seek the exit for a child. She wants to go to market, but its plentiful person. In the evening, we will induce child go for a walk at the field plays the sport replaces , get go to exercise , go to breathe fresh air outside. She , OK , #5p5/139-152*

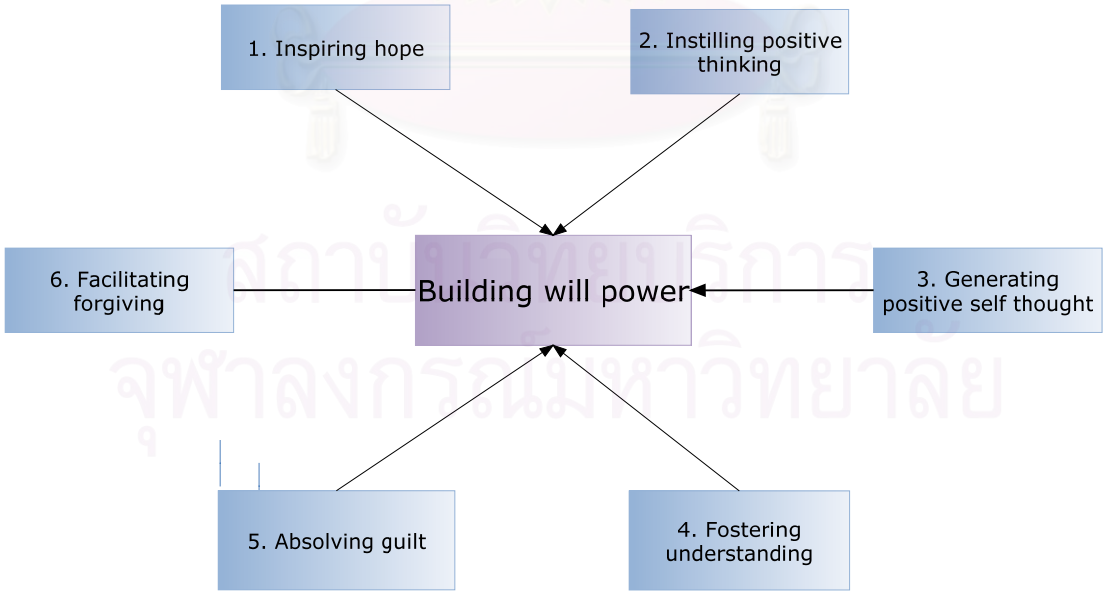
4.7 Promoting avoiding future sexual activity: After being sexual abuse, some school-aged sexually abused children love comfort and convenience, psychiatric nurses tried to change attitudes or misunderstandings about sex for sale, and asked for the children's opinions. Nurses explained that there were other jobs and ways to earn money. It was not the duty of a child to earn money by sex selling but that a child's role was studying. Psychiatric nurses taught the child that child should have sex in childhood, if child had sex child may infected with STDs, AIDS. Including psychiatric nurse taught child to say "no" if someone had a sex with child. Psychiatric nurses explained about appropriate dressing and fine manners toward men and discussed with them some issues about going out at night, wearing short skirts, and being victimized. If psychiatric nurses taught children no have a sex, but they could not practice by nurse's teaching. Nurses taught children how to have safe sex and told the child to take care of themselves.

> *"I talk with her that the event like this…You are in childhood, you must study. You don't work for money. Adult arrives at work for money. There are many ways that worked to make money a lot. I give many ideas for child that in general society, nobody do like this" #1 p18-562-568*

"I support child that it is not child's mistake. But this event is a lesson to be more intelligence. It makes to know other's thinking and is on the alert with carefulness." #7 p21/ 590-593

5. Building will power: Most of school age sexually abused child patients felt low self esteem, and had no their expectancy. They stilled to have guilt and shame feelings in their minds. Psychiatric nurses built will power to school age sexually abused children for having psychological strength to living later. Building will power was defined as an action of psychiatric nurses to make school age sexually abused children that were composed of inspiring hope, instilling positive thinking, generating positive self thought, fostering understanding, absolving guilt, and facilitating forgiving (see in Figure 7).

Figure 7 Sub-categories of building will power



5.1 Inspiring hope: School age sexually abused children lived with loneliness, and hopeless, no expectancy in life. psychiatric nurses promote them to build self hope, to set reasonable goals, how to reach hope in her life, and informing other child's ways chosen, realizing the value of life.

> *"We will tell child that this event already has been passed. As if a bad dream, but we still have a good chance and will meet the good thing." #6 p10/289292*

5.2 Instilling positive thinking: Most of school age sexually abused children who faced bad events as long time, they had many negative thinking to self and others**.** Psychiatric nurses helped to think; tried to teach child to re-think from negatively to positively; or to change to new view during confronting with bad events in their live; or to think positively in self in everyday.

> *"We will must take care closely and help child thinks. We will teach child can think and think positively by her self. We talk and teach child with positive thinking such as in the this morning, you try to explore what're your good points, what's good thing in your life. We will persuade to think and persuade to speak. In very morning, we change speeches, but our concept is positive thinking." #1 p7/189-201*

> *"Child tells me that an abuser as father's friend is hated by others and he can't earn a living. He lives in other location that is a punishment of the society" #7 p13/377-379*

5.3 Generating positive self thought: The grateful numbers of school age sexually abused children had low self-esteem. Psychiatric nurses taught child find out or pull good point of child to give will power to child such as being a good girl. Psychiatric nurses made child felt that I am good me, having value, being beloved.

"When a child thinks to suicide, but she can not do that. Due to she is anxious that nobody takes care a father. …..… I will seek her good points, it is a grateful person. I uses it as a reward to admire her." #7 p20/575-577

"You have gratefulness in today are good child. Look here! The goodness will protect you. When some events go up, everyone comes to help you." #7 p22/619-622

"We have a chance to do light job for successfulness. We assign to decorate a board with the patient-assistants because of having good ideas and having beautiful handwriting. Child is happy with own results and helping others. ….We discovery that child has abilities of singing and playing music, we will inform this prominent point of child to CPCR to study the music on weekend." #1 p8/232-237

5.4 Fostering understanding: Psychiatric nurses taught the child to think, and promoted child to have self-reasoning. Nurses helped child to self-evaluate or to understand other's feelings/reasons. Nurses promoted child tell self information or set self future plans.

"In psychodrama, we will have an empty chair, we will shout loudly like child for listening, self understanding again" #1 p5/156-157

5.5 Absolving guilt: Psychiatric nurses to reduce guilty that leaded to have self-blame by offering ways to express child's feeling; explaining to correctly understand that abuse was the unusual event, an inattentive event and the passed event that and happening inattentively; supporting child; assuring that child is not wrong.

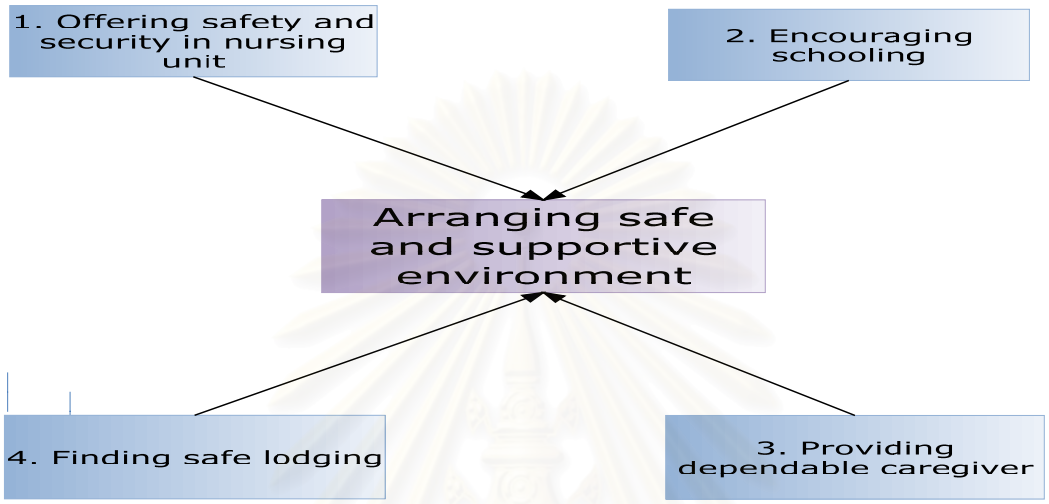
"I tell child that the thing happens is not your mistake. ….. I will not decide that it is a father's mistake that doesn't protect child. I tell child that father might have many hurt in his heart." #7 p20/581-585

5.6 Facilitating forgiving: Even though school age sexually abused children was improved from symptoms, anger was hidden in their minds. Psychiatric nurses to help strategies to cleanse their minds freely from some anger hidden such as anger to an abuser by using old experiences, knowledge related.

> *"Sometimes, an abuser is put in a jail, in short time; the abuser comes to liberate. We must prepare a child to face that truth….. After a child is calm already down, we prepare child's mind that she is not unfortunate or no righteousness. ……I use Buddha's instruction to help child forgives to an abuser. Child is calmed down." #7 p25/ 708-721*

6. Arranging safe and supportive environment: Some school age sexually abused children had aggression, some children had depression and idea to self harm. Therefore, psychiatric nurses were as a therapist to take care for these children. It was necessary to provide safe and supportive environment for life safety both children, other patients, and staff nurses. Arranging safe and supportive environment was an action of psychiatric nurses that included offering safety in nursing unit**,** finding safe lodging**,** providing dependable caregiver**,** encouraging schooling**,** offering safety and security**,** and trying to stay at home (see in Figure 8).

Figure 8 Sub-categories of safe and supportive environment



6.1 Offering safety and security in nursing unit: During providing nursing practice, school age sexually abused children were very fearful. Psychiatric nurses supported child felt safety from danger and establish a sense of security to child. Except informing about a repairman to child and closing care, psychiatric nurses arranged the safe and sense of security in ward for child patients by giving assurance to the patient such as having iron door, having the locked door, having a guardsman in front of hospital, telling someone in ward to protect child.

Besides, school age sexually abused children had more risked behaviors to child and to others. Psychiatric nurses and team prevented violence or dangers in ward for safety of all in ward by modifying physical construction such as changing the mirror to the bended iron, moving extinguish tank to safe place; closing care; using limited setting for

other's safety in ward. Besides, administrator set preventing safety standard in working of hospital, nurses arranged preventive methods in working such as asking child for permission to have others in room during having group, setting closed-circuit television in room for having group, assigning someone to keep watching on monitor.

> *"There is some sound told child to jump from upper floor, we report suddenly to a administer. The repairman come to fix iron wire at ladder. The doctor treats on medicine. " #2 p2/55-57*

> *"Our assistances are making a sense of safety and care closely and making relationships to speak something seen. Child cries and tells that she always has a bad dream. When a repairman gets in ward, child is frightened" #1 p31/968-975*

> *"After the evidence, within team, we will analysis to seek the cause and create defensive standard. If there is how is unusual events, we will self protect . Administrator sets code F1605 as safe hospital system, buy a signal warns to call a person below go to help." #1 p25/782-787*

6.2 Encouraging schooling: Due to school age sexually abused children were admitted in ward in several months and they were in childhood. Sometimes, psychiatric nurses took roles as a teacher. Psychiatric nurses concerned about child development and prepared child's readiness to learn by ages such as training eye-hand coordination; teaching to write, to read; teaching mathematic; arranging duplicated book of writing training. These children could do developmental tasks for adapt easily with new environments. Including, nurse found out new school to be safe and be suitable to child's ability.

> *"Except preparing a new living, I prepare about child's studying. I talk with the special educational teacher. ….In this case, we plan to train the eye-hand coordinators before going to school. #1 p10/308-314*

6.3 Providing dependable caregiver: School age sexually abused children wanted someone who understand and support them when they have problems**.** Psychiatric nurses help them by finding new caregiver/key person for school age sexually abused children, or helping parent easily take care, or being trial to school age sexually abused children and their parents/new caregiver be in nearly real situation. Psychiatric nurses made contracts both child and parents before trying to come back to stay together at home for evaluating child's abilities and skills in daily life and discovery new problems in time. If nurses found that there were new problems, it was sensitivity to solve the problems before discharge for assisting to live back in society.

> *"In this case, when child meets with stress or problems, child will not speak. But child will show manners like this…..We will tell what methods used such as closing up, consistency, child's problem not ending. But this problem is enough acceptable if there is someone to take care and understand and take these data to support next" #1 p11/341-348*

> *"Before child is referred to CPCR, we transfer what child's behaviors that are careful."#1 p15/471-472*

> *"This case is trail to come back 1 week, but child escapes from house to visit with her friends. We terminate child's rights to be trail to come back home because child doesn't deal by contracts/ permission." # 8 p 6/175-179*

> *"We observe child's progress that child came out after dissatisfying a friend. We will plan with team to go out to experience visit home." #9 p 10/307-311*

6.4 Finding safe lodging: Most of school age sexually abused child patients had low IQ or passive personality, For preventing re-abuse, psychiatric nurses try to search for new safe place. Nurses might consult on other profession for finding out a setting be suitable of characters of each child.

> *"In MR case, child escapes from house, mother has depression and father has stress and take care his wife. Thus, child can not send to home, we discuss in team to refer child to close setting and study in special school for MR child."*
> *#1 p10/371-375*

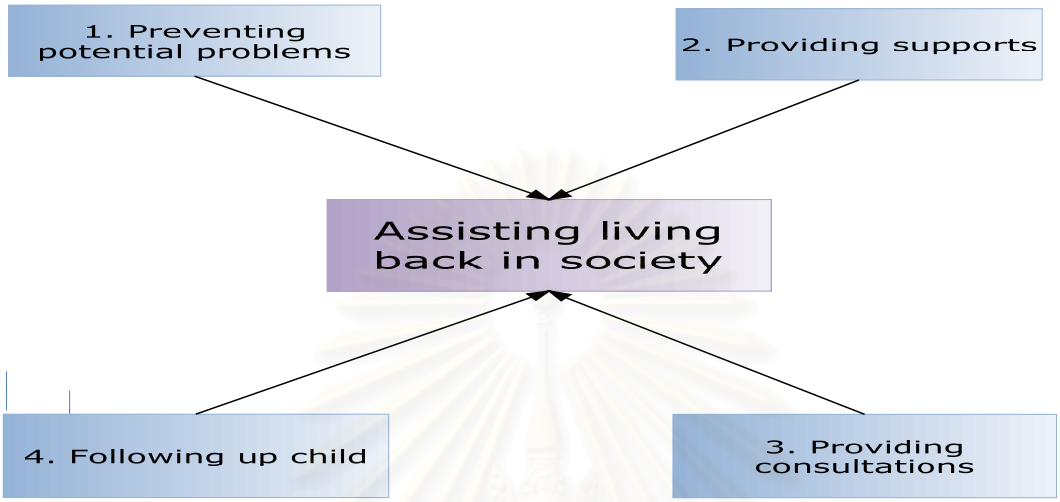
After school age sexually abused child patients passed stage 2, psychiatric nurses and team shared ideas, evaluated child's problems, and discussed for summarizing case child readiness, caregiver readiness, readiness of new place/organization for preparing for discharge to go to stage 3.

The final stage had one category as a stage of assisting living in society.

Stage 3

7. Assisting living in society: Going back to society**,** school age sexually abused children were prepared by multidisciplinary team for child was able to live in society. Assisting living in society was an action of psychiatric nurses to try to fill on something lacked, concerned some problems in future, for living in society, as long as. Assisting to live in society was composed of providing consultation, preventing potential problems, providing supports, and following up child (see in Figure 9).

Figure 9 Sub-categories of assisting living in society



7.1 Providing consultation: Psychiatric nurses told child's information such as child's backgrounds; remained signs and symptoms, improved behaviors to caregivers/new caregivers; taking drugs and following up. Including, nurses told techniques to care for child and offered constant support to child/caregiver/organizations concerning a child's symptoms or behavioral problems. Nurses worked in ward could give suggestion by phone on 24 hours.

> *"We try to help networks to be strengthen, we tell the officer of organization that we are glad to give helps every time if there are problems to take care." #1 p20/ 767-769*

7.2 Preventing potential problems: Psychiatric nurses knew the most child's information, nurse concerns problems happened in future. Thus nurses planed to reduce, prevent child's problems in long term.

> *"This case is MR child, she tries to escape to have sex. We try to refer to safe setting but she always has escaped from house and from setting if being careless. We invite her parents to talk about child's sexual behaviors, and suggest parents to get child to have birth control." #1 p38-39/ 1208-1212, 1230-1232*

7.3 Providing supports: Psychiatric nurses tried to was an action of psychiatric nurses to give supports to School age sexually abused children to stay in their settings, or to give advice caregivers/ to deal with their children. Psychiatric nurses gave the telephone number of ward, if child had more severity to refer case to ward.

> *"From my experiences of discharge case, if we discharge only one child to new living, child can not stay at there. We manage to discharge two cases at the same time, like coming to together, going to together. As if a child still to have a friend, she is not too lonely." #1 p19-20/614-618*

> *"After discharge, we will make a channel for child to talk about livelihood and her problems to live in new settings." #8 p11/329-331*

> *"Child calls to me and asks me about dressing and answering to interview for jobs " #2 p10/315-317*

7.4 Following up child: Psychiatric nurses believed that child was not enough strengthen to have total self care and caregiver's education and parenting skills was limited. Including, community care was not clear. Psychiatric nurses still give helps and supports to child, so psychiatric nurses kept attention with child's information/progress by asking from

child, from parents, or conferencing with organizations for child lived back in society, as long as.

> *"We work with CPCR, there are many cases that refer and discharge. We will ask or follow up case during case conference with team. This case is remained in our sight." #1 p12/353-362*

In each sub-stage of the remolding child process occurred simultaneously with working as a team and self developing. At last, the researcher concisely explored about working as a team and self developing for more understanding to remolding child process.

Working as a team

When school age sexually abused children were admitted in ward, psychiatric nurses had displayed to as a caregiver. To respond on school age sexually abused child patient's complex needs, psychiatric nurses could not work only one profession. Psychiatric nurses depended on multi-professions such as psychiatrists, psychologists, social workers, occupational therapist, special educators, physical trainers, patient-assistants; government organizations; non-government organizations; courts; polices; and school age sexually abused child patient's parents/caregivers. A head-nurse of psychiatric ward assigned someone nurses who were educated on master degree, or had more experiences to be a primary nurse, or a case manager to care for school age sexually abused child patient as a whole. Including, patient-assistants were assigned to be responsible to which cases or some jobs to assist nurses such as routine care, being followers and reporter school age sexually abused child patient's behaviors to psychiatric nurses.

In working as a team, psychiatric nurses acquired some information from senders, but important data were gained by child after nurses trusted. Each psychiatric nurse used acquiring information was a tool to collect data of child, caregiver, child's environment by finding out, seeing/observing, asking about, screening for, measuring with; and re-checking/verifying the data by identifying, clarifying, confirming for searching what real problems of school age sexually abused children/caregivers needed helps.

> *"When we get data that child stole friend's something, before sharing stealing data to team, we find out that it was a stealing behavior or sleeping-act, or not. It is misdiagnosed"#001p15-16/513-517*

Each psychiatric nurse inter-shared data to only professional members of team in kardex round every 8 hours-shift, and recorded data in child's document. It helped nurses getting updated data for preventing misdiagnosis of nurses, or for directly planning nursing care that point. Within team, psychiatric nurses prioritized school age sexually abused children' problems and then planed together to solve problems both in short and long terms. Moreover, psychiatric nurses discussed with in team to have conclusions, or transferred some jobs. Including, psychiatric nurses will hold the same direction to practice to school age sexually abused children. After psychiatric nurses provided nursing care in a range of time, it was evaluated. If the problem was not improved, psychiatric nurses discussed within team to newly assess, or to adjust setting of goal, or to change plans to care. The head-nurse of ward helped staff nurses to have effective working as a team by encouraging and developing member's knowledge/abilities. The head-nurse announced staffs to invent new nursing procedure by themselves, gave suggestions in working, helped to solve complex problems of school age sexually abused children. Moreover, the patient-assistants were taught techniques

of care/helping, or were asked to think, or were informed news in every morning. In nursing team, psychiatric nurses developed patient-assistant's ideas by asking to think and answering, teaching tactics, giving knowledge related to take care for child patients. Including, nurses assigned patient-assistants to observe and tell child's abnormal signs for confirming data before reporting to psychiatrist to give help when necessary.

Assisting child patients to their life goals, psychiatric nurses worked with nursing team and multidisciplinary team. In multidisciplinary team, psychiatric nurses had colleagueship with other professions for child's benefits. Psychiatric nurse was a cooperator such as contacting other professions for helping child, giving information, telling clearly about aims of consult, following up the specific results/ opinions/ evaluations, and helping to plan continuously after discharge. Gaining professional notices is basic to make decisions of team to help school age sexually abused children in next steps. If there is an informal/good personal relationships between nurses with multi-disciplinary team, it is easy to receive helps and advantage for child.

> *"I and social worker have the good relationships. She sympathizes with child. After she gains data of this case, she visits house and family. She tries to look for mother who was lost and seek the new school."*
> *#7 p16/111-114, 451-452*

Self developing

Most of psychiatric nurses who provided nursing care for school age sexually abused children felt self developed by trial and error, learning directly with last cases leading to good nursing care in next case. Some psychiatric nurses mentioned that "school age sexually abused child patient was my teacher." During self developing, psychiatric nurses applied

knowledge from education, training, personal experiences such as Buddha's teaching to practice for each school age sexually abused child patient. Psychiatric nurses were cheered up by head-nurse to encourage to show power/ability in self.

> *"We must do it by a child doesn't make a request. We will encourage, or follow up in the process of judgment what a child should receive the assistance" #7 p24/692-694*

During providing nursing care for school age sexually abused children, psychiatric nurses might face with be scolded, be harmed from patients who could not control self emotion, or be expressed with severe symptoms, or anger to abuser being a father. It was caused to have conflicts between oppressed behaviors and direct responsibilities to patients. It was challenge that psychiatric nurses dealt with self mood to have acceptable behaviors of nursing profession/society. Along being with school age sexually abused children, psychiatric nurses had self awareness to ask self who we were, what we did, tried to think that school age sexually abused children were ill, or school age sexually abused children had low self control. Mostly, psychiatric nurses use self-talking, self reminding, avoiding from situation and asking for others deal with school age sexually abused children. Moreover, psychiatric nurses were careful to situation trapping, and learnt methods to be safe self from experiences of previous cases; training related to violence, limit setting by restraining or being in separated room. Nurses learned to have safety techniques such as avoiding to get in room opened after child's shouting. After self evaluations, it was not safe, nurses locked child in the room and leaving off the situation. Nurses may study from last evidence reports but also reported new events.

Except self developing in a part of knowledge, psychiatric nurses were self developed ultimately in mind. It made psychiatric nurses provided nursing care with concerns and more

attention from after discharge, nurse still follow up case, or give supports. Including, psychiatric nurses highly developed self moral to nursing profession such as to automatically protect benefits/rights for child such as following child's helps/benefits should be gained; or negotiating with public prosecutor to be friend during witness; or creating the public awareness about trauma during asking child's abuse history.

> *"In multi-professional conference, I am invited to present my job. I have induced to announce my working experiences of trauma of child asked again and again. The child who receive sexual abuse, she writes that she doesn't want to mention it again." #7 p17/494-496, 683-685*

Importantly, psychiatric nurse have good characteristics such as quite, listening, empathy were important to lead to effective nursing care. Psychiatric nurses took actions in several roles such as being a mother or a relative, a being a speaker during using remolding.

> *"A child requests me to go with her because of no the relative trusted for witness. The public prosecutor asks me that why you come in room, you are unrelated. You should go out, he will talk individually with a child. I bargains with the public prosecutor that I requests to sit far that a child sees, but not hear for what you say. The public prosecutor said OK. Starting, the child cries and whimpers. I am called to talk with child to stop crying." #7 p8-9/221-224*

CHAPTER V

DISCUSSION

In this chapter, the conclusions of this grounded theory study are discussed. First, the remolding is summarized. Then, the relationship of the remolding to other relevant literature is addressed. Next, implications for nursing practice are presented and implications for future research are proposed. Finally, the limitations of the study are addressed.

Conclusions

The purpose of this study was to explore a process and to develop a substantive theory to describe the nursing care process for school age sexually abused children in psychiatric wards in Thailand. In this grounded theory approach, twelve psychiatric nurses, with a mean age of 45.75 years (ranging from 35years to 59 years old) took part in the study as participants. Eleven of the psychiatric nurses were female, and only one was male. Six participants were single, and six were married. Four participants had graduated with bachelor degrees and eight had graduated at master's degree level. With regard to staff training, only one participant had studied merely the post graduate training in psychiatric nursing. Six of the participants had furthered their studies with both the post graduate training in psychiatric nursing and other additional training**.** Four participants had gone on to study a wide variety of further relevant nursing skills, such as family counseling, examining witnesses/testimonies, psychodrama, psychiatric nursing for children and adolescents,

counseling, negotiation, and observing operations and procedures at psychiatric wards of university hospitals. Only one participant had no additional training since graduation.

Two participants were head nurses, three participants were deputy-head nurses, and the remaining seven were either staff nurses assigned to be primary nurses, leaders of teams, or members of team. The staff's experience of working in general psychiatric wards ranged from 5 to17 years. The mean work experience of the participants, in general wards, was 10.42 years. The staff's general experience of working with school age sexually abused children ranged from 1 to 6 years. Mean work experience with school age sexually abused children of the participants was 3.75 years. Numbers of school age sexually abused children taken care of by these psychiatric nurses ranged from 5 to 35 cases and gave a mean average of 10.25 cases cared for per participant.

Seven categories, properties and dimensions emerged from data analysis as the remolding child. It was the effective therapeutic nursing that the psychiatric nurses gave, as experts in their field with highly developed cognitive processes, experience, and skills, which consequently contributed to effective personal nursing care for school age sexually abused children. The process of remolding child was composed of 3 stages that was happened continuously in sequence. Each stage consisted of sub-stages that had no sequences in their occurrence, and these sub-stages were simultaneous and reciprocal. In remolding child process, the first stage was started with establishing trusts, 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. Each sub-stage of "remolding child" process occurred simultaneously with working as a team and self developing of psychiatric nurses.

Discussions

In the ‘hierarchy of needs’ theory (Maslow, 1970), the individual who suffers deficiency needs, feels anxious. These deficiency needs are physiological needs, safety needs, social needs (love/belonging), and esteem needs. Physiological needs, or the basic human needs, are food, warmth, sex, water, and other bodily needs. The safety needs involve feeling a sense of danger and unfamiliarity such as requiring personal security from crime, financial security, health and well-being, and safety in new places. Social needs involve feeling a sense of belonging and acceptance from a large social group or from small social connections, such as friendship, intimacy, having a supportive and communicative family. Esteem needs are the need to be respected, to have self-esteem, self-respect, to respect others, and to feel accepted and self-valued. All of the preceding four levels are called deficit needs. If people don’t have enough of something, they still feel the need, within each level, until those needs are fulfilled.

When comparing ‘hierarchy of needs’ theory to the ‘remolding’, we can see that School age sexually abused children are ignored by parents and family. School age sexually abused children lack everything, both concrete things and those which are abstract. Psychiatric nurses react to these basic needs by providing physical care, such as food and medicine, sleeping, exercise and playing. In addition, psychiatric nurses respond to the safety needs of school age sexually abused children by arranging a safe and supportive environment; introducing the child to members of staff, helping to cultivate friends and orientating the child so that they become familiar with the nursing environment as a new place. 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 addition, school age sexually abused children 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. Moreover, a great number of school age sexually abused children have esteem needs, and it is the psychiatric nurses who attempt to build patients' will power by generating positive self thought and fostering an understanding of self.

In Hildegard Peplau's Interpersonal Relations Model (1952), Peplau describes six major roles of nurse as the nurse-patient relationship develops, and these roles relate to the roles of psychiatric nurses as the therapists in remolding. The first major role is that of the role of stranger, where the nurse and patient do not know each other. This role fits the 'taking on process', where school age sexually abused children and therapist are strangers and must get to know each other by watching and listening and general interaction over a period of time. In Peplau's second role, the role of the resource person, the psychiatric nurse provides knowledge and decides upon the most appropriate interventions. The nurses function in this resource role throughout the remolding, by asking people whom they know well, by self study and from reading texts, and by applying theory into practice whilst also using their own individual experiences. The third role, the role of teaching, is where psychiatric nurses teach and train patients about daily activities, self-discipline and self-responsibility, social rules, social norms, and schooling. The fourth role, that of leadership, promotes the psychiatric nurses who were either leaders of nursing teams or primary nurses, to be responsible for managing or solving all of their patient's problems. In the fifth role, the surrogate role, psychiatric nurses act as the talker, or the speaker, especially when school age sexually

abused children feel hurt, afraid, and dare not speak. Psychiatric nurses tell everyone involved that the child does not want to repeatedly talk about the abusive events, or they tell the mother that the child wishes for their mother to praise them, which is responding to school age sexually abused children's needs. The last role is that of the counselor. Psychiatric nurses talk individually with school age sexually abused children everyday to allow them to express themselves, and ask them to think about the causes of their problems and ways that they can be solved.

Shives (1994) and Long & Smyth (1998) study relates to establishing trust of remolding. Long and Smyth state that the nurse-patient relationship is the most important aspect of the nurse being accepted and trusted. Although psychiatric nurses start establishing trust, it occurs simultaneously and reciprocally with arranging effective communication, and providing physical care. Shives (1994, p 91) states that the task of the orientation phase of the relationship is to build trust, rapport, establish a therapeutic environment, assess the patients strengths and weakness, and establish a mode of communication acceptable to both patient and nurse included within establishing trust i.e.: building familiarity; arranging friendship; providing confidentiality and offering tangible help; showing respect to the child; behaving consistently; and arranging effective communication.

In the locus of control theory (Rotter, 1996), it is suggested that people are externally or internally controlled. Externally controlled people tend to think their lives are controlled by fate, feel helpless to do anything about it, and thus take little action. Internally controlled people think that their own actions determine a great deal of their life, they feel empowered, and they act to make changes where they see the need.

In comparing locus of control to the remolding, school age sexually abused children tend to enter the nursing care process with an external locus of control where they feel helpless and out of self-control (for example, showing aggressive behavior, lying, stealing, or attempting to escape from the ward). School age sexually abused children are re-socialized, molded, or trained to have the ability or power of self control. It is the psychiatric nurses' hope that School age sexually abused children become more internally controlled within their lives.

Natesuwan (2003) also relates to remolding child. Natesuwan reports one case of an abused child's adaptation, by modifying aggressive behavior, which identified three stages: starting to establish a relationship; exploring the cause of problems, setting goals towards accepted behavior; and lastly assigning self exploration, training in positive communication, and training in adaptation and assertive behavior. In comparing the stages of modifying aggressive behavior and that of remolding, the categories of establishing trust, arranging effective communication, and fostering socialization, show similarities.

Socialization is the process by which people learn the ways of a particular group. In every group, one has to learn the rules, expectations, and truths of that group, whether it be one's family, the army, or the state (nation). Socialization is the process whereby people acquire personality and learn the ways of life within their society. Essentially, one has to learn culture. Learning culture encompasses all the truths, values, rules, and goals that people share with one another. Culture is a shared perspective. The most important time when socialization occurs is between the ages of one and ten; however, we continue to learn throughout our lives. Thus, re-socialization is the process of learning new norms, values, attitudes, and behavior. It refers to the process of discarding former behavior patterns and

accepting new ones as part of a transition in one's life. Re-socialization occurs throughout the human life cycle (Schaefer and Lamm, 1992: 113). Both socialization and re-socialization conform to fostering socialization that teaches social rules; training in self responsibility, self care, problem solving and adjustment to others; changing misunderstanding, and shaping unwanted behavior.

According to Cohen and Mannarino (2000) and Tremblay, et al. (1999) it is suggested that parental support of the child is a strong predictor of the outcome of treatment. These finding are similar to arranging a safe and supportive environment, such as preparing safe lodgings, ensuring a caregiver's readiness and skill to care of their children, promoting mother-father-child relationships and undertaking trial home visits.

The implications for nursing practice

Remolding is an effective nursing practice process for school age sexually abused children that stemmed from interviewing expert psychiatric nurses. The remolding child is a guideline to help novices or inexperienced psychiatric nurses who work with school age sexually abused children admitted to psychiatric wards, to save time, energy, and expense in their nursing care. Thus, school age sexually abused children, who achieve the remolding process, have fewer residual signs and symptoms that are likely to develop into long term consequences in adolescence and adulthood. Lastly, school age sexually abused children are satisfied with their lives and have a better quality of life.

As regards promoting living in society, provided that psychiatric nurses follow up cases after discharge from the ward, and continue this until there is real self adjustment, and a

capacity to solve problems, the procedure will be successful. This is vital due to the limitation of psychiatric community care at present.

From remolding, the parent or caregiver support is found to be highly important and effective in helping school age sexually abused children. Besides this, psychiatric nurses help to promote parents strength, offer training in effective parenting skills, add to a positive child-parent communication and relationship, and add strength to the network.

From data analysis, the researcher noticed that school age sexually abused children often disclose abusive events whilst they are bathing in a wash room and the psychiatric nurses are standing or talking outside. Hence, psychiatric nurses are aware that they should bring the child to bathe by themselves. Including psychiatric nurses choose to use small gifts, or candy, or toy to build trust with this children group.

In school age sexually abused children with complicated problems such as drug addiction, moral retardation, conduct disorders, or father/mother/relative distress with a child's behavior over an extended period of time, both child and caregiver are given treatment at the same time. These particular school age sexually abused children cases often escape from the house or ward, and so they are referred to a closed setting.

The education of nurses may be causes of feeling that they have less knowledge to provide nursing practice for sexually abused children. At the present, the nursing curriculum would be revolted specially the violence content. In nursing practice, nurse educators should apply this finding to study and should develop nursing student's competencies for sexually abused children and family.

Implications for future research

In the future, this research could be extended to sexually abused adolescent patients admitted to psychiatric wards, in order to compare the similarities and differences of results, or to generate the remolding in other groups. Other than studying the nursing care process of school age sexually abused children by interviewing psychiatric nurses, the next research should investigate the nursing care process from the school age sexually abused child patient's perspective and that of the caregiver, so as to give a complete view of the care procedure for school age sexually abused children. Moreover, the additional research should study the two processes as conditions of remolding: 'working as a team' and 'developing personal self'. Not only should psychiatric nurses be interviewed, but also several other professions of the multidisciplinary team, in order to compile a compete view of those involved with helping sexually abused children. From data analysis and notification, the future research should explore under what conditions school age sexually abused children agree to disclose abusive events or keep their conflicts hidden.

Research hypotheses generated from remolding need to be studied and tested as follows: (a) establishing trust that occurred simultaneously and reciprocally with arranging effective communication, and providing physical care, (b) it was the process of fostering socialization, building will power, and arranging a safe and supportive environment that brought about an interchangeable cycle, (c) that, the interchangeable cycle of fostering socialization, building will power, and arranging a safe and supportive environment lead to assisting living in society, and finally, (d) school age sexually abused children who achieved 'remolding child', can live in society. This "remolding child" is a substantive model that get from data, so it is needed to test repeatedly for additional credibility of model.

Limitations of the study

In this study, the researcher used only in-depth interviews, as many school age sexually abused child patient cases were admitted to psychiatric wards in an unstable condition, and therefore the researcher was not able to observe or interview School age sexually abused children 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 who work with school age sexually abused children, and who are experts in their field, represent a very small group, and my own participants comprised only 12 psychiatric nurses.

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APPENDICES

APPENDIX A

ที่ ศธ 0512.11/0487

คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
อาคารวิทยกิตติ์ ชั้น 12 ซอยจุฬา 64
เขตปทุมวัน กรุงเทพฯ 10330

6 มีนาคม 2550

เรื่อง ขอความอนุเคราะห์ให้นิสิตเก็บรวบรวมข้อมูลการวิจัย

เรียน ผู้อำนวยการโรงพยาบาลศรีธัญญา

เนื่องด้วย นางแสงเทียน ธรรมลิขิตกุล นิสิตชั้นปริญญามหาบัณฑิต คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย กำลังดำเนินการวิจัยเพื่อเสนอเป็นวิทยานิพนธ์ เรื่อง "กระบวนการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศในหอผู้ป่วยจิตเวชในประเทศไทย" โดยมี รองศาสตราจารย์ ดร. จินตนา ยูนิพันธุ์ เป็นอาจารย์ที่ปรึกษาวิทยานิพนธ์ และมี ผู้ช่วยศาสตราจารย์ ดร. วราภรณ์ ชัยวัฒน์ เป็นอาจารย์ที่ปรึกษาวิทยานิพนธ์ร่วม ในการนี้ใคร่ขอความอนุเคราะห์ให้นิสิตดำเนินการเก็บรวบรวมข้อมูลการวิจัย จากกลุ่มตัวอย่างพยาบาลจิตเวชที่มีประสบการณ์ในการดูแลเด็กที่ถูกทารุณกรรมทางเพศบนหอผู้ป่วยจิตเวช จำนวน 8 คน โดยใช้แนวทางการสัมภาษณ์พยาบาลจิตเวช ทั้งนี้นิสิตจะประสานงานเรื่อง วัน และเวลา ในการเก็บรวบรวมข้อมูลการวิจัยอีก ครั้งหนึ่ง

จึงเรียนมาเพื่อโปรดพิจารณาอนุเคราะห์ให้ นางแสงเทียน ธรรมลิขิตกุล ดำเนินการเก็บรวบรวมข้อมูลการวิจัยดังกล่าว คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย หวังเป็นอย่างยิ่งว่าจะได้รับความอนุเคราะห์จากท่าน และขอขอบพระคุณอย่างสูงมา ณ โอกาสนี้

ขอแสดงความนับถือ

(รองศาสตราจารย์ ร.ต.อ.หญิง ดร. ยุพิน อังสุโรจน์)
คณบดีคณะพยาบาลศาสตร์

สำเนาเรียน หัวหน้าฝ่ายการพยาบาล
งานบริการการศึกษา โทร. 0-2218-9825 โทรสาร. 0-2218-9806
อาจารย์ที่ปรึกษา รองศาสตราจารย์ ดร. จินตนา ยูนิพันธุ์ โทร. 0-2218-9828
อาจารย์ที่ปรึกษา ผู้ช่วยศาสตราจารย์ ดร. วราภรณ์ ชัยวัฒน์ โทร. 0-2218-9804
ชื่อนิสิต นางแสงเทียน ธรรมลิขิตกุล โทร. 08-7004-1836

APPENDIX B

Informed Consent Form

Title: Remolding Child: Process of Nursing Practice for Sexually Abused Children

Code number: Population or Participant……..

I was informed by Mrs. Sangtien Thamlikitkul who live at 32/59 Ladphrao23 Chankaserm Chatuchak Bangkok 10900. She has signed her name in this document and has explained the objectives of the study, research process, benefit and harm, which may occur during in studying. I asked all doubtful problems until apprehended whole research processes.

I agreed to participate in this study. I may withdraw from the study without reasonable and I recognized side effect or harm that may occur during the study. I will follow what researcher advice me to perform during her study.

I was informed by researcher that if, it is harmful due to her study. I will be protected by the Law. I will report to researcher as possible as I can. If not, I will not be protected by the Law.

I agreed to acquaint the researcher information, so as to bring a benefit to this study.

Finally, I agreed and appreciated to participate in this study under the conditions above.

.....….	.....
Place/Time	Sign consent form
.....….	.....
Place/Time	Main researcher signature
.....….	.....
Place/Time	Witness signature

APPENDIX C

ใบยินยอมของประชากรตัวอย่างผู้มีส่วนร่วมในการวิจัย
(Informed Consent Form)

ชื่อโครงการ การหล่อหลอมเด็ก: กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ
เลขที่ ประชากรหรือผู้มีส่วนร่วมในการวิจัย.....

ข้าพเจ้าได้ทราบจากผู้วิจัยชื่อ นาง แสงเทียน ธรรมลิขิตกุล ที่อยู่ 32/59 ลาดพร้าว23 จันทรเกษม จตุจักร กรุงเทพฯ 10900 ซึ่งได้ลงนามด้านท้ายของหนังสือนี้ ถึงวัตถุประสงค์ ลักษณะ และแนวทางการศึกษาวิจัย รวมทั้งทราบถึงผลดี ผลข้างเคียงที่อาจเกิดขึ้น ข้าพเจ้าได้ซักถาม ทำความเข้าใจเกี่ยวกับการศึกษาดังกล่าวนี้เป็นที่เรียบร้อยแล้ว

ข้าพเจ้ายินดีเข้าร่วมการศึกษาวิจัยนี้โดยสมัครใจ และอาจถอนตัวจากการเข้าร่วมการศึกษาครั้งนี้เมื่อใดก็ได้โดยไม่จำเป็นต้องแจ้งเหตุผล และยอมรับผลข้างเคียงที่อาจจะเกิดขึ้นและจะปฏิบัติตามข้อแนะนำของผู้ทำการวิจัย

ข้าพเจ้าได้รับทราบจากผู้ทำการวิจัยว่า หากข้าพเจ้าได้รับความเสียหายจากการศึกษา ข้าพเจ้าจะได้รับความคุ้มครองทางกฎหมาย และจะแจ้งผู้ทำการวิจัยทันที ในกรณีที่มิได้แจ้งให้ผู้ทำการวิจัยทราบในทันทีถึงความเสียหายที่เกิดขึ้นจะถือว่าข้าพเจ้าทำให้การคุ้มครองความปลอดภัยเป็นโมฆะ(ตามที่กฎหมายกำหนด)

ข้าพเจ้ายินดีให้ข้อมูลของข้าพเจ้าแก่ผู้วิจัย เพื่อเป็นประโยชน์ในการศึกษาวิจัยครั้งนี้

สุดท้ายนี้ ข้าพเจ้ายินดีเข้าร่วมการศึกษานี้ ภายใต้เงื่อนไขที่ได้ระบุไว้แล้วในขั้นต้น

....

สถานที่/วันที่ ลงนามประชากรตัวอย่างผู้มีส่วนร่วมในการวิจัย

....

สถานที่/วันที่ ลงนามผู้วิจัยหลัก

....

สถานที่/วันที่ ลงนามพยาน

APPENDIX D

APPENDIX E

Patient/Participant Information Sheet

1. Title: Remolding Child: Process of Nursing Practice for Sexually Abused Children

2. Researcher name: Sangtien Thamlikitkul

3. Office: Kaukarun College of Nursing

Office number: 02-4216500 Home number: 02-5115183, 02-5110783, 02-9305922

Mobile number: 087-0041836 E-mail: Sangtien_t@yahoo.com

4. Information relevant to informed consent form of this study consist of

4.1 This study focuses on the investigation of the experiences of psychiatric nurses who provide nursing practice for sexually abused child patients in psychiatric wards

4.2 The objectives of the study are to explore and describe nursing care process of psychiatric nurses for sexually abused child patients.

5. Qualitative approach will be employed in this study which investigate through experiences of psychiatric nurses in psychiatric wards of tertiary hospitals. Initial step, researcher will introduce myself, tell the objectives of the my study, appoint date, time, and place to 3 of psychiatric nurses provide the best nursing care in wads. Then, researcher will allow in interview with psychiatric nurses whom are depended on emerged data from analysis may change the characteristic of sample. This study won't have harm or risk to participant's health. Participant's name will be placed by code number. Specific name in the acknowledgement will not be directed links with the research environment. Tape and transcription, record, and data will be placed in security locker and store separately from code identifying.

6. To minimize potential harm of the participants, the consent from states that the

participants can withdraw from the study at any point of time without effects of working

7. During interview, participants can ask doubtful questions or refuse to answer some questions.

8. The appointment will be made beforehand. To confirm availability and to provide an opportunity to cancel, the researcher will call before appointment tome.

9. If the researcher finds whatever benefit or harm relevant to this study, she will inform me without hesitation.

10. I understood all research process of collecting data, benefit or harm due to participation in this study, and I agreed to participation in this study.

11. Without payment

12. The research finding will be presented as a whole picture. Name and address of participants will be kept as a secret. Except in case of receiving permission by Law, all information will be revealed to publish by publication.

13. The number of the participants are 20-30.

14. In case of the participants feel uncomfortable during interview, the researcher will:

    14.1 Stop interviews in advance and provide psychological support

    14.2 Consult the psychiatrist in ward for appropriate intervention and treatment

15. Researcher will be available for all participants 24 hours when they need help or in trouble, contact by mobile phone: 087-0041836.

APPENDIX F

ข้อมูลสำหรับประชากรตัวอย่างหรือผู้มีส่วนร่วมในการวิจัย
(Patient/Participant Information Sheet)

1. ชื่อโครงการวิจัย การหล่อหลอมเด็ก: กระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ
2. ชื่อผู้วิจัย นางแสงเทียน ธรรมลิขิตกุล ตำแหน่ง นิสิตคณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
3. สถานที่ปฏิบัติงาน วิทยาลัยพยาบาลเกื้อการุณย์

   โทรศัพท์ที่ทำงาน 02-4216500 โทรศัพท์ที่บ้าน 02-5115183, 02-5110783, 02-9305922

   โทรศัพท์เคลื่อนที่ 087-0041836 E-mail: Sangtien_t@yahoo.com
4. ข้อมูลที่เกี่ยวข้องกับการให้คำยินยอมในการวิจัยประกอบด้วยคำอธิบายดังนี้

   4.1 โครงการนี้ศึกษาเกี่ยวกับประสบการณ์การทำงานของพยาบาลจิตเวชที่ทำหน้าที่บำบัดทางการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศในหอผู้ป่วยจิตเวช

   4.2 วัตถุประสงค์ของการวิจัยเพื่อสำรวจและอธิบายกระบวนการปฏิบัติการพยาบาลสำหรับเด็กที่ถูกทารุณกรรมทางเพศ
5. การวิจัยครั้งนี้เป็นการวิจัยเชิงคุณภาพ ผู้เข้าร่วมในการวิจัยครั้งนี้เป็นพยาบาลจิตเวชที่ให้การดูแลเด็กที่ถูกทารุณกรรมทางเพศในหอผู้ป่วยจิตเวชของโรงพยาบาลระดับทุติยภูมิ ในระยะแรกของการศึกษาวิจัย ผู้วิจัยจะแนะนำตัว สร้างสัมพันธภาพบอกวัตถุประสงค์ในการศึกษา นัดหมายวัน เวลา สถานที่ตามสะดวก กับพยาบาลจิตเวชผู้ที่ให้การบำบัดทางการพยาบาลดีที่สุดแก่ผู้ป่วยเด็กที่ถูกทารุณกรรมทางเพศที่อยู่ในหอผู้ป่วยเพื่อสัมภาษณ์เชิงลึกเกี่ยวกับวิธีการทำงาน ในระยะต่อมาผู้วิจัยจะแนะนำตัว สร้างสัมพันธภาพบอกวัตถุประสงค์ในการศึกษา นัดหมายวัน เวลา สถานที่ตามสะดวก ในการสัมภาษณ์พยาบาลจิตเวชที่ทำงานในหอผู้ป่วยซึ่งอาจมีคุณลักษณะของกลุ่มตัวอย่างที่แปรเปลี่ยนไปตามผลของการวิเคราะห์ ข้อมูลที่ได้จากการสัมภาษณ์ครั้งก่อน ในการศึกษาวิจัยครั้งนี้ไม่มีอันตราย ความเสี่ยงใดๆที่จะเกิดขึ้นกับผู้ร่วมวิจัย ซึ่งข้อมูลที่ศึกษาจะไม่ถูกเชื่อมโยงหรือพาดพิงถึงพยาบาลจิตเวชที่ทำหน้าที่ดูแลเด็กที่ถูกทารุณกรรมทางเพศในหอผู้ป่วยจิตเวช เพราะข้อมูลที่ได้จะถูกเข้ารหัส แถบบันทึกเสียง และเอกสารบันทึกการถอดเทปจะถูกจัดเก็บไว้ในที่ปลอดภัยและมิดชิด โดยแยกจากรหัสที่ใช้แทนชื่อผู้ป่วย
6. เพื่อลดความเสี่ยงอันตรายต่อผู้มีส่วนร่วมในการวิจัย ใบยินยอมของผู้มีส่วนร่วมในการวิจัยระบุไว้ว่า ผู้มีส่วนร่วมในการวิจัยสามารถปฏิเสธที่จะเข้าร่วมหรือสามารถถอนตัวจากโครงการวิจัยได้ตลอดเวลา โดยการปฏิเสธที่จะเข้าร่วมการวิจัยครั้งนี้ โดยไม่มีผลต่อการพิจารณาความดีความชอบจากการปฏิบัติงานของพยาบาลจิตเวชที่ข้าพเจ้าได้รับแต่ประการใด
7. ระหว่างดำเนินการสัมภาษณ์ ผู้มีส่วนร่วมในการวิจัยสามารถถามหรือปฏิเสธต่อการตอบคำถามได้

8. ผู้วิจัยมีการนัดหมายล่วงหน้าก่อนดำเนินการสัมภาษณ์ และเพื่อเปิดโอกาสให้ผู้เข้าร่วมวิจัยตัดสินใจเข้าร่วมหรือปฏิเสธ ผู้วิจัยโทรศัพท์เพื่อติดต่อยืนยันการตัดสินใจ

9. หากผู้วิจัยมีข้อมูลเกี่ยวกับประโยชน์และโทษเกี่ยวกับการวิจัยครั้งนี้ ผู้วิจัยจะแจ้งให้ข้าพเจ้าทราบโดยไม่ขัดข้อง

10. ข้าพเจ้าได้ทราบข้อมูลของโครงการข้างต้นตลอดจนข้อดี ข้อเสียที่ได้รับจากการเข้าร่วมโครงการครั้งนี้ และข้าพเจ้ายินยอมจะเข้าร่วมโครงการดังกล่าว

11. ไม่มีการจ่ายค่าตอบแทนแก่ผู้เข้าร่วมในการวิจัย

12. ผลการวิจัยจะถูกนำเสนอในภาพรวม ส่วนชื่อและที่อยู่ของผู้เข้าร่วมในการวิจัยจะถูกปกปิดอยู่เสมอ ยกเว้นว่าได้รับความยินยอมไว้ โดยระเบียบและกฎหมายที่เกี่ยวข้องเท่านั้น จึงเปิดเผยข้อมูลแก่สาธารณชนได้ในกรณีที่ผลการวิจัยได้รับการตีพิมพ์

13. จำนวนผู้เข้าร่วมในการวิจัย โดยประมาณ 20-30 คน

14. ในกรณีที่ผู้เข้าร่วมในการวิจัยได้รับผลกระทบกระเทือนด้านจิตใจจากการสัมภาษณ์ ผู้วิจัยจะดำเนินการดังนี้

    14.1 ยุติการสัมภาษณ์และให้การประคับประคองทางด้านจิตใจ

    14.2 ประสานงานกับจิตแพทย์ในหอผู้ป่วย เพื่อให้การรักษาที่เหมาะสม

15. การติดต่อกับผู้วิจัยในกรณีที่มีปัญหา สามารถติดต่อได้ตลอด 24 ชั่วโมงกับผู้วิจัยคือ นาง แสงเทียน ธรรมลิขิตกุล หมายเลขโทรศัพท์เคลื่อนที่ 087-0041836

APPENDIX G

Interview Guide

Number of participants……..…….

Date/month/year……..……Time……

Participants: psychiatric nurses who had at least a bachelor degree; had work experience in general psychiatric wards for more than 5 years; had worked with school-aged sexually abused children in psychiatric wards for at least 1 year; and had experience of providing nursing care to at least 5 cases of school-aged sexually abused children.

Part 1 Demographic data

Elucidation Please check ✓ in the blank of answer

1. How old are you?

   Answer **…….**years

2. What is your marital status?

   ( ) Married ( ) Single ( ) Divorced ( ) Other, please identify

3. What is your highest level of education?

   ( ) Bachelor's degree ( ) Master's degree ( ) Doctor's degree

4. What is your work status

   ( ) Head of Dept ( ) Deputy head ( ) Team Leader ( ) Team Member

5. Have you ever received any extra training?

   ( ) Post graduate training in psychiatric nursing program

   ( ) Other programs, please identify

   .....

6. How long have you had experience with general psychiatric patients?

   Answer**……..**years.

7. How long have you had experience in dealing with this group of psychiatric patients?

   Answer**……..**years.

8. How many of these psychiatric child patients have you had experiencing in caring for?

   Answer**……..**years.

Part 2 Interview guides that focus on participants

2.1 Grand tour questions

"Could you please tell me about your experience in nursing practice for psychiatric children (6-12 years old) or children with behavioral problems who have been admitted to psychiatric ward from being sexually abused?"

Probing questions

"What do you mean?"

"Please tell me more details about that"

"Please explain it."

"What else?"

"What are you saying exactly?"

2.2 Guideline of interview questions

The use of these questions depends on the interview situation and interviewees, for example: the interviewees have not exactly answered the point of the questions or spoken of unnecessary experiences.

Questions concerning the nursing of child patients

"What is the unique nature of nursing care of the abused children?"

"In this case, how did you have nursing principles, when she /he was in the acute phase?

"How did you take care when she/ he was out of acute period?

"In cases of long term abuse, how did it have an effect on your nursing care?

"What conflict did the child have?"

"What did you do to help release the child of any conflict?"

"How did you make this child express this feeling?

"What did you do when the child had guilty feelings?"

"What kind of help did the child require from you?"

"How did you assess the child problems?"

'What nursing care did you give to solve the child's problems?"

"What is the principle of nursing care that helped you to solve problems?"

"What is the nursing care that you used to manage the child's problems?"

"How did you know that your nursing care succeeded?"

"What are the effects of child abuse?"

"What did you learn from providing nursing care for child abuse patients?"

"What are the factors that help you take care of child abuse?"

"What are the troubles that occur during your nursing care of child abuse?"

Nursing questions about the family

"How did you help the family of the child who suffered from sexual abuse?"

"What roles or procedures did you have to help the family of the child?

"What are the problems that occur during caring for the child's family?"

"How did you feel about the family of the child who had been sexually abused?"

"How did you help or protect the rights of child abuse outside of the family?"

Nursing questions to the nurse

"What did you think abut the nursing care that you gave in cases of child abuse?"

"How did you feel when you contacted the family of child abuse?"

"Moreover, what did you feel when you gave nursing care to child abuse patients?"

"How did you prevent the problems of nursing care?"

"Did you receive help to get rid of your negative feelings?"

"If you received help, what did you receive and from whom?"

Nursing questions to nurses and multidisciplinary team

"How did nurses have the roles in nursing care of child abuse?"

"How did nursing teams have a plan for helping child abuse?"

"What are the roles of the multidisciplinary team?"

"Do you have contact with the other multidisciplinary teams?"

"What are your problems and troubles of working with multidisciplinary teams?"

"How did you manage these problems?"

"When did the stage of child care connect to the multidisciplinary team?"

Conceptualizing questions

"Would you like to talk about important topics or offer suggestions?"

"If it may be necessary to ask something else or check the data, would you please allow me to interview you once more time?"

APPENDIX H

แนวทางการสัมภาษณ์

ผู้ให้ข้อมูลหมายเลข……..

วันที่ เดือน ปี พ.ศ..... **เวลา**.....

ผู้ให้ข้อมูลคือ.....พยาบาลจิตเวชที่ผ่านการอบรมเฉพาะทางการพยาบาลจิตเวช และมีประสบการณ์การทำงานในหอผู้ป่วยกับผู้ป่วยจิตเวชทั่วไปอย่างน้อย 5 ปี และประสบการณ์การทำงานกับผู้ป่วยจิตเวชเด็กที่มีประวัติถูกทารุณกรรมทางเพศอย่างน้อย 1 ปีและมีประสบการณ์ในการดูแลเด็กกลุ่มนี้มากกว่า 5 ราย

ส่วนที่ 1 .ข้อมูลส่วนบุคคลและครอบครัว)เมื่อสิ้นสุดกระบวนสัมภาษณ์ พยาบาลจิตเวชให้ข้อมูลส่วนบุคคลและครอบครัว(

คำชี้แจง ขอให้ทำเครื่องหมาย ✓ ในช่องคำตอบ

1. ท่านมีอายุเท่าใด?

…….. ปี

2. สถานภาพการสมรสในปัจจุบัน?

( ) แต่งงาน, ( ) โสด, ( ) หย่า, ( )อื่นๆโปรดระบุ..

3. ระดับการศึกษาสูงสุดของท่าน?

( ) ปริญญาตรี, ( ) ปริญญาโท, ( ) ปริญญาเอก

4. ตำแหน่งในการทำงานของท่าน?

( ) หัวหน้าตึก, ( ) รองหัวหน้าตึก, ( ) หัวหน้าทีม, ( ) สมาชิกทีม

5. ท่านได้รับการฝึกอบรมเพิ่มเติมอะไรบ้าง?

( ) อบรมหลังปริญญาตรีทางการพยาบาลจิตเวชศาสตร์ (PG),

( )อื่นๆโปรดระบุ …….

.....

6. ท่านมีประสบการณ์ในการทำงานกับผู้ป่วยจิตเวชทั่วไปนานเท่าใด?

……..ปี

7. ท่านมีประสบการณ์ในการทำงานกับผู้ป่วยเด็กจิตเวชกลุ่มนี้นานเท่าใด?

……...ปี

8. ท่านมีประสบการณ์ในการพยาบาลผู้ป่วยเด็กจิตเวชกลุ่มนี้มาจำนวนเท่าใด

……ราย

ส่วนที่ 2 .แนวทางการสัมภาษณ์เกี่ยวกับกระบวนการพยาบาลสำหรับเด็กอายุ 6-12 ปีที่มีอาการทางจิตหรือปัญหาพฤติกรรมเนื่องมาจากเคยทารุณกรรมทางเพศ

2 1.คำถามเพื่อเปิดการสนทนา:

"คุณช่วยเล่าประสบการณ์เกี่ยวกับการดูแลเด็กอายุ 6-12 ปีที่มีอาการทางจิตหรือปัญหาพฤติกรรมที่เนื่องมาจากเคยทารุณกรรมทางเพศให้ฟังได้ไหมคะ"

คำถามเพื่อการเจาะลึกในการสัมภาษณ์

-คุณกำลังหมายถึงอะไร

-กรุณาบอกรายละเอียดเพิ่มเติมได้ไหม

-คุณช่วยอธิบายหน่อยคะ

-มีอย่างอื่นอีกไหม

-คุณกำลังจะบอกอะไร

2.2 แนวคำถามเพื่อใช้เป็นแนวทางในการสัมภาษณ์ การใช้คำถามขึ้นอยู่กับสถานการณ์ของการสัมภาษณ์และผู้ให้สัมภาษณ์ เช่น การตอบคำถามของผู้ให้สัมภาษณ์ไม่ตรงประเด็นคำถาม หรือประสบการณ์ที่เล่ามายังไม่ได้เล่าถึงประเด็นสำคัญดังนี้:

คำถามการพยาบาลเกี่ยวกับผู้ป่วยเด็ก

"การพยาบาลเด็กกลุ่มนี้มีลักษณะเฉพาะอย่างไร"

"case นี้ตอนที่มามีอาการเฉียบพลัน รุนแรง คุณมีหลักในการดูแลอย่างไร"

"พอพ้นระยะacuteแล้วคุณดูแลเขาอย่างไร"

"ใน case นี้มีประวัติว่าถูกทารุณกรรมมานานมาก ส่งผลกระทบกับการพยาบาลเขาอย่างไรคะ"

"คุณทำอย่างไรให้เด็กcase นี้ได้ระบายความรู้สึกออกมา"

"เด็ก case นี้มีปมที่ขัดแย้งในใจอะไรบ้าง"

"คุณทำอะไรบ้างเพื่อลดกับความขัดแย้งในใจของเด็ก case นี้"

"คุณทำอย่างไรเวลาที่เด็ก case นี้รู้สึกผิด"

"เด็ก case นี้ต้องการให้คุณช่วยเขาในเรื่องอะไรบ้าง"

"คุณประเมินปัญหาของเด็ก case นี้อย่างไร"

"คุณใช้หลักการพยาบาลอะไรบ้าง ในการแก้ไขกับปัญหา.....ของเด็ก case นี้"

"คุณทำการพยาบาลอะไรบ้างเพื่อจัดการกับปัญหาของเด็ก case นี้"

"คุณรู้ได้อย่างไรว่าการพยาบาลที่คุณให้ case นี้ได้ผล"

"ผลที่คาดว่าควรจะเกิดกับเด็ก case นี้คืออะไร"

"คุณเรียนรู้อะไรบ้างจากการพยาบาลเด็ก case นี้"

"มีปัจจัยอะไรบ้างที่ช่วยให้คุณดูแลเด็ก case นี้ได้ดี"

"มีอุปสรรคอะไรเกิดขึ้นระหว่างที่คุณให้การพยาบาลเด็ก case นี้"

คำถามการพยาบาลเกี่ยวกับครอบครัว

"คุณมีส่วนช่วยเหลือครอบครัวของเด็กที่เป็นผู้กระทำและ/หรือไม่เป็นผู้กระทำทางเพศอย่างไร"

"คุณมีบทบาทต่อครอบครัวของเด็ก case นี้อย่างไร"

"ปัญหาที่พบในการดูแลครอบครัวของเด็ก case นี้คืออะไร"

"คุณรู้สึกอย่างไรกับครอบครัวที่เป็นผู้กระทำและไม่เป็นผู้กระทำทางเพศ"

"คุณมีส่วนช่วยเหลือหรือพิทักษ์สิทธิของเด็ก case นี้ออกจากครอบครัวอย่างไร"

คำถามการพยาบาลเกี่ยวกับตัวพยาบาล

"คุณคิดว่าการพยาบาลที่ให้ในเด็ก case นี้เป็นอย่างไร"

"คุณรู้สึกอย่างไรเวลาที่ต้องติดต่อกับครอบครัวของเด็ก case นี้"

"นอกจากนี้ยังมีความรู้สึกอะไรอีกบ้างที่เกิดขึ้นขณะพยาบาลเด็ก case นี้"

"ความรู้สึกนี้มีผลต่อการดูแลของคุณต่อเด็ก case นี้อย่างไร"

"คุณทำอย่างไรเพื่อไม่ให้เกิดปัญหา....นี้ในการดูแล"

"คุณได้รับความช่วยเหลือในการขจัดความรู้สึกเหล่านี้หรือไม่"

"ถ้าได้รับความช่วยเหลือ มีอะไรบ้างและจากใคร"

คำถามการพยาบาลเกี่ยวกับทีมพยาบาลและทีมสหวิชาชีพ

"พยาบาลมีบทบาทในการดูแลเด็ก case นี้อย่างไร"

"มีการวางแผนงานภายในทีมพยาบาลอย่างไรเพื่อช่วยเด็ก case นี้"

"บทบาทของพยาบาลต่อทีมสหวิชาชีพคืออะไร"

"มีการติดต่อประสานงานกับใครบ้างในทีมสหวิชาชีพ"

"ปัญหาและอุปสรรคของคุณในการทำงานกับทีมสหวิชาชีพคืออะไร"

"คุณจัดการกับปัญหานี้อย่างไร"

"การทำงานกับทีมสหวิชาชีพ จะมีส่วนเกี่ยวข้องในขั้นตอนใดของการดูแลเด็ก case นี้"

คำถามสรุปประมวลความคิด

"มีคำแนะนำหรือประเด็นสำคัญอะไรที่คุณยังไม่ได้พูดถึงแล้วอยากจะฝากไว้"

"หากพบว่ามีข้อมูลบางส่วนไม่ครบถ้วน หรือเพื่อตรวจสอบความถูกต้องของข้อมูล จะขออนุญาตสอบถามข้อมูลเพิ่มเติมอีกครั้ง"

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3.4Master of Education.(Developmental Psychology)	1998
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4. Position

4.1. Staff nurse, ICU of Taksin Hospital	1984-1992
4.2. Nurse instructor	1992-present

5. Research publication

Thamlikitkul, S. (2003). How Nurses Have the Leadership with in Self-Awareness. *Vajira Nursing Journal*, 5(2), 56-67.

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ประวัติผู้วิจัย

นาง แสงเทียน ธรรมลิขิตกุล ประวัติส่วนตัว เกิดวันที่ 8 กันยายน พ.ศ. 2505 สมรสกับ นายมนูญ ธรรมลิขิตกุล ประวัติการศึกษา สำเร็จการศึกษาประกาศนียบัตรวิชาพยาบาลและอนามัย วิชาผดุงครรภ์ชั้นสูง เมื่อปีพ.ศ.2523 และสำเร็จการศึกษาประกาศนียบัตรพยาบาลศาสตร์ต่อเนื่อง 1 ปี (เทียบเท่าปริญญาตรี) เมื่อปี พ.ศ.2524 จากวิทยาลัยพยาบาลเกื้อการุณย์ สำเร็จการศึกษาสาธารณสุขศาสตรบัณฑิต (บริหารโรงพยาบาล) เมื่อปีพ.ศ.2534 จากมหาวิทยาลัยสุโขทัยธรรมาธิราช สำเร็จการศึกษาการศึกษามหาบัณฑิต (จิตวิทยาพัฒนาการ) เมื่อปีพ.ศ. 2541 จากมหาวิทยาลัยศรีนครินทรวิโรฒ ประสานมิตร ประวัติการทำงาน ปี พ.ศ. 2527-2535 ปฏิบัติงานครั้งแรกในตำแหน่งพยาบาลประจำการหอผู้ป่วยหนัก กองการพยาบาล โรงพยาบาลตากสิน ปี พ.ศ. 2535 – ปัจจุบัน เป็นวิทยาจารย์ ภาควิชาการพยาบาลจิตเวชศาสตร์ วิทยาลัยพยาบาลเกื้อการุณย์