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School nurses avoid addressing child sexual abuse

Lisbet Engh Kraft MPH, PhD student

GullBritt Rahm PhD

Ulla-Britt Eriksson PhD, Associate Professor

Karlstad University

Author Note

Lisbet Engh Kraft, MPH, PhD-student, GullBritt Rahm, PhD, and Ulla-Britt Eriksson, PhD,
Associate Professor, Department of Health Sciences, Karlstad University, Sweden.

Correspondence concerning this article should be addressed to Lisbet Engh Kraft,
Department of Health Sciences, Karlstad University, SE-651 88 Karlstad, Sweden.

E-mail: lisbet.ENGH-KRAFT@kau.se

Introduction

Child sexual abuse (CSA) is a global public health problem with major consequences for the individual child and society (Gilbert, Widom, et al., 2009). The U.N. convention on the rights of the child (UNCRC) emphasizes that children should be protected against violence, abuse including sexual abuse, neglect, or exploitation by those nearest to them. UNCRC also stresses the responsibility of the society to give priority to the needs of children and to protect them (UNICEF, 2002).

A common definition of CSA is when a child is involved in a sexual activity that he or she does not understand or is unable to give consent to and is not developmentally prepared for. Consequently CSA is a sexual activity between an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (Butchart, Phinney Harvey, Mian, Furniss, & Kahane, 2006).

The prevalence of CSA differs between studies due to different study-designs, cultural differences, the taboo about CSA, and the effects of CSA that restrain the child from putting words on the CSA. A prevalence study by Edgardh and Ormstad (2000) found 11 percent of female students and 3 percent of male students in Sweden being sexually abused. However, among school non-attenders in the same study, the prevalence was higher (27 percent and 2 percent respectively). A recent Swedish population study of women (n 5681) and men (n 4654) between the ages of 18 to 74 found that 17 percent of the females and 6 percent of the males had been sexually abused by an adult before the age of 18. The abuse included penetration or attempt to penetration for 6 and 2 percent of the females and the males respectively (Andersson, Heimer, & Lucas, 2014). CSA has been associated with higher risk for medical, psychological, behavioral and sexual problems (Maniglio, 2009). Psychological symptoms following CSA such as post-traumatic stress, eating disorders, lack of

concentration, higher levels of dissociation, somatization, anxiety, depression, suicide and suicidal behavior are reported (Briere & Elliott, 2003; Carter, Bewell, Blackmore, & Woodside, 2006; Herman, 1997; Paolucci, Genuis, & Violato, 2001). Also risky sexual behaviors, negative sexual outcomes and subsequent adult victimization are effects of CSA (Briere & Elliott, 2003; Van Roode, Dickson, Herbison, & Paul, 2009). Rahm and her colleagues (2006) suggest shame as a recurrent effect of CSA, which in turn affects life negatively, exhibiting feelings of insufficiency, worthlessness, and of being an outsider.

The process of disclosing is complicated and is dependent on many factors. Confidence in adults in general and the reaction they get when disclosing is crucial (Janson, Jernbro, & Långberg, 2011). The child also has to understand the victimization internally as well as confiding in the choice of when, where, and who to tell (Bonanno, Noll, Putnam, O'Neill, & Trickett, 2003; Schaeffer, Leventhal, & Asnes, 2011; Staller & Nelson-Gardell, 2005).

Schaeffer's research group (2011) states that asking about abuse helped children to tell.

Barriers to disclose are fear or threats that bad things would happen if disclosing, feelings that "the right opportunity to tell" never comes and the closeness of the relation to the abuser (Georgsson, Almqvist, & Broberg, 2011; Schaeffer et al., 2011). Feelings of shame might also prevent the child from a disclosure making the abuse hidden (Rahm et al., 2006).

Bonanno and his fellow researchers (2003) studied non-verbal expressions of shame and found that women, who had been abused as children but did not tell about the abuse when there was an opportunity, showed more such expressions than disclosers did. When a group of persons, where CSA was known, were asked to tell about the most distressing event of their life, as many as 41 percent did not report the sexual abuse (Bonanno et al., 2003). Due to the difficulties to disclose sexual abuse, the number of unrecorded cases is probably high (Lundqvist, Svedin, & Hansson, 2004). The recipient of the disclosure needs to have trust in her-/himself and in the profession as well as trusting the system to protect and support the

abused children. The ability of professionals to detect and support abused children is influenced by trust (Engh Kraft & Eriksson, 2015). A non-blaming conduct is of vital importance for children to disclose abuse and the child also needs an assurance of continuous support following the disclosure according to Grace and her research group (2012).

Unprepared adults might respond in an inappropriate way when children are disclosing due to lack of proper knowledge or fear. Staller and Nelson-Gardell (2005) maintain that the children then will withdraw their disclosure or that the situation will be misinterpreted.

Swedish school legislation stipulates that all pupils (aged 6-18) have the right to school health services aiming at good physical, psychological and social health paying particular attention to children with special needs (National Board of Health and Welfare, 2014). Apart from a school nurse and a school physician providing medical treatment, the school health team also consists of a school counselor, a psychologist, and a special education teacher (SFS 2010:800). The school health service is bound by professional privacy (SFS 1982:763; SFS 2010:800). School nurses have both a health promotion and a child protection role (Crisp & Lister, 2004). The recurring health dialogues and other contacts help building a trustful relation to the pupil and give the school nurse, apart from knowledge of the pupil's health and life situation (Clausson, Köhler, & Berg, 2008; Golsäter, Lingfors, Sidenvall, & Enskär, 2012) good opportunities for detecting and supporting abused children (Gilbert, Kemp, et al., 2009). However, according to Lagerberg (2004), girls and young children in seemingly good health are less likely to be detected, as their signs are unrecognized. All professionals who learn or suspect that a child has been abused are obliged to report this immediately to the Child Protection Services (CPS) and to give information of importance for the investigation (SFS 2001:453). The obligation to report is not always fulfilled due to factors such as the nature of the case, the experiences and education of the professionals and if their judgement that reporting will benefit the child and its family (Engh Kraft & Eriksson, 2015; Svensson &

Janson, 2008). Another obstacle to report abuse is a combination of lack of knowledge and the professional's fear for and worry about identifying abuse (Lazenbatt & Freeman, 2006).

An earlier study (Engh Kraft & Eriksson, 2015) showed that the school nurses did not initially talk about nor mention CSA as one form of child abuse in spite of their obligation as professionals to report suspected CSA. Though, when the subject was highlighted a lot of stories were told (not presented in the previous study). In the present study we returned to the data and asked new research questions. Why did CSA not come forward as child abuse and what can we learn from school nurses about their ability to detect CSA and support sexually abused children? The aim of the study was thus to explore how the school nurses face CSA and their ability to detect and support sexually abused children.

Methods

Design, participants and procedure

A qualitative research design was chosen in order to gain a deeper understanding of the phenomenon studied (Starrin, Dahlgren, Larsson, & Styrborn, 1997). The current study is a secondary analysis of data originally collected to answer research questions about school nurse's ability to detect and support abused children. The original study consisted of two focus group interviews with four groups.

Participants were 23 school nurses with adequate specialist training and 3-38 years of professional experience. The ages of participants were between 46 and 67. All were women which reflect the gender imbalance in the school nurse group as a whole with very few male school nurses. The group sizes varied between four and six. The sessions were led by a moderator, who is also the main author, and was in the form of a discussion on the basis of a thematic interview guide. The interviews lasted about two hours, were taped, and transcribed verbatim shortly afterward. An observer, who is one of the co-authors, documented each

interview in writing. This documentation was read aloud at the end of each interview and the respondents were given the opportunity to confirm or correct the content to increase the validity. Since CSA was hardly mentioned during the first focus group interviews when the school nurses were asked to freely discuss child abuse, the CSA issue was highlighted in the second interview.

Informed consent was obtained for each study participant in accordance with guidelines from the Swedish Research Council (2011). Data were collected during the autumn of 2013. For more detailed information, see earlier report by Engh Kraft and Eriksson (2015). The study was approved by the Ethical Research Review Board in Uppsala (Dnr 2013/160).

Thematic analysis method

The data analysis of the current study began with the authors first separately and later together read the transcripts. When faced with CSA, the informants reported frequent experiences and feelings around CSA. The segments of text that contained information exclusively on CSA became the unit of analysis.

A thematic analysis was made following the guidelines proposed by Braun and Clarke (2006) in order to gain an understanding of the school nurses' approach to and ability to detect CSA. Thematic analysis is a method for identifying, analyzing and reporting patterns or themes within data and interprets various aspects of the research topic (Boyatzis, 1998; Braun & Clarke, 2006). According to Braun and Clarke (2006) some of the phases of thematic analysis are similar to the phases of other qualitative research. Though there are steps to be followed, the thematic analysis is not a linear but more a recursive process with going back and forth throughout the process and it is also a process that develops over time (Ely, 1997). The research group of three persons had different earlier professional experiences such as school nurse, social worker and psychotherapist, which gave a pre-understanding and

facilitated asking the proper questions to the data. The researchers also have long experience of conducting scientific interviews and qualitative analysis.

To familiarize ourselves with our data, each researcher read through each transcript and identified segments for coding. Disagreements were resolved through negotiation. In general, broader inclusion of text to be coded in order not to lose the context was favored. There was no disagreement about the core concept. The next phase was to sort codes into potential themes by making mind-maps and organizing them into theme-piles. This phase included looking for relationships between codes, between themes, and between different levels of themes leading to forming and reviewing of main themes, sub-themes within them and a main overarching theme. Eventually a thematic map of the fully worked out themes was produced (Figure 1) which shows the broader overall story about our data in relation to our research questions. The evidence of the themes is further described in the results section below together with some data extracts to validate and demonstrate the prevalence of the theme.

Results

The main theme that emerged in the analysis was Avoidance, which also permeated other themes. The following three themes were developed in the analysis: 1) Arousal of strong emotions, 2) Disclosure process, 3) Ambivalence of the school nurse. Each theme consists of two to three sub-themes, as shown in figure 1 and described in more detail in the text below.

(Figure 1 about here)

Avoidance

The fact that the school nurses did not spontaneously mention sexual abuse as an aspect of child abuse was the first signal of their ambivalence towards this phenomenon. They demonstrated an inner reticence to referring to this area at all. They preferred not to talk or

even think about CSA. They were concerned about arousal of strong defensive attitudes in both child and parents. If they nevertheless did raise the matter with the pupils, there was a risk of losing contact. Initially in the interviews they suppressed recollection of any CSA events with which they had come into contact in their work. It was not until the discussion centred on the experiences of others in this area that they recalled that they themselves had been involved in similar situations and could describe them. They also expressed an uncertainty as to whether they dared to believe the child or to interpret it as something the child had made up and thus probe further. When a child did show signs of abuse, this was re-interpreted as having causes other than CSA. It may also be added that the school nurses were professionally vulnerable in that they worked alone without supervision or support. They felt a degree of uneasiness about negative reactions in the form of reproaches, which sometimes could be aggressive in nature, when CSA was raised.

Arousal of strong emotions

Sexual abuse aroused strong feelings and opposition in the school nurses both in thinking and talking about it. The theme is built up of the two sub-themes: The sensitive private sphere and creating distance through language.

The sensitive private sphere

Becoming involved in the family's sensitive private sphere aroused ambivalent feelings. As described earlier the nurses were concerned about defensive attitudes in child and parents but they also showed these attitudes themselves. They described an inner opposition against taking action. This opposition was illustrated with the comment: "It is such a taboo area. It is so awful if it is true."

The most difficult situation to deal with was when the abuse had been committed within the family, the most private of spheres. If the incident had occurred outside the family it was

somewhat simpler to deal with, even for the child. Abuse committed by a stepfather was easier to talk about than that committed by a biological father. The nurses even said it was easier to deal with rape committed by a person of the same age as the victim. In these circumstances, however, the child did not want their family to know about it. The nurses also experienced that it was less difficult to approach and talk about abuse against the child by an unknown perpetrator on the internet. Children were described as loyal towards their family. The child had to feel secure before accusing a family member of abuse. The nurses felt that the children understood very well that something very private and forbidden was taking place within the family: "Children protect their parents in every situation." If the nurses suspected that a family member could be the perpetrator, they felt as if they were the accusers: "Thinking of someone in these terms is very harsh." Becoming involved in the family's private sphere might lead to the school nurses losing contact with the pupil, as the following situation taking place between a new pupil at school and a nurse will show. A 12-year-old girl was standing in the corridor crying and the nurse started talking to her. The girl then told her that she had been exposed to sexual abuse when she was 4-5 years old. They agreed that the nurse would call her mother, but she was annoyed and said that the matter had been settled. However, the girl kept coming to see the nurse, who was again concerned and contacted the girl's mother once more. This resulted in the girl being forbidden to visit the school nurse and the girl changing schools. This example underlines that the work of the school nurse entails a balancing act to avoid losing contact with the pupil.

According to the school nurses, there has been an increase in recent years in the number of girls reporting rape at parties. However, the girls did not reveal the rape until they were 18 and thus of age since they knew that the school nurse was then bound by professional secrecy and could not inform their parents. Professional secrecy was perceived by the pupils as protecting their private sphere by not involving their parents, as shown by the following

comment: “A girl ... had been raped (when she was 12-13)... [She] waited [to report it] until she was 18. She checked on me the whole time...She wanted to protect her mother.”

Creating distance through language

The school nurses distanced themselves from CSA by not speaking in plain terms but by using vague language and circumlocutions. In the interviews they seldom used specific words for sexual acts but described them in vaguer terms: “It wasn’t consummated then, but in another way. I don’t want to. Ugh, it’s tough talking about what had happened in detail. But it was then, you know.” Other ways of describing sexual abuse were: “Awful thing”, “that”, “been on her”, “something like that”, and “set about.” They said that speaking plainly and thus being seen as accusatory by the pupil or someone in their family was a problem for them: “The question is whether to put it into words for them. It is extremely difficult to ask about abuse. It really is.” On the other hand, they emphasized the importance of asking and using open questions with pupils.

Disclosure process

Disclosing abuse was a complicated process for the child and for the school nurse. Children seldom spontaneously disclose that they have been subjected to sexual abuse and the nurses were ambivalent and found it difficult to detect signs of CSA. The disclosure process consists of three sub-themes: From blind eye to eye-opener, Children do actually tell and Open up but not give up.

From blind eye to eye-opener

When the school nurses were first asked an open question about child abuse, sexual abuse was not raised. When, at the second interview, they were asked about their experience of CSA as school nurses, several indicated that they had not encountered it. However, recollections of such events were aroused when colleagues talked about their experiences

during the focus-group discussions: “I had completely forgotten about it. I have even been to the district court as a witness.” As the interviews progressed, the nurses described in detail a number of situations where they had been involved in cases of CSA which they had not only forgotten but, as they expressed it, nor had the strength to think about.

Children do actually tell

It emerged from the interviews that the process of disclosing CSA is complicated. The nurses described how children often use both verbal and non-verbal narratives. They indicated that children found it difficult to put what they experienced into words. On the other hand, they could provide metaphorical descriptions of the abuse. For instance, one pupil put it in the following terms: “I am like a radio-controlled car. He wants me to sit in his lap.” Other ways pupils had of signalling abuse was through alarming absenteeism or by exposing themselves to risk: “This is self-destructive then. When you don’t value yourself and it takes different forms of expression. It must have its origins in something.” This shows that the school nurses need to be attentive to many different signs of CSA. Children could come with fantastic stories where it was difficult to say whether they were true or not: “I find this very difficult. What does it mean? What’s her life at home like, was one of my first thoughts.” The above quote refers to a pupil who came to the nurse’s office several times per week. The nurse quickly became concerned but found the girl’s stories confusing and difficult to interpret. Another nurse felt that “it is not easy to see. You have to develop spectacles to see. Extremely hard.” A further means of disclosure pupils might use was to tell their friends about the abuse; these then raised the alarm and might even accompany the pupil to the nurse or some other adult. This shows that children have different ways of disclosing abuse.

Open up but not give up

According to the nurses, children seldom spontaneously disclosed that they had been sexually abused: “I have never had a situation where a pupil has come and given a direct account of

what they have been subjected to.” In the meeting with the pupil, the nurse could instead become concerned that something was not right: “A gut feeling that there was something...that she wanted to make known, but it was very difficult to find out what it really was. It took a long time.” The nurses used various strategies to make children ‘open up’. One such strategy was to let the children draw or write down their stories, which they could then discuss. Others were health questionnaires, health dialogues, participation in sexual education and open consultation. The school nurses, however, sought further assistance in learning how to pose more in-depth questions on abuse.

The health questionnaire, which is completed prior to the health dialogue, was seen as a means of achieving a more in-depth discussion. It was a matter of ‘reading between the lines’ and talking about what was not there. Questions about whether anyone had hurt them, about home-life and well-being could lead to a disclosure of abuse. One such example concerned a girl in the 8th grade who gave a positive answer to the question of whether anyone had hurt her so that she was really scared. It emerged that she had been subjected to CSA and this was then reported to the police. The school nurse gave her support to both the girl and her mother during the judicial proceedings. Another question about well-being at home led to the disclosure that a girl had been sexually abused by her brother: “She was a quiet and timid girl who showed no signs. It was just that she told me... I don’t know what other opportunity she would have chosen.”

Individual health dialogues without parents were routine for pupils from 4th grade upwards. It was seen as essential for several reasons, partly so that the voice of the child should be heard and partly so that they had an opportunity to talk about possible abuse. If a parent wanted to be present anyway, two meetings were arranged, where one was with the pupil alone. If parents insisted on being present at the individual meeting with the pupil, this was seen as an alarming sign and possibly an expression of the need for control: “One girl sent an

SMS on a Saturday evening. Did her father have to be present at the health dialogue? We never have the parents present. That really is a warning sign. What's up?"

The school nurse often takes part in the school's regular sexual education and talks about puberty and the development of the body. An informant usually explains to the pupils that "You own your body and it is you who decides who touches you, how and when they touch you. If you do not feel okay about this, you should talk to an adult you trust." The school nurse's participation in the sexual education programme provided an opening for emotions and further discussion. This was apparent in that afterwards pupils had come to the open consultation and spoken about abuse. Open consultation is described as an arena for building trusting relations with pupils, partly through the pupils making contact themselves, partly through the nurse asking the pupil to come for an extra check-up. On those occasions when pupils were accompanied by friends and disclosed that they had been exposed to abuse, the nurse made it very clear that the adults would now take over responsibility: "(I) told the girls that this was great but that we would deal with it from now on."

Although aware that pupils want direct questions, the nurses found it difficult to ask: "You can't just go and ask these questions without having some sort of previous knowledge... Otherwise it can really go wrong." One explanation was the concern that the pupils would be frightened or that they would feel even worse. On the other hand, they felt that asking was like 'planting a seed', which could encourage the pupils to return. Even if the pupils did not disclose, they believed the questions could pave the way for more information later. It was like laying a puzzle. Even if it was not possible to fit all the pieces together from the beginning, this should not be seen as a failure. It was important not 'to give up' and not stop asking since it is a long process to get a child to desire or manage to disclose abuse. The attitudes of both the children and the professionals are illustrated in the following reflection:

When you [turning to another nurse] say that you had forgotten that you had been involved in it. That it was so long ago [experience of CSA]. Isn't the effect of this on the child obvious? It is fairly normal to receive a negative answer when you ask the first time... But you mustn't give up. You must somehow keep it alive. When we who are right on the edge push it to the back of our minds because it is unpleasant.

Ambivalence of the school nurse

The school nurses had several different roles, both medical and social. Their health-promoting and preventive work enabled them to reach all pupils through, for instance, health dialogues. For the work to function optimally, they needed to have confidence in the activities they were involved in. The theme ambivalence of the school nurse consists of two sub-themes: Not seeing behind the symptoms and Professional vulnerability.

Not seeing behind the symptoms

When children showed signs of not feeling well, these were often linked to other causes than abuse and no questions about CSA were asked. The nurses were, however, aware that there were a number of unrecorded cases and that they did not find all the abused pupils. They were self-critical and felt that on many occasions they should have acted differently by asking more in-depth questions. They indicated the need for more knowledge and better awareness of CSA. The nurses provided several examples where conceivable signs of abuse had led to different diagnoses such as eating disorders, suicidal tendencies and anxiety hysteria and thus preventing or delaying detection. This had occurred despite the involvement of several persons. One case that was discussed concerned a girl who on several occasions had expressed suicidal thoughts. Child and Adolescent Psychiatry (BUP) had been brought in and repeated reports had been made to CPS. Not until the girl had reached the senior level of compulsory school it became clear that she had been subjected to repeated sexual abuse: "She told us herself. She just couldn't cope any longer." On another occasion there was a girl who

showed several serious signs of ill-health: “A girl while in junior school had difficult eating, lost her hair and had stomach ache. Sought school health care repeatedly and also hospital... We just couldn’t understand it.” Several authorities were involved. In this case CSA was only disclosed when a sibling reported it to the police. Being a ‘good pupil’ could also be a means of hiding symptoms and vulnerability: “There was a girl who did well at school and was very helpful towards her schoolmates. There were no alarming signs. That she suffered from anxiety hysteria was nothing. Everybody could see, but...” In this case the professionals ignored the girl having anxiety hysteria, since she was a ‘good pupil’. It became clear later that this girl had been subjected to sexual abuse.

The school nurses felt a sense of ambivalence and made it clear that they needed courage not to miss abused children, as shown by the following comment: “You find what you want to see, you don’t look for what this might stand for, do you? Many times, seeing it is tough, although you don’t realize you are resisting.”

Professional vulnerability

The school nurses were also themselves professionally vulnerable. It was pointed out that they often lacked support and mentoring in their work. Other factors increasing their professional vulnerability were their work load and lack of time, given their responsibility for so many pupils. The lack of time resulted in a sense of powerlessness: “... we just can’t save everyone. You can’t get involved in every case.”

When the nurses made a report on CSA to CPS, they often felt ambivalent and, furthermore, they were alone, since their professional secrecy prevented them from consulting other professionals in school. Professional vulnerability also involved being subjected to reproaches when they made a report to CPS, as shown in the following: “The person who was

married to the perpetrator phoned me and was furious, but I referred them to the social services. Said I didn't investigate such matters... Awful!"

The courage both to see abuse and to take action was affected by their cooperation with and trust in CPS. A nurse described one such difficult situation when a mother had contacted her after discovering that her daughter had bruises on her lower abdomen. She was concerned that the girl's father had abused her. The girl denied it and said she had run into a table. The nurse worked alone on this case and reported it to CPS. However, the only feedback she received from CPS was that the case was closed. An experience of this nature was shared with other nurses and led to undermining the confidence in CPS, which affected the way nurses acted in other cases: "Naturally, I should have reported my concern to CPS but the question is what they would have achieved."

Lack of knowledge was given as a reason for uncertainty in both detection and action. On the other hand, long experience in working as a school nurse with vulnerable children increased their ability to act: "my years of service and experience mean that I am not so scared anymore but feel that I can rely on my gut feeling."

Discussion

The aim of the study was thus to explore how the school nurses dealt with CSA and to study their ability to detect and support sexually abused children. The results show that the nurses avoided CSA in a number of ways, which affected their ability to detect it and support the children. The main theme was constructed on the basis of three themes: Arousal of strong emotions, Disclosure process, and Ambivalence of the school nurse. In their turn, these consisted of a number of sub-themes. The phenomenon of avoiding seeing CSA as an aspect of child abuse permeates the results of the study, as was also the case in other studies. In her thesis Rahm (2009) underlines the fact that CSA is a painful and tabooed area both for those

subjected to it and for the professionals concerned such as teachers, psychotherapists and nurses. Therefore, those subjected to it seldom disclose it and the professionals rarely ask questions about the underlying causes of the symptoms described. In our study, possible signs of sexual abuse were interpreted as symptoms of various medical and psychiatric diagnoses thus delaying the disclosure of CSA. According to Herman (1997), in these cases there is a risk that the victim will fail to receive adequate support and treatment. Powell (2003) argues for practitioners to reflect on abuse as a possible alternative cause.

The nurses in the study used terms such as having repressed, not wanting to think about, not wanting to know, and not remembering. They avoided thinking around CSA both unconsciously and consciously. During the course of the interviews memories were awakened which initially they had forgotten. Shame is an emotion often mentioned in connection with sexual abuse since it is a subject of taboo and painful to deal with. Theories on shame may explain why the nurses in this study failed to address CSA in an attempt to avoid distressing feelings. Shame concerns who I am as a person and is thus an attack on the self; it is therefore described as the most distressing (Retzinger, 1991; Scheff, 1990; Tomkins, 1987). To protect oneself from a sense of shame, there are, according to Nathanson's (1992) shame compass, four main forms of action: *avoidance*, *withdrawal*, *attack self* and *attack others*. Wanting to protect oneself against distressful feelings and thoughts around a matter of taboo, which the school nurses frequently expressed, seem to be expressions of *avoidance*. Shame seems also to have affected the pupils. Giving vague descriptions, being good at helping schoolmates or showing alarming absenteeism are recurring features in the description and may all be interpreted as *withdrawal*. Self-destructive behavior and risk-taking may be seen as a defence against the strong sense of shame *by attacking the self*. Also, the study by Rahm and her colleagues (2006) showed that women who had experienced CSA expressed feelings of shame that affected their lives negatively as adults. They looked upon

themselves as dirty, destroyed and worthless. When the question of CSA was raised by the school nurses, they exposed themselves to reproach and aggressive comments from parents, showing that *attacking others* can be a means of hiding a sense of shame but aggressive behaviour can also be interpreted as fear of being disclosed.

According to Lev-Wiesel and her colleagues (2014), shame is one of the factors preventing disclosure. The effect of a child giving an indirect rather than a direct account may lead to their vulnerability passing unnoticed, as also Fontes and Plummer (2010) have shown. Even the fear of the negative consequences of a disclosure creates a barrier to disclosing CSA (Schaeffer et al., 2011). Negative consequences of this nature also emerged in our study when children were prevented from continuing to contact the school nurse. Experiences like this resulted in the informants either consciously or unconsciously refraining from asking. The nurses were ambivalent about raising questions regarding CSA. On the one hand, the very idea of suspecting someone made them feel like accusers. On the other, they stressed the importance of opening up by asking. Not asking or talking about CSA might also be seen as an expression of the fear of arousing feelings of shame in others (Starrin, 2001). Barriers preventing children from telling become thus barriers preventing the school nurse from acting.

Disclosure is a precondition for initiating measures (Lev-Wiesel et al., 2014). However, Bonanno and his research-team (2003) describe disclosure as a 'cruel paradox', both possibly resulting in benefits such as receiving adequate help, and carrying social risks such as stigmatization, not being believed, or creating or exacerbating problems in the family or in the social network. This 'cruel paradox' seems also to apply to the school nurses in their cooperation with CPS, as they hesitate to ask about abuse due to the uncertainty of what will happen if they report it to CPS (Engh Kraft & Eriksson, 2015). In order to dare to act when abuse is disclosed, it is essential that they can be confident that the abuse will cease and that

the child will receive good treatment and support to prevent negative social, mental and physical consequences (Grace et al., 2012). Fontes and Plummer (2010) have shown the value of identifying and eliminating organizational and systematic barriers in order to increase the capacity to protect children against CSA. Reliance on the system strengthens the nurse's ability to act (Engh Kraft & Eriksson, 2015). The informants in the study pointed out deficiencies in the organization regarding support and mentoring in the disclosure process. They also raised the issue of being lonely in the reporting process and the lack of feedback from CPS. Not receiving response to their reporting increased their uncertainty in handling this type of situations.

Despite the fact that the school nurses avoided addressing CSA, the study shows that they had both knowledge and experience but that their emotional reactions were obstacles to detect CSA and to take adequate action. The knowledge that children not spontaneously make disclosures made the school nurses devise various strategies and tools to help the children tell. Health dialogues were one such tool; these were conducted without parents so that the child could disclose if abused. The study shows that even the question in the health survey about whether anyone had hurt the child opened the path to disclosure. Also Schaeffer and her colleagues (2011) have shown that external influences encouraged children to disclose CSA.

Apart from the importance of building a trusting relationship there is a selection process where the child chooses the time, the place and the person to whom they disclose their situation. Thus it is crucial that this person has time to listen, believes the child's story and reacts in a supportive manner to avoid delaying or even preventing the disclosure process. Staller and her colleagues (2005) further maintain that it is not a one-way process but the child appraises and reacts on the basis of the adult's reactions. As children are imaginative and change their story, there is a risk that they will not be believed, which is apparent in our

study. The school nurses showed in spite of this an awareness of the complex nature of the disclosure process and meant that it was important to plant a seed when communicating with children and not giving up.

One conclusion to be drawn from the study is that CSA is an area in which school nurses need to remain updated in order to stop the abuse and the child to receive support. It has been shown that in some cases the abuse ceases when the child dares to disclose it (Staller & Nelson-Gardell, 2005). Thus it is essential for the school to undertake preventive measures and make children aware that they have the right to their body and integrity (Walsh, Zwi, Woolfenden, & Shlonsky, 2015). One form of preventive approach is the obligatory sexual education in Sweden in which the school nurse generally participates. In the study, these measures proved an opening for a possible return visit to the school nurse for a discussion on sensitive issues.

In this secondary data analysis, the material concerning CSA was extracted for a more in-depth analysis from a previous study of the ability of school nurses to detect and support abused children (Engh Kraft & Eriksson, 2015). The material was collected in two sets of focus-group interviews. Using two sets of interviews made it possible to ask specific questions about CSA in the second interview, since this did not arise spontaneously during the first interview.

As a method of collecting data, the focus group contributed to in-depth discussions where the members of the group gradually began to recall their experiences of CSA. After the interviews several informants have contacted the researchers reporting that the discussions with colleagues during the interviews about their experiences of CSA have provided them with a greater sense of security in dealing with such matters. The focus-group interview as a research method has thus proved to have a positive effect on professional competence and thus on the ability to detect abused children and initiate support measures. Staller and her

colleagues (2005) maintain that a qualitative method can add a missing voice, which is obvious in this study since the stories would not have been told without the school nurses having had the opportunity to discuss the issues further.

One of the strengths of the analytical work has been the competence of the research group regarding both methodological and clinical knowledge, with long-term professional experience of working with exposed groups. This preunderstanding has been essential for asking relevant questions both in the focus-group interviews and of the data. However, there has been an awareness of the risk of allowing preunderstanding to color the analysis of the data, a problem which has been the subject of ongoing discussions (Malterud, 2001). To increase the reliability of the study, the analytical work has been reported in detail and quotations provided to demonstrate the evidence (Graneheim & Lundman, 2004). The results in this study concern the school nurses who took part but it is not impossible that they might also be valid for other school nurses and other professions.

This study adopts the perspective of the school nurse. Further research is therefore necessary on attitudes to and the value of the actions of the professionals from the perspective of the abused children to increase knowledge and develop the work of the professionals with CSA.

School Nursing Implications

School nurses play a central role in detecting and supporting sexually abused children.

Attentiveness of sexual abuse as a possible cause of both physical and mental ill-health requires both knowledge and collaboration. Based on the findings it is important that the work load of the school nurses is adapted to the number of students in school in order to enable building trustful relations through open consultations, individual health dialogues and participations in the school's sexual education. Supervision and networking could be a tool for handling strong emotions awoken by the disclosure of CSA. While reporting policies and

laws may differ across borders, school nurses are in a position to stem CSA. Findings from this study could inform efforts to detail the needs of school nurses elsewhere so that they are empowered to address their own competencies as well as work with administrators to ensure the safety of school children.

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