Incorporation of Sexual Violence in Nursing Curricula Using Trauma-Informed Care: A Case Study

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ABSTRACT

Background: One in five women will experience sexual violence in their lifetime. As a consequence of this violence, survivors face health care concerns such as depression, anxiety, substance abuse, and gynecologic problems. Nurses are at the forefront of health care delivery to survivors of sexual violence, yet literature about nursing curricula addressing sexual violence is scant. Method: A holistic, single-case study from a student survivor about the impact of sexual violence, being taught from a trauma-informed care perspective, is presented. Results: The powerful case study highlights the personal and professional benefits stemming from a sexual violence curriculum being taught from a trauma-informed care lens. The student survivor reports personal growth and an understanding of herself, as well as a new framework with which to care for patients who have experienced sexual violence. Conclusion: In preparation to deliver care to sexual violence survivors, students must be educated about the prevalence, long-term sequela, and health care needs of survivors, which can be effectively done using the model of trauma-informed care. The student’s case suggests that discussing sexual violence is imperative for one’s own healing and contribution to the nursing profession. [J Nurs Educ. 2016;55(4):215-219.]

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Over the course of a lifespan, 19.3% of women (nearly 22 million) are affected by sexual violence, which can include rape, trafficking, prostitution, assault, childhood sexual abuse, incest, and exploitation (Breiding et al., 2014). Furthermore, in the United States, college-aged women are at a high risk for sexual violence, with 23.1% reporting sexual assault or misconduct (Cantor et al., 2015). The Centers for Disease Control and Prevention (2011) presents a clear stance that “sexual violence against girls is a global human rights injustice of vast proportions with severe health and social consequences” (para. 1). The long-term sequela of sexual violence includes anxiety, depression, substance abuse, sexually transmitted infections, and gynecologic problems, such as chronic pelvic pain (Black et al., 2011; World Health Organization, 2014). The health care costs of sexual violence are reported to be $87,000 to $240,776 per rape (The White House Council on Women and Girls, 2014).

Literature Review

Nurses, members of the largest group of health care providers, are at the forefront of health care delivery to survivors of sexual violence (American Association of Colleges of Nursing [AACN], 1999). The AACN (1999) stated that nursing students must be prepared to assess women for past and current sexual violence and to intervene to prevent the cycle of violence. Specifically, all baccalaureate or higher degree programs should contain content on the scope of the problem, how to assess for violence, interventions for women experiencing violence, legal reporting issues, and violence prevention strategies (AACN, 1999). Furthermore, the AACN (1999) indicates that students require opportunities in clinical settings to care for patients experiencing violence to practice screening, assessing, and providing nurse interventions to this vulnerable population.

In light of the AACN’s (1999) recommendations, Woodtli and Breslin (2002) surveyed 395 baccalaureate schools of nursing in the United States and reported that 75% had not developed violence-focused student competencies. Furthermore, 67% of the schools of nursing indicated no systematic evaluation of their violence content occurred within the past 4 years, resulting in students being unprepared to screen for violence (Woodtli & Breslin, 2002). These findings are at odds with the AACN (1999) recommendations to teach violence screening and prevention to nursing students. Overall, despite the prevalence of sexual violence in the United States, more current literature regarding the
incorporation of sexual violence into nursing curricula has not been published.

In addition, the scarcity of sexual violence curricula is also evident at the graduate level. Specifically, nurse–midwives do not feel sufficiently prepared to handle disclosures of sexual abuse (Finnbogadóttir & Dykes, 2012; Herzig et al., 2006; Jackson & Fraser, 2009). Nurses and midwives are not alone in feeling unprepared; obstetricians and gynecologists also report they do not know how to react to, and then subsequently cope with, a woman’s disclosure of sexual abuse (Herzig et al., 2006). As a result, to the detriment of the woman experiencing violence, nurses and women’s health care providers do not routinely inquire about a past or current history of abuse; therefore, the patient’s history remains unaddressed (Finnbogadóttir & Dykes, 2012; Herzig et al., 2006; Jackson & Fraser, 2009).

These findings are at odds with research that concluded that the majority (80% to 93%) of female patients would like their health care providers to screen for a history of sexual violence (Robohm & Buttenheim, 1996; Stenson, Saarinen, Heimer, & Sidenvall, 2001). Women who disclose to their provider a history of sexual abuse or assault report an overall better experience receiving health care services (Havig, 2008). McGregor, Glover, Gautam, and Julich (2010) surveyed survivors and asked what recommendations they can offer health care providers working with women who have a history of sexual abuse. Responses included creating a therapeutic provider–patient relationship and asking about any past history of sexual abuse. Screening has been reported to be most beneficial when the woman’s experience is validated by the health care provider and acknowledged in a thoughtful manner (Havig, 2008).

Furthermore, women have “complained about the societal invisibility of the aftermath of abuse in adult life and lack of opportunity to speak freely about the meaning of the former abuse to their current life” (Dijkstra, 1995, p. 291). Discussing sexual violence histories with health care providers acknowledges the experience for the patient, sometimes for the first time, allowing her to recognize the event as real and to have someone listen to her story (Coles & Jones, 2009). The verbalization of this event can lead to therapeutic healing (Coles & Jones, 2009). Helping survivors to learn about their own bodies can also help them to heal (Heritage, 1998). Nurses and all health care providers working with women who are experiencing violence must become proficient in the available community resources and referral agencies (Heritage, 1998; LoGiudice, 2015).

The high prevalence of sexual violence and the serious health consequences stemming from it speak to the pressing need to ensure that nursing programs are incorporating sexual violence into the curricula. Throughout this process, it is crucial to recognize that students are not impervious to sexual violence and that it is likely there are survivors in the classroom. This article aims to present teaching about sexual violence from a trauma-informed care perspective and offers a single case study from a student survivor on the impact of taking a nursing course taught from this perspective.

What Is Trauma-Informed Care?

The first author (J.A.L.) is a practicing certified nurse midwife and an assistant professor who incorporates trauma-informed care into the maternal and newborn nursing curriculum. Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma (The Trauma Informed Care Project, 2014). Central to this model of care is respecting survivors, understanding the widespread impact of trauma, knowing the signs and symptoms of trauma in patients, integrating education about trauma into practice, and preventing retraumatization in the health care setting (National Center for Trauma-Informed Care, 2015). Trauma informed care also underscores the physical, psychological, and emotional safety of consumers and health care providers and helps survivors to restore a sense of control to become empowered (The Trauma Informed Care Project, 2014). The model involves supporting the patient throughout disclosure, giving the patient control of the health care encounter, and allowing for informed decision making (Linden & Bell, 2012). An example of giving the patient control is letting him or her direct and control the order in which procedures are performed and how the physical examination is performed. For example, if a breast and a pelvic examination are necessary, it is helpful to let the patient choose which examination to have completed first. Another example is allowing the patient to remain in his or her own clothing instead of a hospital gown or paper gown and conducting much of the visit while the patient is fully clothed. Trauma-informed care aims to enhance the health care experience for survivors of sexual violence and other traumas. In the context of maternal and newborn nursing, trauma-informed care iscredibly pertinent, given the invasiveness of procedures during childbirth (i.e., vaginal examinations, the vaginal sensations associated with delivery), which can be reminiscent of past abuse (Roller, 2011). Furthermore, because not all survivors have disclosed their history, it is imperative to provide trauma-informed care to all patients.

A final component of teaching from a trauma-informed care lens is to openly discuss the prevalence and long-term sequelae of sexual violence on the patients for whom nurses will care. Additional discussion of screening patients, handling a disclosure, and referring patients is included in teaching from a trauma-informed care lens. A strong focus is placed on the empowerment of survivors in the health care setting. In teaching from this lens, it is imperative to recognize that students in the classroom may have experienced sexual violence themselves.

Method
Case Study Design and Analysis

According to Yin (2009), a case study is “an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life content” (p. 18). Crucial to case study design is the presentation of the social context of the case. A case study can include, document, and record participant or direct observations, interviews, and physical artifacts (Yin, 2009). Further, a case study should be revelatory (Yin, 2009). The case presented in this article is a holistic, single-case study. Analysis of the case followed the individual-level logical model and was undertaken by the first author. This strategy assumes that the case is about an individual and that a series
of events are associated with an outcome. The hallmark is that the outcome exists because of repeated cause-and-effect events, which are connected in the case.

The current study was submitted to the institutional review board and designated to not need review. The protection of human subjects occurred through the voluntary participation of Sherifa, the second author of this article, in this research after she graduated from the university.

Case Study

After the final examination for maternal and newborn nursing, Sherifa, a student and a survivor, approached the first author and shared her reaction to the course. She later wrote her reaction in the narrative form that follows below. Her description of the connections she made in her own life and of her growth as a nursing student were so powerful that, with her permission, the first author decided to present her experience as a revelatory case study.

As nursing students, we are taught to perform complete assessments on our patients by performing physical examinations and obtaining their health histories. It is ingrained in us that assessment is the most important aspect of nursing because it allows us to discover any abnormal physical, emotional, or mental conditions that the patient might be experiencing. However, I have noticed that we were never taught to ask clients if they were victims of sexual violence. Unfortunately, there are large numbers of women who experience sexual violence. For nursing students, I believe this is something that should be taught in nursing school. I say this because it was in my maternal and newborn nursing class that my professor brought up the care of survivors in the context of childbirth on the first day of class and continued to discuss survivors’ needs throughout the semester. We learned about the normal birth process, and we were then asked to reflect on what this process might look like for a survivor of sexual abuse. The connection of lack of control during childbirth to the lack of control experienced during sexual abuse was highlighted. Throughout the semester, we discussed the health care needs of survivors of sexual abuse, how to give them control, and allowing them to remain dressed. We emphasized screening all women for a history of sexual abuse. I specifically recall a presentation that was given on the current literature (about) survivors of sexual abuse and of my professor’s own research. There were many quotes from survivors in the presentation of a qualitative research study on the childbearing experiences of survivors of sexual abuse (LoGiudice & Beck, in press). There was one [quotation] specifically that stood out to me. The quote was from a woman recalling her experience with receiving an episiotomy and having flashbacks during the procedure to being told what to do when she was being abused as a little girl. This particular story evoked something in me that I had not felt in a very long time. The more I kept hearing her words in my head, the more it became clear to me that I am haunted by the same ghosts, and it was at that moment I realized why I have such irrational fear going to certain health care appointments. Like some of the survivors from the presentation, I screamed these same words in my head during my health care visits: Please don’t touch me! Please stop touching me! Please do not do this to me! This class made me realize [that] things that I do are because of that experience I had in my own past.

As a nursing student and a survivor [of sexual violence], I have experienced two worlds, and I believe that [it] is of paramount importance to add care of survivors of sexual violence to [the] nursing curriculum. I know that as a patient, I want to be asked by my health care providers about my history because I want to be understood and I want to be treated as a whole person. As a nurse, I want to help improve the health status of my patients. Even if I can’t provide all the help, I can provide the resources to my patients to get help. I believe it is my duty to be able to identify obstacles that are keeping my patient from experiencing true health. As a survivor myself, I can talk to my patients who are survivors and relate to them. Through screening and discussing sexual violence histories with my patients, I can provide holistic health care.

Case Analysis

“Haunted by the Same Ghosts:” Personal Growth. The case first addresses how the shared experience of flashbacks during health care procedures resonated with Sherifa personally. For the first time, she made the connection between her reactions during her own health care visits to her past history. Addressing these connections in the classroom setting before caring for patients allowed Sherifa to process how this relates to providing nursing care to survivors. She reflected that she could better relate to her patients as a result of this shared experience.

Identifying Patient Obstacles: Professional Growth. Sherifa identified that without screening for a history of sexual violence, she would be unable to aid her patients in reaching optimal health. She highlights that nursing students are often singularly focused on learning the skills to perform a comprehensive physical examination on their patients. However, Sherifa explicitly stated that to provide holistic care, nurses must look to the psychosocial state of their patients and specifically address a past or current history of sexual violence.

Discussion

Often, in both acute and nonacute health care settings, nurses are the first providers to interact with survivors of sexual violence. Nurses are therefore instrumental in screening for a past or current history of sexual violence. The prevalence, physical and psychological health consequences, and health care costs related to sexual violence are reason enough to incorporate sexual violence into the nursing curricula. However, this case study provides further evidence to support this curricular addition. Research has demonstrated that survivors desire to be screened for a history of sexual violence and to discuss this with their health care providers (Robohm & Buttenheim, 1996; Stenson et al., 2001).

The trauma-informed care model can and should be readily implemented into existing nursing curricula. Incorporating the importance of screening all patients for past or current violence is necessary. Further, teaching students to be aware of the education and preparation before procedures and physical examinations is necessary to offer to all patients, but especially to survivors, before procedures and assessments are conducted will
create a safe environment for all patients. Further, highlighting the impact of trauma and the methods to empower and prevent retraumatization are needed.

The recognition that sexual violence affects not only women and girls but also men and boys is paramount. In fact, nearly 2 million (1.7%) men in the United States have experienced sexual violence in the form of rape (Breiding et al., 2014). Sexual violence impacts all socioeconomic and cultural groups. In addition, nursing students should be informed that in all 50 states, the District of Columbia, and Puerto Rico, either health care professionals or all individuals (in New Jersey and Wyoming only) are mandated to report abuse, neglect, and sexual violence identified in anyone under the age of 18 years (Child Welfare Information Gateway, 2014). The reporting by health care professionals, such as RNs, of domestic violence or sexual violence in men or women age 18 years and older varies in each state.

Although the example provided in this case study is within the context of maternal and newborn nursing, a place exists for sexual violence content to be threaded throughout nursing curricula. Because sexual violence affects both genders, this content has a place in mental health, pediatrics, and medical–surgical nursing courses. The case study demonstrates how teaching sexual violence from a trauma-informed care perspective positively affected a student survivor of sexual violence. The case reveals both personal growth and the nursing role as integral in screening patients for sexual violence.

Implications for Nursing Education

The AACN (1999) stated that nursing students must be equipped to provide care and screening to all patients who are currently experiencing or who have a history of sexual violence. Knowledge of how to screen for violence and to intervene when abuse is occurring is recommended in every baccalaureate nursing program (AACN, 1999). In the clinical setting, nursing students should screen for violence as part of comprehensive nursing care (AACN, 1999). The trauma-informed care model can comprehensively provide this content so that nursing students can best address the needs of survivors in the clinical setting.

Conclusion

Vast benefits exist from teaching from a trauma-informed care lens. First, survivors in the classroom may exhibit personal growth and healing. Second, patients who are experiencing sexual violence or who have a history of this violence will be cared for by students who have an appreciation and understanding for the unique health care needs of survivors. The current case study offers the reminder that discussing sexual violence in the nursing curricula is imperative for a survivors’ own healing, as well as their contribution to the nursing profession. On a broader level, with an increased emphasis on sexual violence in nursing curricula, more men and women who are currently experiencing this violence will be identified by nurses and started on the process of recovery.

References


