



Challenges of caring for victims of violence and their family members in the emergency department



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ABSTRACT

Introduction: Interpersonal violence causes illness and suffering for victims and their family members. Emergency nurses are often given responsibility for forensic patients and their family members, but there is limited knowledge of their experiences regarding this task. This study aimed to describe nurses' experiences when caring for victims of violence and their family members in the emergency department.

Methods: Individual interviews were conducted with twelve nurses from seven emergency departments. Data were analyzed using qualitative content analysis.

Results: The analysis resulted in the theme: a challenge to create a caring encounter. Hindering factors comprising this challenge are described under four categories: struggling to intervene and talk about violence; contradictions when caring for family members; being helped by forensic guidelines but needing more knowledge; and dealing with one's own strong emotions towards violence.

Discussion: Creating a caring encounter is perceived as a prerequisite to providing forensic care. Nurses often felt hindered to act and forensic issues were left unaddressed. Family members are offered little or no support in the aftermath of violence. The hindering factors must be overcome to ensure forensic care for victims of all types of violence.

1. Introduction

Interpersonal violence causes illness and suffering for victims and their family members [1–4]. Nurses in emergency departments (EDs) are often given special responsibility to care for victims of violence [5,6] as well as their family members [7]. Thus, nurses in EDs play an integral role to address forensic issues and to support both victims and family members [8,9]. By providing forensic care, nurses can alleviate suffering and facilitate the patients' right to justice. It is imperative that nurses are competent and feel confident to intervene and to provide forensic care in the aftermath of violence [10,11].

2. Background

Health consequences of interpersonal violence include both short and long-term suffering and illness such as chronic pain, anxiety, depression and post-traumatic stress disorder [1,12–15].

Victims of violence often seek medical care in EDs without any prior interaction with police, and patients may not initially disclose being victimized [3]. Therefore, all ED patients with injuries or medical

conditions that could be the consequence of any type of interpersonal violence ought to be considered forensic patients with potential legal issues that need to be addressed [9,11]. Health care staff must identify violence as the cause of ill-health and offer forensic care. This includes, in addition to medical care, providing support, collecting evidence, documenting and referring to the criminal justice and societal support systems [6]. Previous studies point to a lack of sufficient training in forensic care among emergency nurses [16,17]. Less than one-third of emergency nurses in Sweden have received specific training concerning forensic nursing care [18]. Available policy and routines in EDs seem to vary and mainly focus on specific groups such as women and children [5,19]. The most previous research on ED care for victims of violence focuses domestic abuse and violence against women [20] which indicates a lack of studies that encompass ED forensic care for victims of all types of violence including both men and women.

Care in the ED is mostly individual and patient-centered [21], but considering that ill-health of one family member is influenced and influences the whole family [22,23], violence can have significant health implications for the victim's family members. Yet, care for family is rarely included in policy documents, training or routines for victims of

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violence in EDs [5]. Nurses have been shown to have a unique role in caring for family members in general in EDs [7], and nurses report that they aspire to include family members in the care of victims of violence [18]. However, there is a lack of knowledge about how and to what extent family members are included.

Further knowledge of forensic care for victims of violence as well as their family members in the ED from the nurses' perspective can contribute to a better understanding of how forensic care can be improved. Therefore, this study aimed to describe emergency nurses' experiences when caring for victims of violence and their family members in EDs.

3. Methods

3.1. Study design, setting and sample

A descriptive qualitative approach was chosen to capture emergency nurses' experiences of caring for victims of violence and their family members. Nurses were recruited by both advertising online in emergency nurses association forums and by directly contacting nurses working at EDs already involved in a larger research project [18]. In the sampling process, variation was sought [24] by contacting nurses at EDs spread out geographically in Sweden including both larger university hospitals as well as smaller hospitals. Participants were recruited until a variation in regard to age & gender was attained. Inclusion criteria were registered nurses who worked at EDs. All contacted nurses that wanted to participate were included.

3.2. Data collection

Individual interviews [25] were conducted between January and April 2015. By choice of the nurses, the interviews were conducted at the nurses' workplaces in rooms where it was possible to talk privately. The first author interviewed the nurses individually using a semi-structured interview guide. The interview started with questions concerning demographic data and was followed by open questions such as, "What experiences do you have caring for victims of violence and their families in the ED?" "Which forensic tasks do you do?". During the interview, follow-up questions were asked, and participants were encouraged to give examples. Interviews were audio recorded after participants granted permission and lasted 40–60 min each.

3.3. Data analysis

Qualitative content analysis inspired by Graneheim & Lundman [26] was used to analyze data inductively by a process of identifying meaning units, formulating codes, and deriving categories and themes. All interviews were transcribed verbatim, and the transcripts were read several times to gain an overall impression and a sense of the whole material. The transcripts were then reread marking out meaning units in the text. These meaning units were then condensed and labeled with a code. The generated codes were contrasted and compared to form subcategories. By looking at similarities and difference, the subcategories were then grouped to create categories. This part of the analysis encompassed the manifest content, and categories were formulated by content-characteristic words. Verbatim examples from the interviews were chosen to illustrate the categories. The underlying meaning of the categories, the latent content, was then reflectively discussed among the authors (JR, EB, CE) and formulated as one theme. To achieve trustworthiness, the criteria of credibility, confirmability, dependability and transferability were used [26,27]. Remaining aware of preunderstandings and openness to data were paramount in the analysis process [28]. Interpretations were continuously discussed and questioned to find possible alternative interpretations to enhance credibility of the analysis. For confirmability, quotes from the interviews have been used to verify the relevance of the categories. The process is described in detail for dependability and to support the

reader in deciding if these findings are transferable to other contexts [24,27].

3.4. Ethical considerations

The study adheres to the ethical guidelines of the Helsinki Declaration [29] and was approved by the Research Ethics Committee in Linköping, Sweden (dnr. 2014/480-31). Participants were informed verbally and in writing about the study and all participants gave informed consent in writing and verbally before the interviews.

4. Results

There were twelve nurses who participated: ten women and two men aged 22–62 years (median 47 years). Participants were registered nurses from seven EDs in Sweden in both small and large cities (range from 19,000 to 600,000 inhabitants in the EDs area of practice). Work experience as a nurse ranged from 8 months to 29 years (median 16 years), and work experience in the ED ranged from 8 months to 23 years (median 4.5 years).

The analysis resulted in four categories: *Struggling to intervene and talk about violence*, *Contradictions when caring for family members*, *Being helped by forensic guidelines but needing more knowledge*, and *Dealing with one's own strong emotions towards violence*. Recurring across these categories, was nurses' strong sense of responsibility for these patients and that creating a caring encounter with victims of violence and their family members was a prerequisite to providing forensic care. The participants' descriptions revealed that specific forensic tasks were not the most difficult part of forensic care; instead, creating a caring encounter to enable the provision of forensic care was the main challenge. This caring encounter was characterized by the courage to intervene, being genuinely present, showing honest concern, validating the patient as a fellow human being, and advocating for the patient's and the family's needs. The four categories, which reveal several complicating factors to creating a caring encounter, formed the theme *A challenge to create a caring encounter*.

4.1. Struggling to intervene and talk about violence

Most participants described how they struggled to create time and a private place to talk to patients about violence and that it needed to be a priority even though it was not prioritized in the ED organization.

You feel that you need to spend more time with the patient, time that I do not have. While sitting with the patient, I know that I have twenty-two other patients that I should do something for, so it seems impossible... but that's the way it is. It is something that you, yourself need to prioritize. (P3)

Participants also described that the work situation in the ED made it difficult to attend to more than the patient's actual physical injury. Even when patients and family members showed signs of emotional distress and needed support beyond medical care, the physical injuries were always the top priority, and participants saw little opportunity to provide care beyond that.

Many times, they need more than the medical treatment, but that is what we have time for. Medical treatment is not what they mostly need but it is difficult to know what more to do and how to suffice. (P2)

Participants had many experiences of meeting patients who presented with vague physical symptoms that could indicate violence. They described having a gut feeling but did not act upon this suspicion as often as they would have wanted in retrospect. This was partially explained as uncertainty to act and not wanting to intrude and cause problems for the patient in the aftermath of violence.

When the patient doesn't tell you themselves about the violence, then it is

difficult. It feels like you are intruding and messing with something that is not your business. It seems like they really don't want you to know. (P10)

In cases of suspected domestic violence, participants recognized the importance of talking privately with patients without family members present to protect the patient and to enable them to talk freely. Although most participants described being proactive when trying to talk privately, some participants acknowledged that they only talked privately with patients if they by chance were left alone with them. One concern raised was talking privately to elderly patients as they were rarely separated from their family members or caretakers in the ED because they were dependent upon them for help. Another concern was that men victimized by domestic violence were much less likely to be asked about violence because of preconceptions that men are typically not victims of domestic violence.

Participants' behavior was thought to influence whether patients would disclose the violence and be willing to participate in forensic examination. Being at ease while talking to patients about violence was facilitated by preparing oneself by thinking beforehand about one's way of posing questions and handling answers. Participants also pointed out that it was important to be openminded and not limited by one's beliefs and assumptions about violence, victims, and perpetrators. Many pointed out that showing patients that they had time to listen and to be consciously present was primary when talking about violence.

They need to feel that you really want to listen to them. I must show that I am entirely committed and not busy doing other tasks... and that I am not asking to fill out some piece of paper, but I ask because I want to know, and I care. I think that's most important. (P11)

Despite this, talking with patients about violence was sometimes avoided as it was considered difficult, requiring sensitivity and knowledge, and simply taking more time than participants felt they could give.

4.2. Contradictions when caring for family members

Participants' perceived contradictions when caring for families of victims of violence as they wanted to include family members in care but, at the same time, had to be suspicious of family members as they could be perpetrators of violence. The family situation was not easily assessed in the ED, and situations were not always as they initially seemed. Participants struggled between wanting to protect the patient while being unsure of their suspicion and also wanting to care for family members if they were not perpetrators.

Accompanying family members rarely want to leave the patient... You think they are there because they care, and many are..., but one should have that in the back of one's mind, knowing that the perpetrator rarely wants to leave the patient. (P11)

Some participants reasoned that as family members could be perpetrators, they never involved family members in care while other participants involved family members depending on their gut feeling or the patient's wishes. In cases of non-domestic violence, participants described care for family members as listening, being present and available to answer questions, and providing them with continuous information.

It is enough to just be there. I see it as being their extended arm. I can help them to call and arrange things. You don't have to say so much, it is more just being there for them. (P8)

However, for patients with serious physical injuries, an assistant nurse was instead assigned to be available for the family. Most participants described that they had no help to offer families and only occasionally they could offer referral to the hospital counselor. The only avenue of help that family members who suffered from the experience

had was to contact healthcare providers themselves as patients to receive help.

Maybe I could give them a card with contacts to some crime victim organization maybe but otherwise there is not much I can do for them if they are not a patient. (P3)

4.3. Being helped by forensic guidelines but needing more knowledge

Participants described that forensic guidelines helped to give a sense of confidence to provide care and address issues related to the violence. By providing forensic guidelines and routines, participants felt the ED was backing them up, making it easier for them to take action. Despite having guidelines and routines in some areas of forensic care, participants often expressed lacking knowledge and hands-on suggestions on how to handle forensic situations.

I would like to know exactly what to do, with clear routines so that when it comes up, that they have been victimized, I know what to do. How can I help? Where can I refer the patient for follow up care?... sometimes it hasn't worked out before, so I hesitate to ask or engage because I don't know what to do or what will happen if I try to refer. (P9)

Routines for asking about violence varied but most participants felt that more patients ought to be routinely asked and that the routines should apply to all patients if nurses felt comfortable asking those questions. Most participants knew that there were routines for photo documentation and reporting of child abuse, but they had concerns that the ED lacked routines for nursing documentation regarding violence. They felt uncertain as to whether it was their responsibility to document issues related to violence.

No, I don't document things about violence or document if I asked a question about violence. I think it is the physician's responsibility to do that. (P8)

Many participants expressed hesitations reporting suspicions of child abuse despite knowing about the legal responsibility to report suspicion of child abuse. Participants also experienced a lack of knowledge and routines in order to care for victims of violence with psychiatric ill-health or substance abuse. Caring for them in the aftermath of violence was seen as especially complex and the participants were often unsure of their professional responsibility to offer help beyond obvious physical issues for which the patients were admitted. The participants experienced that these patients fell between the cracks separating different clinical specialties with no one taking charge of their care. Participants also described an uncertainty and frustration about lack of continued support that patients could be referred to after discharge from the ED. Management's commitment and support were seen as important and as means to prioritize forensic care. Specific forensic education was given occasionally, but participants felt it was not prioritized often enough. Knowledge of forensic care was according to the participants dependent upon individual efforts to seek information. Besides specific education and training, participants pointed out the importance of maintaining an open dialogue with colleagues in the department as a way to learn from each other and broaden preconceptions about violence, victims, and perpetrators.

4.4. Dealing with one's own strong emotions towards violence

Encountering patients who have been victimized by violence and their family members often evoked strong emotions for the participants. They described that it could be emotionally draining to care for these patients and their families, giving rise to frustration as well as feelings of anger and aggression towards the perpetrators. Participants described that their own strong emotions could hinder them from addressing issues concerning violence.

Many times you just want to keep it far away from yourself, because it is so terrible. And then you choose to keep your distance and not get involved. It is like you just don't want to see that such terrible things happen. (P6)

Different types of violence raised different reactions among the participants, and many participants viewed these different reactions as a risk for treating patients differently. At times, they felt it was very challenging to remain professional toward patients and their family members and to keep their own emotions out of the equation.

With intimate partner violence, everybody gets very upset and concerned about protecting the patient and doing their very best... If it's perhaps a young man who has been beaten at the pub, then nobody cares particularly... People assume that it's the patient's own fault. (P10)

In general, participants saw that having extensive personal life experience was an asset that prepared them emotionally to meet patients and their family members in difficult situations. However, participants also expressed that having your personal experiences of violence could influence you to either avoid dealing with violence issues among patients or being sensitive and understanding of their situation. Participants pointed out that peer support at the workplace was of great importance to deal with one's personal emotional response.

When you have experienced difficult situations, you need support from peers at work... You can't always just brush it off... You have to take a step back and take some time, so you don't carry it with you when you go home. So that you keep the strength to go on working. (P7)

5. Discussion

This study sheds light on nurses' perspectives when caring for victims of violence and their family members in EDs. The nurses' descriptions showed that specific forensic tasks were not the most difficult part of when caring for victims of violence; instead, creating a caring encounter with this patient group in the ED was the main challenge. A caring encounter was seen as a necessary prerequisite for providing forensic care. However, nurses often felt hindered due to uncertainty of how to act in the aftermath of violence, and it was not prioritized in the ED organization. When the perceived challenges were not overcome, nurses avoided situations that required forensic care and only focused on apparent medical issues. The uncertainty of taking action, as the nurses describe, can be seen from the patients' and families' viewpoint as disinterest, insensitivity, coldness and even inhumanity and can be described as an uncaring encounter according to Halldorsdottir [30]. Previous studies have shown that uncaring encounters with health care professionals can leave victims of violence retraumatized and create even more suffering [3,31,32]. This may result in patient's distrust in the system, fear of reporting the crime and not wanting to participate in evidence collection and documentation, thereby jeopardizing the possibility for justice [11]. For nurses to feel confident to engage in caring encounters with victims of violence and their families, the challenges that cause uncertainty need to be overcome. ED organization and priority for forensic patients and their families need to be adjusted to better support nurses in this task.

One of the challenges that nurses expressed in this study was the struggle to intervene and talk about violence. Talking about violence with patients and addressing forensic issues was dependent on nurses' individual efforts to gain knowledge, ways to prioritize tasks and personal experiences of violence. This can result in an unequal provision of forensic care depending on the nurse's individual views. Difficulties talking about violence not only apply to domestic violence according to the nurses but also can be a factor in gang-related or youth violence. Nurses were also less likely to address issues of violence with special groups of patients such as men suffering from domestic violence as well as elderly persons dependent on their caretakers. Part of this described

challenge to intervene and talk about violence can be seen as a product of the caring culture in EDs that has been shown to often exclude patients' psychosocial needs [33,34]. This might be especially important to consider for victims of violence in EDs in light of previous research that has pointed out the importance of providing psychological and emotional support especially for those suffering from violence [3,35,36].

The results also show how nurses perceived contradictions to create caring encounters with accompanying family members. Participants only briefly described caring for family members despite specific follow-up questions during interviews. Even though caring for family in EDs is considered by nurses as their responsibility, it is not generally prioritized in ED care [37,38]. Accordingly, the participants in this study only recognized family members accompanying victims of violence in the ED as separate individuals that might need support, but there was little or no support available for them. Previous research, however, shows that family members can be invaluable support for victims of violence and can benefit from being encouraged and supported proactively by health care staff [39]. Nurses have also been shown to have profound importance to help families in the situation of having a critically ill family member in the ED [40]. Including family members of victims of violence in care in EDs seems to be a major area needing improvement.

The results point to a need to implement clear forensic guidelines, provide continuous training, and facilitate peer support among nurses regarding forensic patients and their family members to better support nurses to create a caring encounter. Without this foundation, nurses tend to avoid dealing with forensic issues. Nurses expressed frustration regarding follow-up care after discharge from EDs as there was no clear bridge from the ED to societal support systems. Even though earlier studies have pointed to a need for more knowledge and training in forensic care among emergency nurses [16,17,41] there still seems to be insufficient knowledge, and nurses need more support to feel competent and confident to provide forensic care.

The current results show that there can be a strong emotional impact on nurses when encountering victims of violence, which is in accordance with previous research [42–44]. The findings add knowledge of how preconceptions and life experiences of violence can both be hindering for some nurses, but, for others, it can be an advantage. In addition to feeling powerless in relation to the challenges in these encounters, it increases the risk of stress and burnout for nurses and, therefore, needs to be acknowledged [44]. The findings also show the pivotal importance of organizational support, as well as peer support, which can serve as a means to reduce the impact of stress that these encounters can elicit in ED nurses.

5.1. Strengths and limitations

The descriptive qualitative approach facilitated a deeper understanding of nurses' experiences. The heterogeneous sample gave broad variation and nuances in the data which could increase the possibility of transferability [45]. This study encompasses all types of interpersonal violence to provide an understanding of what nurse's face when encountering forensic patients in general. It does not provide specific in-depth knowledge of forensic care required for specific types of violence. Preunderstandings can influence data analysis [24,27], but, to minimize this risk, all three authors have reflectively re-evaluated and discussed alternative interpretations to ensure that the categories found are grounded in data.

6. Conclusion & implications for clinical practice

Creating a caring encounter with victims of violence and their families was the nurses' main challenge in providing forensic care. Uncertainty and lack of means to overcome this challenge can result in uncaring encounters and forensic issues that are left unaddressed. This

can, in a wider context, limit the patients' and families' possibilities for alleviated suffering and gaining legal justice. The present findings raise awareness of how important the caring encounter is as a prerequisite for forensic care. It also adds knowledge of several hindering factors that must be overcome to ensure forensic care for all victims of violence in EDs. Results point to the need for prioritizing issues concerning violence for patients in EDs. In line with this, nurses need clear forensic guidelines as well as hands on knowledge of how to provide care for victims of violence. This, in turn, could be facilitating for nurses to engage in caring encounters with victims of violence and to thereby provide forensic care. Offering family members support in the aftermath of violence seems to be an area requiring improvement and EDs may want to evaluate how family members are/could be included in care for victims of violence. Researchers can contribute by conducting studies exploring forensic care and support in EDs from the perspective of victims of violence as well as their family members. In light of the findings in the present study, conducting intervention studies to further develop forensic care in the ED is especially motivated.

Conflict of interest

None.

Ethical statement

The study adheres to the ethical guidelines of the Helsinki Declaration and was approved by an advisory board from the Research Ethics Committee in Linköping, Sweden (dnr. 2014/480-31).

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