

Nursing Care Challenges of Child Violence Victims: A Qualitative Study

Abstract

Background: Violence against children is a serious global phenomenon. The severity of the injuries caused due to violence toward a child is sometimes so great that it sends them to the hospital. Nurses have the first contact with Child Violence Victims (CVVs). These nurses experience different challenges. This study was aimed at exploring nurses' experiences of challenges in care provision to CVVs. **Materials and Methods:** This conventional content analysis and qualitative study was conducted in 2018–2019. Using a purposive sampling method, 17 nurses with experience in care delivery to CVVs were recruited from among those working in Children's Medical Center, Tehran, Iran, and Bu-Ali Subspecialty Hospital, Ardabil, Iran. In-depth semi-structured interviews were conducted to collect the required data. Data were analyzed through the conventional content analysis method. **Results:** During data analysis, the 3 main categories of role conflict, lack of continuity of care, and emotional resentment and 9 subcategories were identified. Nurses experience challenges in care provision to CVVs. They do not have enough knowledge about CVVs, are unable to maintain the continuity of care, and experience role conflicts and emotional resentment. **Conclusions:** Nurses experience some difficulties and challenges in the process of care delivery to CVVs. They tried to overcome emotional resentment, different conflicts, and concerns about the lack of continuity of care without adequate support and resources. Thus, planning to support nurses in this regard seems essential.

Keywords: Iran, nursing, qualitative research, violence

Introduction

Centers for Disease Control and Prevention (CDC) in its latest book in the field of violence applied the general term "maltreatment". Maltreatment is an umbrella term that encompasses all forms of violence and intentional harm to children by caregivers. The abused child and the Child Violence Victim (CVV) have the same meaning. CVVs include those who are subjected to all type of violence by parents or other caregivers, peers, romantic partners, or strangers.^[1,2] Violence against children is among the major, preventable, and most devastating threats to children's health and wellbeing.^[3,4] It is a multidimensional problem that has many facets, and encompasses specific concepts of physical, psychological, sexual violence, and negligence.^[3] It is a major problem among millions of children in all communities throughout the world resulting in deaths, physical injuries, and psychological complications in children.^[4-6] Although all types of violence are destructive, physical

violence can hurt victims physically and psychologically more than other forms.^[7] Violence is an all-too-real part of life for children around the globe regardless of their economic circumstances and sociocultural background and has many consequences.^[8] Studies have shown that more than 1 billion children—half of all children in the world—are exposed to violence every year.^[9] Approximately, 1 out of 8 children is a victim of violence.^[10] It is estimated that 1 billion children have been the victims of violence by 2018.^[11] One of the targets (target 16.2) of the 2030 Agenda for Sustainable Development is to "end abuse, exploitation, trafficking, and all forms of violence against children."^[12] CVVs do not have time to enjoy their lives, because all their energy is consumed by the effort to survive. They need to be cared for and nursed.^[13]

Nurses are often the first group of healthcare providers who deliver health services to CVVs and their families.^[4] Therefore, they occupy a unique position

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that allows them to detect and report suspected cases of CVVs to child protective services.^[14,15] A study in Poland reported that 86.25% of nurses had provided services to CVVs at their workplaces.^[13] Lavigne *et al.*^[16] reported this rate at about 78.75% in the USA. Herendeen *et al.*^[17] stated that most pediatric nurse practitioners (89%) had encountered a case of suspected CVV during their career. Many of them (69%) were confident in their ability to identify children at risk of abuse; however, 21% did not feel they had adequate knowledge about CVVs. Pediatric nurse practitioners' confidence in managing and identifying CVVs was significantly associated with insufficient training. The study by Borimnejad and Fomani is among the limited number of studies conducted in Iran in this regard; they found that Iranian nurses had some ethical and legal barriers and knowledge deficit in child abuse reporting.^[4] It seems that Iranian nurses are faced with some challenges in encountering CVVs and there is no exact knowledge in this regard.

Violence against children is a difficult subject from a nursing perspective. It is a complex phenomenon with different dimensions. Care delivery to CVVs is challenging for nurses. Reporting child abuse and professional conflicts, ethical conflicts, sympathy versus responsibility, communication with parents, and legal and ethical dilemma are some of these challenges. Because of these challenges, nurses do not know how to deal with CVVs. They do not have the necessary preparation for such encounters. Basically, everyone avoids violent and challenging situations.^[4,9,18,19]

In addition to the common needs of children, CVVs need special health care services.^[20] Due to the paucity of studies on nurses' challenges in care delivery to CVVs, there is limited data on nurses' experiences and challenges in the management of CVVs. Except for one study, there is limited evidence on Iranian nurses' challenges in these area.^[4] There is no doubt that participation in the child protection process for nurses is challenging and stressful. However, there is a scarcity of knowledge from a nursing perspective on encountering CVVs in nursing practice and shortage of literature on nurses' experiences of challenges in care provision to CVVs.^[21] This can be remedied through studies with a qualitative approach for deep understanding. The best way to study experiences is through qualitative studies. Therefore, the aim of the present study was to explore nurses' experiences of challenges in care provision to CVVs. This study is part of a larger research program, illuminating how nurses encounter CVVs in hospitals to increase the understanding of ways of intervening to improve the quality of care provision for CVVs.

Materials and Methods

This qualitative study was conducted from January 2018 to March 2019 using conventional content analysis method. Participants were selected purposefully and included nurses

who worked in the emergency departments, pediatric general wards, and pediatric intensive care units (ICUs) of Children's Medical Center, Tehran, Iran, and Bu-Ali Subspecialty Hospital, Ardabil, Iran. The first center is a leading subspecialty pediatric center affiliated to Tehran University of Medical Sciences, Tehran, Iran, and the second center is the only subspecialty hospital in Ardabil Province, Iran. Because the researcher worked as a pediatric nurse in different departments of Ardabil Medical Center, she interviewed with her informed colleagues. Moreover, Children's Medical Center is one of the largest specialized pediatric centers in Iran. Interview participants were selected from among the staff of these centers. Data collection of stopped when saturation was reached in the concepts derived from the data; therefore, 17 nurses were recruited from the 2 centers through purposive sampling method. The study inclusion criterion was the experience of care provision to CVVs. Thus, nurses active in all work shifts with more than 6 months clinical experience of care provision to CVVs were selected and interviewed. The participants consisted of 15 female nurses and 2 male nurses. The demographic characteristics of the participants are given in Table 1. Semi-structured interviews were conducted to collect the required data. All interviews were held by the first author who had the experience of interaction with nurses in pediatric wards as a clinical instructor. First, an appointment was made for an interview with each participant. Then, an interview was held in a private room at the participant's workplace. Interviews were started with general questions, and then, moved toward more in-depth inquires based on participants' answers and the purpose of the study. The opening questions in the interviews were the following: "Would you please explain your experiences of care provision to CVVs?" Overall, 17 interviews with a

Table 1: Participants' characteristics

No.	Age	Gender	Educational degree	Position	Clinical experience
P1*	46	Female	Bachelor's	Head nurse	23
P2	41	Female	Bachelor's	Nurse	20
P3	44	Female	Bachelor's	Head nurse	18
P4	37	Female	Bachelor's	Nurse	5
P5	35	Female	Bachelor's	Nurse	12
P6	30	Female	Bachelor's	Nurse	3
P7	40	Female	Bachelor's	Head nurse	17
P8	48	Female	Master's	Head nurse	22
P9	46	Female	Master's	Supervisor	23
P10	47	Female	Master's	Head nurse	24
P11	44	Female	Bachelor's	Head nurse	14
P12	57	Male	Bachelor's	Nurse	29
P13	43	Male	Bachelor's	Matron	21
P14	35	Female	Bachelor's	Nurse	10
P15	41	Female	Bachelor's	Nurse	19
P16	40	Female	Bachelor's	Nurse	15
P17	38	Female	Master's	Supervisor	12

*Participant

duration ranging from 45 to 60 minutes were conducted. In addition, 3 five-minute follow-up interviews were also conducted with 3 participants. Interviews were recorded using a pocket voice recorder. After each interview, the interview was transcribed using Microsoft Office Word software and the transcript was analyzed.

Data analysis was performed via conventional content analysis method as explained by Graneheim *et al.*^[22] The transcript of each interview was read several times to obtain a general understanding. Then, meaning units were identified, condensed, abstracted, and coded. Primary codes were grouped into subcategories based on their similarities and differences. Simultaneously, subcategories were grouped to form the main categories as the latent content of the data on the basis of their similarities and differences. Main categories were then grouped into more general themes.^[23] The MAXQDA software (version 10; VERBI Software GmbH, Berlin, Germany) was employed to manage the data. Table 2 shows the development of a category based on its primary codes and subcategories. The repetition of concepts from the code, and finally, the achievement of duplicate and common concepts illustrated that saturation of the concepts was reached. Saturation occurs when redundancy is reached in data analysis and signals that the researchers may cease data collection. The proliferation of common concepts in data analysis showed that the collection of new and duplicate information has stopped, that is, and saturation has been reached.

The criteria proposed by Lincoln[†] and Guba including credibility, dependability, confirmability, and transferability were used to ensure the trustworthiness of the findings.^[24] The study was supervised by adroit researchers experienced in the field of qualitative research. In order to obtain credible data, the research team had a prolonged engagement with the study subject matter and directly observed nursing care delivery to CVVs in hospital settings. For instance, the first researcher observed the whole process of care delivery to a child suffering from deliberate poisoning by methadone syrup, from hospital admission to hospital discharge. Moreover, 3 participants were provided with a summary of the findings. They confirmed the similarity of the

findings with their own experiences. Data collection was performed through interviews and field observation, and the participants were recruited with maximum variation in terms of clinical experience, educational level, and marital status. Confirmability of the findings was established through peer debriefing. Peers were coauthors who had enough experience in nursing and the concept of violence. The peers actually read, critiqued, and gave feedback to the researcher throughout the research project.^[25] Moreover, the process of data analysis was supervised by coauthors. In addition, to ensure dependability, data collection and analysis were performed concurrently; moreover, the process of data collection was continued based on the generated codes and categories. To ensure transferability, the study findings were presented to 3 nurses who were not enrolled into the study. They confirmed the consistency between the findings of the study and their own experiences.

Ethical considerations

This study was extracted from a PhD dissertation in nursing which had been approved by the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences, Tehran, Iran (code: IR.USWR.REC.1396.268). All the participants read and signed an informed consent form. A written consent was obtained from the participants for recording interviews, and they were assured of their right to withdraw from the study at any time. They were also assured of the confidentiality of their data. The participant's recorded voice was stored in a safe place. A code was assigned to each participant to maintain confidentiality.

Results

Analysis of the data resulted in the identification of 3 main categories that reflected nurses' challenges in care provision to CVVs. The 3 identified categories are role conflict, lack of continuity of care, and emotional resentment and contain 9 subcategories.

Role conflict

Nurses experience role conflicts when facing CVVs, because they cannot simultaneously act as care provider, child and family advocate, police officer, and interrogator.

Table 2: A brief report of the development of the categories

Subcategories	Category
Feeling compassion	Emotional resentment
Anger suppression	
Painful experiences due to child violence	
Feeling continuous sorrow	Role conflict
Conflict in personal presumptions about parental roles	
Conflict in role performance	Lack of continuity of care
Parents' avoidance of receiving care services	
Discontinuation of care after hospital discharge	
Resource constraints	
Nurses' limited knowledge and lack of practical guidelines	

The subcategories of role conflict include conflict in personal presumptions about parental roles and conflict in role performance.

Conflict in personal presumptions about parental roles

Based on family-centered care, nurses usually expect parents to support their hospitalized children. However, parents of CVVs usually do not support their children and even maybe the culprit of violence against their children or may have contributed to it. In this regard, a participant said: *"There was a boy in our ward whose parents worked in a store. The store owner had raped the boy; poor baby. His father consented to hospital discharge and took his son home. He did not complain. He said that he had no option, but to work in that store to meet his household expenses"* (Participant (P 6).

Conflict in role performance

Nurses had to act as a police officer or interrogator in order to assess the children and acquire the necessary data on patient conditions and the cause of damages. *"We had to prevent parental visits of CVVs. It is a very difficult task. If we do not restrict visits, a mother for example, who had been the source of violence, may stealthily give her child another poisoning drug during the visit"* (P 8).

Lack of continuity of care

CVVs spend the acute phase of violence-related problems in a hospital and deal with the long-term consequences of violence after hospital discharge. However, the participants' experiences revealed the lack of continuity of care and the child's unknown status after hospital discharge. This category consisted of 2 subcategories, that is, parents' avoidance of receiving care services and discontinuation of care after hospital discharge.

Parents' avoidance of receiving care services

CVVs often live in families with different problems. Their parents may resist receiving care services and prefer early hospital discharge, because they are afraid of legal prosecution by hospital authorities and being blamed by others. Moreover, they may decide to illegally take their hospitalized children out of hospital. A respondent stated: *"Although we had previously warned the security staff, the mother illegally took the child out of the hospital"* (P 2).

The participants also faced barriers to care delivery because of some parents' reluctance to continue receiving treatments and care services for their children. A participant remarked: *"The rate of personal consent for hospital discharge is high among parents of CVVs. The parents are afraid of blame or legal prosecution for their violence; hence, they give consent for early hospital discharge"* (P 1).

Discontinuation of care after hospital discharge

After hospital discharge, CVVs had been either transferred to welfare organizations or sent back home. Thus, all the

participants complained of discontinuation of care and lack of support for CVVs after hospital discharge. One participant noted *"After all those events, we yielded the child to the welfare organization. Three to four days later, I saw the child with her grandmother who was begging in a city square"* (P 7).

Resource constraints

Care delivery to CVVs requires facilities and dealing with CVVs is a time-consuming activity. A respondent stated: *"Child violence cases are more sensitive than other cases, and hence, they require more time. However, we have problems due to time limitation and staff shortage"* (P 5).

Families of CVVs may decide to take their children out of hospital illegally; hence, there is need for more staff to protect CVVs. One respondent pronounced: *"Once, I had no option, but to assign 1 of our ward staff to protect CVVs for several days"* (P 10).

Limitation of facilities such as private rooms is a barrier to effective care delivery. One respondent declared: *"We have neither private rooms nor psychologists in the hospital to talk with these patients"* (P 1).

Nurses' limited knowledge and lack of practical guidelines

Participants reported a limitation of knowledge about care delivery to CVVs, which was attributed to the lack of in-service training on child violence. Accordingly, the participants reported such programs as their top educational needs. On this topic, one of the participants stated: *"We have not received any appropriate training in this area, except for a simple lecture by a nurse about child abuse that was presented 2 years ago. We do not have any guidelines. We have not been informed of the laws"* (P 11).

Emotional resentment

Nurses may experience emotional resentment during care delivery to CVVs because child violence not only directly affects CVVs, but also indirectly causes emotional burnout in nurses who provide care services to CVVs. This category consisted of 4 subcategories which are briefly explained below.

Feeling continuous sorrow

For a long time they felt sorrow not only because of violence, but also due to the lack of serious actions against the perpetrators. A participant said: *"A father had raped his six-month-old girl. I still really feel sad and suffer from sorrow when I remember that hospital authorities gave the child to her parents to take home"* (P 4).

Feeling compassion for CVVs

Most of the participants felt compassion and pity for CVVs throughout the process of care delivery to them. In this regard, a participant stated: *"I felt pity for the child and I*

was concerned about another case of violence against her by her mother in future" (P 3).

Anger suppression

While providing care to CVVs, the participants felt a deep anger against the perpetrators such as parents. However, they had no option, but to suppress their anger and other emotions. A participant noted: "Although we are sad and angry, we cannot express our anger toward the families, and thus, we try to suppress it. I was very angry, but I had to remain silent" (P 6).

Painful experiences due to child violence

The participants noted that their most painful experiences were related to care delivery to CVVs, particularly those who had experienced sexual violence. They also noted that remembering CVVs was always a painful experience. In this regard, a participant stated: "One of my most painful experiences of care delivery to CVVs was related to a 6-month-old girl whose father had raped her while her mother filmed them" (P 4).

Discussion

The present study results indicate that pediatric nurses are faced with some challenges in care provision to CVVs. Nurses have to interact with parents who are not only not supportive of their children, but are also the direct causes of injuries leading to hospitalization of CVVs. In delivering care to child patients, nurses assume that parents are supportive of their children and help them regain their health. This fact contradicts nurses' presumptions about parental roles and obliges them to protect CVVs against their parents through some interventions such as preventing child-parent visits. In about 40–70% of cases of child violence, parents are the sources of violence.^[11,26] In accordance with our study results, Tingberg *et al.*^[15] reported that nurses described feeling hatred for the abuser while simultaneously feeling empathy for the child's parents. However, in some cases in which the parents were the perpetrators nurses experienced emotional ambivalence and conflict in personal presumptions about parental roles.^[15] Nurses need to support children and protect them against potential injuries by their parents or family members. In other words, nurses need to keep CVVs away from the sources of violence. The need to support both CVVs and their families simultaneously and keep CVVs away from their families leads to conflicts in role performance. Moreover, under such conditions, nurses need to act as a police officer or interrogator in order to assess the children and acquire the necessary data on patient conditions and the cause of damages which leads to a perception of role conflict for nurses. Tingberg *et al.*^[15] reported that nurses found it difficult to keep their professional role when faced with the parents of these children; they were unhappy in their conflicting roles of both policing and nursing.

Care provision to CVVs inflicts nurses with heavy emotional resentment. It triggers many feelings that nurses must deal with. These feelings can haunt them over time.^[27] Saifan *et al.*^[28] also found that nurses tried to manage these situations. Nurses feel empathy with their children and are concerned about their future. Moreover, professional practice requires them to manage their anger and other negative emotions. Similarly, a study reported that violence against children, chiefly sexual abuse, had devastating effects on nurses and resulted in their emotional frustration.^[18,21] In difficult situations, psychological support is important. Nurses need support throughout the whole process in child welfare cases. Our participants, like the nurses participating in the study by Skarsaune and Bondas, were in grave need of psychological support, but they do not always receive the support they need. Care delivery to CVVs is a time-consuming process, and, in addition to psychological support, it requires different workforces and physical resources. However, the participants in this study reported a shortage of workforce, facilities, time, and resources in this process.^[6]

Nurses noted that discontinuation of care services after hospital discharge makes their attempts futile and causes readmission. Based on the study by Buicko *et al.*^[29] readmission rates are being frequently used as quality indicators of patient care and readmission of CVVs represents a significant resource burden. To the best of our knowledge, none of the previous studies reported this finding, denoting that post-discharge care discontinuation is a problem specifically occurring in our context. A reason for the discontinuation of post-discharge care is the lack of interdisciplinary collaboration among hospitals, the welfare organization, family counseling centers, and charities.^[30] Another reason is the lack of community-based nursing services in Iran.^[31]

In spite of the fact that nurses are in a unique position to identify CVVs due to their role in providing health care in a variety of settings, nursing curricula does not routinely focus on this fact.^[18,32] Highly skilled and knowledgeable nurses are required to treat CVVs. More over adequate knowledge is necessary for identifying violence.^[18,32] Nurses must be prepared when CVVs are ready to share their experience of violence and abuse.^[19] Herendeen *et al.*^[17] found that, for the provision of effective care to CVVs, nurses require further education, both in their curriculum preparation and continuing education, this was in line with the current study findings. There was no clear clinical guideline or protocol in setting for care delivery to CVVs. Moreover, in Iran's latest version of bachelor nursing curriculum, only a 2-hour session is held to introduce and explain child violence to pediatric nurses. Nurses' lack of knowledge about child violence reduces their abilities to identify and resolve CVVs' problems.^[33,34] Furthermore, Saifan *et al.*^[28] reported that most of the health care providers who directly deal with

CVVs have had no training regarding CVVs. Borimnejad and Fomani^[4] have also reported the need for broadening nurses' knowledge about child violence and developing clear guidelines. According to the recommendations of many studies, nurses need theoretical and practical training in this field and knowledge is needed on how to handle difficult situations.^[13,28]

We had some limitations in this study. The majority of nurses in pediatric wards in Iran are women. Since only 2 male nurses participated in the study, we had a limited access to male nurses' experiences. Moreover, we did not have access to psychiatric nurses who had experience in caring for CVVs. Furthermore, the participants were recruited from only 2 Iranian referral hospital units. Thus, it is recommended that similar studies be performed in hospitals in different regions of Iran. In addition, it is suggested that studies be conducted in the field of designing nursing care models for CVVs. Studies should be designed in the field of appropriate educational interventions and nurses overcoming experiences of role conflicts. Role conflict, lack of continuity of care, and emotional resentment are the most important challenges for nurses in dealing with CVVs. It is essential to provide qualified care by managing these challenges.

Conclusion

Based on the understanding gained from this study, the world of nurses that care for CVVs is a world composed of some challenges that generate a constant state of role conflict and emotional resentment. The lack of continuity of care, staff shortage in this area, lack of specific guidelines, and lack of specialized training are the items need to be managed by out-the-system authorities. Nurses had to overcome different emotional resentment, different conflicts, and concerns about the lack of continuity of care without adequate support and resources. In order to empower nurses to provide care to CVVs, comprehensive in-service training programs should be developed and implemented. Nursing managers need to reduce the problem of staff shortage in this area, consider specific private places for providing counseling services to CVVs and their families, design guidelines, and employ strategies to maintain the continuity of care after hospital discharge.

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Conflicts of interest

Nothing to declare.

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