Original Article

Iranian Nurses' Experiences of their Roles in Care Provision to the Victims of Child Violence: A Qualitative Study

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Abstract

Background: As the largest group of healthcare providers, nurses have many different responsibilities in care provision to child violence victims (CVVs). Yet, their roles in care provision to these victims are poorly known. **Objectives:** The aim of this study was to explore nurses' experiences of their roles in care provision to CVVs. **Methods:** This qualitative study was conducted in 2018–2019. Fourteen nurses were purposively recruited from two pediatric specialty hospitals in Tehran and Ardabil, Iran. In-depth semi-structured interviews were held for data collection. Data were analyzed through conventional content analysis. **Results:** Data analysis revealed that nurses' roles in care provision to CVVs included the four main categories of protective, diagnostic, reporting, and educational roles. **Conclusions:** Nurses play significant roles in care provision to CVVs through diagnosing violence, reporting it, protecting CVVs, and providing education to CVVs and their families. Nonetheless, they receive limited education, if any, in this area.

Keywords: *Child abuse, Maltreatment, Nursing roles, Pediatric nursing, Qualitative study, Victims, Violence*

Introduction

Violence against children is a global health problem.[1] It consists of all forms of violence against individuals under eighteen committed by parents, caregivers, peers, romantic partners, or strangers.[2] The Department of Health and Human Services in the United States reported that in 2017, more than 57,000 children in this country suffered violence. This number is just the tip of the iceberg because only one twentieth of cases are reported.[3] Iran has a population of more than 80 million, 31% of which are younger than 19 years of age. Violence against children is a crime in Iran. Despite studies in different areas of Iran into child violence, there is no overall estimation of its prevalence in the country. A systematic review in Iran showed that the prevalence rates of physical violence, emotional violence, and neglect were 9.7%–67.5%, 17.9%–91.1%, and 23.6%–80.18%, respectively.[4] This study revealed a high prevalence of child abuse in Iran. It seems child abuse in Iran is in the critical condition.

Child violence has numerous detrimental personal and social consequences.[5] The social cost of child violence in Japan was sixteen billion dollars in 2012, which is equivalent to the costs of Tokyo earthquake and Fukushima tsunami in 2011.[6]

Providing care to child violence victims (CVVs) is among nurses' daily responsibilities. They have a key role in detecting all types of child violence.[7] As the largest group of healthcare providers, nurses have numerous roles and responsibilities in providing care, improving care quality, enhancing health,[8] and shaping the future of healthcare.[9] Their professional roles include caring, educational, advocacy, research, managerial, consultative, and disease prevention roles.[8,10,11] In the Health People 2020 initiative, the United States Department of Health and Human Services defined violence prevention as one of the most important roles of nurses.[12]

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Nurses' roles in preventing and reporting child violence are very complex due to the complexity of child violence phenomenon[13] and vary in different countries.[14] In some countries, they act as forensic nurses in dealing with CVVs.[3] A qualitative study in Iran addressed barriers to child abuse reporting.[15] Yet, nurses experiences of their roles in care provision to CVVs are poorly known and further studies are needed to provide detailed data in this area in the real world.[14]

Objectives

The aim of this study was to explore nurses' experiences of their roles in care provision to CVVs.

Methods

Design and participants

This qualitative study was done using conventional content analysis in 2018–2019.

Study setting was specialty pediatric wards in two pediatric specialty hospitals in Ardabil and Tehran, Iran. These two hospitals were Children's Medical Center affiliated to Tehran University of Medical Sciences, Tehran, Iran, and BooAli Children's Hospital affiliated to Ardabil University of Medical Sciences, Ardabil, Iran. Fourteen nurses were purposively recruited from emergency rooms, internal medicine wards, and pediatric intensive care units. Inclusion criteria were a work experience of more than 6 months in pediatric wards, experience of care provision to CVVs, and agreement for sharing personal experiences. Sampling was done with maximum variation concerning participants' gender, work experience, education level, marital status, and affiliated ward. Table 1 shows Participants' characteristics.

Data collection

Data were collected through in-depth semi-structured face-to-face interviews. Each interview was started using an open-ended question about care provision to CVVs, i.e. "What experiences do you have about care provision to CVVs?" Then, it was guided according to interviewee's response. With appointment, interviews were held in a room at participants' workplace. The length of interviews was 45–60 min. All interviews were held by the first author who had the experience of interaction with nurses in pediatric wards for 22 years as a nursing student, nurse, and clinical instructor. Interviews were recorded using a pocket voice recorder. In total, seventeen interviews were held with fourteen participants. Data collection was continued until reaching data saturation. After each interview, it was immediately transcribed and then, typed in Microsoft Office Word.

Data analysis

Immediately after the first interview, data analysis was started using conventional content analysis method proposed by Graneheim *et al*. Each interview transcript was reviewed several times. Then, meaning units were identified, abstracted, and coded. Codes were categorized into subcategories according to their similarities and then, subcategories were grouped to form main categories as the latent content of the data.[16] Table 2 shows an example of data analysis. The MAXQDA software (MAXQDA 10, Verbi company, Berlin, Germany) was employed to manage the data.

Trustworthiness

Trustworthiness was maintained using Lincoln and Guba's criteria, namely credibility, transferability, dependability, and confirmability.[17] To maintain credibility, the first author had prolonged engagement with the data for more than 18 months. To ensure transferability, clear descriptions

Table 1: Participants' characteristics

n	Age(years)	Gender	Marital status	University degree	Number of children	Organizational position	Work experience (years)
1	46	Female	Married	Bachelor's	2	Head nurse	23
2	41	Female	Married	Bachelor's	2	Nurse	22
3	44	Female	Married	Bachelor's	2	Head nurse	18
4	37	Female	Single	Bachelor's	0	Nurse	12
5	35	Female	Married	Bachelor's	2	Nurse	12
6	30	Female	Single	Bachelor's	0	Nurse	3
7	40	Female	Single	Bachelor's	0	Head nurse	17
8	48	Female	Married	Master's	2	Head nurse	22
9	46	Female	Married	Master's	1	Supervisor	23
10	47	Female	Married	Master's	2	Head nurse	24
11	44	Female	Married	Bachelor's	2	Head nurse	14
12	57	Male	Married	Bachelor's	2	Nurse	29
13	42	Female	Married	Bachelor's	2	Nurse	14
14	42	Male	Married	Bachelor's	1	Matron	20

Table 2: An example of data analysis

Condensed meaning unit	Codes	Subcategory
Suspected violence due to parents' inconsistent statements	Suspected violence due to companions' inconsistent statements	Nurses' diagnostic role
Suspected violence due to companions' inconsistent statements		
Diagnosing violence through assessing the symptoms and analyzing the inconsistent data obtained through history taking		
Suspected violence due to the inconsistency between symptoms and parent's statements		
Suspected violence while changing the position of the child	Noticing a suspected violence based on clinical symptoms and history data	
Noticing the age-inappropriate behaviors of the child		
Suspected violence due to the frequent hospitalizations of the child		
Suspected violence due to the multiple unusual injuries of the child		
Diagnosing primary symptoms of suspected violence by the nurse	Nurses as the first who suspect violence	
Nurses are the first who get aware of violence against children in hospitals		
Confirming violence through collecting data about patient's history and based on physical and behavioral symptoms	Complementary role in diagnosing violence	
Nurses' follow-up measures for the definitive diagnosis of violence through consultation with forensic specialists		
Nurses' request for repeating laboratory tests		
Nurses' effort for the definitive diagnosis of sexual abuse through consulting gynecologists		

were provided about participants' characteristics such as age, gender, work experience, and educational level and all steps of the study were explained in detail. Dependability was ensured through peer checking by coauthors. The members of the study team were experienced qualitative researchers with extensive experience in research, nursing, and violence. During member checking, coauthors frequently reviewed the processes of data reduction, coding, and categorization. Moreover, data collection and analysis were performed simultaneously and all study documents (including interviews) were kept for auditing by others. Moreover, a piece of the data was simultaneously analyzed by two of the authors which produced similar results. To ensure confirmability, excerpts of the interview data and their corresponding codes were given to three participants. They approved the congruence between our findings and their own experiences.

Ethical considerations

This study was part of a PhD dissertation in nursing approved by the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences, Tehran, Iran (code: IR.USWR.REC.1396.286). Study objectives were explained to all participants and they were ensured of the voluntary participation and confidential management of the study data. Informed consent for participation was obtained from all participants.

Results

Participants were fourteen nurses who had the experience of providing care to CVVs. Most participants were female and had bachelor's degree [Table 1].

None of the participants had already received educations about CVVs. All of them highlighted that their therapeutic role in relation to CVVs was the same as their therapeutic role in relation to other patients. Moreover, they claimed that they performed all therapeutic measures needed for CVVs, especially in the acute phase of managing violence-related injuries. The essence of nursing is care. Therapeutic role is seen everywhere in providing nursing care. As nurses' therapeutic role was clear and none of the participants clearly talked about it, we avoided addressing this role in detail in the present study.

In total, 78 codes were generated regarding nurses' experiences of their role in care provision to CVVs. These codes were categorized into nine subcategories and four main categories [Table 3]. The four main roles of nurses in care provision to CVVs were protective role, diagnostic role, reporting role, and educational role.

Protective role

Participants considered CVVs as defenseless individuals and hence, attempted to protect them against possible injuries. They noted that violence is not a single event in the past; rather, it is a process started in the past which may continue in the future, resulting in further violent behaviors towards CVVs. Accordingly, they were vigilant about others' suspicious behaviors towards CVVs in order to protect them against other violent incidents. This main category consisted of three subcategories, namely

Table 3: Subcategories and main categories of the study together with examples of their primary codes

Main categories	Subcategories	Codes
Protective role	Monitoring people related to the child	Controlling people who enter and exit the ward
		Monitoring child's visitors to prevent re-poisoning
	Attempting to meet the needs of the child and the family	Provision of financial support to families by nurses
		Referring families to NGOs
	Ensuring environmental safety	Providing outdoor security to protect the child
		Checking doors and windows
		Request for the repetition of suspected laboratory tests
Diagnostic role	Suspicion about violence due to inconsistent statements of CVVs' companions	Noticing inconsistencies in parents' statements
		Suspicion of violence due to inconsistencies in companions' statements
	Suspicion about violence based on history and examination data	Noticing the inappropriate developmental behaviors of the child
		Noticing frequent hospitalizations of the child
		Noticing poor child-family relationships
Reporting role	Reporting violence to other healthcare providers	Reporting child abuse to nursing colleagues in different shifts
		Reporting child abuse to social workers and psychologists
		Reporting child abuse to hospital legal affairs
	Reporting child abuse to child protection staff	Reporting child abuse to parents
		Reporting child abuse to social emergency department
		Reporting child abuse to judicial authorities
		Reporting child abuse to police
Educational role	Providing education to CVVs to reduce their stress	Sending child to playroom
		Teaching child how to use books and how to paint
	Providing education to CVVs' parents to reduce CVVs' stress	Teaching parents not to express negative emotions at the child's bedside
		Teaching mothers to distract the child

CVV: Child violence victims, NGO: Non-Governmental Organization

monitoring people related to CVVs, attempting to meet the needs of CVVs and their families, and ensuring environmental safety.

Monitoring people related to child violence victims

Participants acted as guards for CVVs and attempted to protect them against potential risks.

> *Not only we are vigilant about suspicious visits in the morning shift, but also I tell nurses in the evening and the night shifts to be watchful about people who visit CVVs in their shifts in order to prevent them from harming CVVs (P. 3).*
>
> *At the visitation time, I saw two men who separately introduced themselves as the child's father. To prevent potential risks, I checked all visitors and asked them to show their identity cards. This strategy revealed that none of those two men was the child's father (P. 2; explaining a case of suspicious child selling).*

Attempting to meet the needs of child violence victims and their families

Participants attempted to meet the needs of CVVs and their families during their relationships with them. For instance, they bought gifts for CVVs in order to gain their trust.

> *We really support these children. For example, we attempt to make them happy by giving them a doll, a toy car, or a small thing. Children become happy with small things. By this technique, we try to establish close relationship with them and make them hopeful. Some time they have not clothes and diapers due to poor economic conditions, we provide for them (P. 7).*

Participants not only personally protected CVVs, but also attempted to introduce them to support groups and organizations despite having no clear guideline for such introduction. Public health nurses have no distinct position in the healthcare system of Iran and hence, there are problems in care provision to CVVs after they are discharged from hospital. Therefore, our participants attempted to meet the psychological and financial needs of CVVs and their families even after hospital discharge.

> *We support them. Sometimes, we refer them to NGOs that provide them with psychological and financial support (P. 8).*

Ensuring environmental safety

Nurses have improved the environment safety for child protection. Some time they provided outdoor security guard for child protection.

> *Sometimes, I ask a security staff to stay in front of the ward entrance and close the door and the windows because somebody may kidnap the child (P. 10).*

Diagnostic role

Nurses have an important role in diagnosing violence against CVVs. This category consisted of two subcategories. Table 2 shows details.

Suspicion about violence due to inconsistent statements of child violence victims' companions

> *The companions of the child did not say anything to us. Instead of her parents, a boy from relatives had taken the child to hospital. Inconsistent statements made us get suspicious that there was a problem. The 3-year-old girl behaved like adults and used make-up (P. 7).*
>
> *The stepfather of the child said that the child slipped in the bathroom and experienced head trauma. However, some other parts of the child's body were also bruised and his mother said that he had a fall in the yard. Thereby, I found that they were not telling the truth (P. 1).*

Suspicion about violence based on history and examination data

Participants noted that they suspected violence against children based on the data they obtained during history taking and clinical examination. Moreover, they noticed evidence of violence during changing children's position. Inconsistencies between the data obtained through history taking from children and the data obtained during interviewing their parents also made them suspect violence.

> *We had a 12-year-old girl with rectal bleeding. History data were not consistent with clinical symptoms and the data provided by family members. Further examination revealed a rape (P. 11).*

Reporting role

Nurses' role in violence reporting had two subcategories, namely reporting child abuse to other healthcare providers and reporting child abuse to child protection staff.

Reporting violence to other healthcare providers

Participants noted that they were responsible for reporting any evidence of child violence to their colleagues and superiors, including head nurse, nursing manager, physicians, social workers, and forensic doctor resident in their hospitals.

> *When providing care to a hospitalized boy whose mother had hurt him, I informed our head nurse. She asked me to inform the supervisor and the social worker of the hospital and I did it (P. 2).*

Reporting child abuse to child protection staff

Besides intra-organizational reporting of violence, participants highlighted that they reported cases of child violence to authorities out of their organizations, including public prosecutors, judicial authorities, and police. Moreover, some parents were unaware of violence against their children and hence, participants informed them.

> *Evidence of assault on all parts of the child's body, from the face to the extremities, made us suspicious of violence. Therefore, we informed the social workers of our center as well as the child's mother. Social workers and the child's mother attended our ward. There, it was proved that the child's stepfather had hurt him. We reported the case to judicial authorities (P. 1).*
>
> *A 13-year-old child with rectal bleeding was brought to the emergency unit. While examining her, we noticed she was raped. We informed her parents; but the poor girl died due to severe bleeding (P. 13).*

Educational role

While providing care to CVVs, nurses also play educational roles. They provide education to CVVs and their parents in order to reduce their stress.

Teaching children to reduce their stress

Nurses make effort to practically educate the children the ways of reducing tension and anxiety.

The PICU nurse with 12 years of clinical experience talked about one of her experiences and said: "A kid who was abused and admitted to the ward I brought him a painting and storybook book that we have in the ward and asked him to come and play whenever he wanted" (P. 4).

Providing education to child violence victims' parents to reduce child violence victims' stress

Participants also trained CVVs' parents to use techniques for reducing CVVs' stress. These techniques included reading stories, painting, and spending time with children at playroom. A participant described her experience of providing education to the parents of a child who had been raped by the child's companion in the nursery way:

> *I told them to take their child to the nursery themselves and not to trust anyone. I also taught them some preventive techniques. They were very upset and I asked them not to cry at their child's beside in order to ease the child's stress (P. 1).*

Discussion

Findings revealed that beside therapeutic role, nurses played many different roles in providing care to CVVs, namely protective role, diagnostic role, educational role, and reporting role.

Protective role was the most important role of nurses in care provision to CVVs. Providing protective and safeguarding care to CVVs is one of the daily responsibilities of nurses.[18] Nursing interventions to protect children against abuse vary from prevention, diagnosis, and postabuse interventions.[19] Despite the necessity of playing active role by healthcare providers in child protection against violence, a population-based study in Germany showed that 19% of participants had experienced at least one type of violence committed by nurses.[20] This is against the principles of ethical nursing practice which require nurses to protect children and take care of them.[21]

After getting suspicious about violence, our participants attempted to assess suspicious cases of child violence and help physicians in diagnosis. Nurses have a significant role in diagnosing child violence. Early diagnosis of violence is important for early beginning of comprehensive care.

In 2002, the parliament of Iran enacted the child protection law with nine components. According to the first component, child abuse is considered a general crime without any need for plaintiff's complaint. The sixth component also requires all individuals, institutes, and centers that are in charge of care provision to children to report any case of child abuse for further prosecution. Avoidance from such reporting is considered a crime.[22]

Care provision to CVVs is a multidisciplinary task and hence, nurses should report cases of child violence to the members and authorities of healthcare team. The findings of the present study showed that nurses played significant role in reporting child violence cases to other healthcare providers and relevant authorities. Similarly, a former study in Iran reported that nurses actively engaged in reporting child violence to relevant authorities.[15] A study in Korea also introduced violence reporting as one of the main responsibilities of nurses and recommended that nurses should be provided with educations about appropriate violence reporting and should be supported by authorities to appropriately and confidently report cases of violence.[23]

Our participants also noted that they attempted to provide education to CVVs and their families in order to reduce their stress and prevent further injuries to them. Two earlier studies showed that pediatric nurse practitioners had the necessary knowledge and skills for providing care to CVVs.[24,25] Moreover, education can improve nurses' violence-related knowledge.[26] However, none of our participants were nurse practitioner and had received any violence-related education. Similarly, a study in Pakistan[27] and a study in Africa[28] reported that healthcare providers received no meaningful education regarding child violence and hence, had limited violence-related knowledge. Therefore, coherent educational programs are needed to improve nurses' knowledge about child violence. The Committee of School Nurses also highlighted that nurses should be responsive to and responsible for children, be aware of the strategies for reporting child violence, protect children against potential risks, be provided with educations about the signs and symptoms of child violence, act as a bridge between families and society, and collaborate with organizations to prevent and reduce child violence and its complications.[29]

In line with our findings, a study showed that psychiatric nurses have numerous roles in care provision to CVVs including reporting suspected cases of child violence, assessing and treating CVVs, providing violence-related education to children, and acting as a legal expert and a member of a multidisciplinary team in order to protect children against violence.[30] Another study also noted the necessity of working in a multidisciplinary team for effective child violence prevention and management.[28]

Provision of training programs to prevent and manage violence can lead to minimizing the consequences.[31]

Because of limited resources, this study was conducted only in two hospitals. Moreover, most nurses in pediatric wards were female and hence, we could include only two male nurses in the study. Future studies can show whether male nurses have different experiences.

Conclusions

Nurses play numerous roles in care provision to CVVs. These roles include protecting CVVs against potential risks, diagnosing cases of child violence, providing CVVs and their families with education in order to reduce their stress, and reporting suspected cases of child violence to colleagues and authorities. However, they receive limited education, if any, about violence and its diagnosis, reporting, prevention, and management. Therefore, university-based and in-service educational programs are needed for improving their violence-related knowledge and their ability to diagnose, report, prevent, and manage violence.

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Conflicts of interest

There are no conflicts of interest.

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