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JOSEFIN RAHMQVIST

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Forensic care for victims of violence and their family members in the emergency department
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Abstract

Rahmqvist, Josefin (2018). *Forensic care for victims of violence and their family members in the emergency department,* Linnaeus University Dissertations No 337/2018, ISBN: 978-91-88898-18-0 (print), 978-91-88898-19-7 (pdf). Written in English.

Aim: To explore forensic care in EDs for victims of violence and their family members from the perspectives of ED department heads, ED nurses, and a family member of a victim of violence.

Methods: Study I consisted of a questionnaire to all heads of EDs in Sweden, data were analyzed with descriptive statistics. Study II consisted of a similar questionnaire which also included the instrument Families' Importance in Nursing Care-Nurses' Attitudes. It was sent to all nurses at 28 EDs and data were analyzed using descriptive statistics, multiple linear and ordinal regression analysis. Study III comprised of individual interviews with twelve nurses from seven EDs and data were analyzed with content analysis. Study IV was a single case study with two interviews with a family member of a victim of violence. Data were analyzed with a Gadamer-inspired hermeneutic approach.

Results: ED preparedness for forensic care varied and was often limited to women and children. Nurses played a key role, but most of them had no training for this task and felt uncertain (I, II, III). Creating a caring encounter was the main challenge for providing forensic care and nurses perceived hindering factors to overcome this challenge (III). Family members were rarely included in forensic care and nurses perceived that family members were offered little help (I-III). Having ED documents that included family members, was associated with a more positive attitude to family members, which in turn was associated with involving them in care (II). For the family member, perfunctory encounters and caring alliances had a major impact and the experience re-framed life (IV).

Conclusion: Lack of preparedness in EDs to care for all types of victims of violence and differences between individual nurses may prohibit the provision of equal care. Hindering factors for a caring encounter can result in forensic care being unaddressed, which may limit possibilities for alleviated suffering and legal justice. Family members were rarely included in forensic care, but caring encounters can be crucial for the family member in the aftermath of violence.

Keywords: interpersonal violence, family member, forensic care, emergency department, nurses, experiences

To my family

In memory of Erik Lönn

Contents

Original papers

This thesis is based on four original papers that will be referred to in the text by Roman numerals I-IV.

I. Rahmqvist Linnarsson J., Benzein E., Årestedt K. & Erlingsson C. (2013). Preparedness to care for victims of violence and their families in EDs. Emergency Medicine Journal, 30, 198-201. doi:10.1136/emermed-2012-201127

II. Rahmqvist Linnarsson J., Benzein E., Årestedt K. (2014). Nurses' views of forensic care in EDs and their attitudes, and involvement of family members. Journal of Clinical Nursing, 24, 266-274. doi: 10.1111/jocn.12638

III. Rahmqvist J., Benzein E. & Erlingsson C. Challenges of caring for victims of violence and their family members in the emergency department. International Emergency Nursing. Accepted.

IV. Rahmqvist J., Benzein E. & Erlingsson C. Vicarious victimization in the aftermath of violence. A family member´s experience from the emergency department. Manuscript.

Preface

My professional as well as personal experiences have raised my awareness and increased my interest in victims of violence and their family members in emergency care. In addition to being a nurse, I have a law degree and at first, I thought that nursing and the practice of law were worlds apart. But I have come to learn that for patients and families subjected to violence, the healthcare and the legal system are in many ways intertwined.

When training to become a nurse, I had some professional experiences from emergency departments. I have always been interested in emergency care and at first, I thought that the emergency department was where I was going to work, but I never ended up working as a registered nurse in the emergency department. Instead, the first education in forensic nursing in Sweden caught my interest when it was launched in Kalmar in 2009 and it gave me the possibility to continue with forensic nursing research.

Through personal experiences of being a family member in emergency care, I have also become aware of what crucial impact healthcare staff can have for family members in traumatic situations. When I was studying forensic nursing, I realized that there is a lack of research concerning emergency care for victims of violence that includes a family focus. This aroused my curiosity and is a starting point for this thesis focusing on care for victims of violence and their family members in the emergency department.

Introduction

Each year several millions of people suffer from interpersonal violence (Krug et al., 2002). Both victims and their family members are affected and beyond death and injury, violence increases the risk of long-term health consequences such as mental illness, suicidality, chronic diseases, infectious diseases, social problems and substance abuse (Dong, 2015; Gini & Pozzoli, 2013; Krug et al., 2002; Le et al., 2016; Li et al., 2014; McLaughlin et al., 2012; Ttofi et al., 2016; Weber et al., 2016). Healthcare has an integral role in society in responding to interpersonal violence, to alleviate suffering, and prevent health consequences for victims and their family members (Krug et al., 2002). Within healthcare, the emergency department (ED) is often the first point of entry for those exposed to violence. Therefore, it is crucial that there is preparedness in EDs to be able to identify violence as the cause of ill health and to provide care for victims of violence as well as their family members (Filmalter et al., 2017; Lynch & Duval, 2011; McCracken, 1999; Pasqualone & Michel, 2015).

Care provided in the aftermath of violence is referred to as forensic care as it includes legal considerations that can be of significance for the possibility of justice (Lynch & Duval, 2011). Forensic care constitutes a bridge over the gap between healthcare and the legal system. Forensic care encompasses the specific care for victims of violence, which in addition to physical medical care includes: identifying violence related to ill health; providing support to disclose and report the crime; collection and documentation of forensic evidence; initial contacts with authorities such as police and social services; and referral for continued support (Lynch & Duval, 2011).

Although victims of violence and their family members may require legal aspects to be addressed, as well as specific practical and emotional support (Leppakoski et al., 2011; Loke et al., 2012; Lynch & Duval, 2011; McCracken, 1999), emergency care focuses on the acute physical injuries of the individual patient (Carlsson Sanz, 2008; Kothari & Rhodes, 2006). Recognizing violence causing ill-health and including forensic aspects in care has not been a regular part of emergency care. ED care distinguishes itself by short encounters and quick medical decisions and can sometimes lack a holistic perspective (Nyström, 2002). On account of this, victims and their family member's suffering may remain unalleviated. In light of this situation, this thesis focuses on forensic care for victims of violence and their family members in the ED.

Background

Forensic care

The term *forensic* is a Latin word with origins in Roman criminal charge cases that were presented and discussed before a group of individuals in a public forum to achieve justice. The term has since then been used to refer to issues related to courts of law and methods pertaining to the investigation of crime, for example securing legal evidence. By using the term *forensic*, the connection between a broad spectrum of sciences can be highlighted. Societal systems use a variety of forensic sciences which contribute in different ways by elucidating issues related to crime that could be of importance to legal proceedings. Through collaboration between agents in healthcare, as well as with legal and social systems, the healthcare system can contribute by providing forensic care. Forensic care includes identification, management, and prevention of injuries caused by violence. This does not replace or compete with criminal investigations or other law professionals, rather fills a void between forensic issues within healthcare and other societal systems involved in forensics (Lynch & Duval, 2011).

The term *forensic nursing* has evolved as a concept that addresses nursing care related to violence and crime. Forensic nursing has also been adopted as a nursing specialty in several countries (Kent-Wilkinson, 2011; Lynch & Duval, 2011), but not yet in Sweden. The concept was developed to recognize the responsibility of healthcare in contributing to the reduction and prevention of interpersonal violence and its consequences. It has been defined by the International Association of Forensic Nurses as, "*the practice of nursing globally when health and legal systems intersect* "(International Association of Forensic Nurses (IAFN), 2009, p. 3). Today, forensic nursing is an integral part of the healthcare system in many countries and entails care for victims of violence, perpetrators, as well as families affected by violence (Lynch & Duval, 2011).

In this thesis, the focus is on care for victims of violence and their family members. The term forensic care is used in the articles to encompass the care that is specific for those affected by violence. Forensic care as such includes:

- Identifying violence causing ill health. With specific knowledge of risk factors, acute signs and long-term effects of violence, healthcare staff can recognize violence-related injuries or illness and ask patients about experiences of violence. Individuals may present with injuries or medical issues that are not always apparent consequences of violence or patients may not disclose about experiences of violence (Catallo et al., 2013; Kothari & Rhodes, 2006; Loke et al., 2012; Lynch & Duval, 2011; Mills et al., 2006).

- Providing care and support. A professional response with respect for the patient's experience is pivotal to support the patient to disclose and report a crime. Psychological and somatic care should be provided depending on the patient's individual needs. Practical and emotional support, as well as risk assessment, may be needed depending on the situation (Constantino, 2013; Garbacz Bader & Gabriel, 2010; Lynch & Duval, 2011).
- Documentation and collecting of forensic evidence. Health consequences of violence should be documented for patient safety as well as for future legal proceedings. This documentation includes both written notations in a privacy secured part of the patient's chart and photographs of injuries. For future legal proceedings, healthcare staff should have knowledge about collecting evidence and how to handle clothes and other objects on the patient that could be possible evidence (Constantino, 2013; Foresman-Capuzzi, 2014; Lynch & Duval, 2011).
- Collaboration for continued care and support. For the patient's safety and recovery, healthcare staff needs to collaborate with authorities such as police, social services or other organizations, and refer patients to continued support after the healthcare visit. This also includes healthcare staff knowing about obligations or possibilities to report violence (International Association of Forensic Nurses (IAFN), 2009; Lynch & Duval, 2011).

Violence and health consequences

Violence has been given a broad definition by the World Health Organization (WHO),

> *"The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"* (WHO Global Consultation on Violence and Health, 1996, pp. 2-3).

This definition doesn't only encompass violence that causes injury or death but also includes violence that can cause serious physical, psychological or social problems for individuals, families, and society. WHO refers to three categories of violence; self-directed violence, interpersonal violence, and collective violence. The nature of these categories of violence can be described as physical, sexual, psychological, deprivation or neglect. This thesis includes all types of interpersonal violence, both violence within family and violence within the community involving both victims who know their perpetrators and individuals who are strangers.

It is difficult to report with certainty the magnitude of violence, as many acts of violence are never reported to the police. In addition, population surveys and study samples differ in definitions and inclusion criteria. Therefore, statistics reporting prevalence of violence may differ significantly depending on the different studies. Globally, WHO suggests that in a year, one out of two children have experienced physical, sexual or psychological violence and one out of six older people have experienced abuse. In a lifetime, one out of thirteen women have been sexually assaulted, and one out of three women have suffered intimate partner violence (World Health Organization (WHO), 2016). Beyond direct impact of violence on these victims, violence can also have adverse negative effects on family members which results in hundreds of millions of individuals being affected in some way by interpersonal violence (Krug et al., 2002).

A recent report in Sweden (The National Centre for Knowledge on Men's Violence Against Women (NCK), 2014) shows that 46% of women and 38% of men have at some point during their lifespan been subjected to severe sexual, physical or psychological violence. The report shows some sex differences regarding which type of violence individuals are subjected to. Women were more often than men a target of sexual violence and severe psychological violence, whereas men were more often than women subjected to physical violence. For most women, the perpetrator is a known person in her social context, and most of these crimes are never reported to the police while men are more frequently subjected to assault (Leander et al., 2012). In Sweden, it is estimated that around two-thirds of interpersonal violence acts are never reported to the police (The Swedish National Council of Crime Prevention, 2012).

For all types of violence, there are risks of short- as well as long-term health consequences which can include both physical and psychological sequelae (Campbell, 2002; Johansen et al., 2006; Johansen et al., 2007; Kilpatrick & Acierno, 2003; Singer et al., 1995). Being subjected to violence at some point during a lifespan, is associated with a significantly increased risk for mental health issues, depression, self-harm, alcohol abuse and somatic diseases such as chronic pain, gastrointestinal disease and stroke (Dong et al., 2013; Holt et al., 2015; McLaughlin et al., 2012; Monnat & Chandler, 2015; The National Centre for Knowledge on Men's Violence Against Women (NCK), 2014). This also results in an increase of healthcare utilization and costs lasting long after the violence has ended (Brown et al., 2011; Knapp, 2011; Rivara et al., 2007). A study in Sweden showed that violence has persistent adverse effects throughout life in regard to work, income, sick leave, suicide and mortality (Ornstein, 2017). Being exposed to violence is also associated with an increased risk of being a victim or perpetrator of further violence (Dubowitz et al., 2001; Krug et al., 2002; Ttofi et al., 2016). Poly-victimization, i.e., being a victim of several

types of violence, has been shown to carry even more adverse health outcomes (Cater et al., 2014; Hamby et al., 2018; Jackson-Hollis et al., 2017).

Research concerning the health impact of violence on family members is scarce. However, it has to some extent been recognized that violence can have consequences for family members (Gunnels, 1997; Krug et al., 2002) and that by acknowledging family members' concerns and reactions in relation to violence, negative consequences could be prevented, such as severe stress and anxiety (Hopkins, 1994).

Forensic care in emergency departments

Following interpersonal violence, EDs are often the first point of entry when seeking healthcare. The number of victims of violence that present at EDs is likely to be much higher than cases reported to the police (Sivarajasingam et al., 2009). This puts emergency departments in a special position in society to help those at risk and those affected by violence (Krug et al., 2002).

In general, care at the ED is often characterized by short and fragmented encounters with a high demand of efficiency (Andersson et al., 2012; Nyström et al., 2003). Patients present at EDs with different needs, illnesses and/or injuries. Their condition can rapidly change, and staff has to evaluate constantly and re-prioritize care (Andersson et al., 2012). The ED care system is mainly based on teams of assistant nurses, registered nurses and physicians who work together to provide care (Cronin & Wright, 2005; Lynch & Cole, 2006). Care in EDs focuses on physical injury and lifesaving medical treatment, which is necessarily a top priority (Shepherd & Rivara, 1998). When caring for victims of violence and their family members, EDs are also part of a larger context with clear links to the legal system (McCracken, 1999).

All ED patients with violence-related injuries or health issues may require forensic care (Lynch & Duval, 2011). Failure to identify violence as the cause of health problems can contribute to misdiagnosis, inadequate care, and loss of legal evidence (Hofner et al., 2005; Howe et al., 2002). Health issues that relate to violence often involve multiple healthcare visits, either for direct consequences of violence or for more long-term violence-related health issues (Kothari & Rhodes, 2006). Forensic care involves legal issues but foremost it involves knowledge of how to interact and support individuals that have been victimized. Previous research regarding women who have been subjected to intimate partner violence shows that they can experience re-victimization within healthcare when staff is nonresponsive, making them feel ashamed and neglected (Pratt-Eriksson et al., 2014). Also, men who had experienced intimate partner violence described healthcare professionals as "doorkeepers" with a strong influence on victim's decision to disclose violence (Simmons et al., 2016). ED professionals therefore need to be prepared to intervene and care for

victims and family members affected by violence (Gunnels, 1997; Lynch & Duval, 2011; Shepherd & Rivara, 1998; The National Centre for Knowledge on Men's Violence Against Women (NCK), 2010).

In Sweden, EDs have a general responsibility as a part of the healthcare system to prevent ill-health and provide good care to the population on equal terms (Hälso- och sjukvårdslag [Healthcare law], SFS 2017:30). However, there has up until recently not been any specific legislation concerning healthcare responsibilities for victims of violence and forensic care. Twenty years ago, a Swedish government Bill on Violence against Women (Kvinnofrid, 1998) was passed to fight violence against women through several measures in society. Since then several legal changes have been made and national strategies developed to prevent and combat men's violence against women. In 2014, new legislation concerning healthcare for victims of violence in close relationships was adopted (Våld i nära relationer [Violence in close relationships], SOSFS 2014:4). This legislation gives healthcare, including EDs, a responsibility to: establish routines for victims of violence in close relationships; to ask questions about violence; to collaborate with social services and other authorities and organizations; to document symptoms and signs of violence; to ensure staffs competence within this area; and to care for children that are affected by violence. One part of forensic care that this legislation does not include is the responsibility for healthcare to collect forensic evidence.

Being prepared for the responsibility of forensic care can be facilitated by standardized policies, procedures, or protocols (Assid, 2005; Benak, 2001; Eldredge, 2008; McCracken, 2001). In the last few years, several county councils have adopted regional care programs to ensure their responsibility for victims of violence in close relationships in accordance with the legislation. The National Centre for Knowledge on Men's Violence Against Women (NCK) has developed a national program for the healthcare of victims of sexual assault to improve the treatment and care of patients within the Swedish healthcare system. The program includes knowledge of interaction with healthcare professionals, providing better evidence to the legal system, documentation, and contact with the legal system (The National Centre for Knowledge on Men's Violence Against Women (NCK), 2008). NCK has also contributed in many ways to spread knowledge, research, and training courses to increase knowledge of men's violence against women and has developed methods to identify violence exposure (The National Centre for Knowledge on Men's Violence Against Women (NCK), 2010). These efforts play an essential part in improving societal support for women subjected to violence and also in raising awareness about violence against women and also children.

Similarly, the vast majority of research worldwide concerning violence has a clear focus on specific groups, especially women and intimate partner violence (Plichta et al., 2006) and child abuse (Teeuw et al., 2012). Although violence against women has been highlighted as an area of special concern, it has been

recommended that the healthcare system address the care and treatment of all victims of violence (Krug et al., 2002; Statens Offentliga Utredningar, SOU 1998:40). Yet only a few empirical studies have addressed the organization of healthcare and education of staff regarding care for victims of violence in general. However, these studies point toward a need for more forensic expertise (Abdool & Brysiewicz, 2009; Doyle, 2001; Hammer, 2000; Lynch & Duval, 2011; McCracken, 1999).

Family members of victims of violence in emergency departments

Strengthening family and importance of family support have been pointed out as crucial factors to alleviate suffering and reduce risks of re-victimization when it comes to children, youth and young adults (Buka et al., 2001; Crush et al., 2018; David-Ferdon et al., 2018; Phelps et al., 2006; Shepherd & Rivara, 1998; Strom et al., 2017). That violence in general impacts families has been recognized to some extent and family interventions have been suggested as a part of care for victims of violence (Gunnels, 1997; Krug et al., 2002).

The importance of caring for family members has been highlighted in the Swedish national action program for sexual assault victims in healthcare (The National Centre for Knowledge on Men's Violence Against Women (NCK), 2008). Despite this, there were no published studies found with a focus on forensic care and family members in EDs when searching relevant literature databases, e.g. Medline, CINAHL, and PsychINFO. However, several studies from emergency care in general, show that family members of a critically ill or injured person experience the situation as a highly distressing life event with high levels of stress, anxiety, and depression (Auerbach et al., 2005; Paparrigopoulos et al., 2006). Most previously published studies focus on family member's needs, and especially family member's needs in an intensive care environment (Rahmqvist Linnarsson et al., 2010; Van Horn & Kautz, 2007). Located studies concerning family members in EDs were focused specifically on family members being present during resuscitation or in connection to sudden bereavement (Compton et al., 2011; Leung & Chow, 2012). Therefore, little is known about the families' unique situation when a family member is cared for in the ED (Maxwell et al., 2007; Rahmqvist Linnarsson et al., 2010; Redley et al., 2003). It has been highlighted that experiences of care in the ED may differ depending on the patient's background and the reason for the visit (Muntlin et al., 2008). It is therefore important to understand the experience of care based on specific patient populations.

A population survey in Sweden showed that there seems to be a tendency not to talk to family or friends about experiences of violence, especially if the violence occurred during childhood or in cases of sexual violence (The National

Centre for Knowledge on Men's Violence Against Women (NCK), 2014). Women that suffer intimate partner violence are often controlled and restricted by their abusive partner and behavioral adaptation is common to avoid risks of further violence (Taket et al., 2014). When violence occurs within a family, the family system is especially threatened and even more careful consideration for each family member must be undertaken (Benzein et al., 2012). Other family members than the perpetrator might be able to provide support and also be in need of support themselves to ease suffering and minimize ill health (Coker et al., 2002; Escriba-Aguir et al., 2010).

A review study has shown that nurses, in general, have a unique position in emergency care to attend to family members and provide support (Rahmqvist Linnarsson et al., 2010). The quality of care can however be influenced by the nurses' attitudes about the importance of families in nursing care. Previous research shows that nurses in critical care in general are positive towards families in care (Al-Mutair et al., 2013; Hallgrimsdottir, 2000) but there is no previous research concerning nurses' attitudes towards families to victims of violence in EDs. The need for care that encompasses family members can vary and might not always be appropriate or necessary (Wright & Leahey, 2013). The inclusion of family members may be difficult or too great a risk if the perpetrator is within the family or has close connections to other family members. However, in cases when there is no risk for the victim, involvement of family members in care may strengthen the family and alleviate suffering and emotional distress (Eggenberger & Nelms, 2007).

Rationale of the thesis

Both victims and their family members suffer from interpersonal violence. EDs have a central role in society to respond to interpersonal violence by providing care for victims of violence and their family members. Responsiveness in EDs can contribute to alleviating suffering and reducing health consequences in the aftermath of violence. It is therefore essential that there is preparedness to provide forensic care for victims of violence and their family members, taking both health and legal aspects of care into account. However, there is a lack of knowledge concerning preparedness for forensic care in EDs in Sweden, and the majority of healthcare research concerning violence and care for victims has a clear focus on specific groups. Increased knowledge from the perspective of ED professionals concerning the organization of forensic care for all victims and their family members, may reveal areas of potential development and improvement. To meet and support family members to victims of violence there is also a need for deeper understanding of family member's situation and their experience of the care provided. The importance of caring for family members of victims of violence has been previously highlighted and research from emergency care, in general, has shown that family members experience the situation as highly distressing. Despite this, there is a lack of knowledge of how the family member perceives the situation in the ED in the aftermath of violence. By exploring forensic care from these different perspectives, new knowledge can be generated to serve as guidance for interventions and caring strategies to improve forensic care for victims and their family members, aiming to alleviate suffering and reduce adverse health consequences of violence.

Aims

Overall aim

The overall aim of this thesis was to explore forensic care in EDs for victims of violence and their family members from the perspectives of ED department heads, ED nurses, and a family member of a victim of violence.

Specific aims

I. To describe the preparedness to provide care for victims of violence and their families in EDs in Sweden.

II. To describe nurses' views of forensic care provided for victims of violence and their families in EDs, to identify factors associated with nurses' attitudes towards families in care and to investigate whether these attitudes were associated with the involvement of patients' families in care.

III. To describe emergency nurses' experiences when caring for victims of violence and their family members in EDs.

IV. To explore an accompanying family member's experiences of care at the ED in the aftermath of interpersonal violence.

Theories relevant for this thesis

This thesis is written within the research field of caring science; a research field based on a humanistic and holistic approach. Caring science concerns processes on individual, family, and societal levels that promote health, well-being and alleviate suffering (Eriksson, 2001, 2002; Rogers, 1989). Forensic care in this thesis is enfolded in caring sciences as it has been developed to alleviate suffering, protect and preserve life and promote health and well-being for those affected by violence (Lynch & Duval, 2011). This thesis focuses on family members of victims of violence with the assumption that ill health of one family member affects the other family members and the family as a whole (Wright et al., 2002). Thereby, family focused care (Benzein et al., 2012; Wright & Leahey, 2013) is a fundamental and key theoretical perspective in this thesis. To further enrich understanding of the results in study III and IV, Halldorsdottir's theory of caring and uncaring encounters (Halldorsdottir, 1996) has been used as a part of the discussion of the results.

Family focused care

The concept of family does not have a universally accepted definition, and the word family can mean different things in different disciplines. A traditional definition of family has been that it consists of individuals that are bound together by blood-ties or by law and living in the same household (Burgess & Locke, 1953). However, this definition of family is not inclusive enough to represent families' diversity in today's society as it excludes many groups who consider themselves family but do not match the traditional definition (Stuart, 2001). As used in this thesis, the term family based on an open and inclusive research-based definition that has been developed in an academic context with Swedish nursing students,

> *"Family is constructed through legal or biological connections, of ties of sharing everyday life in common. Families are bound together by ties of love and the dependability of caring for and being cared for by those who one considers close. Each individual decides from circumstances to circumstance who is close and therefore a part of one's family"* (Erlingsson & Brysiewicz, 2015, p. 233)

In the studies in this thesis, family members are referred to as the individuals that the victim of violence considers to be family at the moment of the ED visit.

Viewing family as an integral part of healthcare is a basis of family focused care (Bell, 2013; Wright et al., 2002). Within family focused care, two

orientations have been developed: family-centered care and family-related care. Family-centered care views family as a unit of care with a focus on the family as a system. Family-related care has the patient in focus while including family as a context and as a part of the individual's social support system or, has individual family members in focus with the patient as a context (Benzein et al., 2012). This thesis has a family-related approach. The studies with aims to explore the organization of forensic care through the perspectives of ED heads of department and ED nurses' (I-III), views family members as a context and a part of the social support system for the victim of violence. In study IV the focus is on an individual family member with the patient as a context.

In family focused care the family – nurse relationship is of central importance for health and well-being. It is viewed as a non-hierarchical relationship which consists of collaboration and respect for each individual and their contribution to the relationship is equally important (Wright et al., 2002). The family and the nurse co-create the encounter with their resources and knowledge, both contributing to the possibility of mutual learning and new meanings (Meiers & Tomlinson, 2003; Wright et al., 2002). This assumption has its basis in a constructivist approach that situations can be described from different perspectives. Each individual can perceive the same reality differently, making reality multi-verse and co-created (Maturana, 1988). This means that each individual's different descriptions of the same situation are equally truthful as an expression of their experience. In the studies in this thesis, the different experiences and descriptions of forensic care in EDs are seen as equally important to understand the co-creation of the family-nurse relationship and to identify areas of improvement.

Halldorsdottir's theory of caring and uncaring encounters

The theory of caring and uncaring encounters developed by Halldorsdottir (1996) has been used to deepen understanding of care for victims of violence and their family members in EDs when discussing results of studies III and IV. Several nursing theorists have stressed that an interpersonal relationship is fundamental in nursing care (Paterson & Zderad, 1988; Travelbee, 1971) but the specific caring aspects of Halldorsdottir's theory has been found applicable in emergency care (Wiman & Wikblad, 2004). The theory conceptualizes basic modes of being with another which can be perceived as caring or uncaring. There are two major metaphors in the theory: *the bridge* which symbolizes openness in communication and connectedness in the experience. The second metaphor is *the wall*, which symbolizes a lack of or negative communication, detachment and lack of a caring connection. The theory has illuminated the importance of *professional caring* (Halldorsdottir & Hamrin, 1997;

Halldorsdottir & Karlsdottir, 1996) and that caring encounters can increase well-being and health and promote *empowerment*. Uncaring, on the other hand, has negative consequences and can decrease well-being and health and be a *discouragement*. Empowerment and discouragement in this theory are defined as subjective experiences. The theory also points out the importance of seeing the recipient of care in his or her inner and outer contexts.

Methods

Design of the studies

The studies in this thesis use both quantitative (I-II) and qualitative (I-IV) approaches in an attempt to explore forensic care in EDs from different perspectives and to gain a broader as well as deepened understanding (Patton, 2004). The aims of the studies have guided the choice of methods which are shown in an overview in Table 1. Studies I-III explore forensic care for victims and family members from the perspectives of ED heads of department and ED nurses. Study IV explores the family member perspective of forensic care in the ED. Study results (I-III) have contributed to new knowledge that provided a foundation for the development of the designs of the following studies.

Table 1. Overview of the four studies in this thesis

STUDY	DESIGN	SAMPLE	DATA COLLECTION	ANALYSIS
I	Descriptive cross-sectional	Heads of EDs (n=46)	Web-based questionnaire with study specific closed and open-ended questions	Descriptive statistics and content analysis
II	Correlational Cross-sectional	Registered nurses (n=457 from 28 EDs)	Web-based questionnaire with study specific closed and open-ended question, and FINC-NA*	Descriptive statistics, multiple linear and ordinal regression analyses
III	Qualitative descriptive	Registered nurses (n=12 from 7 EDs)	Individual interviews	Qualitative content analysis
IV	Qualitative explorative single case	Family member (n=1)	Individual interviews	Hermeneutic narrative analysis

*FINC-NA: Families' Importance in Nursing Care – Nurses' Attitudes

Study I

Participants

Participants were recruited from all hospital EDs in Sweden (N=66). A total of 46 out of 66 (response rate 70%) of the heads of department completed the questionnaire, all of whom were physicians. Of the 21 county councils in Sweden, 17 were represented in this sample. Both metropolitan regions with university hospitals as well and sparsely populated regions with smaller hospitals were included in the sample. The estimated number of inhabitants in the EDs service areas ranged from 22 000 – 600 000 with a median of 127 500 inhabitants. The estimated number of patients seeking ED care per year ranged from 1500 – 103 000 with a median of 29 000 patients.

Data collection

Data collection consisted of a web-based questionnaire that was developed specifically for this study to elicit responses regarding the structure and content of forensic care in the EDs from the perspective of the heads of departments. Construction of the questionnaire was based on a thorough literature search of forensic care aspects and questions were formulated by the authors. Questions were then evaluated by an expert group of eight clinicians (5 nurses and 3 physicians) and five researchers with Ph.D. degrees, to ensure content validity (Streiner & Norman, 2008). The questionnaire was edited after the expert group's feed-back concerning phrasing of some of the questions and three questions were separated into two questions instead of one. The final questionnaire had a total of 42 items consisting of closed-ended questions followed by open-ended questions, that allowed participants to elaborate their answers. The questions covered demographic data (6 items), regulating documents and routines (15 items), organization of care (11 items), education and further development of care for victims of violence and their family members in the EDs (10 items).

Data analysis

Data analysis was performed using descriptive statistics for the closed-ended questions (Altman, 1991). The free text responses to the open-ended questions in the questionnaires were analyzed on a manifest level by identifying reoccurring words and responses with similar content (Cavanagh, 1997).

Study II

Participants

Participants were recruited among all registered nurses (n=867) working at 28 EDs in Sweden. These were all the EDs from study I that gave consent to continue with this study. A total of 457 nurses (response rate 53%) participated in the survey. Out of the 21 county councils in Sweden, 14 were represented in this sample. Both metropolitan regions with university hospitals as well and sparsely populated regions with smaller hospitals were included in the sample. The participants were 372 women and 85 men. They were aged from 22-65 years (mean 40.4 years) and had worked as registered nurses from 3 months to 42 years (mean 12.9 years). One-third of the participants had a nursing specialist degree (critical care/anesthesia, emergency care, prehospital/ambulance care, medical/surgical care, district nursing, or other).

Data collection

Data were collected by a web-based questionnaire that had been specifically developed for this study, using similar questions as in study I, aiming to elicit responses concerning nurses' views of forensic care for families. The questions were also evaluated by an expert group of eight clinicians (5 nurses and 3 physicians) and five researchers with Ph.D. degrees to ensure content validity (Streiner & Norman, 2008). The questionnaire was revised after the expert group's comments and resulted in a total of 19 items, with both closed and open-ended response format. The questions covered demographic data (4 items), ED policy documents, routines and education for staff (9 items) as well as nurses' work and personal experiences (6 items). All closed-ended questions needed to be answered in the questionnaires to enable submission. The questionnaire also included the instrument Families' Importance in Nursing Care–Nurses' Attitudes (FINC-NA) (Saveman et al., 2011). This is a generic instrument that measures nurses' attitudes regarding the importance of families in nursing care (Benzein et al., 2008). The revised version of the instrument that was used has shown good measurement properties regarding validity and reliability (Saveman et al., 2011). FINC-NA consists of 26 items with a 5-point Likert response scale (from 1= "Totally agree" to 5= "Totally disagree"). FINC-NA is a multidimensional instrument and comprises of four subscales (Benzein et al., 2008); family as a resource in nursing (Fam-RNC, 10 items, score range 10-50), family as a conversational partner (Fam-CP, 8 items, score range 8-40), family as a burden (Fam-B, 4 items, score range 4-20), and family as its own resource (Fam-OR, 4 items, score range 4-20). The subscale Fam-B differs from the other subscales as it has inverted items. For all of the subscales except Fam-B, the higher the score, the more positive attitude towards families in nursing care. Internal consistency reliability was estimated with Cronbach´s alpha which

reflected good reliability (0.79-0.90) for all subscales except for the subscale Fam-B (0.59).

Data analysis

Descriptive statistics were used (Altman, 1991) to present demographic data and nurses' views of forensic care in the ED for victims and their family members.

Multiple linear regression analyses were used to identify factors associated with nurses' attitudes to families (forced entry method, i.e., all variables entered in the equation in one step) (Cohen et al., 2003). In the regression model, the FINC-NA scales were included as dependent variables, and the independent variables were sex, years working as a nurse, specialist nursing degree, knowledge of documents concerning family members, education on care for family members, and own experience of a critically ill family member.

Ordinal regression analysis was applied to investigate if nurses' attitudes were associated with the involvement of patients' family in care (Cohen et al., 2003). The question "Do you involve family members of victims of violence in care", which had three possible response alternatives (Yes, always / Yes, sometimes / No), was included as the dependent variable. The ordinal regression analysis was made in two steps for each of the FINC-NA subscales (FINC-NA total, Fam-RNC, Fam-CP, Fam-B, Fam-OR). In the first step, initial regression models included each FINC-NA scale as single independent variables. In the second step, full regression models were considered with each FINC-NA scale together with the covariates that were significantly associated with FINC-NA in the multiple linear regression model. Those were sex, own experience of critically ill family members, and knowledge of documents concerning family members.

Study III

Participants

Participants were recruited by advertising online in emergency nurses' forums and by directly contacting nurses working at EDs from the sample in study II. Heterogeneity was sought regarding sex, age, ED location and demographics in the sampling process. The sample included 12 nurses (10 women and 2 men). Their ages ranged from 22-62 years with a median of 47 years. The participants worked at seven different EDs in Sweden in both small and large cities, ranging from 19 000 – 600 000 inhabitants. The participants work experience as a nurse ranged from 8 months to 29 years (median 16 years), and their experience at the ED ranged from 8 months to 23 years (median 4.5 years). Forensic nursing is

not a specialty degree in Sweden, but seven participants had or were at the time completing some other specialist nursing degree.

Data collection

Data were collected by individual interviews using a semi-structured interview guide. Each participant chose the location for his/her interview. All interviews were carried out at the nurses' workplaces in secluded rooms where it was possible to talk privately. The initial questions in the interview covered demographic data. After that, open-ended questions were asked to encourage the participants to speak freely about the research topic. Interviews lasted 40-60 minutes each and were audio recorded.

Data analysis

Data were analyzed using qualitative content inspired by Graneheim and Lundman (2004). The analysis process was inductive with several steps to identify meaning units, formulate codes and derive categories and themes. As a first step, the audio recordings were transcribed verbatim and transcripts were read several times to gain an overall impression. In the second step, the transcripts were reread to mark out meaning units in the text. These units were then condensed and labeled with a code. The codes were then compared and contrasted which led to the forming of sub-categories. As a next step, the sub-categories were grouped by similarities and differences, creating categories that constitute the manifest content of the interviews. Content characteristic words and verbatim examples from the interviews were used to illustrate these categories. In the last step of the analysis, the underlying meaning of the categories was discussed and reflected upon to formulate a theme. The interpretations were continuously discussed and questioned throughout the analysis process to be vigilant of preunderstandings and to remain as open as possible to data (Graneheim et al., 2017).

Study IV

Participants

The participant in this case study was recruited during a sampling process for a previous study design by using advertisements online, in newspapers, emergency departments and nursing colleges. The participant was a married woman in mid-life living in the suburbs of a large city in Sweden with her husband and two adolescent sons. She had a master's degree and was working as well as pursuing a Ph.D. She had visited the ED previously for illness and

injury, but never for a violence-related injury. The experience that she described in this study concerned her visit to the ED together with her son who had suffered violent assault.

Data collection

The data consists of two in-depth interviews with the participant about her experiences when accompanying her son for care at the emergency department following the assault. By interviewing the participant twice, the interviewer and participant became acquainted with each other, reducing tension and uncertainty in the interview situation, opening up for expressing deeper thoughts and emotions (Åstedt-Kurki et al., 2001). Both interviews were conducted in a secluded meeting room in the participant's work place, in August and in October 2017. The interviews consisted of open questions and the participant was encouraged to narrate her story freely. As narratives are created in the context of the situation and in relation to the listener (Frid et al., 2000), it was important to strive for openness and sensitivity when listening and responding to the participant. Before the interviews, preunderstandings were reflected upon and written down to increase awareness of thoughts and feelings. Critical reflection throughout the interviews was a core part of the data collection process. The first interview lasted 50 minutes and was initiated by asking the participant to describe her family, the situation that occurred, and her experience of being with her son in the emergency department. Follow-up questions were asked to gain more depth in the descriptions. After the first interview, data were preliminary analyzed. The second interview lasted 67 minutes and was characterized by questions following up the first interview to gain more depth and richness in the descriptions of the experience.

Data Analysis

Both interviews were transcribed verbatim and inductively analyzed by a Gadamer-inspired hermeneutic theory of interpretation (Fleming et al., 2003). Hermeneutic interpretation is a way to gain a deeper understanding of human phenomena. The analysis process can be described as a circular or spiral movement between the parts and the whole in search for meaning in patterns, reoccurring experiences and key issues (Fleming et al., 2003). It is a constant process of contextualization and de-contextualization during the analysis, where the context is crucial to the interpretation and understanding (Ödman, 2016). Through a dialectic process, the "fusion of horizons" between the researcher and the text is stimulated, which according to Gadamer (2013) is a necessity for reaching a new understanding. Thus, pre-understandings were taken into consideration throughout the process, and interpretations were questioned and challenged continuously within the research team (Fleming et al., 2003). The analysis was carried out in the following steps. In step 1, both interview

transcripts were read several times as a whole to search for the fundamental meaning and to gain an understanding of the whole narrative. In step 2, the narrative was then re-read to identify recurrent key issues and patterns exposing meaning for understanding this experience. The issues and patterns were then clustered into themes. In step 3, the themes were then related back to the sense of the text as a whole through a process of moving back and forth between parts of the narrative and the whole in a hermeneutical circle to deepen understanding. In step 4, passages in the narrative that were representative of the themes were identified and are included in the results as quotations to increase insight. Interpretations and meaning found in the narratives were throughout the analysis process openly questioned and challenged as they were discussed within the research team. In the analysis, the participant's experience revealed itself as a dramatic event with the structure of a drama. Therefore, the results are represented as a drama to attempt to represent the experience as a whole.

Ethical considerations

The studies in this thesis are designed and conducted in accordance with the World Medical Association Declarations of Helsinki (World Medical Association, 2008) and Swedish Ethics legislation (Lag om etikprövning av forskning som avser människor [The act concerning ethical review of research involving humans], 2003:460). The principles of autonomy, beneficence, non-malfeasance, and justice have been considered throughout the process of designing the studies to data-collection, analysis, and reporting.

All participants received information about the study before they participated. The written information included the purpose of the study, the voluntary nature of their participation, and contact information for any questions that could arise. All participants were also guaranteed confidentiality and that the reporting would be presented in such a way that individuals nor EDs could not be identified. A written consent form was signed by all the participants before every interview.

Ethical approval was discussed within the research group as well as with an ethical advisory board member before conduction study I and II. The ethical discussions resulted in a decision that formal ethical approval was not required for these two studies according to Swedish ethics legislation. The collected data did not include sensitive personal information and the participants answered in their role as healthcare professionals. Only the researchers had access to the collected data and no individual could be identified when the results were presented. The head of each ED approved that the studies were to be conducted at their department and with their staff. Ethical consideration for the web-based questionnaires focused on the respondents receiving information about the

study so that they could make an informed judgment about whether they wished to participate. Written information was sent to the participants which included the aim and benefits of the study and how data would be collected and handled. Voluntary participation was stressed, and confidentiality assured. Collected data were stored in a locked safe where only the researchers had access. Contact information for any additional questions was also provided.

Formal ethical approval for study III and IV was gained from the Ethical Review Board in Linköping, Sweden (No. 2014/480-31 study III; and No. 2014/89-31 study IV). Ethical considerations were discussed within the research team prior to the interviews as they concerned violence which can be a sensitive topic. Some individuals may have their own experiences of violence which might put them in a vulnerable situation and give rise to unpleasant feelings (McBrearty, 2011). It was therefore important to be attentive to sensitive issues and strong emotions that can surface during the interviews. There was a need for continuous ethical consideration and balancing of responsive questions (Hewitt, 2007). The participants were informed by the first author (JR) at the beginning of the interviews that they decided what experiences they wanted to share and if they wanted to answer questions that were asked. They were also informed that if they needed more support after the interview, the researcher was available for questions or could help them to refer to adequate professional support. After the interviews, none of the participants have expressed any adverse reactions. Instead, some participants indicated that they were relieved to be able to share their experiences. The risks of the interviews were outweighed by the potential for beneficence as participants were given an opportunity to express their experiences in an open and encouraging environment.

Results

In this section, the main findings from the four studies included in this thesis are described. Study I and II contribute together to the overall aim of this thesis by describing ED care for victims of violence and their family members from the perspective of the heads of department (I) and nurses (II) with the use of a web-based questionnaire with some similar questions, providing a broad description of forensic care. The results from these two studies are therefore presented together. Results from study III and IV are described separately as these studies contribute differently to answering the overall aim by providing more detailed in-depth descriptions of nurses' experiences (III) and family member's experiences (IV) of forensic care in the ED.

Care for victims and their family members from perspectives of ED heads and nurses (I-II)

Victims of violence in EDs and responsibility to care for them
In a vast majority of the emergency departments (78%), the heads of the department did not know how many of the patients seeking care at their department were victims of violence. For those that could estimate this figure, it ranged from 0.2% to 30% of the total of patients seeking care annually at the department (I). In most departments (63%) a designated person or a group was assigned to specifically care for victims of violence (I). Nurses were indicated in the open-ended responses as having this key position for forensic patients (I). Therefore, study II was designed to focus on the nurses' perspective. In congruence, the second study results show that almost all nurses (97%) perceived that they provide care for victims of violence at the ED. Results also show that less than one-third of these nurses had received any education for this task and a majority (83%) reported that they needed such education (II).

Specific documents and routines for forensic care at the ED
There are congruent findings from study I and II as to there being preparedness in documents and routines to care for women and children that have been subjected to violence according to the answers of the open-ended questions. Most of the heads of EDs (61%) reported that they had specific policy documents for victims of violence although these policy documents focused on women and children specifically (I). Most nurses also (78%) reported that their EDs had specific documents specifically for care of women and children who are victims of violence (I).

Few of the EDs (9%) had routines for asking all patients about experiences of violence (I), and only 3% of the nurses asked all their patients about experiences of violence (II). Most heads of the EDs (50%) stated that they had routines for asking patients when there was suspicion that an injury was caused by violence (I), and most nurses (72%) asked about violence when there was a suspicion (such as obvious violence-related injury) or only for specific patient's groups such as women and children (II). Sixteen of the heads of the EDs (35%) stated that they didn't have any routines for asking patients about experiences of violence (I) and 28% of the nurses did not ask any patients about violence (II).

The results also point to EDs having more routines concerning sexual abuse compared to assault (I). Most of the departments (74%) had routines for photographing injuries caused by violence as part of the documentation. Most heads of EDs (89%) reported that continued care and support was offered to victims of violence, primarily as referrals to counselors at the hospital as reported in the open-ended answers.

Organization of care for family members of victims of violence and nurses' attitudes and involvement of family members

Results show that family members are rarely included in policy documents, routines, or education (I-II). Care for family members were included as part of policy documents in 30% of the EDs or as part of other specific ED documents in 41% of the EDs (I). Most of the nurses (91%) did not know of any documents that included family members (II). According to heads of EDs, written routines included family members in around one-third of the departments and education to the staff included information about family members in the ED in one-fourth of the departments (I). However, most nurses (sometimes 79%, always 11%) perceived that they included family members when caring for victims of violence to some extent (II). Less than a tenth of the nurses had received any kind of education concerning forensic care that included care for family members (II). The multiple linear regression analyses revealed that being a woman, knowing about documents in the ED concerning family members and having own experience of a critically ill family member were associated with a more positive attitude towards family in nursing care (II). The ordinal regression analyses revealed that a more positive attitude towards family members and having own experience of a critically ill family member were associated with involving of patients' family in care (II).

Nurses' challenges when caring for victims of violence and their family members (III)

The results revealed a main theme *A challenge to create a caring encounter*. Nurses showed a strong sense of responsibility for patients who had been victimized by violence. Creating a caring encounter with them and their family members was seen as a necessary prerequisite for forensic care. This was the main perceived challenge and not the specific forensic tasks. The caring encounter was characterized by courage to intervene, being genuinely present, showing honest concern, validating the patient as a fellow human being, and advocating for the patients and the family's needs. There were several factors that hindered the nurses from such caring encounters and thereby also hindered forensic tasks being addressed. These complicating factors are illustrated 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; Dealing with one's own strong emotions towards violence.

Struggling to intervene and talk about violence

Nurses struggled to create time and a private place to talk about violence and to make it a priority. The ED work situation made it difficult to provide care beyond the patient's physical injury. Nurses had to rely on their gut feeling to make decisions on how to intervene. There were specific concerns for elderly patients as they rarely talked to them separately from family members or caretakers. There were also concerns for men being victimized by intimate partner violence and they perceived it as less likely that men would be asked about violence. The nurses perceived that their own behavior influenced if the patients would disclose violence and participate in a forensic examination. Being at ease when talking about violence, being open-minded, and showing patients that they had time to listen and were consciously present were seen as essential when intervening and talking about violence.

Contradictions when caring for family members

Nurses wanted to include family members in care, but they were at the same time also suspicious of family members who might possibly be the actual perpetrator. The family situation was not easily assessed in the ED. Some nurses never involved family members while others involved family members, or not, depending on their gut feeling. When involving family members, the nurses pointed out that listening, being present and available to answer questions and providing continuous information were important. Most participants described that they have no help to offer families and only in rare cases referred them to a hospital counselor.

Being helped by forensic guidelines but needing more knowledge
Guidelines helped nurses by providing a sense of confidence to address forensic issues, but there remained a lack of knowledge and hands-on suggestions about how to handle situations involving forensic issues. Routines, guidelines, and education in the ED gave nurses a feeling of being backed up by the organization, making it easier to act. Unclear routines caused uncertainty and hesitations. Patients with psychiatric ill health and substance abuse were described as being particularly at risk of falling between the cracks of different specialties and subject to the staff's uncertainty about how to help. There was frustration about the lack of or uncertainty about continued support for victims of violence and their family members after discharge from the ED. Knowledge of forensic care was seen as dependent upon individual efforts among the nurses. An on-going open dialogue was seen as a way to broaden preconceptions and learn from each other's experiences.

Dealing with one's own strong emotions towards violence
Recognizing that a patient was a victim of violence often evoked strong emotions and could cause frustration and be emotionally draining. Their own strong emotions could hinder nurses from addressing issues concerning violence. Different types of violence raised different reactions among nurses causing them to treat patients differently and address forensic issues differently. Extensive personal life experience was seen as an asset for nurses to prepare them emotionally for difficult situations. On the other hand, personal experiences of violence could influence either to avoid addressing issues of violence among patients or be dedicated to helping and understanding the patient in their situation.

A family member's experience of ED care and vicarious victimization (IV)

The experience is represented in the results as a drama. The prologue introduces the main character, Linda, a married woman in mid-life, mother of two adolescent sons, living in the suburbs of a large city in Sweden. On a New Year's Eve, Linda's oldest son and his friend were violently assaulted. They called emergency services, but there were no ambulances or police available to help them. They got to the ED with the help of acquaintances and Linda rushed to meet them there. The drama then comprises three acts.

Act 1 Numbed by fear – Managing chaos
Linda's initial reaction was an overwhelming numbing feeling of fear and panic. Linda and her son were dependent on the emergency department staff and felt vulnerable. Time seemed to be in a fast-forward mode, and the panic and fear

made it difficult to grasp the situation. While feeling uncertainty and fear, Linda searched for information and clues to manage the chaos inside of her. Proximity to her son and clues providing hope helped her to manage chaos. In the midst of this chaos, Linda also experienced a frustrating responsibility for her son's friend as she acted substitute parent for him because he had no family member present at the ED.

Act 2 Disillusioned – Regaining trust
Her son's assault and the situation after that left Linda feeling vulnerable and disillusioned. Her son had received no help from emergency services or police at the crime scene. Trust in society and other people had been lost and at the ED Linda and her son seeks and expects care and safety. But the ED environment feels like an unsafe place in turmoil. The relations with staff are the only way to rebuild a sense of mutuality and trust in other persons. A nurse that was close to them the entire time at the ED gave continuity and opportunity for them to create a relationship. This nurse was calm and relatable. He showed compassion, humanity and shared experiences which made them feel like they were not alone. Encounters with physicians were short and fragmented and did not give any feeling of trust but instead left them in more uncertainty. An orderly played a major role in rebuilding trust as he accompanied them to x-rays and consultations. He was open, a good listener, talkative and showed genuine empathy and concern. He also gave Linda a feeling that they were not alone as he shared his experiences from the ED and often displayed a closeness by using touch in the right moments.

Act 3 Not wanting to be a bother – Advocating for one's family
Linda was grateful for the help at the ED and didn't want to be a bother for the busy staff. She took a step back and felt like a spectator. But at the same time, she felt responsible for communicating with the rest of their family as well as the family of her son's friend. This responsibility was at times a heavy burden and very frustrating. She was left to deal with her fears and concerns by herself while struggling to advocate for the family. In hindsight, she accepted things that in another situation would have been unacceptable. As this also was a new situation, her son being victimized by violence, she did not know what to ask for.

There were no forensic issues addressed by the ED staff that she knew of. The police only came to inform that the case would not go to trial and it was not necessary to report it. The legal situation was extremely discouraging and frustrating, and Linda had to have a lot of courage to file a report despite the police officer's recommendations.

The epilogue. Re-framing of life by perfunctory encounters and caring alliances
The drama then ends with an epilogue which shows that this experience had a strong impact in both the short and long-term for Linda and her family. The experience can be described as a vicarious victimization, i.e., the traumatic experience invoked in Linda after the criminal assault on her son. The encounters in the aftermath of the violent act have, for Linda, contributed to a re-framing of life, having a long-lasting impact on feelings of trust and safety. The perfunctory meetings have left her with lack of trust in society, especially the legal system. These encounters were described as a violent provocation for Linda and her family. Long-term consequences have been feeling unsafe and always looking over her shoulder. Her family's large social support system was an essential part of recovery for her and her husband. The caring alliances created in the ED played a pivotal role to regain trust and hope and to keep the strength to support her son in this experience.

Discussion

The overall aim of this thesis was to explore forensic care in EDs for victims of violence and their family members from the perspectives of ED department heads, ED nurses, and a family member of a victim of violence. The main findings were that nurses in EDs played a key role in care for victims of violence but most of the nurses hadn't received any education for this task and felt uncertain about how or if to take action. Also, preparedness reflected in routines and policy documents varied and were often limited to women and children (I-III). Forensic care was dependent on nurses overcoming several challenges to create a caring encounter and to thereby address forensic aspects of care. The caring encounter was also of utmost importance for the family member (III, IV). Most nurses perceived that they involved family members of victims of violence in care, but they also experienced contradictions as it could potentially pose a risk for the patient e.g. a family member could be the perpetrator (II, III). Having ED policy documents for forensic care that included family members was associated with a more positive attitude to family which in turn was associated with involving the patient's family members in care (II). Family members to victims of violence were rarely included in ED organization of forensic care, and nurses perceived that family members were often offered little or no help. From the perspective of the family member, caring encounters played a pivotal role in the aftermath of violence and the experience re-framed life (I-IV).

Nurses key role for forensic care and lack of preparedness in EDs (I-III)

Findings show that registered nurses were given specific responsibility for victims of violence in the ED organization (I). Most of the nurses perceived that they cared for victims of violence, but that they lacked education, knowledge, and support from the organization for this task. Only one-third of the nurses had received some kind of education or training to care for victims of violence and most of the nurses reported that they felt a need for such training (II, III). In line with this, previous studies from other countries also point to nurses' need for more education concerning forensic care (Abdool & Brysiewicz, 2009; Alsaif et al., 2014; Eldredge, 2008; Henderson et al., 2012). In Sweden, forensic nursing is not a recognized specialty as it is in some other countries (Kent-Wilkinson, 2011; Lynch & Duval, 2011), nor has it been a regular part of the nursing curriculum. Seen in the light of the magnitude of violence and its consequences, both short- and long-term (The National Centre for Knowledge on Men's Violence Against Women (NCK), 2014), it is surprising that it hasn't

been a natural part of nursing education. In recent years, several nursing colleges have included the topic of violence against women and children in the nursing curriculum and some of the nursing specialty programs. These changes need to continue to evolve and might provide future nurses with more education and knowledge concerning women and children who have been victims of violence (Inkinen et al., 2015).

Knowledge is crucial as it facilitates the first step in providing forensic care which is to identify violence causing ill health. To do so, nurses need specific knowledge of risk factors, acute signs, and long-term effects of violence as well as training on how to ask questions concerning violence. ED patients can have injuries or medical issues that are not always obvious consequences of violence and they do not always disclose their experiences of violence (Catallo et al., 2013; Kothari & Rhodes, 2006; Loke et al., 2012; Mills et al., 2006). Findings show that most EDs have routines for staff to ask about violence only when suspected or when women and children are involved (I). Most nurses who participated in the studies also asked about violence based on suspicion, or only women and children (II, III). Previous research also shows that suspicion screening seems to be current practice in other countries, and focus is on women and children (Leppakoski & Paavilainen, 2013; Louwers et al., 2012; Olive, 2007). Suspicion-based screening presumes that there is enough knowledge to recognize signs of violence and to ask questions. The decision to ask lies with the individual nurse. In light of this, findings show that nurses often feel uncertain which causes them to avoid asking questions (III). The nurses in this thesis described that when screening is limited to special groups, other victims of violence, for example men (Carmo et al., 2011; Nayback-Beebe & Yoder, 2012) or older persons (Bond & Butler, 2013), may remain undetected.

According to nurses' ethical code, nurses hold a personal responsibility and accountability for practice and for maintaining competence by continual learning (International Council of Nurses (ICN), 2012). Nurses in this thesis also expressed an individual responsibility for victims of violence in the EDs despite lack of organizational support. They felt and often assumed responsibility despite there being a lack of policy, routines, and knowledge. Previous research has pointed out that clear guidelines concerning medical tasks in EDs often exist, but caring was up to each individual nurse (Nyström et al., 2003). This focus on medical tasks was also described by the nurses in this thesis and they perceived a lack of time and opportunity to provide care beyond those tasks. They often felt that it was up to their individual efforts whether or not forensic aspects of care would be included (III).

Importance of caring encounters for providing forensic care and for the family member (III, IV)

Findings highlight the caring encounter as the main challenge and also a prerequisite for providing forensic care (III). This is in contrast to most previous studies of forensic nursing from professional's perspective which have focused on evidence collection and more technical parts of forensic care (Abdool & Brysiewicz, 2009; Filmalter et al., 2017; Glittenberg et al., 2007; McCracken, 2001; McGarry, 2017; Watt et al., 2008). Previous research about the importance of a caring encounter has most often been from the perspective of victims of violence at the ED (Loke et al., 2012; Olive, 2017; Pratt-Eriksson et al., 2014; Simmons et al., 2016). Encounters in EDs are often short and the number one priority is to efficiently assess the patient's condition and provide treatment for physical injuries (Nyström et al., 2003). This priority was described in this thesis as well, but the interviewed nurses also recognized patient's and family member's emotional distress and need for support and care beyond the physical injury (III). Previous studies also highlight healthcare professionals' responsibility to ensure that the encounter is caring and beneficial to the patient (Eriksson & Svedlund, 2007; Nyström et al., 2003). It has been described as a shifting between an instrumental and an attentive mode depending on the patient and the situation with flexibility between the physical and psycho-social care (Wiman et al., 2007).

Halldorsdottir's theory of caring and uncaring encounters (Halldorsdottir, 1996) was used in this thesis to deepen understanding of the nurse-family member relationship (III, IV). The specific caring aspects of Halldorsdottir's theory have been found applicable in emergency care (Wiman & Wikblad, 2004) and were also apparent in the results of study III and IV in this thesis. Findings concur with the modes of being with another as described in the theory, i.e., being open and perceptive, genuinely concerned, morally responsible, truly present and dedicated, and being appropriately involved as a professional nurse (Halldorsdottir, 1996). Nurses describe this as their main challenge for providing forensic care. As in Halldorsdottir's metaphor, they were aware of how this caring encounter could constitute a bridge for openness and connectedness in the experience for the patient or the family member. The second metaphor in the theory, the wall, symbolized by negative or lack of communication and detachment, was also apparent in the findings, e.g., that nurses were aware of situations when they could be perceived as "a wall", as a consequence of their uncertainty and lack of attention to more than the physical injuries (III).

The theory illuminates the importance of professional caring (Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996) and for victims of violence, a professional response is pivotal for disclosing the violence they have been subjected to and to reporting the crime (Hinsliff-Smith & McGarry, 2017).

Halldorsdottir's theory (1996) also shows the importance of including the patients inner and outer contexts. The findings of the family member's experience show that caring encounters were crucial to support well-being and promote empowerment (IV). Uncaring encounters, on the other hand, decreased well-being and were perceived as a discouragement. The family member pointed to caring encounters as key in the ED for regaining trust and strength to support family and recover (IV).

Nurses often experienced trepidation to act and include forensic aspects in care. These situations caused frustration of not being able to offer help and support (III). Personal or organizational hindrances to provide care can cause moral distress (Oh & Gastmans, 2015). Moral courage can be seen as a tool and empower nurses to address issues of violence and to relieve such moral distress (Crigger & Godfrey, 2011; Hawkins & Morse, 2014; Iseminger, 2010; Numminen et al., 2017). As described in these findings, nurses' uncertainty about whether to act was at times overcome by a strong feeling of responsibility (III) which could be explained by moral courage. As in the seven core attributes that a concept analysis of moral courage in nursing identified; true presence, moral integrity, responsibility, honesty, advocacy, commitment and perseverance, and personal risk. "Moral" is related to attitudes of right and wrong or good and bad, and "Courage" relates to an attitude of facing fear and acting on one's convictions instead of withdrawing. Moral courage can entail personal and professional development and a feeling of empowerment (Numminen et al., 2017). As moral courage relates to individual values it is important to critically reflect upon attitudes concerning violence and victims as this can influence care provided. Peer discussions and sharing experiences were seen as important aspects for nurses in the findings to challenge and influence attitudes (III) as well as in previous research (Johansson et al., 2006).

Difficulties to include family members in care and experience of vicarious victimization (I-IV)

Findings show that family members of victims of violence were often not included in the organization of care for victims of violence, as this was rarely a part of policy documents, routines or education (I, II). These findings can be seen in light of previous research that has pointed to the importance of including family members in care in EDs, both in general and specifically, for victims of violence (Cypress, 2014; Eggenberger & Nelms, 2007; Krug et al., 2002; Ogilvie et al., 2015; Rahmqvist Linnarsson et al., 2010). Findings also show that having ED documents for forensic care was one factor that was associated with nurses having a more positive attitude to family which in turn was associated with involving patient's family members in care (II). These findings are in line with the underlying assumption in family focused care and the

family-nurse relationship, i.e., that nurses' beliefs and attitudes can facilitate or hinder nurses from addressing illness and suffering in the family (Wright et al., 2002). Thus, having an organizational priority and including family members in ED policy documents concerning of care for victims of violence can make a difference in nurses' attitudes and it is the one factor that can be influenced directly by adjusting ED policy and routines.

Despite family members not being included in policy documents and routines, most nurses demonstrated a positive attitude to families in care (II). However, nurses also perceived that family members were often offered little or no help at the ED. Despite having a positive attitude and feeling of responsibility, the nurses had difficulties in finding opportunities to actually involve family members in care (III). These findings are in accordance with research on family members in emergency care in general that point to nurses feeling responsible for family members, but providing care for them is perceived as difficult and not prioritized (Alshahrani et al., 2018; Hallgrimsdottir, 2000; Redley et al., 2003). Involving family members in care has been described by nurses as a means to increase efficiency, and family members were only involved according to the terms of the system in the ED (Hoffmann & Olsen, 2018). With a focus on family members in EDs, the terms of involvement are instead guided by the individual family member to promote health, well-being, and alleviate suffering. The family – nurse relationship is of central importance to achieve this goal. Findings exemplify the importance of a family focus in the ED by describing how a family member and nurse relationship can be the crucial mediating factor in the aftermath of violence to regain trust and to support recovery (IV). The relationship was non-hierarchical and consisted of collaboration and respect viewing the nurse's and the family member's contribution as equally important. This kind of family-nurse relationship lies at the core of family focused care, recognizing that both the family member's and the nurse's individual resources contribute to mutual learning and new meanings (Meiers & Tomlinson, 2003; Wright et al., 2002).

Furthermore, findings show that the family member's experience in the aftermath of violence can contribute to a re-framing of life. The experience can also lead to vicarious victimization, meaning that the family member experienced trauma invoked by the victimization of her son (IV). A traumatic and significant event such as the violent crime represented in study IV, can have a strong effect on family members and on the family as a whole. Therefore, it may be beneficial to recognize potential health risks as well as resources within a family to support both the patient and the family members (Benzein et al., 2012; Wright & Leahey, 2013). Relationships and interaction in the family can influence how families adapt to change. Health may be promoted by supporting family members to achieve balance and develop strategies to meet challenges that they face (Friedemann, 1995). The family in study IV was not offered continued care or support from the ED but they were fortunate to have a large

social support system which was pointed out as central to recovery. Nurses have an important role to support and refer both the patient and the family member for them to find sources of structural and functional social support within family and community following the ED visit (Escriba-Aguir et al., 2010). This presumes that nurses have knowledge of possibilities for continued care and support in society. However, findings show that nurses hold uncertainties concerning such knowledge causing them to withdraw instead of intervening (III).

Collaboration for continued care and support is especially important for patients who have been victims of violence from a perpetrator within the family to reduce the risk of further victimization. For the patient and their family's safety and recovery, collaboration with authorities such as police, social services or other organizations is crucial (Lynch & Duval, 2011). Nurses also need to have knowledge of their possibility or obligation to report some types of crime, such as for example violence against children. Yet findings point to there being many uncertainties among nurses as to this responsibility (II, III). Involving family members in care in EDs for patients who have been victims of violence from a perpetrator within the family presents an additional challenge for the nurses. Although most nurses perceived that they involved family members of victims of violence in care, they also felt uncertain in doing so due to this risk of the perpetrator being within the family (II, III). Maintaining safety for the patient has to be a priority in forensic care when there is uncertainty whether the perpetrator actually is within the family or not (Hinsliff-Smith & McGarry, 2017). Involving family members has to be dependent on the individual patient's situation. In cases of violence within a family, a risk assessment for the patient must precede practical and emotional support for family members. However, it should be acknowledged that other family members, aside from the perpetrator, can be of invaluable support for the patient and may also need support. Therefore, practical and emotional support from ED staff to these family members should be considered. Previous research concerning women subjected to violence has shown that a greater social support with satisfying social relationships was associated with a significantly reduced risk of adverse psychological health consequences (Coker et al., 2002; Escriba-Aguir et al., 2010).

Methodological considerations

A combination of quantitative and qualitative approaches has been used to achieve the aim of this thesis. There is a difference in epistemology with these approaches, however, combining them can contribute to both a general and an in-depth description (Creswell & Creswell, 2018; Katz et al., 2016) of forensic care in EDs. The methodological considerations for the quantitative approaches are discussed in terms of validity, reliability, and generalizability. The qualitative approaches are discussed in terms of trustworthiness which comprises credibility, confirmability, dependability, and transferability (Graneheim et al., 2017; Polit & Beck, 2016).

Quantitative approaches (I, II)

Design and sample

The cross-sectional, descriptive (I) and correlational design (II) provided descriptions and associations that were valuable for setting the map and providing clues for future studies (Polit & Beck, 2016). However, as data were collected at the same point in time, there are limitations as to causality and there can be more than one interpretation of the causal direction (II) (Cohen et al., 2003; Polit & Beck, 2016). The use of a total population in study I provided the possibility for wide coverage of the ED organization, reducing the risk of missing potential insights. An additional strength in study I was the high response rate (70%), with respondents from both large and small hospitals spread out geographically. In study II, the large sample provides possibilities to generalize the findings. This sample was limited to those EDs that gave permission to conduct the study and the questionnaire was sent to all nurses in these departments. The EDs that gave permissions to conduct study II did not differ in regard to size and geographical locations in comparison with the EDs that did not wish to participate. The response rate in study II was 53%, but the sample (n=457) was large enough to provide satisfactory statistical power in the regression analyses. Non-respondents did not differ in regard to age and sex, but we cannot assess if they might differ in some other way. Global generalizability of the results needs to be considered in relation to structure and organization of EDs which can differ substantially in between different countries.

Data collection

The web-based questionnaire in study I was developed specifically for the study population as there were no previous questionnaires found focusing on care for victims of violence and their family members. In study II, the first part of the questionnaire was also developed specifically for the study with similar questions as in study I. In addition, the questionnaire in study II also included the FINC-NA instrument at the end of the study-specific questionnaire. The FINC-NA instrument was chosen as it is an instrument concerning nurses' attitudes and family in care and it has shown satisfactory measurement properties in terms of validity and reliability in previous research (Benzein et al., 2008; Saveman et al., 2011).

The specifically developed questionnaires consisted of single items used to derive descriptive statistics without the properties of a psychometric instrument. To ensure content validity, the questions in the questionnaire were evaluated by an expert group (Streiner & Norman, 2008) consisting of 8 clinicians (5 nurses and 3 physicians) and 5 researchers with a Ph.D. degree. The results from the questionnaires consisted of self-reports, which have a potential risk of social-desirability bias. The use of factual questions and assurance of confidentiality should, however, have limited the risk of such bias (Streiner & Norman, 2008). There were no missing data as all the questions needed to be answered to submit the questionnaire. The use of mandatory questions might cause dropouts and pose a risk of receiving inaccurate responses. However, open-ended questions throughout the questionnaire were provided to give respondents the possibility to comment or specify their answers which may reduce the risk of dropouts, and it serves as a safety net to complement the closed-ended questions (O'Cathain & Thomas, 2004).

Data analysis

The scores from the FINC-NA were high (II) which could point to a social desirability bias, with negative attitudes being left out. However, the scores were lower when compared to a previous study with nurses using this instrument (Saveman et al., 2011). A power analysis was calculated post hoc for the linear regression (effect size $R^2 = 0.05$, significance level 5%, 6 predictors, n = 457) which gave a power of 0.97. Reliability assesses the consistency of results across items within a test (Streiner & Norman, 2008). Internal consistency reliability was estimated with Cronbach´s alpha which reflected good reliability for all subscales except for the subscale Fam-B. The lower level of internal consistency in sub-scale Fam-B has also been seen in previous studies using the FINC-NA instrument (Saveman et al., 2011) and it might be explained by the inverted items which stand in contrast to the other subscales. This might indicate that findings from the subscale Fam-B may need to be interpreted with caution. Inverted items are used to prevent response bias

but there is no consensus that it is an effective strategy. It has been argued that items with mixed direction can be counterproductive as it can contaminate responses by respondent's inattention or confusion (Van Sonderen et al., 2013). In order to achieve high statistical validity, statistical methods have been chosen based on data level and data distribution. In addition, basic assumptions about the different analyses have been evaluated. In the linear regression analysis, no problems of linearity, homoscedasticity, and multicollinearity were identified. On the other hand, the residues were not normally distributed. Therefore, robust standard errors were used to account for this in the analysis (Acock, 2016). For the ordinal regression analysis, the parallel lines assumption was not violated based on the Brant test (Long & Freese, 2006).

Qualitative approaches (I, III, IV)

The trustworthiness of the qualitative findings was assessed in regard to the interrelated aspects of credibility, confirmability, dependability, and transferability. Credibility refers to how well data and the research process addresses the intended focus and the believability of the results (Graneheim et al., 2017; Patton, 2004; Polit & Beck, 2016). As a first step to strengthen credibility, variation was sought in the sampling process in regard to age, gender, ED location and demographics (I, III). Participants in study III were recruited until no more new data were generated, which was judged by discussions within the research team after reading transcripts of the interviews. The heterogeneous sample in study I and III gave broad variation and nuances in data, shedding light on the area of research from different views. In study IV, one participant was chosen to explore and reach a deeper understanding of the family member's situation in the aftermath of violence as research in this area is limited. With two interviews in the case study (IV), there was the opportunity to explore the area at focus with more depth and to make sense of the whole (Sandelowski, 1996). The interviews in study III and IV were conducted at a place chosen by the participants, with priority to create as fertile conditions as possible for the interviews. All interviews were initiated with small talk and with ample time for reflections and questions to build trust. The researcher (JR) strived to listen curiously with a deep genuine interest in each interview to gain as rich data as possible from the participants' different perspectives (Kvale & Brinkmann, 2009).

Confirmability refers to how the research findings are supported by the data collected. Efforts were made to provide as much detail as possible in the description of the research process (I, III, IV) and to use representative quotations from the transcribed text (III, IV) to ensure confirmability. Qualitative data in study I consisted of short answers to the open-ended questions in the questionnaires. The answers were single words or short phrases

and they were categorized by identifying similar words and manifest content which all three authors agreed upon. In study III and IV all three authors discussed and critically reflected upon the interpretations of the data as preunderstanding influences the analysis and interpretations (Patton, 2004). The authors tried to find alternative interpretations and to ensure that the results were well grounded in data. In study III, content analysis was carried out and interpretations were discussed and questioned within the research team to confirm the findings (Graneheim et al., 2017; Graneheim & Lundman, 2004). In study IV, which was analyzed with a Gadamer-inspired hermeneutic theory of interpretation (Fleming et al., 2003), the idea is that there is no universal truth, and understanding is dependent on interpretation. According to Gadamer (2013), preunderstandings reflect our history and prejudice which are a core part of understanding. Although we can never be fully aware of our preunderstandings, attentiveness, reflectiveness and critically questioning of abstractions and interpretations can contribute to new understandings. During the research process, the researcher (JR) strived to reflect and be aware of preunderstandings by writing down thoughts and expectations. During the analysis, interpretations were constantly questioned and continuously discussed within the research team. The researchers (JR, EB, KÅ, CE) have different areas of expertise from nursing contexts which added different perspectives, created discussions which developed new understandings.

Dependability refers to the interpretations being representative and stable over time (Polit & Beck, 2016). The same researcher (JR) conducted all the interviews and made the transcriptions in study III and IV. The interviews were conducted with interview guides, but flexibility to the issues raised by the participants was a priority by asking follow-up questions during the interviews. The interviewer (JR) was also evaluated by the co-authors continuously from interview to interview to give a possibility for reflection and to minimize bias. In study IV, the participant was interviewed twice to strengthen dependability.

Transferability refers to the extent which the findings can be transferred to other settings and populations (Polit & Beck, 2016). To facilitate judgements of transferability, efforts were made to provide as clear and distinct descriptions as possible of the context and the participants' characteristics. The findings have also been compared to previous studies in this area of research. The heterogeneous sample in study I and III gave broad variation in data which can increase the possibility of transferability. The case study (IV) might have limited transferability and further studies are needed to ascertain the representativeness of these findings.

Conclusion

When considering the results in this thesis it can be concluded that there is a lack of general preparedness in EDs to care for all victims of violence, regardless of gender and age, and family members are rarely a part of guidelines or routines. This may prohibit the provision of equal care for all victims of violence. As the organization of forensic care in EDs strongly focuses on women and children, nurses are left without guidance about how to care for other patient groups. Thereby, situations of violence causing ill-health may be left unaddressed. Nurses in EDs are given a key role in the care for victims of violence, but many of them indicate that they are not prepared enough for this task with sufficient knowledge and specific training. This leaves nurses with uncertainty and lack of means to intervene and address the violence that causes ill-health and suffering. The greatest challenge for ED nurses in providing forensic care was to create a caring encounter. There were several hindering factors to creating such a caring encounter such as difficulties to intervene and talk about violence, to care for family members, and to deal with one's own strong emotions towards violence. Lack of means and knowledge to overcome these hindering factors resulted in issues related to violence being left unaddressed. This can in a wider perspective limit the possibilities to alleviate suffering and to provide the victim and their family members with the possibility of legal justice. An overall conclusion from the results in this thesis is that family members are rarely included in the organization of forensic care in EDs. Although nurses demonstrated a positive attitude towards family members in care, family members of victims of violence were rarely offered help and support at the EDs. This can be seen in light of the results indicating that a family member can be vicariously victimized. The experience may have a major impact on the family member and caring encounters can contribute to a re-framing of life. This indicates that all individuals encountering family members in the aftermath of violence can play an important part to alleviate suffering for family members.

Clinical implications

The results in this thesis yield knowledge that may be useful for decision-makers of ED organization as well as ED nurses. As policy documents and routines are lacking or vary between EDs there is a need to further develop the organization of forensic care to include all victims of violence regardless of age or sex and to also include family members. In order to ensure equal care for all victims of violence, there is a need for clear national guidelines and routines

concerning all aspects of forensic care. Nurses in EDs that are given specific responsibility for victims of violence and their family members need to be equipped with knowledge to ask questions about violence, provide support, document and collect evidence as well as to collaborate for continued support and care. As nurses encounter victims of violence in their daily clinical work they can strive to continuously challenge the ED organization concerning forensic care and push the organization to develop training and routines. Nurses value the role of family members in care but are hesitant to offer help and support due to uncertainty and lack of priority to care for family members in EDs. This indicates a need to rethink how family members are included in the organization of care. Including care for family members in ED documents concerning forensic care could be a starting point to initiate change. There is a need for knowledge and clear routines in EDs about how to include family members when possible without jeopardizing the victim's safety. All professionals encountering family members in the aftermath of violence should recognize their potentially important role to alleviate suffering and rebuild trust and safety for the family member as they may be vicariously victimized.

Future research

In order to develop forensic care for victims of violence and their family members in EDs there is a need for further research. Additional studies are needed to obtain more knowledge and a deeper understanding of the victim's and family member's perspective of forensic care provided in the ED. Further studies are needed to create clear routines concerning all parts of forensic care following all types of violence, from identifying violence as the cause of ill-health to collaboration and referral after the visit to the ED. There is also a need for studies to develop and implement intervention strategies aiming to increase knowledge and support for nurses to create a caring encounter, thereby facilitating forensic care for all victims of violence and their family members. The representativeness of the results in this thesis concerning the family member's experience in the aftermath of violence needs to be further assessed and also to include the experience for family members to victims of different types of violence. Further research should target how family members can be included in care in the aftermath of violence with a focus on emotional support and safety.

Summary in Swedish

Forensisk vård för våldsutsatta personer och deras familjemedlemmar på akutmottagningen.

Bakgrund

Varje år drabbas flera miljoner människor av våld världen över. Våldet berör inte bara de som direkt utsätts utan även deras familjemedlemmar (Krug et al., 2002). Våldsutsatthet orsakar död, skada och långvarigt lidande. Våldsutsatthet är relaterat till ökad psykisk ohälsa, sociala problem, missbruk, suicidalitet, kroniska sjukdomar samt infektionssjukdomar (Dong, 2015; Gini & Pozzoli, 2013; Krug et al., 2002; Le et al., 2016; Li et al., 2014; McLaughlin et al., 2012; Ttofi et al., 2016; Weber et al., 2016). Hälso- och sjukvården har en viktig roll i samhället att fånga upp våldsutsatthet och förebygga ohälsa både för dem som utsatts för våld samt deras familjemedlemmar (Krug et al., 2002). Då många personer som utsatts för våld söker vård på akutmottagningen är det särskilt viktigt att det finns en beredskap där för att upptäcka våldsutsatthet och erbjuda vård som förebygger ohälsa och minskar lidande (Filmalter et al., 2017; Lynch & Duval, 2011; McCracken, 1999; Pasqualone & Michel, 2015). Vård efter våldsutsatthet kan benämnas forensisk vård. Denna specifika vård tillvaratar rättsliga aspekter som kan ha betydelse för möjligheten till rättslig upprättelse. Forensisk vård är tänkt som en länk mellan sjukvården och rättssystemet för att därigenom bidra till kontinuitet och minskat lidande för de utsatta. Utöver medicinska åtgärder, innefattar forensisk vård: att upptäcka våldsutsatthet, bemöta och erbjuda stöd, spårsäkra, dokumentera och samverka med polis, socialtjänst och andra organisationer eller myndigheter i samhället som kan erbjuda fortsatt stöd och hjälp (Lynch & Duval, 2011). Utöver att rättsliga aspekter av vården beaktas efter våldsutsatthet, behövs ofta både emotionellt och praktiskt stöd för de utsatta och deras familjemedlemmar (Loke et al., 2012; Lynch & Duval, 2011; McCracken, 1999). Generellt är vården på en akutmottagning inriktad på den individuella patienten och de uppenbara fysiska skador (Carlsson Sanz, 2008; Kothari & Rhodes, 2006) och präglas av korta möten och snabba medicinska beslut vilket. Det kan innebära att det saknas ett helhetsperspektiv som kan behövas för att minska lidande (Nyström, 2002). Det saknas idag kunskap om Sveriges akutmottagningars beredskap för forensisk vård för våldsutsatta personer och deras familjemedlemmar. Det saknas också kunskap om hur familjemedlemmar upplever vård kopplat till våldsutsatthet. Detta trots att tidigare forskning pekar på vikten av att inkludera

familjemedlemmar i vård efter våldsutsatthet (Gunnels, 1997; Krug et al., 2002).

Syfte

Det övergripande syftet med avhandlingen var att utforska forensisk vård för våldsutsatta personer och deras familjemedlemmar på akutmottagningen från verksamhetschefers och sjuksköterskors perspektiv samt från en våldsutsatts familjemedlems perspektiv.

Metod

Den första delstudien var en nationell tvärsnittsstudie där ett webbaserat frågeformulär skickades ut via e-post till verksamhetscheferna för samtliga sjukhusbaserade akutmottagningar i Sverige. Frågeformuläret innehöll en kombination av frågor med fasta svarsalternativ samt öppna fritextsvar. För de fasta svarsalternativen bestod analysen av beskrivande statistik, för svaren i fritext användes innehållsanalys. I den andra delstudien fick samtliga sjuksköterskor på 28 akutmottagningar ett webbaserat frågeformulär med liknande frågor samt även instrumentet FAMBO–Familjers betydelse i omvårdnad (FINC-NA på engelska) (Benzein et al., 2008; Saveman et al., 2011). Svaren analyserades med beskrivande och analytisk statistik (som multipel linjär och ordinal regressionsanalys). I den tredje delstudien utfördes individuella intervjuer med 12 sjuksköterskor från 7 akutmottagningar och data analyserades med kvalitativ innehållsanalys. Den fjärde delstudien var en s k fallstudie där en person intervjuades vid två tillfällen, i detta fall en familjemedlem till en våldsutsatt person. Här analyserades data med tolkande textanalys, inspirerad av en hermeneutisk ansats (Fleming et al., 2003).

Resultat

Syftet med delstudie I var att beskriva beredskapen för vård av våldsutsatta personer och deras familjer på akutmottagningar i Sverige. Av de 66 verksamhetschefer som fick web-frågeformuläret svarade 46 (70%). Resultatet visade att de flesta akutmottagningar (78%) inte visste eller kunde ange hur många våldsutsatta patienter som de tog hand om varje år. Beredskap i form av policydokument och rutiner för att ta hand om våldsutsatta patienter fanns på många akutmottagningar men gällde inte alla patienter utan hade fokus på kvinnor och barn. Rutiner att fråga patienter om våldsutsatthet saknades helt på

35% av akutmottagningarna, det vanligaste var att fråga vid misstanke om våld (50%). Sjuksköterskor fick ofta ett särskilt ansvar kring vården för våldsutsatta. Familjemedlemmar var sällan inkluderade i dokument, rutiner eller utbildning för personalen i relation till vård för våldsutsatta patienter.

Syftet med delstudie II var att beskriva sjuksköterskors syn på forensisk vård för våldsutsatta personer och deras familjer på akutmottagningen, att identifiera faktorer associerade till sjuksköterskors inställning till familjer i omvårdnad samt att undersöka om deras inställning hade ett samband med inkluderandet av patienternas familjemedlemmar på akutmottagningen. Frågeformuläret besvarades av 457 sjuksköterskor (53% av de tillfrågade). Resultaten visade att de flesta sjuksköterskor (97% av de som svarade) ansåg att de vårdade våldsutsatta patienter men mindre än en tredjedel av dem hade fått någon utbildning för det. Sjuksköterskorna angav att det fanns en viss beredskap för kvinnor och barn men inte för alla patientgrupper. De flesta sjuksköterskor angav att de inkluderade familjemedlemmar i vården (79% ibland, 11% alltid), trots att familjemedlemmar sällan fanns med i dokument eller rutiner kring våldsutsatta patienter. Faktorer som att vara kvinna, att det fanns policydokument som inkluderade familjemedlemmar, samt egen erfarenhet av att vara familjemedlem till en allvarligt sjuk person kunde knytas till en positivare inställning till familjer i vården. En positivare inställning till familjer i vården kunde relateras till att sjuksköterskor i högre utsträckning inkluderade familjemedlemmar i vård av våldsutsatta patienter.

Syftet med delstudie III var att belysa sjuksköterskors erfarenheter av att vårda personer som utsatts för våld och deras familjemedlemmar på akutmottagningen. Resultatet baserades på intervjuer med 12 sjuksköterskor från sju olika akutmottagningar. Det visade att den största utmaningen som sjuksköterskorna upplevde var att skapa ett vårdande möte och inte de specifika forensiska åtgärderna. Det vårdande mötet präglades av mod att ingripa, vara genuint närvarande, visa ärlig omtanke, bekräfta patienten som medmänniska och att företräda patienten och deras familjemedlemmar. De beskrev dock flera hinder för att skapa det vårdande mötet med våldsutsatta patienter och deras familjemedlemmar, vilket i sin tur innebar att de inte tog sig an de forensiska åtgärderna. Det som ansågs hindrande sammanfattades i fyra kategorier: Kämpar för att ta sig an att prata om våld, Motsägelser att ta hand om familjemedlemmar, Hjälpt av riktlinjer - men i behov av mer kunskap, Hantera egna känslor i förhållande till våld.

Syftet med delstudie IV var att beskriva erfarenheter av att vara med sin familjemedlem som vårdas på akutmottagningen efter att ha utsatts för våld. Resultatet baserades på två djupintervjuer med en mamma i medelåldern vars son och dennes vän hade utsatts för misshandel av en okänd gärningsman. I den hermeneutiska analysen tolkades berättelsen som ett drama och resultatet beskrivs därför i en prolog, tre akter samt en epilog. I prologen introduceras Linda, vars son utsatts för en grov misshandel av okända gärningsmän. Den

första akten beskriver hennes första reaktion som sammanfattas som en bedövande rädsla samtidigt som hon försöker hantera kaos både känslomässigt inombords men även i miljön på akutmottagningen. I den andra akten beskrivs hur hon känner sig desillusionerad i förhållande till det som hänt men även till situationen efter våldet som lämnat en känsla av otrygghet och bristande tillit, vilket hon då försöker återskapa i mötena på akutmottagningen. I den tredje akten beskrivs en motsägelsefull situation där hon är tacksam för vården och vill inte vara i vägen men samtidigt kämpar för att stötta sin son och familjen hemma. Dramat avslutas med en epilog som visar hur bristfälligt bemötande och vårdande relationer haft en påverkan på livet därefter.

Slutsats

På akutmottagningarna saknas det ofta beredskap för forensisk vård för alla våldsutsatta patienter, oavsett kön och ålder. Familjemedlemmar är sällan inkluderade i riktlinjer eller rutiner. Då organiseringen av forensisk vård tydligt fokuserar på kvinnor och barn, lämnas sjuksköterskor utan vägledning för att ta hand om andra patientgrupper. Detta kan leda till att vissa våldsutsatta patienter inte erbjuds forensisk vård och våldet som orsakar ohälsa lämnas därhän. Resultaten visar att sjuksköterskor på akutmottagningen ofta fick en nyckelroll i vården av våldsutsatta. Få av dem hade specifik utbildning och de ansåg sig vara i behov av mer kunskap om forensisk vård. Sjuksköterskorna beskriver osäkerhet och brist på möjligheter ingripa för att ta itu med våldsutsatthet hos patienter som orsakar ohälsa och lidande. En bristande beredskap för forensisk vård samt skillnader mellan sjuksköterskors kunskap och deras personliga erfarenheter kan innebära en ojämlik vård för våldsutsatta. Sjuksköterskorna beskrev att den största utmaningen vid forensisk vård var att skapa ett vårdande möte. Det vårdande mötet ansågs vara en förutsättning för att ingripa och ta sig an våldsutsatthet. Det fanns flera hinder för att skapa ett vårdande möte såsom bristande kunskap och prioritet för detta på akutmottagningen. Många gånger kunde sjuksköterskorna inte övervinna dessa hinder vilket innebar att patienter våldsutsatthet lämnades utan åtgärd. I ett större perspektiv begränsar detta möjligheterna att lindra lidande och ge våldsutsatta personer och deras familjemedlemmar möjligheten till rättvisa genom en efterföljande rättslig process. En övergripande slutsats från resultaten i denna avhandling är att familjemedlemmar sällan ingår i organiseringen av forensisk vård på akutmottagningen. Sjuksköterskor visade ändå på en positiv inställning till familjemedlemmar. Trots detta beskrev sjuksköterskorna att familjemedlemmar sällan erbjöds stöd eller hjälp på akutmottagningen. För en familjemedlem kan upplevelsen ha långsiktig inverkan på livet och de vårdande relationerna kan vara avgörande för att återskapa trygghet och tillit.

Implikationer

Resultaten i denna avhandling bidrar till kunskap som kan vara till nytta för beslutsfattare inom akutsjukvården samt sjuksköterskor på akutmottagningar. På organisationsnivån visar resultaten att policydokument och rutiner saknas eller varierar mellan akutmottagningar. Dessa kan därför behöva vidareutvecklas för att inkludera forensisk vård för alla våldsutsatta oavsett ålder eller kön samt att även omfatta familjemedlemmar. För att säkerställa lika vård för alla våldsutsatta personer behövs tydliga nationella riktlinjer och rutiner för alla aspekter av forensisk vård. Sjuksköterskor på akutmottagningen som ges specifikt ansvar för våldsutsatta patienter och deras familjemedlemmar måste vara utrustade med kunskap för att kunna ställa frågor om våld, ge stöd, dokumentera och samla bevis samt samarbeta för fortsatt stöd och vård. Resultaten visar vidare att sjuksköterskor värderar familjemedlemmarnas roll i vården men är tveksamma till att erbjuda hjälp och stöd på grund av osäkerhet och bristande prioritet att ta hand om familjemedlemmar på akutmottagningen. Detta pekar på ett behov av att ompröva hur familjemedlemmar ingår i vården på akutmottagningen. Att det fanns dokumenterade riktlinjer som inkluderade familjemedlemmar i vården av våldsutsatta var förknippat med att sjuksköterskorna var positiva till familjemedlemmar i vården. Detta kan vara en utgångspunkt för att initiera förändringar. Dessutom pekar resultaten på ett behov av mer kunskap, stöd och prioritet på akutmottagningen för att sjuksköterskor ska övervinna de hindrande faktorerna för ett vårdande möte vilket ansågs vara en förutsättning för att ta sig an forensisk vård. Resultaten pekar på att alla yrkespersoner som möter familjemedlemmar efter våld bör ta tillvara på sin potentiella viktiga roll att lindra lidande och återuppbygga tillit och trygghet för familjemedlemmen. Det finns ett behov av kunskap och tydliga rutiner kring att inkludera familjemedlemmar i vården utan att riskera den våldsutsattas säkerhet.

Fortsatt forskning

För att utveckla forensisk vård behövs ytterligare forskning kring vård för våldsutsatta personer samt deras familjemedlemmar. Fler studier behövs för att öka kunskapen och för en djupare förståelse för våldsutsatta och familjemedlemmars perspektiv på forensisk vård på akutmottagningen. Framtida studier behövs för att skapa tydliga rutiner kring alla delar av forensisk vård för all våldsutsatthet, från att upptäcka våld som orsakar ohälsa, till att samverka med olika samhällsaktörer inblandade vid våldsutsatthet. Det finns också behov av studier för att implementera och utvärdera interventionsstrategier som ökar sjuksköterskors kunskap och ger stöd och möjlighet att skapa ett vårdande möte för att våga ingripa och erbjuda forensisk

vård till alla grupper av våldsutsatta personer. Framtida forskning föreslås för att öka kunskapen om familjemedlemmars erfarenheter i samband med vård efter olika typer av våld. Ytterligare forskning bör inriktas på hur familjemedlemmar kan inkluderas i forensisk vård med fokus på emotionellt stöd samtidigt hur man kan värna om säkerheten om våldet skett inom familjen.

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