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UNIVERSITY OF APPLIED SCIENCES

The Forensic Nursing Care Given to Victims of Violence

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Degree Thesis in Health Care and Social Welfare

Education: Bachelor of Health Care, Nursing

Vaasa 2021

BACHELOR'S THESIS

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Degree Programme: Nurse, Vaasa
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Title: The Forensic Nursing Care Given to Victims of Violence

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Date 11/2021 Number of pages 42 Appendices 4

Abstract/Summary

Forensic nursing care is a concept addressing nursing care to violence and crime, it is a global nursing practice where the health and legal system intersect. Plenty of nurses are not prepared to care for or able to recognize a patient who is a victim of violence. Violence is a sensitive and broad topic and all nurses are likely to encounter a victim of violence at some point in their career. Therefor nurses need to gain more knowledge and skills training in forensic nursing care. Caring science, Paplau's (1952) theory of interpersonal relations and Husteds' (1991) symphonological bioethical theory has been presented in the theoretical framework. The aim of this study was to describe the experiences, including the preparedness and confidence among registered nurses when providing care for victims of violence. Information has been gathered with a qualitative approach, using a questionnaire. Approval for the collection of data was obtained. There were 10 participants taking part in the study. The material has been analysed using qualitative content analysis. The results show that participants agreed that violence is a trauma that requires intervention and support. Half of the participating nurses have had training in how to approach a victim of violence, but most have never heard of the term forensic nursing care. Eight nurses answered previously having cared for a victim of violence, meaning nurses have cared for these patients without having enough training. The nurses have different feelings toward their own confidence and preparedness in encountering a patient exposed to violence. Participants emphasized to create a non-judgmental and safe environment for discussion with the patient affected by violence. Participants agreed that it is important to be a good listener and support the patient's wishes whatever the decisions may be. Around half of the nurses participating, would approach with more sensitivity after learning about the violence. Further research is needed, especially since the help being sought for violence is increasing.

Language: English Key words: Forensic nursing care, violence, victims

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EXAMENSARBETE

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Titel: Forensisk Omvårdnad för Våldsoffer

Datum 11/2021 Sidantal 42 Bilagor 4

Abstrakt

Forensisk omvårdnad har utvecklats som ett koncept som tar upp omvårdnad i samband med våld och brottslighet, det är en global vårdpraxis där hälsovård och rättssystemet möts. Många sjukskötare kan inte identifiera och är inte beredda på att vårda en patient som blivit utsatt för våld. Våld är ett känsligt och brett ämne och alla sjukskötare kommer sannolikt att stöta på ett offer för våld någon gång i sin karriär. Det är därför sjukskötare behöver mer kunskap och färdigheter inom forensisk omvårdnad. Vårdvetenskap, Peplaus (1952) teori om interpersonella relationer och Husteds (1991) symphonologiska bioetiska teori har presenterats i den teoretiska utgångspunkten. Syftet med denna studie var att beskriva erfarenheter, inklusive beredskapen och självsäkerheten bland legitimerade sjukskötare vid vården av våldsoffer. Information har samlats in med ett kvalitativt förhållningssätt, med hjälp av ett frågeformulär. Tillstånd för insamling erhölls. Det var 10 sjukskötare som deltog i studien. Materialet har analyserats med hjälp av kvalitativ innehållsanalys. Resultaten visar att deltagarna var överens om att våld är ett trauma som kräver åtgärd och stöd. Hälften av deltagarna har fått utbildning i hur man bemöter ett våldsoffer, men de flesta har aldrig hört talats om forensisk omvårdnad. Åtta deltagare svarade att de tidigare vårdat ett våldsoffer, vilket innebär att sjukskötare vårdat dessa patienter utan mer utbildning i hur man bemöter dem. Sjukskötarna har olika tankar kring den egna självsäkerheten och beredskapen att möta en våldsutsatt patient. Deltagarna betonade att skapa en icke-dömande och säker miljö för diskussion med den våldsutsatta. Deltagarna var överens om att det är viktigt att vara en bra lyssnare och stödja patientens önskemål och beslut. Ungefär hälften av sjukskötarna som deltog skulle bemöta patienten med mer försiktighet efter att ha fått reda om våldet. Ytterligare forskning behövs, speciellt eftersom våldsutsatta som söker hjälp ökar.

Språk: Engelska Nyckelord: Forensisk omvårdnad, våld, offer

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1 Introduction

Apart from studying a degree program in health care to become a nurse, I have also taken courses in criminology. It is through criminology I started reading about forensic science. An acquaintance of mine, who is a nurse, told me about forensic nursing and it immediately caught my interest. The health care system and the criminal justice system are closer intertwined from what I first thought. Forensic nursing care is interesting and important since it is about caring for the patient in a holistic manner and at the same time, to gather evidence as a possibility for justice.

There were 9900 victims of domestic violence and intimate partner violence offences reported in 2018 in Finland. This is 3,6 percent more than the year previous. Women constitute 76,5 percent of adult victims. Of all victims, 24,4 percent are minors (Statistics Finland, 2019). Victims of intimate partner violence have an increased risk of abusing substances, getting anxiety, depression, being suicidal and showing symptoms of posttraumatic stress disorder, PTSD. Women who are physically abused by their partners are almost two times more likely to experience depression. Services need to be provided for those experiencing violence. The health sector is an important part in responding to violence, alleviating suffering and to prevent health consequences for victims (Soleimani, Ahmadi & Yosefnezhad, 2017).

Lynch (2000) published the first literature on forensic nursing. This work identified the value of the role of the forensic nurse and to have a multidisciplinary approach in caring for the forensic patient. Lynch advocated for forensic nursing education to be incorporated into the curricula of nursing schools. The American Academy of Forensic Sciences formally recognized forensic nursing as a scientific discipline in 1991. In 1995, the American Nurses Association officially recognized forensic nursing as a nursing specialty. (Price & Maguire, 2016, p. 21)

Violence is a part of many people’s lives around the globe and affects us all in a way. Some try to stay out of harm's way by locking the door at night. For some, violence occurs behind locked doors and is impossible to escape. In this thesis, the nursing care for convicted offenders will be mentioned, but the main focus is on the forensic nursing care given to those affected by violence. The aim of the thesis is to describe the experiences, including

preparedness and confidence in registered nurses when providing care for victims of violence. Violence has serious consequences for a person's health and entire life. It is important for the victim to get help and for healthcare professionals to know how to approach these patients.

2 Background

The background part of this thesis covers the meaning of forensic nursing care, different types of violence, including physical, sexual and psychological violence, and their health consequences. Since the study in this thesis has been conducted in Finland, there is information about the forensic nursing care given in Finland to both victims and offenders. Healthcare professionals are in a front position to screen for violence and provide information and support. The background part additionally includes details concerning the forensic care given in Finland and elsewhere in the world.

2.1 Forensic Nursing Care

The term forensic comes from *forensis*, which is a Latin word meaning "in open court" or "public". When something is described as forensic, it often has to do with finding evidence to solve a crime. Forensic science is the application of science to the law. The main purpose of nursing is the promotion, protection and optimization of health, prevention of illness and injury and the alleviation of suffering. Forensic nursing is the global nursing practice where health and the legal system intersect. Forensic nursing is a term that has evolved as a concept addressing nursing care related to violence and crime. (Price & Maguire, 2016)

Forensic nurses give care to patients affected by violence and other traumas. The patients can be living or deceased victims as well as perpetrators of violence. Forensic nurses are nurses and use the nursing process to provide care in a compassionate and holistic manner. This defines forensic nurses as healthcare professionals rather than criminal justice or forensic science professionals. Forensic care focuses on improving patient health and legal

outcomes. This includes to address the bio-psycho-social-spiritual needs to promote physical and psychological health and recovery of the patient affected by violence and trauma. Forensic nurses use proper evidence collection, documentation and preservation practices to ensure optimal analysis findings. (Valentine, 2018)

Forensic nursing as a practice developed in response to the rise in criminal and interpersonal violence in society. For long, nurses have focused on the physical and psychological care of patients, however, many nurses are not prepared to care for or able to recognize a patient who is a victim of violence. Therefore, nurses find themselves unprepared in determining whether evidence should be collected and preserved. To care for the patient in the best possible way, both healthcare issues and forensic implications must be considered together. Important aspects of holistic care are added, these include evidence collection, preservation and maintenance of the chain of custody of evidence. For the nurse to address these aspects, the nurse has an opportunity to help the patient regain control of their life and to provide forensic expertise and support that can lead to a possible preferable legal outcome. (Sekula, 2005)

Evidence collection is a part of forensic care. The aim of collecting evidence is to preserve traces from the perpetrator to use to get as fair a trial as possible. In evidence collection, a pre-packaged box is used, containing material such as swabs and tubes for blood and urine samples. Health care professionals encounter victims of sexual violence. A person coming to the hospital in an acute phase after experiencing sexual abuse shall be offered a complete physical examination, regardless if the person at that stage has intentions to report to the police or not. The physical examinations include full body examination, gynecological examination, tests for sexually transmitted diseases and collecting evidence using the pre-packaged box. If the victim has done a police report, the evidence shall be given to the police for further investigation, if not, the evidence shall be stored in a safe manner in the hospital. The first 72 hours after sexual violence is defined as the acute phase, but evidence can be collected up to 10 days after the offence. The victims always have to give consent before starting evidence collection. Getting consent regarding collection of evidence on a child can be problematic since it typically requires both caregivers' consent, which can be difficult if the caregiver is a possible suspect. (Socialstyrelsen, 2018)

2.2 Terminology: Victim or Survivor?

The terms victim and survivor are both appropriate to use. They serve different purposes for the person who has experienced violence. A victim refers to someone who has recently experienced violence, and is used when discussing a crime and in referencing the criminal justice system. The term survivor usually refers to someone who is going through a recovery process. A person exposed to violence can identify as a victim or survivor. The term victim additionally serves as a status that provides lawful rights. The word does not imply weakness, guilt or blame. The term survivor can give a sense of empowerment to the person who has experienced violence. The word survivor can imply that the person has started a recovery process and may have gained peace. People identifying as a survivors may not see themselves as victims because they have gained strength through the healing process. (Sexual Assault Kit Initiative, SAKI, 2015)

2.3 Aspects and Definition of Violence

Violence can be defined in many possible ways. The World Health Organization, WHO, defines violence as:

"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." (WHO World report on violence and health 2002, p. 5)

Violence can be divided into self-directed violence, interpersonal violence and collective violence. This categorization divides violence depending on who is committing the act. The intention of the offender is one aspect that concerns violence. (WHO World report on violence and health, 2002)

2.3.1 Intentionality

One aspect of the definition regarding violence is about intentionality. A person might have intended to use physical force or power but did not intend to cause any damage or injury. There exists a disparity between intended behavior and intended consequence. A perpetrator can intentionally commit an act that is judged to be dangerous and likely to result in adverse health effects, although the perpetrator perceives it differently. Another point related to intentionality is in the intent to injure and the intent to use violence. Violence is culturally determined. People can intend to harm others, but because of their cultural beliefs, they do not see their acts as violence. Certain behaviors, for example hitting a spouse, can be viewed as an accepted practice in some cultures. (WHO World report on violence and health, 2002)

2.3.2 Self-Directed Violence

Self-directed violence means suicidal behavior and self-abuse. It is behavior that deliberately results in potential or actual injury to oneself. There are types of self-inflicted violence that are socially accepted and even desirable within a given cultural context. This includes plastic surgeries and piercings or playing sports while in pain. Self-inflicted violence can also be evidence of psychopathology. People with histories of severe childhood maltreatment and invalidation, also referred to as complex trauma, can show behavior such as cutting or burning oneself, banging one's head against something, punching oneself or forcing oneself to vomit. For many people taking part in self-directed violence, the act counts as a coping strategy for violence inflicted upon them by others, especially intimate and care-giving others. To be cut, burned and beaten have become mundane in their lives. Moreover, people who self - inflict harm experience a strong feeling of themselves as deserving of harm, or even asking for it. (Brown & Bryan, 2007)

2.3.3 Interpersonal Violence

One part of interpersonal violence is family and intimate partner violence. This violence usually happens at home and occurs between family members and intimate partners. The other part of interpersonal violence is the so-called community violence, which is violence occurring between individuals who are unrelated and may not know each other. (WHO World report on violence and health, 2002)

Intimate partner violence, IPV, involves all physical, sexual and psychological harms, and controlling behaviors aggravated by a current or former partner. Approximately 30 % of women around the world report being affected by violence inflicted by an intimate partner at some point in their life. Research shows that structural factors such as gender inequality, poverty, alcoholism and police corruption help sustain IPV. The forms of IPV can be associated with age, region, wealth status, controlling behaviors of partner, frequency of alcohol consumption, witnessing parental violence, duration of relationship and parity. To witness parental violence as a child is associated with all forms of IPV. It is seen as a learnt behavior among men who perpetrate violence because they saw their father's violence towards their mothers and among women who accept violence because they witnessed their mothers being abused by their fathers. (Gubi, Nansubuga & Wandera, 2020)

2.3.4 Collective Violence

Collective violence can be divided into social, political and economic violence. This suggests possible motives for violence committed by larger groups of individuals or states. The nature of the different types of violence can be divided into physical, sexual, psychological or involving deprivation or neglect. (WHO World report on violence and health, 2002)

Collective violence occurs every day in many parts of the world. Collective violence includes violent conflicts between nations and groups, state and group terrorism, rape as a weapon of war, movement of people displaced from their homes and gang warfare. The health effects in terms of deaths, physical illness, disabilities and mental distress are immense. The violent conflicts are rooted deep and may be a result of a long-standing tension between groups. Risk factors include a lack of democratic processes and unequal access to

power, social inequality and control by a single group of natural resources such as diamonds or oil. Early signs of violent conflict situations can often be detected in the health sector. Health care workers have an important role in drawing attention to the manifestations. (WHO, 2002)

2.4 Health Consequences of Violence

Violence is a serious risk factor for health-related symptoms, both in men and women and of all ages. The time of exposure to violence could be an important factor in determining the long-term health risk. Violence experienced during childhood and adolescence can be particularly damaging to their health over time. This is because personal and psychological resources that guide cognition and decision making and ultimately influence health, are developing in younger individuals. (Olofsson, Lindqvist, Shaw et.al., 2012)

Children and adolescents exposed to interpersonal violence pose a threat to physical, emotional and interpersonal safety and security. It is well indicated that emotional insecurity increases risk for psychological and adjustment difficulties in childhood as well as later in life. People that have survived interpersonal violence pose a risk, not only for general psychological distress following the violent event, but also conditions such as posttraumatic stress disorder, PTSD, depression and substance abuse. Youth exposed to violence are especially at risk for behavioral problems, such as acting out, drug and alcohol use and risky sexual behavior, all of which pose challenges for caregivers. (Jobe-Shields, Williams & Hardt, 2017)

PTSD is a psychiatric disorder, involving symptoms such as dissociation, feelings of shame, flashbacks, social isolation and changes in the sense of self. Feelings of shame affect stability and social functioning and disturbs cognitive processes and behavioral intentions. PTSD is related to violence as it appears to describe the symptoms of inescapable and repetitive abuse. It is indicated that PTSD is prevalent and might be present in 34% - 84% of victims of violence. Prolonged trauma with repetitive exposure can result in more severe psychobiological disruptions, including complex PTSD. Complex PTSD has additional symptoms such as changes in self organization, emotional disturbances and disturbances in

relationships. The dissociative symptoms may be triggered by keeping oneself safe and distant from harmful emotions. In a study to explore to what extent practitioners working with domestic abuse was familiar with PTSD and complex PTSD, it was found that practitioners have limited understanding of this matter. The lack of understanding of domestic abuse and PTSD among practitioners might impact the treatment and work with patients. (Kozlowska, 2020)

Violence is usually unexpected and consequences cannot be prepared for. In addition to possible physical and financial consequences, a victim often displays psychological and social consequences. Reactions to a crime are normal and a lot influences how the person reacts, for example their own history, life situation, energy resources and method of dealing with the experience. A victim can experience strong emotions that are brought on by the thoughts of what could have happened. Victims of violent crimes are affected in various ways, some go through a traumatic crisis while for others, it only causes mild concern. Insecurity, fear and anxiety are common feelings, the experience of a crime can feel unreal. It is common that the victim has feelings of guilt about what happened, as if the victim provoked the violent act, therefore it can also feel shameful for the victim to talk about it. The victim might be afraid of the offender, the thought of the encounter at trial may be overwhelming. (Rikosuhripäivystys/Brottsofferjouren, RIKU, 2020)

Trying to ease the pain, the victim may deny the experience as a defense mechanism. The victim can suffer from depression, eating disorders or self-destructive behavior. Suicidal thoughts and attempts as well as alcohol or drug use may occur. The victim can feel powerless and isolated, have emotions of anger, aggression and anguish. The ability to think and act rationally may weaken and to understand information may be difficult. A victim of sexual violence may take a shower immediately, despite the fact having heard it should be avoided before seeing a doctor. (Rikosuhripäivystys/Brottsofferjouren, RIKU, 2020)

Stress is a known risk factor for high blood pressure. In a study measuring the effects of intimate partner violence, IPV, in adolescents and young adulthood on blood pressure and incident hypertension, it was found that exposure to severe victimization and severe perpetration implicates higher blood pressure in men. This study involved 9157 participants in the USA National Longitudinal Study of Adolescent Health. Blood pressure was measured and the frequency and severity of exposure to intimate partner violence was assessed. This study also includes variables such as sex, ethnicity, educational attainment and financial

distress. Data was statistically analyzed using chi-square test and logical regression. The study found an association with high blood pressure in men exposed to IPV victimization and perpetration. Regarding women, there were no associations found linking high blood pressure and IPV. Women report greater distress and are more likely to smoke and use alcohol as a response to violence. Changes in blood pressure as an association to IPV can although be seen in older women who may have had longer exposure to violence than younger women. The findings of the study are consistent with existing literature. (Clark et.al. 2014)

Consequences of violence can be immediate and direct, long-term, indirect or psychosomatic. Half of women in abusive relationships sustain physical health consequences, these injuries vary from minor to life-threatening. A study investigating associations between IPV and traumatic physical injury among women between 15-49 years of age in Nigeria, found that bruises were the most common physical consequence of IPV. This study used cross-sectional data from the Nigeria Demographic and Health Survey conducted in 2008 to identify women exposed to IPV. A domestic violence questionnaire was used when collecting data material. Over 4000 women participated in the survey. Multilevel logistic regression was used to statistically analyze the material. Of the women participating, 26% experienced bruises as a consequence of IPV, this is followed by sprains, dislocations or minor burns with 12%. Less frequent consequences were wounds, broken bones, broken teeth, severe burns or other serious conditions, experienced by 6% of the women. (BMC Women's Health, 2011)

2.5 Violence in Finland

Violence against women is a widespread issue in Finland. According to the National Crime Victim Survey from 2018, every tenth woman had been subjected to physical or sexual violence in the past year, and five percent of women had been exposed to violence by a current or former partner. Finland has prepared a program to combat violence against women. The focus of the program is to prevent violence, improving the competencies of the criminal prosecution authorities and more efficiently counsel and help offenders who use violence. Several actions in the program focus on prevention measures aimed at young

people. For example, trying to influence actions against sexual harassment through a campaign that highlight's the role of someone witnessing sexual harassment happening to someone else. Young people also receive information about being in safe relationships. Measures are also taken to raise awareness regarding honor-related violence. (Oikeusministeriö /justitieministeriet, 2020)

In 2019 in Finland, 10 600 offences involving domestic violence reached the attention of the authorities, this is an increase of 7 percent from the previous year. The majority of victims of domestic violence were women in the ages 25-34. Although, for those under 18 the majority of victims were boys. The cases of violence brought to the authorities against minors have doubled over the past decade. However, violence is likely underreported due to the unlikelihood of a spontaneous disclosure, meaning an accurate number of victims are difficult to quantify. In 2019 there were a total of 18 intimate partner homicides in Finland. This refers to a person killing someone they have dated or a current or former spouse. In 80 percent of these cases, the relationship ending in homicide had previously been violent, often over a longer time. (National Institute for Health and Welfare, THL, 2021)

In 2018 in Finland, 95 cases of violent crimes resulting in death occurred, this is an increase of 28 percent compared to the previous year. This was a break of the two decades long decrease in deadly violence. In Finland, violence with fatal outcome occurs mostly among alcohol intoxicated men. In relation to the population, it is estimated that the occurrence of deadly violence in Finland is lower than in Russia, but does not differ considerably compared to the Nordic countries in the west (Ministry of the Interior, 2019)

Over 35 000 violent crimes are brought to the authorities' attention in Finland every year. These crimes involve assaults, homicides and sex offences. Concerning the sex offences in Finland, in year 2020, there were over 4 400 offences reported to the authorities of which almost half were directed towards children. This number has increased in the previous years. Sex offences include harassment, sexual abuse, coercion into a sexual act, rape and sexual abuse of a child. Sex offences are underreported, this can be due to fear or feelings of shame for the victim. It is also estimated that children are susceptible to sexual acts online every day. If the sexual act towards a child is performed by an adult, it is a crime, no matter if it occurs in an online environment. Sexual harassment, an act that violates a person's sexual self-determination, became punishable by law in Finland in 2014. (Poliisi, 2020)

A study conducted in Finland aimed at describing frequency of visits to the emergency department for women affected by physical intimate partner violence as estimated by health care professionals. Data for the survey were collected from 28 emergency departments in 13 different Finnish hospital districts. The collected data was analyzed using statistical analysis and qualitative content analysis. It was found that 48 % of the healthcare professionals reported having encountered women exposed to IPV at least once a month, some participants even reported having encountered the same women repeatedly visiting the emergency department for IPV related injuries. The study found that health care professionals with training on violence, identified women exposed to IPV more often. To improve identification of IPV, more training for health care professionals is required. (Leppäkoski, Åstedt-Kurki & Paavilainen, 2010).

2.6 Forensic Care in Finland

The purpose of forensic care is different around the world, forensic nursing care in Finland is mostly about the psychiatric care and evaluation given to offenders with mental illness. A person who has been affected by violence in Finland, are usually referred to Victim Support or the shelters existing that provide a safe place free from violence. A lot is depending on the knowledge possessed by the health care professionals.

2.6.1 The Care and Support for Victims

Various patients can have a background of violence. Nursing professionals are on the front concerning identification and intervention when a patient might have been exposed to violent acts. The health sector is vital in preventing violence, helping to identify abuse early, provide necessary treatment and to refer patients to appropriate and informed care. A patient must feel safe, be treated with respect, given quality and informed support and not to be stigmatized. Identifying violence in health care is difficult because of patients' denial of violence, particularly male victims may be reluctant to report violence due to fear of being

rejected, humiliated and ridiculed by the professionals in healthcare. Male victims can feel they are being blamed and labelled by professionals. Healthcare professionals often have some stereotypical thoughts concerning patients who experience interpersonal violence, therefore it is important to educate staff about violence dynamics. Training is necessary in identifying violence and gaining knowledge regarding how to ask about it. This training improves healthcare workers' confidence, practice and skills in identification and responses. (Kivelä, Leppäkoski, Helminen et.al., 2017)

A person exposed to violence often primarily seek support from family and friends rather than institutions or organizations. The help being sought for more serious and common violence is increasing. Patients with violent experiences have more hospital visits and the average duration of hospital care is longer and medical treatment expenses higher than patients with no experience of violence. Some victims of violence have found it difficult to access the healthcare services, this can be due to inappropriate responses by professionals, discomfort with the healthcare environment, perceived barriers to disclosing violence and a lack of confidence in the outcomes of disclosure to a healthcare worker. Health professionals should be encouraged to focus on the overall physical and mental well-being of the victims of violence and their families. Professionals can alleviate feelings of fear, shame and isolation by creating a supportive and non-judgmental caring environment that is free of any prejudice. (Kivelä, Leppäkoski, Helminen et.al., 2017)

A Seri support center for victims of sexual violence was first opened in Helsinki in 2017 and today there are 10 support centers in Finland. A referral to the center is not required. The Seri support center is open for all victims of sexual violence regardless of gender. The support center offers psychological and social support to process the traumatic event. They also perform the forensic medical examination, provides medications, vaccinations and emergency contraception that might be needed. The Seri support center is staffed with physicians, nurses, crisis nurses, social workers and sexual counsellors. The staff is trained in how to approach and care for victims of sexual violence. The support center also cooperates with other organizations that provide support for victims. (Turku University Hospital, 2020)

Victim Support Finland, RIKU, is an organization that is based on a cooperation agreement, it was started in 1994. RIKU is maintained by the Finnish Red Cross, the Finnish Association for Mental Health, the Federation of Mother and Child Homes, the Mannerheim League for

Child Welfare, the Finnish Federation of Settlement Houses and the National Church Council. RIKU is a member of Victim Support Europe, VSE, advocating on behalf of all victims of crime. The main operation of RIKU is to improve the position of the victim of crime and their loved ones, and the witness of the criminal act by producing support services. One method used is working in groups, including those to improve the position of the victim together with the authorities and other third sector operations. RIKU's main actions are to give statements on the position and needs of the victim, training, communication, promotion of research concerning the position of victims of crime and to participate in public debates. They offer practical advice and psychological support and help the victim to take actions according to his/her rights and to support in coping with the experience of crime. All the operations are based on professionally guided voluntary work. The aim is to provide appropriate, humane and equal services to victims. The work principles include respect for the victim's right to self-determination, observing confidentiality and to treat all victims equally. RIKU produces various guides and other material that can help victims and their loved ones. (Rikosuhripäivystys/Brottsofferjouren, RIKU, 2020)

When a person becomes a victim of a violent crime, it is important to receive help as soon as possible. The first days after the experience may not feel like much. Shock protects the victim's mind from stressful emotions. If the victim talks about the experience and the emotion it has caused, the coping process can progress better and quicker. Some victims can feel it is helpful to read, being outside or to listen to music. RIKU offers support persons to help both psychosocially and with handling practical matters such as finding a lawyer. (Rikosuhripäivystys/Brottsofferjouren, RIKU, 2020)

The Act of reimbursement out of State funds for providers of shelters for victims of domestic violence (1354/2014) took effect in January 2015. The responsibility is on the state to finance the services provided. The Finnish institute for health and welfare, THL, is responsible for the national coordination of the shelters for those affected by violence. A shelter is a place where victims find a refuge from violence and also get help on how to stop it. Victims get support, guidance and counselling from professionals at the shelter and also assistance and information for dealing with practical arrangements. The length of stay at a shelter is individual, but it is meant to be a short refuge. It is possible to go to a shelter and be anonymous and the stay is free for the client. A person may not only seek a shelter for physical violence, but also for threats of violence. Anyone can reach out to a shelter if they

are concerned about their own or a client's situation. (National Institute for Health and Welfare, THL, 2015)

At the shelter, the staff discusses with the client and explores what kind of support is needed. The staff collaborates with the municipality and other service providers if necessary. The municipality is responsible for providing community care and further support after the person leaves the shelter. The social and healthcare staff at the shelter complete a risk assessment to determine how dangerous the situation is. The staff should make up a safety plan for every person at the shelter. The risk assessment and safety plan are a measurement for both the client and staff to understand the danger violence contributes. If a person is not safe at home, a place in a shelter must be arranged immediately. (National Institute for Health and Welfare, THL, 2015)

Nollalinja, started in 2017, is a service with low threshold for victims of violence in Finland. The Finnish Institute for Health and Welfare conducted and evaluation study to examine the underlaying factors and content of over 10 000 calls to Nollalinja. It was found that one third of the callers used the phone line as the first service to seek help for domestic violence. The majority of the calls concerns violence within a couple relationship and 9 out of 10 victims are women. The helpline is available 24 hours a day, is free of charge and the call is anonymous. They offer support in Finnish, Swedish and English and can also interpret other languages such as Arabic, Somali and Russian. It is expected that the calls to Nollalinja will continue to increase because of the expanding awareness of the helpline. (Finnish Institute for Health and Welfare, THL, 2020)

A Finnish research and development project (2008-2013) aimed at improving the preparedness of the social and healthcare professionals to manage domestic violence. The focus was on evaluating how well interprofessional education (IPE) provides knowledge and skills for identifying and intervening in domestic violence. It was also assessed whether IPE could improve collaboration among social and healthcare professionals and other support providers. A previous baseline staff survey (Leppäkoski et.al, 2012) indicated that healthcare professionals found it difficult to identify and intervene in domestic violence. A major barrier was identified to be lack of education and training. IPE intervention is when two or more professionals learn from each other to improve collaboration and the health of victims of domestic violence. The data was collected orally and in written form and qualitative content analysis was used for analysis. It was found that IPE is useful for

improving interprofessional collaboration in treatment of victims. In the study it was discussed that it is difficult to intervene in domestic violence because of a lack of services to refer victims to. Organizing services for victims is on municipalities' responsibility and despite being invited to the study, decision makers did not participate. Managers should make sure domestic violence training is included in the annual planning. This study is consistent with previous literature. (Leppäkoski, Flinck & Paavilainen, 2015) This study was conducted a decade ago and new services has been organized since. However, this study shows the need for services and continuous training in violence.

2.6.2 The Care Given to Offenders

Mental disorders are linked to some offence types, in Finland especially regarding violence. Many of the mental disorders have been linked with poor neuropsychological performance. Neurocognitive deficits are common among male offenders and it seems to be associated with a higher risk of antisocial activity. From 5% to 49% of the male prisoners taking part in a study, marked neurocognitive deficits in test measuring motor dexterity, visuospatial/construction skills, verbal and visual memory and attention shift. Among other studies measuring different offence categories, it was found that seriously violent offenders had impairments in shifting attention. (Tuominen, Korhonen, Hämäläinen et.al., 2014)

Offenders sentenced to prison are expected to participate in an accredited program related to their offending. For some offenders, their release may depend on program participation. Although, the programs rarely take in consideration or offer training in executive or other neurocognitive skills. The cognitive skills program is used to learn offenders about the impact of thinking about their behavior and emotions. The program also helps the offenders to develop better problem - solving and interpersonal skills. It is widely recognized that prisoners have a high prevalence of mental disorders. (Tuominen, Korhonen, Hämäläinen et.al., 2014)

The Health Care Services for Prisoners, provide health care to all prisoners in Finland. They offer most of the primary health care services, oral health care and psychiatric specialized medical care and have expertise in somatic care, substance abuse and mental health care. The aim of the administration is to provide the world's best health care services for prisoners. The administration of the Health Care Services for Prisoners operates under the National

Institute for Health and Welfare (THL) and is in close cooperation with the Criminal Sanctions Agency. (Health care services for prisoners, VTH)

In Hämeenlinna, the Prison Hospital led by general practitioners, provides healthcare to prisoners, this includes multidisciplinary treatment and rehabilitation for somatic illnesses. The hospital also provides substance abuse related psychiatry for pregnant women and patients with severe withdrawal symptoms. Meanwhile, the Psychiatric Hospital for Prisoners is an acute hospital that provides services nationwide for prisoners. This hospital has one unit in Turku and one unit in Vantaa, but the hospital provides outpatient services to local prisons. The services include periods of care, examination periods for advanced ADHD diagnostics, mental examinations, statutory danger assessments and violent risk assessment, initiation of opioid replacement therapy as well as assessment periods for the statutory medical treatment of sex offenders. (Health care services for prisoners, VTH)

There are two state mental hospitals in Finland that are responsible for providing high-quality, specialized forensic psychiatric services and mental examinations, they also train personnel. There are three types of patients admitted having a history of violence. The first group includes patients with a psychotic disorder, who have committed a severe crime but could not be found guilty by reason of insanity. The second group consists of patients with psychotic disorders for whom treatment is difficult or dangerous to implement in a local community hospital. The third group are patients undergoing forensic mental examinations. Over 90 percent of forensic mental health patients have schizophrenia and have either been found not guilty due to insanity, or are considered too dangerous to treat in other hospitals. Most of the patients have a history of extreme violent behavior that is continuous despite regular treatment. Aggressive acts and suicide attempts are usually sudden and unpredictable. (Askola, Nikkonen, Putkonen et.al., 2017)

In Finland, there is help available for people who wants to stop using violence. There are tests online where perpetrators of violence can assess their own situation and learn how to take responsibility for the violence they have used. The help offered aims at learning the perpetrator to recognize signs and emotions that precede violence and how to control the agitation with different methods. In many cases, the violence one perpetrates is based on the person's life pattern, violence may have been current since childhood. The Federation of Mother and Child Homes and Shelter provide support for perpetrators wanting to get help to end their violent behavior. The support involves discussion about the violence, support

groups, conversations with the family and help in dealing with emotions causing violence. (Nettiturvakoti, 2021)

The Miessakit Association is a non-governmental association that provides services for men supporting the psychological and social growth. The association provides group activates for men where they can discuss their lives and the challenges they face. A service they provide, Lyömätön Linja, is to help men to stop using violence by using individual psychotherapeutic work (Miessakit Association, 2021). Maria Akatemia is a non-profit organization in Finland. The aim is to promote well-being and human inner growth. The organization specializes in recognizing and helping women's inner health and violence. The Demeter program was started in year 2003 and the goal is to prevent violence by women (Maria Akatemia, 2021).

2.6.3 International Comparison

Forensic nursing is a cross-cultural profession, despite this, literature shows significant differences internationally regarding the role, scope of practice and qualifications. For example, in the United Kingdom and in many European countries, a forensic psychiatric nurse works mainly with mentally disordered offenders. In the USA though, the work focus is on the victims of crime. In Finland, there are two state mental hospitals, where the main function is to perform forensic psychiatric evaluation and to perform treatment. Despite the challenges of forensic nursing, there is no national educational standard for the competences of forensic nurses in Finland. (Koskinen, Likitalo, Aho et.al., 2013)

In Australia, forensic nursing is an established and growing specialty area, it is an area that is beginning to expand because of the growing number of forensic nursing courses being developed. It is recognized that nurses play an important role in helping victims of crime (Keast, 2020). South Africa has high rates of crime but low rates of conviction, contributing to this is the poor collection of evidence among health care professionals. Research on forensic nursing in South Africa reveal that nurses seldom or never perform forensic tasks, this is due to lack of training and knowledge in forensic nursing care (Abdool & Brysiewics, 2009). In Norway, there are receptions offering holistic care for victims of sexual assault. The physicians and nurses offer forensic examination and documentation. Although little is known about the tasks performed by registered nurses and the competences, they possess in

the Norwegian sexual assault reception center. A study shows that a fourth of the nurses in the sexual assault reception wishes to have a dedicated education program specializing in clinical forensic medicine (Gustavsen, Baste & Alsaker, 2020).

2.7 Screening for Violence

Nurses have an important role in addressing violence. Early identification can reduce further consequences and prevent future violence. It is unfortunate that nurses and health care professionals do not routinely screen for violence, child abuse or neglect. Even in situations where it is obvious a violent act caused an injury; professionals do not ask or identify violence. It seems the focus for nurses is on fixing the injury while dismissing the violence. The reluctance and discomfort for professionals asking about violence is ascribed to lack of time, lack of training and effective interventions, partner presence and the complexities of providing whole family care. Training and organizational changes can rise the knowledge of violence and how to identify presentations of violence, as well as nurses' confidence to ask victims about violence. The identification of violence can be difficult, and a lot of nurses are unaware of written guidelines and the legal aspects of falling victim to violence. (Leppäkoski, Flinck & Paavilainen, 2014)

Shame can be conceptualized as an intense and painful emotional experience. An inherent aspect resulting from shame is the urge to hide and cover oneself of what is seen as bad. The shame that follows the person exposed to violence can be disempowering, deeply distressing and destructive to one's sense of self and place in the world. For victims of violence, a disclosure of their experiences can be the beginning of healing and recovery. Shame can be a barrier to disclose the violence and therefore limiting help-seeking. For health care professionals to understand operations of shame and how it affects a disclosure can give insight in how to better support victims. Taylor and Norma's (2013) qualitative study show that 76% of women reported that shame was the most frequent reason for not disclosing violence and seeking help. (MacGinley, Breckenridge & Mowll, 2019)

Health care professionals are in a unique position to raise awareness and break the silence that is associated with violence and abuse. Violence is prevalent in our society, a lot of patients are or have experienced it, and it is known to have negative consequences on well-being. If violence is occurring in the patient's life, it is a factor to consider in health care planning. These are reasons to consider universal screening of all patients regardless of risk factors, moreover a casual disclosure from a patient affected by violence is unlikely. Nurses and other health care providers are, however, more likely to screen for violence when they have had training in screening, feel competent and receive support from the institution. It is also important that nurses believe screening for violence is within their role as a nurse and part of their responsibility. Universal screening would encounter the isolation commonly accompanied with violence and create an atmosphere legitimizing communication about violence if a patient chooses to discuss it. Sufficient training in universal screening would bring confidence in the nurses' ability to respond to patients disclosing violence. Asking questions about violence communicates that the nurse recognizes violence as a public health issue and a willingness to discuss violence at any time during the treatment of the patient. Table 1 shows suggested health care responses to perceptions and myths about violence. (Davies, Todahl & Reichard, 2015)

Table 1

Suggested Health Care Responses and Myths about Violence

Violence & Myths	Effect on victims of violence	What Research Show	Suggested Response by Health Providers
Asking the patient about violence will damage the nurse/patient relationship	Reduced likelihood for nurse to screen for violence and decrease victims' comfort for seeking support	A nonjudgmental attitude, privacy and explanation for the purpose of screening, the patients, victims or not, are usually supportive of the violence screening	Screen all patients for violence
Female patients do not want a male nurse asking about violence related history	Can prevent male nurses to screen female patients, further decreasing the patient's access to support	A lot of women have no preference discussing violence with male or female healt care provider, only a small number report greater comfort with one of the sexes	Screen all patients for violence, provide options to be screened by either male or female health care provider
Only women are affected by violence and sexual assault	Can lead to male patients not being screened for violence, which reduce intervention opportunities and increases the shame for male victims	It is estimated that 1 out of 14 men has experienced interpersonal violence at some point in their life	Screen both female and male patients for violence
The time it takes to screen for violence prohibits nurses from screening	Discourages nurses from screening and reduces chances of identifying violence and provide interventions for victims	Violence screening is not necessarily time consuming, only one screen question can increase violence detection rates	Use screening tools best administered in that setting and for the population it serves

Comment: This table is a modified version of the table from "Creating a Trauma-Sensitive Practice: A Health Care Response to Interpersonal violence", av J Davies, J Todahl and A Reichard, 2015, *American journal of lifestyle medicine, 11*(6), 451–465

2.7.1 Screening in Finland

There are forms developed for professionals in healthcare to screen for and document patients that are victims of violence. Professionals using the forms should be educated in interpersonal violence and filling of the forms should always happen in interaction with the patient. Filling in the form is an intervention itself to end the violence. As mentioned earlier, only few victims disclose their abuse. Professionals should ask directly about violence and if needed, be able to describe different sorts of violence. The initial question in the screening form (see appendix 1) is if the respondent has been exposed to physical, emotional or sexual violence and if this affects the respondent's health and wellbeing. The professional shall listen to the patient and be aware of the emotional state, such as feelings of shame, fear and trauma. Before going on with more in-depth questions about the abuse, the atmosphere should be trustful and safe. It is also important to establish a written personal security plan with the patient, about where to go and how to get there if the patient again is put in a violent situation. (National Institute for Health and Welfare, THL, 2021)

The RAP – manual is used by health care professionals as a guide in acute care for rape and sexual assault victims. The manual includes information for victims, instructions for health care providers on the forensic medical examination and instructions for a psychiatric evaluation for the victim before a trial. The RAP – manual also consists of information for friends and family about being a victim of rape and sexual assault. MARAK, see appendix 2, is a risk assessment form and is only meant to be used by professionals who have gotten training in the MARAK method. This form is used to assess whether a person is in risk of being a victim of interpersonal violence at home. Using the MARAK method, measures are planned by a multi-professional team to ensure safety for the victim. In 2019, a total of 203 cases of severe violence were referred to a regional MARAK working group. These cases were mostly referred from shelters and social work. The majority of the victims referred to MARAK were women having children living in the same household. (National Institute for Health and Welfare, THL, 2021)

3 Theoretical Framework

The theoretical framework of this thesis aims at providing a rationale for predictions about the caring relationship between the nurse and a victim of violence. The theories discussed in this chapter all belong to the discipline of nursing and will give the reader a structural guide on how this thesis is epistemologically, methodologically and analytically approached. I have chosen caring science, which is a fundamental part of nursing, Peplau's (1952) theory of interpersonal relations and lastly the symphonological bioethical theory by G. Husted and J. Husted (1991).

3.1 Caring Science

This thesis is written within the research field of caring science. This field is based on a humanistic and holistic approach. Lifeworld, lived body, health and well-being, suffering and caring relationships are central concepts in caring science. For a caregiver to get a greater understanding about the patient and their life situation, knowledge must be developed. To be able to meet the patients' needs, the caregiver must continuously work to gain knowledge and understanding. The meaning of caring as well as the meaning of health and well-being is paramount for caring science. The aim of caring is to support and strengthen the health process of the patient. The caregiver's role is to support the patient's own capability, meaning the caregiver requires to adopt the perspective of the patient. The understanding is fundamental in establishing a caring relationship. (Hörberg, 2015)

3.2 Peplau´s Theory of Interpersonal Relations

Peplau (1952) published her book Interpersonal Relations in Nursing, it describes a definition of nursing as an interpersonal, investigative, nurturing and growth-provoking process. Peplau (1952) views theories of interpersonal relations relevant for work within healthcare. She found that the interaction occurring between a care provider and patient had

a qualitative impact on the patient's outcomes. Peplau (1952) identifies issues in health care practice, such as frustration and conflicting feelings. The issues must be dealt with to be able to facilitate a healthy development of patients. Healthcare professionals with a deep knowledge and ability to use applications of theories about interpersonal relations will have increased possibilities to understand the patient's problems. Interpersonal aspects of giving nursing care and the importance of understanding expressions of issues, such as frustrations, human needs, dreams and possibilities are vital in health care. (Nyström, 2007)

The theory of interpersonal relations describes the importance of the nurse-patient relationship. Stranger, resource person, teacher, leader, surrogate and counselor are nursing roles that Peplau described in her theory. Peplau's work on the relationship between a nurse and a patient is internationally known and continues to influence nursing practice and research. (Alligood p. 12-13, 2018)

3.3 Husteds' Symphonological Bioethical Theory

Agreement is a defining word for symphonological bioethical theory. This theory was developed by two theorists, G. Husted and J. Husted, and first presented in the book Ethical Decision Making in Nursing (1991). Symphonology is described by the authors as the study of agreements and the necessary elements in forming an agreement. In health care, this theory focuses on the agreement between health care professionals and patients. The agreement requires standards of behavior, pre-elements necessary to agreement and professional interaction that can be possible by a contextual understanding and the application for ideal interactions in the health care setting. Bioethics is about the ethics of interactions occurring between a patient and a professional within health care. A nurse has an ethical responsibility, that through interactions, encourage and strengthen the qualities in a patient that serve life, health and well-being. (Alligood p. 418 - 421, 2018)

All agreements have a final value that can be attained through interactions that are possible by understanding. Context is fundamental when determining what actions are ethical within the nurse - patient agreement. The theory has three elements of context: the context of the situation, the context of knowledge and the context of awareness. The first context includes the facts relevant to a situation to get an understanding and to be able to act effectively. The

knowledge is all that is known about the facts of the situation. The context of awareness is an integration of the awareness known about the facts of the situation and the preexisting knowledge about how to deal with the facts. The decisions of nurses must be made with ethical consideration since it can profoundly affect the lives of the patients. Therefore, the symphonological bioethical theory has certain principles, these are autonomy, beneficence, fidelity, freedom and objectivity. Beneficence includes the idea to act according to the best interest of the patient. Fidelity in agreements in nursing is the commitment to the obligations that are required in the professional role. (Alligood p. 419 - 427, 2018)

4 Aim and Study Question

There is little research investigating the extent to which nurses in Finland are familiar with forensic nursing when caring for victims of violence. Repeated violence can take away a person's ability to function. Violence has serious implications for a person's health and entire life, this is why it is important for a victim to seek help and for healthcare professionals to have skills in how to approach these situations. This thesis was written to explore forensic nursing care for victims of violence from the perspective of registered nurses. The thesis consists of a qualitative study. The aim was to describe the experiences, including the preparedness and confidence when providing care for victims of violence.

The study question is:

- What are nurses' experiences of encountering victims of violence?

5 Method

In this thesis, a qualitative study approach consisting of a questionnaire was used to explore the forensic nursing care given to victims of violence. The method was used to gain a broad and deep understanding of how registered nurses' approach and care for patients that have been exposed to violence. The data has been analyzed using qualitative content analysis. The aim and the study question have determined the choice of method and data analysis. Table 2 display an overview of the study.

The study of qualitative research occurs in the natural setting of what is studied. The researcher tries to make sense of and interpret phenomena in the meanings that people bring to them. Qualitative data can be defined as detailed descriptions of situations, people, events, interactions and observed behaviors. Qualitative studies also involve direct quotations from people about their experiences, attitudes, beliefs and thoughts (Newman & Benz, 1998). Qualitative methods are flexible and iterative, meaning that according to what is learnt, the study questions and data collection can be adjusted and changed. Qualitative research has the ability to provide a complex description of how people experience a specific issue. Qualitative method is one way of conducting scientific research, consisting of investigations and systematically used procedures that seek answers to a question (Mack, Woodsong, MacQueen et.al, 2005).

Table 2. Overview of study

Design	Sample	Data Collection	Analysis
Qualitative	Registered nurses in Central Hospital (n=7), nurses from healthcare clinics (n=3) in Western Finland	Qualitative questionnaire containing two fictitious cases concerning interpersonal violence Case I: Intimate partner violence Case II: Community violence	Qualitative content analysis

5.1 Participants

Purposive sampling is one of the most common strategies used in qualitative research when choosing participants. This selects participants based on a criterion relevant to the research question. Sample sizes can be determined based on time and resources available. Purposive sample size is determined based on the theoretical saturation, which is when the new data collected no longer bring more information to answer the research question. To identify and enroll participants requires a recruitment strategy. This is a plan for screening for potential participants and number of people to be recruited. If the recruitment strategy is not working as well as anticipated, it is allowed to change the strategy as long as approvals are obtained. This is possible since qualitative research is an iterative process. (Mack, Woodsong, MacQueen et.al, 2005)

For the study, I wanted participants that were most likely to come in contact with possible victims of violence. Therefore, I decided to do my study in the hospital wards that deal with emergency care. Later in the process, I decided to include a healthcare clinic. The participants for the data collection were 7 registered nurses working in a Central Hospital in the Western part of Finland and 3 nurses working in a healthcare clinic in the same area. Including the healthcare clinic was decided after struggling to receive enough data material from the hospital. In one of the wards, 16 questionnaires were given but only one answered questionnaire was returned. This contributed to a lot of stress and many calls were made to search for another suitable place to find participants to conduct data collection. All of the healthcare clinics contacted were also in the middle of the hectic covid-19 vaccinations. In one place, the nurse dealing with research applications were also the main nurse in charge of the covid-19 vaccinations. After a lot of effort, 10 nurses participated in the study and provided enough data material to begin the qualitative content analysis.

5.2 Data Collection

In qualitative research, there are many different kinds of data collection methods, including structured or unstructured interviews, group discussions, case studies, open-ended surveys or questionnaires, observational studies and analysis of textual sources. Data collection in a qualitative study bring out narrative or non-numeric information. The data collection

attempts to gain access to the participant's view, without making any value judgements at the collection stage (Bowling & Ebrahim 2005, s. 215). A qualitative questionnaire uses open- ended questions to produce answers that aim at revealing opinions, experiences and narratives. A qualitative questionnaire can be iterative or modified to produce new information during the data collection. Qualitative questionnaires can additionally include quantitative questions to establish certain elements (Deakin University, 2021).

For data collection I decided to use a qualitative questionnaire, see appendix 3. The qualitative questionnaire contained two fictitious cases describing patients exposed to interpersonal violence. The cases were designed to create a context to which registered nurses can answer open-ended questions. The questionnaire initially begun with questions about the nurses' knowledge and experience about forensic nursing care. The qualitative questionnaires were printed and given to participants to answer when they saw fit. The answered questionnaire was collected after 2 weeks. One advantage of this method was that the nurses could complete the surveys at their convenience and they got enough time to reflect on the questions. The answers in the questionnaire were likely to contain rich data material if the nurses were expressive and cooperative. A questionnaire is quicker than other qualitative research methods and can reach a larger group of people, which help make the results more credible and valuable.

To get approval for the data collection, an approval form was filled and sent to the research nurse at the hospital. The approval form (appendix 4) was sent together with the qualitative questionnaire and the research plan. After receiving the answers from the hospital, I decided to extend my study to also involve participants from a primary healthcare organization in the same area. To get approval for the data collection in the healthcare clinic, I sent the required documents to the person in charge at the clinic. To collect the data, the questionnaires were printed and delivered to the wards together with a locked postbox to put the answered questionnaires in. Getting enough answered questionnaires from the hospital was a struggle, and is partly the reason why I decided to include a healthcare clinic. Including a healthcare clinic in the same area also gives a better understanding of the overall preparedness in giving care to people exposed to violence in the area. I received a total number of 10 answered questionnaires. Therefore, the analysis will be based on 10 answered questionnaires.

5.3 Analysis

The data has been analyzed by qualitative content analysis. This is a commonly used method when analyzing qualitative data in nursing science research. Content analysis represents systematic and objective means to describe and quantify phenomena. To do a successful content analysis, data is transformed into concepts that describe the research phenomenon. This is done by creating categories, concepts, a model, conceptual system or a conceptual map. For readers to be able to clearly follow the analysis and resulting conclusions, it is important to explain how the results were created. (Elo, Kääriäinen, Kanste et.al., 2014)

This is a method of analysis where the content of the message creates the basis for drawing conclusions about the matter. To do content analysis, there must exist a specific statement of the study or a research question. In content analysis, the collected information about the phenomena is converted into data that can be treated in a scientific manner. After formulating a research question and selecting an appropriate sample, the content categories can be developed. Content categories can be defined as compartments with specific boundaries where units of content can be coded for analysis. The main idea of content analysis is to develop a system of categories to classify the body of text. The content categories must be thoroughly defined to explain the material that is included in that category. For each category there are coded units. The units may be a word, letter, symbol, a short story or an article. The counting of units can be performed using time, space or frequency. For example, frequency is the number of times a given unit is figured in a text. Finally, the analysis of the collected material can start by a description of the main categories and later a more complex analysis comparing data sets. (Prasad, 2008)

After collecting the 10 questionnaires, the qualitative content analysis could start. After reading through all the answers, they were transcribed to one single document. The document was printed and each answer was cut apart. Some of the answers were similar and related to the same idea or thoughts, these developed a separate content category. Going through the answers thoroughly, subcategories emerged where the answers were more specific. The categories and subcategories were defined. During the analysis, the research aim and study question were considered and compared to the developed categories and subcategories. Citations from some answers were used to further describe the content of the categories.

5.4 Ethical Considerations

The qualitative study in this thesis is designed to follow the ethical guidelines presented by the Finnish National Board on Research Integrity. The ethical principles have been written in support of researchers and research groups in protecting the people participating in the research. The principles include respect for the dignity and autonomy of the participant. The rights of the Finnish constitution are held, these involve the right to personal liberty, integrity and privacy. The research should be conducted in such a way, that there is no significant risk, damage or harm caused to the research participant. (TENK, 3/2019)

Approval for data collection was needed. To gain approval for the data collection, an approval form, research plan and the questionnaire were sent to the research nurse at the hospital and to the research nurse at the healthcare clinic. All participants received information about the study before they participated. Participation was voluntary. Confidentiality was assured, and the results has been presented in a way in which individuals cannot be identified. The collected data was stored in a safe manner. Ethical considerations to discuss regards violence as a sensitive topic. Individuals that participated in the study may have their own experiences of violence, which could put them in a vulnerable situation bringing up unpleasant memories and feelings for them. It was important that participants were attentive to their own feelings. Participants were reminded in the questionnaire, that they decide themselves what experiences they want to share and what questions in the questionnaire they want to answer. All the answers were treated confidentially and the questionnaires were destroyed after the final analysis was completed.

6 Result

In the result part, I have presented the result and analysis of the collected questionnaires. During the analysis of the data, I searched for common thoughts, ideas and experiences to create content categories. The three main content categories are **Emotions**, **Caring Relationship** and **Cooperation**, each category contain two subcategories. The initial five closed questions of the questionnaire gave an understanding of the training and experience the participants have of forensic nursing care. Half of the participants have had some sort of training in how to approach a victim of violence, but most of the participants (80%) were not familiar with the terms forensic care or forensic nurses. Only one participant answered having gotten training specifically in forensic nursing care. Eight of the participants have previously cared for a patient they know to have been a victim of violence. Eight of the participants also answered having cooperated with the police when caring for someone.

6.1 Emotions

The content category **Emotions** presents nurses' emotions regarding violence and caring for a patient that has been exposed to violence. Reading the answers, it was clear that participants had very different feelings on their own preparedness and confidence when approaching and caring for a victim of violence. The category is divided in two subcategories; ***Ability*** and ***Victim Approach***.

6.1.1 Ability

The subcategory ***Ability*** refers to professionals' feelings toward their ability to care for a victim of violence. For both fictitious cases, the participants could choose a number from 1 to 10 how confident they would feel to care for that patient. The average score became 6,6 with the highest number chosen being 9 and the lowest 3. One participant answered having cared for several sexually assaulted victims. Regarding a sexually assaulted victim, one

participant expressed concern about never knowing what could trigger the patient. The most common thought among the participants were that no one could be fully prepared in caring for a victim of violence.

"*Tror aldrig riktigt man blir tillräckligt förberedd för såna saker.*" (Own translation: "*I do not think you ever get prepared enough for such things.*")

"Man vet aldrig vad som kan trigga patienten och man kan i värsta fall göra så att patient en inte vågar berätta." (Own translation: *"You never know what can trigger the patient, in the worst case you can make the patient afraid to open up."*)

6.1.2 Victim Approach

The subcategory ***Victim Approach*** is about how nurses feel towards approaching a victim of violence. Participants answered that violence is a very sensitive topic and that it can be difficult to approach victims. Participants were more suspicious of a victim that has been stabbed, saying that the lack of background knowledge about the patient would make them to be more cautious, one even questioned the safety and deemed the patient as perhaps being erratic. Most of the answers can be divided quite equally into those who would approach the patient as any other patient and those who would approach more receptive and with more sensitivity.

"Synen på patienten skulle inte ändras oberoende om patienten berättar eller ej. Vården är samma ändå. Berättar patienten tillkommer bara lite fler arbetsuppgifter." (Own translation: *"The view of the patient would not change regardless of whether the patient discloses the abuse or not. The care is the same anyway. If the patient discloses, it will only add a few more work tasks."*)

"Känsligt ämne och svårt att bemöta ifall man berättar om våld och på det viset söker hjäl p men endå ej vill anmäla." (Own translation: *"Sensitive topic and difficult to approach if the patient tells about the violence and seeks help but does not want to report it."*)

"Vården av patienten och bemötandet är lika som med alla andra patienter." (Own translation: *"The care of the patient and the approach is the same as to any other patient."*)

"Att man kanske inte vet allt om patientens bakgrund, är patienten oberäknerlig osv?" (Own translation: *"You may not know everything about the patient's background, is the patient erratic etc.?"*)

6.2 Caring Relationship

This content category **Caring Relationship** deals with the nurses' view on what is important in the relationship with the patient exposed to violence. The participants were united in what they regard as important when caring for the patient. The two subcategories are ***Victim Autonomy*** and ***Awareness***.

6.2.1 Victim Autonomy

The subcategory ***Victim Autonomy*** is about the patient's right to make decisions about their care. All participants emphasized the patients' rights to make decisions regarding their own care and wellbeing. Whether it involves doing forensic examinations, taking photos, reporting to the police or contacting close ones, it is up to the patient to decide. Participants answered that after giving the patient different options and information, there is not much else they can do in regards to the violence.

"Att inte tvinga fram någonting. Att berätta om vilken hjälp som kan fås, patienten väljer s edan själv vad hon gör med informationen." (Own translation: *"Not to force anything. To tell about the help offered, the patient then chooses what to do with the information."*)

"Att patienten väljer själv hur hon vill gå vidare efter att ha blivit undersökt och rekommenderad olika vårdåtgärder." (Own translation: *"The patient decides how to proceed after being examined and recommended different caring interventions."*)

6.2.2 Awareness

In this subcategory, ***Awareness***, it is presented what the participants thought were good nursing characteristics to show awareness and understanding of the victims' experiences of violence. A large part of the participants answered that the most important thing is to listen to the patient and what he/she needs. Some also mentioned to create a safe environment, where the patient does not feel judged. Participants also put emphasis on creating possibilities for discussion.

"Att man är lyhörd och en god lyssnare. Betonar att hon inte gjort något fel. Att det finns d e som vill hjälpa henne. Hon är inte ensam." (Own translation: *"To be receptive and a good listener. Emphasizes that she has done nothing wrong. That there are those who want to help her. She is not alone."*)

"Lyhördhet, att inte sätta ord i hennes mun och att inte på något som helst sätt döma eller anklaga/ifrågasätta henne." (Own translation: *"Being receptive, not to put words in her mouth and not in any way judge or accuse/question her."*)

"Lyssnar, frågar om det hänt flera gånger och om hon har fysiska skador. Frågar om hon vågar återvända till honom nu, tar reda på och ger info om alternativ för kvinnor i hennes situation. Frågar om jag kan ringa någon för hennes skull." (Own translation: *"Listens, asks if it has happened before and if she has any physical injuries. Asks if she has courage to return to him now, finds out and gives her information about alternatives for women in her situation. Asks if I can call someone for her."*)

6.3 Cooperation

Cooperation is essential in healthcare today. This category tries to explain the sharing of responsibilities regarding the patients' care plan. All participants mentioned cooperation in some way. Participants highlighted different interventions and what they would recommend a patient who is a victim of violence. The category is divided into ***Multiprofessional Teamwork*** and ***Nursing Actions***.

6.3.1 Multiprofessional Teamwork

The subcategory ***Multiprofessional Teamwork*** is about the work with fellow healthcare professionals. The answers of the questionnaire mention the work with the physicians, psychiatric nurses, social workers, police and also the teamwork with fellow nursing colleagues. To have another professional to discuss with regarding the care of a patient exposed to violence, is a way to ensure the best care for the patient. All participants mentioned the possibility to talk with a psychiatric nurse.

”Frågar om jag får informera läkare för att ha någon att kolla med hur vi går vidare. Vid behov kontaktas socialskötaren. Erbjuder samtalsstöd t.ex. genom att kontakta psyk.skötaren.” (Own translation: *“Ask if I can inform the doctor so I have someone to check with how we proceed. A social worker is contacted if necessary. Offers conversational support e.g. by contacting the psychiatric nurse.”*)

“Om patienten är stabil kan polisen komma in och ta bilder, annars tas det bara ifall kirurgen vill ha.” (Own translation:*”If the patient is stable, the police can come to take photos, if not, photos are only taken if the surgeon requires it.”*)

”Polisen tar kontakt om det är något de undrar eller vill hålla förhör. Läkaren bedömer om patientens tillstånd är sådant att han kan förhöras.” (Own translation: *“The police contact us if they have questions or want to have an interrogation. The physician assesses if the patient is in a condition for interrogation.”*)

”Rekommenderar psykologiskt stöd, ger info om vart personen kan vända sig för stöd och ytterligare information.” (Own translation: *"Recommends psychological support, gives information about where to get support and further information.”*)

6.3.2 Nursing Actions

This subcategory, ***Nursing Actions***, presents the procedures, information and recommendations participants would offer a victim of violence. All participants agreed that violence is a trauma that cannot be ignored and requires some sort of support. Participants answered that they would provide information about conversational support, shelters for

women and children, victim support, treatment for alcoholism and the possibility to do the forensic medical examination. Some participants pointed out to create a safe environment and to motivate the patient to courage and honesty.

”Ett övergrepp är ett trauma som man ej kan ignorera. Kräver någon form av åtgärd/stöd.” (Own translation: *“Assault is a trauma that cannot be ignored. It requires some type of intervention/support.”*)

*”Som vårdare bör man erbjuda hjälp och berätta om t.ex. kvinnohem. Man kan ta upp om alkoholproblem och berätta om olika behandlingar/program för alkoholism.” (*Own translation*: ”As a caregiver you should offer help and provide information about e.g. women’s shelters. You can bring up alcohol issues and provide information about treatments/programs for alcoholics.”*)

”Jag berättar att här finns hjälp att få, hon kan få prata med vår psyk.sköterare och vi kan även ta SERI-prov (seksuaalirikos undersökning) fastän hon inte väljer att anmäla i nuläget. Proverna kommer att sparas hos oss över ett år om hon väljer att anmäla senare. Hänvisar även till turvakoti/rikosuhripäivystys.” (Own translation: *“I say there is help available, she can talk to our psychiatric nurse and we can perform the forensic medical examination even if she does not want to report at the moment. The samples will be stored for over a year in case she decides to report it later. Also refers to women’s shelter/victim support.”*)

“Våga vara ärlig. Jag vill ej påverka patienten men jag kan motivera till ärlighet och ge säkerhet till patienten.” (Own translation: *“Encourage honesty. I do not want to affect the patient but I can encourage honesty and give safety to the patient.”*)

Most participants answered that they know about the forensic medical examination performed on victims of sexual assault, but many said that it is not done in their ward and therefore they do not know details about it.

“Jo har varit med flera gånger. Man bör vara noggrann för det är rättsmedicinskt och kän sligt för patienten.” (Own translation: *“Yes, have participated several times. You should be thorough because it is forensic and sensitive for the patient.”*)

”Ja, vet att en sådan kan göras, men den är inte aktuell på vår avdelning, har aldrig gjort en och vet inte detaljer kring den.” (Own translation: *“Yes, I am aware it can be done, but it is not current in our ward, have never done it and do not know any details about it.”*)

7 Discussion

This part includes a discussion about the results and methods used in this thesis. I have discussed how well the result of the study comply with the nursing theories mentioned in the theoretical framework; caring science, Paplau's (1952) theory of interpersonal relations and Husteds' (1991) symphonological bioethical theory. The result discussion includes reflection of the background information and how it correlates to the result of this study. The aim of the study was to describe the experiences, including the preparedness and confidence when providing care for victims of violence. The study question was; what are nurses' experiences of encountering victims of violence?

7.1 Result Discussion

It is important to listen to the story of a patient exposed to violence and to offer support and compassion. The results show that participants agreed that violence is a trauma that requires intervention and support. Although, everyone does not feel prepared or confident to care for a patient exposed to violence. In the study, the lowest number chosen on the confidence scale were 3, from a 1-10 scale. This participant may not know the interventions needed and the support available to care for the patient exposed to violence, perhaps because of lack of training in the subject. There was one participant choosing a 9 on the confidence scale. This participant had been trained in how to approach a victim of violence, knew about forensic nursing and had cared for several patients exposed to violence. Despite maybe not knowing everything about how to approach and care for a victim of violence, some participants specifically expressed that they would find out more information to give to the

patient. Forensic nursing care is based on caring science, meaning the care is holistic when the nurse recognizes violence as trauma that requires intervention, listens to the patient's story and finds out appropriate information.

The understanding of the patient's perspective and life situation is important in caring for someone exposed to violence and crime. It can be crucial for the recovery process and a part of giving successful care. Caring science was developed to alleviate suffering, protect and preserve life and to promote health and well-being. A nurse continuously has to work to gain knowledge and understanding about a patient's situation and needs. The field of caring science is founded on a humanistic and holistic approach. (Hörberg, 2015)

The symphonological bioethical theory is relevant in interactions between a nurse and a patient that is a victim of violence, considering the bioethical principles. If a patient has been sexually abused by someone close to them, the patient has the right to make decisions and to act independently. The decision and desire of the patient should always be given priority over, for say, a family member's desire. In any case of violence, the nurse or caregiver may find it more beneficial for the patient to file a report to the police, but it is the patient that has the freedom to decide what is beneficial. The patients have an understanding of their own surrounding and situation and have the right to maintain that understanding. In making ethical decisions, the nurse should only consider the patients' feelings. This was shown in the results, as all participants answered that no matter the context, it is always up to the patient what they decide. The patient is the one deciding how to proceed after being given information. One participant specifically wrote not to affect the patient but to encourage honesty and to create a safe environment.

Symphonology is about the necessary elements of forming an agreement. Bioethics is about the ethics of the interaction that occur between a nurse and a patient. Through interaction, the nurse has an ethical responsibility to encourage and strengthen the qualities in a patient that serves health and well-being. The symphonological bioethical theory has principles, these are autonomy, beneficence, fidelity, freedom and objectivity. Beneficeance is to act according to what is best for the patient and fidelity is about the commitment to obligations in the role of a nurse. (Alligood p. 418 - 427, 2018)

The theories fit well with the findings of the study. Participants emphasized creating a judgmental and safe environment for discussion with the patient affected by violence. It is

agreed that it is important to be a good listener and support the patient's wishes whatever the decisions may be. Around half of the nurses participating, would approach with more sensitivity after learning about the violence. Violence is a sensitive topic and should be approached as such not to compromise the caring relationship between the nurse and patient. This complies with studies; Kozlowska (2020), Kivelä et al. (2017) and MacGinley et al. (2019), stating that nurses can alleviate feelings of fear and shame by creating an understanding, supporting and non-judgmental environment. The theory of interpersonal relations (Nyström, 2007) states that the caring relationship with interactions between the nurse and patient have an impact on the health and well-being of the patient. Healthcare professionals with knowledge and ability to use theories of interpersonal relations have increased potential to understand patients' issues. Interpersonal aspects in nursing care include understanding the patient's expressions of frustrations, human needs, dreams and possibilities.

One participant specifically pointed out that if the patient discloses the abuse, it will add some more work tasks. In other words, this indicates that if the nurse screens and ask about violence, it leads to more work, which takes time. It is known that screening can be seen as time consuming and therefor nurses may not choose to acknowledge the signs of violence. An aspect that can be discussed is how it affects nurses' consciousness and feelings toward not having enough time to ask a patient about violence if there are clear signs of it. Previous research (Davies, Todahl & Reichard, 2015) points out that it is a myth that screening takes a long time. This prohibits nurses from asking about violence, even if one question is enough in detecting if interventions are needed. This also comply with the study from Leppäkoski, Flinck & Paavilainen (2014).

Among participants, they all have different experiences about caring for patients affected by violence. Furthermore, violence is a sensitive topic that can bring out certain perceptions. In the study, one example is that some participants seemed more cautious about a man being stabbed than a woman being sexually assaulted. This coheres with previous research about stereotypes among professionals regarding patients affected by violence. Kivelä et al. (2017) states that identifying violence in healthcare is difficult. This is partly due to the patient's denial of violence, especially male victims can be reluctant to report violence due to fear of being rejected and ridiculed by healthcare professionals. Male victims may feel they are

being blamed and labelled by nurses. Healthcare professionals often have stereotypical ideas about patients who experience violence.

The result of the questions regarding participants' training of forensic nursing care show that many are not familiar with the term forensic nursing. This is despite most participants have cared for a patient affected by violence. Half of the participants answered that they have gotten training in how to approach a victim of violence but 8 of the participants answered having cared for a victim of violence. This means nurses have cared for patients exposed to violence without having training in how to properly do so. All nurses should have some sort of training since violence is common and detrimental to an individual's health. It was a struggle getting enough nurses to answer the questionnaire, perhaps this could mean there is an even bigger percentage of nurses not knowing how to care and approach these patients. Kivelä et al. (2017) emphasizes that it is important to educate staff about violence. Training improves healthcare professionals' confidence, practice and skills in identification and responses. A study (Leppäkoski, Åstedt-Kurki & Paavilainen, 2010) showed that nurses with training in violence identified victims of violence more often than the nurses not trained.

This thesis was written using the term victim to refer to a person that has experienced violence. Being a victim has no implications of weakness or blame. The term is used in this thesis since the person that has experienced violence and discloses it to a healthcare professional, typically is not past the recovery of the traumatic experience but wish for help to get there. SAKI (2015) describes a victim as a person recently affected by violence and serves as a status that provides legal rights. A survivor is a person who has experienced violence and is going through or has gone through a recovery process.

7.2 Method Discussion

In the critical review the results of the qualitative study will be reviewed by reliability, validity, generality and objectivity. Strengths and weaknesses with the study is brought up and discussed. Reliability concerns data collection and analysis. Reliability is higher when there is a proper description of the research approach and analysis (Johannessen, Tufte & Christoffersen, 2019, p.220-221). To collect the data, a qualitative questionnaire was used. The questionnaire contained fictitious cases to provide a specific context that the participants answered questions to. The questionnaire was printed and brought to the wards. The

researcher has been unable to ask follow-up questions to unclear answers, which is a weakness when using a questionnaire as a data collection method. The participants answering the questionnaire were all nurses or health care nurses likely to have been in contact with a victim of violence, therefor their experiences concluded in the result is reliable. The participants were also given enough time to properly consider the fictitious cases and questions to give articulated and quality answers. The data was analyzed using qualitative content analysis. The method was properly described and presented in a simple way using headings, sub-headings and citations to make the text perspicuous.

Validity in a qualitative study refers to whether the research approach and result reflects the aim of the study and if this is a representation of reality. Methods that can be used to strengthen validity in qualitative research are triangulation and persistent observation. Triangulation is when the researches use different methods to explore a topic, or uses several new environments and places. Persistent observation is about spending enough time on the research field to learn the difference between relevant and irrelevant information. Validity concerns the truthfulness of the research findings (Johannessen, Tufte & Christoffersen, 2019, p.221). The aim of the study was to describe the experiences, preparedness and confidence when caring for patients affected by violence. The study question was about nurses' experiences when encountering these patients. Every participant has their own experience about caring for a victim of violence. This means all answers may not be the same but is still in the reality of the participant. The method of gathering data was expanded due to low participation among nurses in the hospital. Higher participation in the study would have been preferable since the answers to a few questions in the questionnaire were inadequate. Despite this, most answers were expressive and answered well to make a sufficient analysis. The study approach and result reflect the aim of the study.

Generality in research is about how well the established descriptions and concepts can be useful in areas that have not been examined. It is expected of qualitative research to bring a unique perspective. The objectivity of the study concerns to what degree other researchers who conduct the study gets similar conclusions. The researcher should be aware of possible prejudices, earlier experiences and perceptions that can affect the result (Johannessen, Tufte & Christoffersen, 2019, p.222-223). The results of the study can be applicable to areas that have yet not been examined concerning violence and forensic care. The study brings a foundation for researchers wanting to peruse research in forensic nursing care. Finding

information about how nurses encounter victims of violence was difficult, which implies that further research in forensic nursing care is needed. The researcher of this study has been aware of the possible prejudices and perceptions about the topic. The research approach and analysis are explained thoroughly, making it possible for another researcher to conduct a similar study. This study was conducted in an ethical manner. Participation was voluntary and it was decided entirely up to the participant what he or she wanted to share. Approval for the data collection was obtained by sending an approval form and research plan to the research nurse in the hospital and in the health care clinic. After concluding the analysis and presentation of the results, the answered questionnaires were demolished. Results have been presented in such a way, identification of participants is not possible. The study has been conducted in an ethical manner.

7.3 Conclusion

This thesis was written about the forensic nursing care given to victims of violence. Forensic nursing is the care given to victims, this developed as a response to a rise in the awareness of violence in society. The aim of the study in the thesis was to explore the experiences in giving forensic nursing care to victims of violence. This included nurses' experience of their own preparedness and confidence when caring for these patients. The expectations of the research were to answer the aim and research question and to gain knowledge to use in my future as a nurse. I encountered trouble in finding enough participants to my data collection. It is possible the struggle to get nurses to answer the questionnaire about forensic nursing care is based on limited knowledge in the subject. Some nurses answered they would approach a victim of violence as any other patient, perhaps this is due to a lack of tools and proper guidelines when caring for these patients. Another possibility is that nurses choose not to see the violence, they may be too focused on fixing the injury or they may even believe that it is not part of their job tasks. It was difficult to find previous research about forensic nursing care in Finland. This indicate that further research is needed, especially since the help being sought for violence is increasing. Additionally, a lot of material could not be studied because it only existed in the Finnish language. Violence is a broad topic and all nurses are likely to, at some point in their career, encounter a patient that happens to be a victim of violence. It is my understanding that all nurses should get training in forensic nursing care and how to approach these patients, not only because it is detrimental to a

person's health and well-being but because it is a nurse's duty and desire to treat the patient in a holistic manner.

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Appendix 1

INSTITUTET FÖR HÄLSA OCH VÄLFÄRD

Blankett för screening och kartläggning av närståendevåld (1)

Klientens/patientens namn:_____Personbeteckning:_____-_____

Verksamhets-/vårdenhet:_____

Anställd:_____

Datum: _____

Screeningsfrågor

1 Har du i en nära relation* i något skede av ditt liv varit utsatt för fysiskt, psykiskt eller sexuellt våld eller blivit illa behandlad?

Ja ☐ Nej ☐

2 Påverkar det våld du upplevt fortfarande din hälsa, ditt välbefinnande eller dina möjligheter att bemästra ditt liv?

Ja ☐ Nej ☐

3 Förkommer det för närvarande fysiskt, psykiskt eller sexuellt våld eller dålig behandling i dina nära relationer?

Ja ☐ Nej ☐

Om svaret på 2 eller 3 är JA ska du ställa följande kartläggningsfrågor:

Kartläggningsfrågor

1 Hurdant närståendevåld har du upplevt?

☐ **fysiskt våld** (t.ex. att knuffa, slå, sparka, lugga, dunka huvudet mot föremål, klösa, riva, att skaka spädbarn, använda skjut- eller eggvapen, hota om fysiskt våld)

☐ **psykiskt våld** (t.ex. att underkuva, kritisera, kalla vid öknamn, visa förakt, kontrollera, begränsa det sociala umgänget, visa stark svartsjuka, isolera, förstöra saker, skada husdjur eller till exempel att hota med självmord)

☐ **sexuellt våld** (t.ex. våldtäkt, våldtäktsförsök eller påtryckningar för att förmå en person till olika former av sexuellt umgänge eller att tvinga till sex, hot om sexuellt våld, sexuellt förakt, tvinga någon till pornografi, förbjuda användning av preventivmedel, tvinga till abort, begränsa den sexuella självbestämmanderätten)

☐ **illa behandling eller försummelse** (t.ex. att lämna ett barn, en åldring eller funktionshindrad utan vård, hjälp eller omsorg i situationer när han/hon är beroende av det, att skada en annan person med läkemedel, droger, kemikalier eller lösningsmedel.)

☐ **ekonomiskt våld** (t.ex. hindra självständig penninganvändning, hindra deltagande i ekonomiskt beslut eller tvinga någon att ge sina egna pengar till någon annan, hota med ekonomiskt våld eller utpressning)

☐ **kulturellt eller religiöst våld** (t.ex. tvinga på någon en religiös övertygelse, hota med våld eller utöva våld med hänvisning till religion eller kultur, exempelvis s.k. hedersvåld, hota med saker som hör till religionen)

2 När har du senast varit utsatt för sådant närståendevåld som du beskriver?

senaste dygn ☐ vecka ☐ månad ☐ år ☐ någon gång tidigare ☐

3 Hur ofta har du utsatts för närståendevåld?

bara en gång ☐ flera gånger ☐ många gånger ☐ ständigt ☐

4 Vem eller vilka har utövat våld mot dig?

_____

5 **Den här frågan ställs bara om närståendevåld förekommer för närvarande.**

Finns det i din familj minderåriga barn som har utsatts för våld?

Ja ☐ Nej ☐

6 **Den här frågan ställs bara om klienten/patienten är gravid.**

Har din make utsatt dig för våld under graviditeten?

Ja ☐ Nej ☐

*) Med närstående avses klientens/patientens familjemedlemmar, släktingar eller partner eller andra personer i jämförbara beroendeförhållanden eller i mycket nära känslomässiga relationer.

INSTITUTET FÖR
HÄLSA OCH VÄLFÄRD

Bedömning av hjälp/vård behovet (2)

Klientens/patientens egen bedömning (0 = ingen påverkan, 5 = stor påverkan)

Hur bedömer du att det närståendevåld som du har upplevt påverkar din nuvarande hälsa på skalan 0-5?

Bedömning:_____

Hur bedömer du att det närståendevåld som du har upplevt påverkar ditt nuvarande välbefinnande på skalan 0-5?

Bedömning:_____

Hur bedömer du att det närståendevåld som du har upplevt påverkar din nuvarande säkerhet på skalan 0-5?

Bedömning:_____

Hurdan hjälp skulle du önska i din situation?

Den anställdas bedömning

Bedöm risken för klientens/patientens hälsa, välbefinnande och säkerhet. Om du bedömer att någon av riskerna är betydande, ska du noggrant tillsammans med klienten/patienten gå igenom hurdana åtgärder man borde vidta för att främja hennes hälsa, välbefinnande och säkerhet.

Du ska alltid vidta åtgärder i följande situationer:

1. om klienten/patienten har berättat, att hon för närvarande är utsatt för våld i nära relation
2. om närståendevåldet som klienten/patienten i något annat skede av livet upplevt enligt din bedömning tydligt påverkar klientens/patientens hälsa och välbefinnande ELLER
3. om du bedömer att åtgärder är nödvändiga på grund av någon orsak eller oro för klientens/patientens nuvarande hälsa som väcks hos dig av hennes berättelse om våldet.

Utgående från bedömningen vidtas följande åtgärder:

I följande fall ifylls en separat blankett för bedömning av säkerhetsrisk:

- ☐ a) om klienten/patienten i sin nuvarande nära relation är utsatt för våld OCH om hennes egen bedömning av inverkan på den egna säkerheten är minst 3
- ☐ b) om klienten/patienten i sin nuvarande nära relation är utsatt för våld OCH om hon är gravid.
- ☐ en säkerhetsplan görs upp
- ☐ en plats på ett skyddshem ordnas för klienten/patienten
- ☐ kontakt tas med socialjouren i klientens/patientens hemkommun eller till nödcentralen
- ☐ en barnskyddsanmälan görs (görs ALLTID, om svaret på kartläggningsfråga 5 är JA)
- ☐ en föregripande barnskyddsanmälan görs, om klienten/patienten är gravid och hon för närvarande utsätts för våld
- ☐ uppgifter om klienten/patienten förmedlas till en MARAK-kontaktperson*, när risken för förnyat våld är förhöjd
- ☐ behandlingen av upplevelserna av närståendevåld fortsätter som en del av klientarbetet/vården
- ☐ klienten/patienten uppmanas att ta kontakt med läkare/moderskapspoliklinik
- ☐ du kontaktar eller uppmanar klienten/patienten att kontakta dejourerande kristjänst
- ☐ klienten/patienten uppmanas att kontakta polisen eller Brottsofferjouren för en brottsanmälan och/eller ansökan om besöksförbud eller konsultation med polis begärs eller en brottsanmälan görs med klientens/patientens samtycke
- ☐ du kontaktar eller uppmanar klienten/patienten att kontakta enhetens socialarbetare (t.ex. inom hälsovården eller hos polisen) för kartläggning av hemkommunens tjänster
- ☐ fortsatta åtgärder behövs inte (t.ex. för att klienten/patienten redan får hjälp, exempelvis i form av familjerådgivning, terapi, mentalvårdsbyrå, kommunalt socialarbete)

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*) MARAK-riskbedömningmetoden används i alla landskap (mer information www.thl.fi/marak). Nollinjen tel.080 005 005 ger stöd för klientarbetet och information om tjänster som focuserar på arbetet med våld i nära relationer på ditt område (www.nollalinja.fi).

Appendix 2

INSTITUTET FÖR HÄLSA OCH VÄLFÄRD

Checklista för riskbedömning (MARAK)

Offrets namn: Datum: Diarienummer:

Förklara att frågorna ställs för att ge skydd och trygga kundens säkerhet. Markera med ett x när frågan har besvarats på ett tillfredsställande sätt. I slutet av blanketten finns utrymme för kommentarer om du vill lämna kompletterande uppgifter om de svar du har fått. De uppgifter som har angivits i checklistan antas i allmänhet komma från offret. Om informationen har lämnats av någon annan ska det anges i kolumnen till höger.	Ja	Nej	Vet ej	Kommentarer
1. Har det våldsbrott som nu är under behandling orsakat skador? (Hurdana skador? Är det första gången som offret har fått skador?)	☐	☐	☐	
2. Är du väldigt rädd?	☐	☐	☐	
3. Vad är du rädd för? Är du rädd för nya skador eller mera våld? Berätta vad du tror att (namnet på våldsutövaren/våldsutövarna...) gör och gentemot vem, inklusive barnen.	☐	☐	☐	
4. Känner du dig isolerad från familjen/vännerna? Försöker (namnet på våldsutövaren/våldsutövarna...) till exempel hindra dig från att träffa dina vänner/din familj/en läkare eller andra?	☐	☐	☐	
5. Är du deprimerad eller har du självmordstankar?	☐	☐	☐	
6. Har du skilt dig eller försökt flytta isär från (namnet på våldsutövaren/våldsutövarna...) under det senaste året?	☐	☐	☐	
7. Har ni gräl när det gäller kontakten med barnen?	☐	☐	☐	
8. Sänder (...) ideligen textmeddelanden till dig eller ringer, tar kontakt, följer efter dig ibland eller systematiskt (stalking) eller är på annat sätt närgången? (Berätta närmare vad. Tror du att han gör det avsiktligt för att skrämma dig? Fundera i vilka sammanhang det sker och hur (...) beter sig.)	☐	☐	☐	
9. Är du gravid eller har du fött ett barn under de senaste 18 månaderna?	☐	☐	☐	
10. Sker misshandeln oftare nu jämfört med tidigare?	☐	☐	☐	
11. Har våldet blivit grövre?	☐	☐	☐	
12. Försöker (...) kontrollera allt du gör och/eller är (...) väldigt svartsjuk? (Frågor om människorelationer: Vem håller du kontakt med? Vaktar (...) dig där hemma och bestämmer till exempel vad du ska ha på dig? Ta hedersrelaterat våld i beaktande och be om detaljerade uppgifter om hur (...) beter sig.)	☐	☐	☐	
13. Har (...) någonsin använt vapen eller andra föremål för att skada dig?	☐	☐	☐	

INSTITUTET FÖR HÄLSA OCH VÄLFÄRD

Checklista för riskbedömning (MARAK)

14. Har (...) någonsin hotat att döda dig eller någon annan så att du verkligen har trott på det? Dig ☐ Barnen ☐ Någon annan ☐	☐	☐	☐	
15. Har (...) någonsin försökt strypa/kväva eller dränka dig?	☐	☐	☐	
16. Säger eller gör (...) sådana sexuellt laddade saker som för dig känns obehagliga eller som orsakar dig eller någon annan fysisk skada? (Och om det riktar sig mot någon annan, i så fall mot vem?)	☐	☐	☐	
17. Har någon annan person hotat dig eller är du rädd för någon annan person? (Om svaret är ja, i så fall vem och varför? Beakta även hela släkten i samband med hedersrelaterat våld.)	☐	☐	☐	
18. Vet du om (...) har varit våldsam mot någon annan? (I så fall mot vem, inklusive barn, syskon eller äldre släktingar. Beakta hedersrelaterat våld.) Barnen ☐ Andra familjemedlemmar ☐ F.d. partner ☐ Andra, vem? ☐	☐	☐	☐	
19. Har (...) någonsin använt våld mot djur eller familjens husdjur?	☐	☐	☐	
20. Finns det ekonomiska faktorer som borde beaktas? Till exempel, är du ekonomiskt beroende av (...), har du eller (...) nyligen förlorat din/sin arbetsplats eller har ni andra ekonomiska bekymmer?	☐	☐	☐	
21. Har (...) under det senaste året haft problem med läkemedel, droger, alkohol eller den mentala hälsan så att de orsakat bekymmer i vardagen? (Om svaret är ja, ge närmare information.) Droger/mediciner ☐ Alkohol ☐ Mental hälsa ☐	☐	☐	☐	
22. Har (...) någonsin hotat att begå eller försökt begå självmord?	☐	☐	☐	
23. Har (...) någonsin brutit mot besöksförbudet, reseförbudet, villkoren för övervakad frihet på prov eller avtalet om umgängesrätt med barnen? (Det kan vara bra att även bedöma hur misshandlaren har följt dessa i förhållande till sin före detta partner.) Besöksförbud ☐ Reseförbud ☐ Övervakad frihet på prov ☐ Avtal om umgängesrätt med barnen ☐ Annat ☐	☐	☐	☐	
24. Vet du om (...) någonsin har haft problem med polisen eller om (...) har ett straffregister? (Om svaret är ja, be om närmare information.) Partnervåld ☐ Sexuellt våld ☐ Annan typ av våld ☐ Annan orsak ☐	☐	☐	☐	
Ja-svar totalt				

INSTITUTET FÖR HÄLSA OCH VÄLFÄRD

Checklista för riskbedömning (MARAK)

Saker som den professionella frågeställaren bör överväga: Finns det annan information (från offret eller rent yrkesmässigt) med anknytning till ärendet som kan öka risken för våld? Fundera över offrets situation med tanke på till exempel fysisk funktionsförmåga, missbruk av rusmedel, mental hälsa, kulturella och språkliga hinder, hedersrelaterad praxis och nedvärderande attityd. Är offret redo att ta emot hjälp eller tjänster?

Vilka primära åtgärder krävs för att förbättra offrets säkerhet?

Vad är misshandlarens yrke/hobbyer? Ger de en möjlighet att komma åt vapen?

1. **Finns det skäl att lämna detta ärende till ett multiprofessionellt team för riskbedömning (MARAK)? Ja ☐ Nej ☐** (se kriterierna för riskbedömningen nedan)

- Din professionella bedömning av situationen: är du allvarligt orolig?
- 14 eller fler ja-svar
- Antalet polisutryckningar till hemmet på grund av familjevåld under de senaste 12 månaderna (tre stycken eller fler)

2. **Tror du att det finns risk för våld mot familjens barn?**

- **Ja** ☐ Har en barnskyddsanmälan gjorts (Barnskyddslagen 25 §)? **Ja** ☐ **Nej** ☐
- **Nej** ☐ / **Inga barn** ☐

3. **Fyll i de samtyckesblanketter som behövs och lämna de till kontaktpersonen för det multiprofessionella teamet.**

Namn och yrkesbeteckning:

Ämbetsverk/avdelning: Ort:

Telefonnummer/e-postadress:

Underskrift och datum:

Appendix 3

Qualitative Questionnaire

Thesis Title: The Forensic Nursing Care given to Victims of Violence

Cecilia Mansén

Degree Thesis in Health Care and Social Welfare
Education: Nurse, Bachelor of Health Care

Vaasa, 2021

Information letter

This is a qualitative questionnaire developed to gather information for a degree thesis in health care and social welfare. The thesis is written to explore the forensic nursing care given to victims of violence from the perspective of registered nurses.

Forensic nursing is a global nursing practice where health and the legal system intersect. Forensic nursing has evolved as a concept addressing nursing care related to violence and crime. Forensic nurses give care to patients subjected to violence and other traumas. The patients can be living or deceased victims as well as perpetrators of violence. Forensic nurses are nurses and use the nursing process to provide compassionate and holistic care. This defines forensic nurses as healthcare professionals rather than criminal justice or forensic science professionals.

For long, nurses have focused on the physical and psychological care of patients, however, many nurses are not prepared to care for or able to recognize a patient who is a victim of violence. Therefore, nurses can find themselves unprepared in determining whether evidence should be collected and preserved. For the nurse to address these aspects, the nurse has an opportunity to help the patient regain control of their life and to provide forensic expertise and support that can lead to a possible preferable legal outcome.

Aim of Questionnaire

The aim of this questionnaire is to gather information about the experiences in providing care for victims of violence and to get an understanding of the preparedness and confidence in caring for these patients.

My name is Cecilia Mansén and I am a nursing student at Novia University of Applied Sciences. I first became interested in forensic science after taking a course in criminology. An acquaintance of mine, who is a nurse, told me about forensic nursing and I immediately wanted to know more.

Ethical Considerations
Participation in this questionnaire is voluntary. The one participating is free to choose which questions to answer. The results will be presented in a way in which individuals cannot be identified.
Violence is a sensitive topic. Individuals participating in this study may have their own experiences of violence. This can put the participant in a vulnerable situation and remind them of unpleasant feelings and memories. Be attentive of your emotions and health, remember that participation is voluntary and you yourself chooses what experiences to share.

I want to Thank you for taking your time to answer this questionnaire. All the information gathered in this questionnaire will be crucial in understanding how nurses provide care for those who have become victims of violence.

Contact Information
Cecilia Mansén
Email & number

Supervisor: Marlene Gädda
Email & Number

Instructions
This questionnaire begins with five general questions to which only a yes or no answer is required. The rest of the questionnaire consists of two fictitious cases with specific questions for each case, this part has open-ended questions where the participant chooses what to answer. A time for collection of the questionnaire will be given, but each question will be answered within this time when the participant seems fit. Questions can be answered in English or Swedish.

……

General Questions
Mark the answer yes or no

Have you ever heard about forensic nursing or forensic nurses? Yes / No

Have you had any training in forensic nursing? Yes / No

Have you had any training in how to approach a victim of violence? Yes / No

Have you ever cared for a person that you know has been exposed to violence? Yes / No

Have you ever had to cooperate with the police when caring for someone? Yes / No

……

Fictitious Case I

- Victim: Female in her 20s
- Arrival reason: heavy alcohol intoxication

A 24 year old woman arrives at the emergency clinic with an ambulance. She is heavily intoxicated. In the hospital, the woman is monitored until the alcohol has left her system. She is exhausted and is crying. When a nurse comes to check up on her, she discloses that she has been sexually abused by her partner and she does not know what to do. She is afraid that her partner will get in trouble if she reports it to the police.

➸

Three quarters of women with substance abuse issues also reported prior physical or sexual abuse. As a result, alcohol and other drugs signify to deal with the psychological after-effect of abuse.

➸

Questions

Read the fictitious case and answer the following questions. Remember that you are free to choose which questions to answer and what you write. Write your answer on the lines following each question.

After reading the story, what happens next? How do you react?

What is important to think about when communicating with this patient?

Have you ever cared for patients like this?

How confident and prepared would you be in caring for this patient on a scale 1-10, circle the answer

1 2 3 4 5 6 7 8 9 10

Would you feel more confident if the patient did not disclose her abuse? explain your answer

Have you reported cases of sexual abuse to the police? How is this done?

Do you know about the forensic medical examination? What should the nurse consider when doing the examination?

What is your comment or professional advice for this patient?

Fictitious Case II

- Victim: an 18-year-old male
- Arrival reason: stab wounds

The 18-year-old arrives with stab wounds on the neck and torso. He is in unstable condition, experiencing a lot of pain. When the condition of the patient is stable, it is determined that the patient has lowered function in his right arm.

Questions

Read the fictitious case and answer the following questions. Remember that you are free to choose which questions to answer and what you write. Write your answer on the lines following each question.

What does this entry look like? What happens next with this man? Are the police here?

Are pictures taken? Is the condition of the patient continuously reported to the police?

Is the family of the patient contacted & why?

Have you ever cared for a patient with stab wounds? If yes, did you feel prepared caring for that patient? If not, what can you do to prepare yourself for caring for a patient with stab wounds?

How confident would you be in caring for this patient? (1-10) Why?

1 2 3 4 5 6 7 8 9 10

How do you approach this patient?

What is important to keep in mind when caring for this patient?

How would you establish an understanding for what this patient has been through?

How is your approach to the victim's family/close ones?

……..

Thank you again for participating in this questionnaire. I sincerely appreciate your time and input. If there is something you would like to discuss, feel free to contact me.

Thank You,

Cecilia Mansén

Appendix 4

/ 20
Datum för när ansökningen ifyllts

Studerande Cecilia Mansén Adress, telefonnummer och e-postadress	
Studieplats Novia Utbildningsprogram: Bachelor of Health Care, Nursing	
Examensarbete Namn på examensarbetet The Forensic Nursing Care Given to Victims of Violence Kort beskrivning av examensarbetet Forensic nursing is the global nursing practice where health and the legal system intersect. Forensic nursing is a term that has evolved as a concept addressing nursing care related to violence and crime. Syfte: The thesis is written to explore forensic nursing care for victims of violence from the perspective of registered nurses. The thesis will consist of a qualitative study, collecting data with a questionnaire. The aim is to describe the experiences, preparedness and confidence when providing care for victims of violence. The participants for data collection will be registered nurses. The data collected will be analysed using qualitative content analysis. This is a commonly used method when analyzing qualitative data in nursing science research. Content analysis represents systematic and objective means to describe and quantify phenomena. To do a successful content analysis, data is transformed into concepts that describe the research phenomenon. The qualitative questionnaire contains two fictitious cases describing patients exposed to interpersonal violence. The cases were designed to create a context to which nurses can answer open questions. The questionnaire initially begins with questions about the nurses' knowledge and experience about forensic nursing care. The answered questionnaire will be collected after 3 weeks. One advantage of this method is that the nurse can complete the survey at their convenience and they get enough time to reflect on the questions. All answers are treated confidentially and will be destroyed after the final analysis is complete.	

Handledare för examensarbetet Marlene Gädda Telefonnummer, e-postadress gemensamt överenskommits med den studerande och handledaren / 20	
Beslut	

Tillstånd för examensarbetet beviljas enligt anhållan

Tillstånd för examensarbetet beviljas inte

Ansökan för godkännande av examensarbetet kräver:

Beslutsfattare §

/ 20
Datum

Underskrift och tjänsteställning

Förtydligande av namnet