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## **Caring for women with experiences of intimate partner violence**

Nurses' perspectives in Hanoi, Vietnam

## **Vård av kvinnor med erfarenhet av våld i nära relationer**

Från sjuksköterskans perspektiv i Hanoi, Vietnam

## Abstract

- Background:** Intimate partner violence affects 30 percent of women globally and implies physical, sexual or psychological harm to a person, caused by their partner or ex-partner. There exists gender inequality in Vietnam that affects women negatively during their lifetime. Vietnamese nurses follow a similar ethical code to the International Council of Nurses, but are mostly focused on technical tasks at their workplace. Women with experience of intimate partner violence express that their caring needs are not being met.
- Aim:** The aim was to describe registered nurses' experiences of caring for women with experiences of intimate partner violence, in hospital settings in Hanoi, Vietnam.
- Method:** Data was collected through a descriptive qualitative method with semi-structured interviews with eleven participants recruited from two hospitals in Hanoi, Vietnam. A qualitative content analysis was used for analysis and themes were formed.
- Results:** One main theme emerged from the study: Nurses approach to their profession correlates with their view of life, emotions and actions when caregiving. Five sub-themes was formed from that theme: The relation between nurses view of life and women; Presence and absence of competence when encountering women with experience of intimate partner violence; The process of providing person centered care; Experiencing the emotional strain that emerges out of caring for women with experiences of intimate partner violence; Crossing professional boundaries in nurse-patient relations.
- Discussion:** Vietnamese nurse's caregiving is influenced by their view of life which causes them to give bias advice that focus on women's responsibilities in society. The absence of guidelines results in nurses using their own moral compass when providing care for women with experience of intimate partner violence. The result will be discussed with Jean Watson's term *consciousness* in her theory of human caring/caring science.
- Keywords:** Intimate partner violence; Vietnam; nurses; care; caregiving; nurse-patient relation.

## Sammanfattning

- Bakgrund:** Våld i nära relationer drabbar 30 procent av kvinnor världen över och innefattar fysiskt, sexuellt och psykologiskt våld som orsakas av en nuvarande eller före detta partner. Att det i Vietnam inte är jämställt påverkar kvinnor negativt under deras livstid. Sjuksköterskor i Vietnam följer en liknande etisk kod som International Council of Nurses, men fokuserar mest på tekniska uppgifter på arbetsplatsen. Kvinnor med erfarenhet av våld i nära relationer uttrycker att deras behov inte blir tillgodosett i omvårdnaden.
- Syfte:** Syftet var att beskriva legitimerade sjuksköterskors erfarenheter av att vårda kvinnor med erfarenhet av våld i nära relationer, i sjukhusmiljöer i Hanoi, Vietnam.
- Metod:** Data samlades genom deskriptiv kvalitativ metod med semistrukturerade intervjuer med elva deltagare som rekryterades från två sjukhus i Hanoi, Vietnam. En kvalitativ innehållsanalys användes under analysen.
- Resultat:** Ett huvudtema utformades i studien: Sjuksköterskors förhållningssätt till professionen korrelerar med deras livsåskådning, känslor och agerande vid omvårdnad. Fem subteman utformades från huvudtemat: Relationen mellan sjuksköterskors livsåskådning och kvinnor; Närvaron och frånvaron av kompetens vid mötet med kvinnor med erfarenhet av våld i nära relationer; Processen av att ge personcentrerad vård; Att erfara den känslomässiga belastningen som sker vid omvårdnaden av kvinnor med erfarenhet av våld i nära relationer; Att överskrida professionella gränser i sjuksköterska-patientrelationer.
- Diskussion:** Vietnamesiska sjuksköterskors vårdgivande är färgat av deras livsåskådning vilket leder till partisk rådgivning som fokuserar på kvinnors ansvar i samhället. Frånvaron av riktlinjer resulterar i att sjuksköterskor förlitar sig på sin egna moraliska kompass när de vårdar kvinnor med erfarenhet av våld i nära relationer. Resultatet kommer diskuteras utifrån Watson's begrepp *medvetenhet* från hennes omvårdnadsteori om mänsklig omsorg.
- Nyckelord:** Våld i nära relationer, Vietnam, sjuksköterskor, vård, omvårdnad, sjuksköterska-patientrelationer.

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## **Introduction**

Our interest in intimate partner violence (IPV) comes from a desire to shed light on the problematic power structure within society that foretells women have less value than men and IPV can be interpreted as a symptom of it. Women all over the world suffer daily by the hands of men and we feel the urge to intervene and our opportunity to do so is integrated with our nursing education. Nurses have a huge possibility to detect women who are going through abuse and we want to investigate how this process is conducted since our knowledge is limited. Because of the cultural differences, Vietnam might have another approach to the process than Sweden and we therefore chose it as a suitable location to conduct the study. We want to find out how they care for women with experience of IPV and thoroughly analyze it in order to improve healthcare globally. Since our voices of power lies within the nursing field, this is our entry to pursue it.

## **Background**

### **Intimate partner violence**

IPV is a global phenomenon of assault that exists in all countries and cultures, and implies physical, sexual or psychological harm to a person caused by their partner or ex-partner (Ali, Dhingra & McGarry, 2016; Gandhi, Poreddi, Nikhil, Palaniappan & Math, 2018). The World Health Organization (WHO) (2012) defines IPV as acts of physical violence, sexual violence, emotional abuse and controlling behaviors. Slapping, hitting, kicking and beating to the body are examples of physical violence, while sexual violence often takes form of sexual coercion. Emotional abuse can be expressed as insults, belittling, humiliation on repeated occasions, intimidation or threatening to harm. According to the WHO, isolating a person from their kin and monitoring their movements are examples of controlling behavior as well as restricting access to money, employment, education and medical care.

According to a report from 2013, the WHO highlights that IPV will affect 30 percent of all women at some point in their lives, 25 percent of women will be affected in Sweden (Brottsförebyggande rådet, 2014), and 34 percent of women in Vietnam (<http://evaw-global-database.unwomen.org>). However, UN Vietnam states that the prevalence is even higher with 58 percent (<http://www.un.org.vn/>). Studies show that unrecorded and unreported cases for IPV occur, meaning that IPV is a larger global issue than assumed (Jayatilleke, Poude, Yasuoka, Jayatilleke & Jimba, 2010; Overstreet & Quinn, 2013). The concept of domestic

violence is often used as a synonym for IPV (WHO, 2012). IPV affects men as well as women, however this study will focus solely on women.

### **Gender equality in Vietnam**

In Vietnam, the female population holds the position in society that earns less money from work, as well as conducts the greatest amount of unpaid family work (<https://www.ilo.org>). The Vietnamese women get discriminated due to gender bias which results in them having reduced access to education. When they perform paid labor, they earn two thirds of what men of the same education level and work experience does (<http://www.un.org.vn/>).

Another dimension of gender inequality in Vietnam is the high ratio of men being born more often than women (<http://www.un.org.vn/>). In society men are considered more valued than women and therefore Vietnam has high rates of abortion of female fetus. This affects the population structure within the country and can in the long-haul cause women to be forced into marriage at an earlier age as well as being victims of trafficking and prostitution.

During 2009-2011, the United Nations and the Vietnamese Government worked together on a program to improve gender equality (United Nations Office on Drugs and Crime, 2011). The program contributed to the implementation of the Law on Domestic Violence Prevention. The law addresses which responsibilities individuals, families, organizations and institutions hold in preventing domestic violence and protecting the victims.

### **The definition of nursing and caring**

The International Council of Nurses (ICN) (2012) writes in the Code of Ethics for Nurses that they have a responsibility “to promote health, to prevent illness, to restore health and to alleviate suffering” (page 1). Ideally, nurses should protect the human rights of every individual as well as respecting beliefs and values (ICN, 2012). Watson (2012) describes caring in the sense of human caring which involve values, a will and commitment to care and maintaining knowledge. Human caring is always fragile as being of nature dependent on social, moral and spiritual engagement between the nurse and the patient. How these ideals are translated and operationalized to clinical practice can be elusive.

### **Nursing in Vietnam**

In Vietnam, the nurses follow the Ethical Standards for Vietnamese Nurses (<http://hoinhap.kcb.vn/>), which are similar to the ICN Code of Ethics for Nurses (2012).

These standards describe nurses' approach to their profession like respecting patients' autonomy, integrity and gender as well as being honest and fulfilling their responsibilities as nurses (<http://hoinhap.kcb.vn/>). There are three different education levels for nurses in Vietnam, from two up to four years (Ha & Nuntaboot, 2016a). All levels of education are considered eligible when applying for a nursing position at a hospital, although only nurses with three or four years of education are considered to be registered nurses (RNs). 86 percent of nurses at hospitals in Vietnam has two years of education (WHO, 2016), which results in them not being able to care for patients sufficiently (Ha & Nuntaboot, 2016a). Since 2012, the bachelor and college degrees have improved their educational programs to contribute to a more safe and high-quality caregiving (Ha & Nuntaboot, 2016b).

Nurses' area of work in Vietnam is mostly focused on technical tasks, such as administration medications and caring for physical wounds (Pron, Zygmunt, Bender & Black, 2008). Nurses work with one type of task at a time, such as a medication nurse that handles all medications at a unit or a dressing nurse who goes from room to room to care for patients' wounds. Nurses in general are not responsible for teaching patients about self-care, as this is a physicians' responsibility. Furthermore, members of the patient's family are an integrated part of caring for them and will assist the nurse during the hospitalization.

### **Caring for women with experience of intimate partner violence**

A global qualitative meta-analysis study reviewed a number of guidelines in regards of how to care for women with experience of IPV, showed that these guidelines did not use evidence from qualitative studies to support their recommendations (Feder, Hutson, Ramsay & Taket, 2006). The study presented the findings from 29 studies with the women themselves and formed their own guidelines for healthcare personnel. The guidelines included healthcare personnel understanding the nature of IPV, having knowledge in how to develop trust and not behaving judgmental when listening to the women (Draucker, 1999). They should also ensure the privacy and safety in the meeting as well as being respectful and supportive. Other guidelines were to ask about the abuse on multiple occasions and to not put pressure on the women.

The essence of the study emphasizes nurse's inability to have a nonjudgmental approach (Lutenbacher, Cohen & Mitzel, 2003) and to understand the long-term difficulties these women face when going back to their social circumstances (Feder et al., 2006). The women also mentioned the lack of patient-nurse confidentiality, which intensified their fear of

everyone amongst their friends and family knowing about the abuse (Feder et al., 2006). They also mentioned how they did not find a medical solution to be the answer to their problems. They were not interested in continuous contact with the nurse, but instead pleased with getting professional guidance in how to deal with the situation (Prosman, Lo Fo Wong & Lagro-Janssen, 2014).

### **Problem statement**

IPV is a global phenomenon that affects a third of all women and entails different forms of abuse. In Vietnam, prevalent gender roles place women in a lower and more exposed position than men. Nurses in Vietnam obtain different levels of education, from two to four years, which causes them to have different depths of knowledge. Women with experience of IPV express that nurses often behave judgmentally and express a need to receive professional guidance. This study can contribute to the understanding of nurses' experiences caring for women with experience of IPV. It is of interest for any nurse in general to learn more about IPV to optimize nurse-patient relations and this study could therefore benefit nurses in Vietnam as well as Sweden.

### **Aim**

The aim was to describe registered nurses' experiences of caring for women with experiences of intimate partner violence, in hospital settings in Hanoi, Vietnam.

### **Theoretical Framework**

Jean Watson's theory of human caring (2008) consists of what approach and mindset the nurse should have in nurse-patient relations, so the meeting will be authentic for both parties. The authors will use Jean Watson's term *consciousness* in the concept of *transpersonal caring relationship* (2012) in her theory of human caring/caring science in the discussion part of the study.

For caring to be more than just pragmatic, nurses have to reflect on their own ability to care as well as their attitudes (Watson, 2012). For caring to be intentional, nurses' approach has to emerge out of a higher level of consciousness for the patient to receive it as authentic. A conscious approach means truly being in the moment together with the other person, both physically and spiritually.

In a transpersonal caring relationship, nurses hold an ethical and social responsibility to care for the patient with a conscious approach (Watson, 2012). If nurses solely give care out of feelings of duty and moral it foretells nothing about if they actually care for the patient genuinely (Watson, 2012). Nurses must therefore possess awareness about the patient's need for care and knowledge in caring in order to give it intentionally. This will generate positive changes for the patient who is no longer resistant to feel or express their true emotions.

As feelings are transmittable nurses must be aware of their expressed emotions so the patient doesn't copy nurses' state of mind (Watson, 2012). Instead, nurses ought to stay in the presence of the patient's expressed emotions. That way, the patient will finally be allowed to fully express themselves in order to find meaning and harmony. This will only happen if the patient truly trusts the nurse and the nurse in return recognizes the patient as a whole with their humanity and together create a union which results in a transpersonal caring relationship. Nurses need to understand and fully embody this concept in order to intentionally be conscious with their actions. This leads to the patient restoring their subjective self and quality of life, in opposite to many healthcare meetings where the patient is solely looked at as an object for radical treatment.

## **Method**

### **Design**

The study was of a descriptive qualitative design and contained individual interviews due to the intent of studying lived experiences (Henricson & Billhult, 2017). This type of study has a holistic approach and seeks to understand and describe someone's lived experiences where the researchers are involved and engaged in every step. This method was chosen as it promotes the participants to be free and expressive when sharing their experiences.

### **Participants**

The inclusion criteria were that the participants had to be registered nurses with five or more years' experience of nursing and in their practice had encountered women with experience of IPV. Female and male RNs, speaking English or Vietnamese, were included.

A total of eleven RNs agreed to participate in the study. The participants consisted of ten women and one man from Hanoi, Vietnam. They had between 6-34 years of experience in nursing, with an average of 19 years. Their ages were between 28-54 years, with an average of 41 years.

## Data collection

The authors emailed the Vice President of the Vietnam Nurses Association (VNA) in Hanoi, Vietnam. They asked for assistance with finding hospitals in Hanoi to conduct the interviews in and recruiting registered nurses at these locations. The VNA is ruled by the Government of the Socialist Republic of Vietnam and represents nurses as well as other medical professions (<http://hoidieuduong.org.vn/>). The Vice President of the VNA agreed to the authors requests and was sent the inclusion criteria for the selection of participants as well as a written presentation of the study to show the prospect hospitals and the RNs. The Vice President assisted in recruiting an interpreter who was of female gender and had no earlier relation to the participants. She had no formal interpretation education, but had experiences of interpretation on multiple occasions in research purposes.

Two hospitals accepted the authors requests and six RNs agreed to participate from the first hospital and five from the second one. The interviews in the first hospital were conducted in an office at their nursing department and in the second hospital in a conference room. To build a trusting relationship, the authors offered the participants beverages and small snacks, conducted small talk and were aware of their body language throughout the meeting. During the interviews, the authors did not give any signals about their own opinions to the RN's narratives. The interpreter was used consistently throughout all eleven interviews.

The interviews were semi structured, individual interviews with open-ended questions so probes could be based on the given answer (Danielson, 2017a). When probing, the authors used ladder questions (Price, 2002) with a phenomenological approach (Bullington, 2018). Ladder questions are a systematic way of structuring questions by beginning with questions about actions, followed by knowledge and lastly about feelings (Price, 2002). This intensified way of communication enables the participant to respond open and honestly. A phenomenological approach aims for the interviewer to adapt the probes to the participants narratives (Bullington, 2018). The reason for conducting individual interviews was that the RNs might feel more comfortable speaking with only the authors and the interpreter present.

The interview began with the authors giving a written consent form (appendix 1) to the RN. The authors emphasized that the RN could answer which questions they wanted as well as quit the interview at any given moment without it affecting them negatively. Two audio recording devices were used for the reason to increase optimal sound quality as well as having a backup copy if a malfunction occurred. The authors gave a verbal presentation (appendix 2) which followed by the basic starting questions about background data (appendix 3) to create

an open-speech environment. The two main questions had the purpose to let the RN feel free to share their experiences about their encounters with women with experience of IPV.

Both authors paid attention to the RN, took notes and used ladder questions with a phenomenological approach when probing. The probes were based on the RN's story and they were asked to elaborate in order to get a deeper understanding of the context as well as the authors verbally acknowledged their facial expressions. Examples of these probes can be found under appendix 3. In order for the RNs narratives to be in focus, the authors tried to be aware and exclude their preconception (Malterud, 2014). The RNs received gifts in the form of small tokens, such as Swedish candy, as appreciation for their time. The eleven interviews had an average of 45 minutes, with a range between 24-64 minutes. During two interviews, it emerged that the participants had not encountered women with experience of IPV and those interviews were excluded from the study.

## **Data analysis**

All eleven interviews were audio recorded and nine interviews were transcribed. Analog communication was added to the transcribed material, that were interpreted together with the RNs narratives in order for a deeper analysis. The authors used slightly modified verbatim mode when transcribing (Twinn, 1997). It entails removing unnecessary words in order for the true meaning to emerge, as unedited transcript material can cause the participants to seem ridiculous. One of the authors listened to the audio recorded material and dictated to the other author who wrote it digitally. If there were any uncertainties, both authors would relisten and agree on the meaning of the content.

An inductive qualitative content analysis was applied to the transcribed material (Danielsson, 2017b) and can take form in strategically categorizing the participants sentences into different steps (Graneheim & Lundman, 2004). An inductive approach implies that the theory of choice will be added in the end of the research process, for example in the discussion part of the study (Henricson, 2017). The authors re-read the transcript material and agreed on which parts that could be interpreted as meaning units. The authors condensed every meaning unit in order to maintain its core while shortening the text. The underlying meaning was discussed and interpretations were formed with a latent content approach. The principal of latent content deals with the text's underlying meaning and do not only interpret the visible. The authors chose this approach to reach a deeper context of the gathered material.

The following step included coding the material through reflective discussions which then emerged into 15 codes (Graneheim & Lundman, 2004). The authors wrote all codes onto sheets of paper that were spread out in order to get a clear overview. It was discussed which codes fitted together in different sub-themes. Five sub-themes were concluded and gathered under one main theme.

Table 1. Example of the analysis process

Meaning unit	Condensed meaning unit	Interpretation	Sub-Theme	Theme
I'm just thinking about the reason why these women would get beaten by their husbands. I think of two reasons. Firstly, maybe the wives earn more than their husbands, so the husbands feel lower and unequal to their wives and then they hit their wives. And the second thing, maybe the husband was too jealous, because his wife was having an affair or maybe he was just too furious or jealous that he would hit his wife.	There are two reasons for husbands to beat their wives. Firstly, if the woman's salary is higher than her husbands, and secondly if he got jealous because she is having an affair.	A perception that women who are exposed to abuse themselves are creating it through their liberal life decisions	The relation between nurses' view of life and women	Nurses approach to their profession correlates with their view of life, emotions and actions when caregiving
If it is serious, like if they broke their arm, or broke their legs, or have to go to the hospital, then they would go. But when they go to the hospital, they are still silent in general or shy. They never tell others about how they got the pain. And if it is more serious, I will just see the patient cry. Cry and cry and cry.	If their wounds are serious and they're in need for hospital care they would go there and act silent or shy and they will cry. They never tell others about the abuse.	Hospitalized women never confess to being abused	Presence and absence of competence when encountering women with experience of intimate partner violence	
This is my own methodology, my own strategy to many patients. I don't ask them immediately with a lot of questions, I ask them day-by-day and step-by-step. I think it is a strategy to be closer to the patients.	It's my own strategy to not ask them immediately, but gradually. It allows me to get closer to the patients.	Using a conversation technique to promote sincerity	The process of providing person centered care	
I feel like I want to do something, it is not right, it is not fair at all for a woman. Why can he hit her? A woman who he lives with and who takes care of his family. So how can he hit her?	I want to do something about the abuse. I don't understand why he hits her when she's taking care of their family.	Feelings of sympathies and a wish to intervene	Experiencing the emotional strain that emerges out of caring for women with experiences of intimate partner violence	
I would tell the women that their husbands should share the housework and other work with her, but the woman should ask her husband gently: 'Can you help me to do something, this or that?' [This must be asked] gently. The woman should cook the dishes that her husband likes a lot.	Giving advice that the housework should be divided equally, but the wife must gently ask for her husband's help and cook his favorite dishes.	Giving advice that women who's been abused have responsibilities towards their husbands	Crossing professional boundaries in nurse-patient relations	

## Research Ethical Considerations

The study followed basic ethical principles that includes participants voluntary participation, anonymity and safe storage of data (Kjellström, 2017). The participants received information about the study beforehand and were provided sufficient time to consider their participation in the study and that their participation was voluntary with the opportunity to withdraw anytime. The data was stored in a secure place that only the authors and their supervisor had access to. The participants were kept anonymously except from their head of department, the authors and the interpreter. The audio records as well as the consent forms were deleted and destroyed once the thesis was completed. The study was approved by the Research Ethics Committee at the Department of Health Care Sciences at Ersta University College in Stockholm, Sweden on the 2019-06-06.

The authors reflected on their preconceptions before conducting the interviews which consisted of beliefs that nurses do not want to dig into the patient's private life and that there exist both nurses who believe that IPV is morally wrong, but also those who think it is morally right. The authors also reflected on beliefs that they would have to encourage the participants to answer thoroughly because of culture differences.

## Result

The result is gathered in the theme "Nurses approach to their profession correlates with their view of life, emotions and actions when caregiving". This theme is presented in five sub-themes that describe from different dimensions how nurses' approach to their profession correlates with their view of life, emotions and actions when caregiving. These dimensions reflect nurses' view of life in relation to women, their competence, caregiving and emotional strain as well as crossing professional boundaries.

Table 2. Overview of the theme and sub-themes

Theme	Sub-themes
Nurses approach to their profession correlates with their view of life, emotions and actions when caregiving	The relation between nurses' view of life and women
	Presence and absence of competence when encountering women with experience of intimate partner violence
	The process of providing person centered care

	Experiencing the emotional strain that emerges out of caring for women with experiences of intimate partner violence
	Crossing professional boundaries in nurse-patient relations

### **Nurses approach to their profession correlates with their view of life, emotions and actions when caregiving**

#### *The relation between nurses' view of life and women*

The nurses expressed their central value system through their view on different kinds of reasons for the abuse. Some believed that the cause for the abuse is the husband's state of mind which includes him being drunk or stressed, having lost money on gambling or failed to be self-controlled. Other reasons emerged from the woman's actions; being unfaithful, behaving incorrectly or provocative, or earning more than her husband. Some of the nurses argued that because of her actions she deserves to be abused. A nurse described:

*"A typical situation is that the wife suddenly provokes her husband by saying something and of course she would get hit! That's typical."*

*(Participant 6)*

Some of the nurses had only received a few cases of women with experience of IPV despite having worked at the hospital for multiple years. The nurses believed that the reason for it is their perception that the phenomenon is hidden within the society, which can be seen as a part of their central value system. One nurse described that the role of the wives is not equal to the husbands. The wives have the lower position and this leads to them keeping the abuse a secret as well as not seeking healthcare.

Some of the nurses' perceptions were that women feel ashamed to have been abused by the hands of their husbands. Other reasons were that they gradually adapt to their situation to the point where they no longer believed that the ongoing abuse is wrong. The nurses also spoke about women being afraid to be the topic of gossip in the neighborhood and fear of being misunderstood. Feelings of loyalty towards their husband also caused them to keep the abuse a secret. All this caused women to keep the abuse a secret, which by extension complicated nurses' caregiving. A nurse described:

*“It’s common in Vietnam that we don’t tell others our secrets, particularly if we are beaten by our husbands, because people might want to talk about our secrets, so we hide them away. And maybe people are afraid to have a bad reputation.”*

*(Participant 11)*

Some of the nurses emphasized their perceptions on women’s responsibilities to prevent further abuse as an expression of their central value system. This included not provoking their husbands, for example by behaving incorrectly. It is women’s responsibility to not overreact and to figure out their own faults in the occurring abuse. Their role in the family is to not oppress their husband, but rather emphasize on his strengths as well as create opportunities for them to be close together to enable his happiness. If the husband gets angry, the wife should stay away to avoid further abuse. If abuse has occurred, nurses highlight that women are responsible to talk to their husbands about their disagreements and solve the problems. A nurse described:

*“I would tell her to be close to her husband and I would tell her to keep away from him when he was irritated, angry or furious. ‘Speak to him as nicely as possible and try to please him, try to be happy with him. You should try to create some good opportunities to spend time together, for example travelling together. That could solve the problem.’ I would tell the women that: ‘You should try to find the strength point, what are his strengths? And then encourage those strengths points in him and reduce the weak point. Don’t strengthen the weak points, but reduce them. So, encourage him and emphasize his strengths and this will solve the problem.’”*

*(Participant 2)*

### *Presence and absence of competence when encountering women with experiences of intimate partner violence*

The nurses explained what kind of injuries women with experience of IPV can have, indicating their competence in the area. Common injuries are bruises, often all over the body, as well as severe pain or short of breath. Other injuries occur through beating or stabbing towards body parts which can result in organ failures. A nurse explained that the severity of an ongoing abuse can result in psychosomatic consequences like cramping. Besides nurses’ competence in caring for the women’s visible physical injuries, they also expressed the

importance of tending to their mental pain if they behave worried or terrified. A nurse described:

*“A woman was sent to the hospital with the situation that she got pain here [points to upper body] and she said she was stabbed with scissors .... So hard that the liquid from her lungs came out.”*

*(Participant 11)*

The nurses expressed that they have developed a competence in intuition when meeting women with experience of IPV. They explained that these women cry differently than others and behave unlike the rest of their patients. The nurses' perception was that these women sometimes distance themselves and tend to be sad or frustrated and don't want to receive care from their husbands. They are often silent or upset and these signs provide the nurses with a sense that abuse has occurred. Some of the nurses shared that their competence in analog communication shapes their perception of what had happened to these women. A nurse described:

*“With my experience, as I have been working as a nurse for a long time, I have my own feelings with the patients who will come to visit this hospital, [it is] differently from the others. Because the others will greet you and will speak to you nicely and happily, friendly. But a person like this type of patient, she never shows her feelings and by the signal I told you before: she cries or is frustrated or will speak later. That is the difference.”*

*(Participants 2)*

Some of the nurses shared that abuse is a difficult topic for women to talk about and that they are experiencing a lack of competence when bringing up the subject. Their perception was that women will often hide and lie about the ongoing abuse to avoid exposing their pain. Provided excuses are accidents or relationship conflicts. Other reasons for the insincerity could be a present abuser at the hospital.

The lack of competence expressed itself through the nurses' feelings of not wanting to dig into women's secrets as it feels too private and causing them additional pain. The reason they avoid asking further questions comes from their perception about how women's privacy should be respected. A nurse described:

*“Because she hides away, she wants to keep the secret, why should I ask her when she is trying to keep a secret? I don’t want to dig in, because of course it will hurt her. If she says anything to me it will hurt her. So, when she tries to hide away, I respect her.”*

*(Participant 5)*

A number of the nurses talked about the lack of guidelines and proper education when caring for women with experience of IPV. They wished for a local policy at the hospital as well as a national policy from a macro perspective, so these women can be taken care of by competent personnel. In addition to this, they expressed a lack of competence when legal authorities should be notified if suspecting that crimes have been committed. A nurse described:

*“There should be [a policy], but not only at the hospital, but every branch and other agencies and the whole society should work together to set up a policy to declare the role of the health worker and how to treat that kind of patient. But we still don't have a policy, but I wish we did. “*

*(Participant 1)*

### *The process of providing person centered care*

The nurses expressed that the first step in caregiving is to investigate if abuse has occurred. This can be done through women or in some cases her relatives being sincere with the nurse. One of the nurses talked about having a certain conversation technique, however a majority of them meant that friendly and gentle caregiving, which includes sharing, talking and sympathizing, are the most effective ways to find out if abuse has occurred. Another one of the nurses spoke about empowering women and creating a deep nurse-patient relation that enables them to be sincere as well as being given the opportunity to reveal the abuse in their own time. A nurse described:

*“To be a nurse, I think it is better to sit with the patient to enlighten and to talk with them, in a comforting way. To follow them, to care for them and to take care of them as friendly as you can, so that they can trust you and tell you the truth. I think it’s better to be friends with them, to help them overcome the problematic psychology.”*

*(Participant 8)*

The nurses described physically caring for women's symptoms and being attentive to their pain, functional being and their nutritional status. If needed, bandages will be changed, injuries treated and further observations, such as blood pressure measurements and documentation in their journals, will be performed. Physical and mental pain can be medically treated, depending on each case. A nurse described:

*“When I saw her crying, I took a wet towel and cleared her eyes and took care of her and asked her: ‘Does it hurt you?’ And you should comfort her. But very gently, very gentle actions.”*

*(Participant 2)*

The nurses described that an important part of caregiving is its psychosocial dimension. This can be done through friendly comforting, sympathizing and stimulating the women with the aim to overcome their mental pain. Some of the nurses expressed that these women should feel safe and protected and that it is therefore the nurse's duty to be present and not to leave them alone. A number of the nurses spoke about the importance of actively engaging, empowering as well as encourage them as a strategy to strengthen their psychology. One of the nurses emphasized that they should never get angry towards these women because of their suffering. They should never act opposite to what women are feeling, but rather to gently share their feelings with an ethical approach. Another nurse spoke about how it is nurses' duty to guide, inform and educate these women in order to improve their self-care. A nurse described:

*“To be a nurse, I think that caring and educating the patients is vital and very important.”*

*(Participant 8)*

Some of the nurses expressed involving other departments at the hospital when caring for women with experience of IPV. A social work office exists at the hospital where women can get more proficient care than in the hands of the nurses. Some of the nurses described that the social workers are specialized educated and can therefore assist with a more professional approach. The nurses had a perception that these women have trust in the social workers because of their education. At the social office women can get treatments and be assisted with legal measurements.

Caring for women with experience of IPV also includes systematically engaging other departments at the hospital, for example the department of surgery. The nursing team will notify each other when changing work shifts when a woman with experience of IPV is a patient of theirs in order to give proper care. If an abusive partner or husband visits the hospital, some of the nurses explained that they would call for security. A nurse described:

*“If the person got psychological disorders, I will help her to contact the social work office, because there is a professional there and he will give her professional advice and he knows how to explain [to] any woman who’s experienced intimate partner violence. That office can offer more information on their website, on their Facebook and they will try to solve the problem for her as there is a professional expert there. Why don't we [just send her there]?... .. We can simply contact them.”*

*(Participant 9)*

### *Experiencing the emotional strain that emerges out of caring for women with experiences of intimate partner violence*

When meeting women with experience of IPV, some of the nurses explained that they sometimes feel a lack of comprehension. Feelings of not understanding why women were abused or how their abuser can visit them at the hospital and sometimes even have the capability of caring for them together with the nurse like nothing had happened. Other puzzled feelings emerged from the unacceptable fact that some of these women continues to stay in the abusive relationship. A nurse described:

*“But with another case when the husband stabbed his wife and then suddenly came to the hospital and took care of her. I have nothing to say. I don’t understand why.”*

*(Participant 5)*

The nurses expressed different kinds of negative emotions that emerge out of caring for women with experience of IPV. Some of the nurses explained that if a woman was hurting in pain, they would feel empathy with her as well as feel frustrated, worried and upset for her situation. They continued to share their anger towards the abusers who caused their patient such suffering. Other emotions that aroused was feeling sorry and compassionate for the life of every woman who is being dominated by their husband. The nurses also shared that they

vent with their colleagues to handle the emotions of not being enough for these women. A nurse described:

*“I just feel sorry and angry for them.”*

*(Participant 10)*

All female nurses shared that they had a deeper sense of sympathy towards women with experience of IPV as they identify with the same gender as them. They saw themselves in their female patients and from that point feelings of frustration and anger evolved. They expressed the ease to put themselves in their position and could foresee the abuse happen to themselves by their own husband. They all described that this feeling developed an exclusive compassion for these women and therefore also a great obligation to help them. A nurse described:

*“She is just a woman like me and now she was hit by her husband.”*

*(Participant 6)*

### *Crossing professional boundaries in nurse-patient relations*

A majority of the nurses expressed that women with experience of IPV need to be taken care of better and more attentive than other patients. They explained that they will prioritize and spend more time with them compared to other patients. One of the nurses would remind their colleagues about this, so the whole team would act in agreement.

There is also another dimension about prioritizing amongst women with experience of IPV that the independent and strong women should not receive the same care as the dependent and suffering women. One of the nurses had the perception that lighter cases of abuse do not need the same amount of care as more serious ones, since it is not as problematic. A nurse described:

*“I remind my colleagues that that patient should be paid more attention because she was beaten by her husband. The patient should receive the treatment better than others, because she got violated by her husband.”*

*(Participant 10)*

One of the nurses described that they will sometimes share the women's narratives with colleagues and discuss them. Other contact points that some of the nurses expressed was with the women's relatives who they will approach without their knowledge. They explained that this is necessary in order to get thorough information about the women's life situation. One nurse said that the abuse will never be known unless the relatives are asked and they emphasized the importance of gathering information from both directions. Another nurse expressed that they would search for a person who is close to the abuser and ask them to talk to him about reducing the violence. This would also be done without the women's awareness. A nurse described:

*"I would find out if that partner is close to anyone, and if he is close to any person, I would ask that person to help him, to analyze him or advise him so he would reduce the domestic violence."*

*(Participant 2)*

A majority of the nurses described the different kind of advice they give to women with experience of IPV. Some of them would advise women to stay at the hospital or with their relatives for safekeeping from their husband to avoid further abuse. If they return to their home, they should keep calm and avoid his anger and if he does get violent again, they should scream so the neighbors can hear them. Another piece of advice is going to legal authorities as well as mentioning the rights of women and information about gender equality. Other aspects of advice are recommending women to be healthy, eating properly and reducing tensions. It could also include leaving their husbands. One nurse told the woman that an abusive husband will never change, if he could abuse her once he will do it again.

Some of the nurses explained giving other type of advice. They emphasized on the fact that women should forgive their abusive husband, especially if they both still love each other. They should be patient, think of their children and be solution oriented. The nurses continued with advising the women to keep calm and be communicative with their husbands when they get discharged from the hospital. If he gets intoxicated, she must behave kindly and/or not talk to him at all until he is sober. In the everyday life she should gently ask for her husband's help and then prepare him his favorite dishes. A nurse described:

*"I would ask the woman to try to be kind when her husband gets drunk."*

*(Participant 7)*

The nurses described the reasons for why they give advice to women with experience of IPV. They spoke about a wish to improve women's lives and therefore give advice on the solution to make the abuse stop, especially if it has occurred on multiple occasions. Some of the nurses expressed that the origin of their advice sometimes comes from knowing the abuser personally or out of own experience. They also emphasized that it is vital to not give general advice, but on a person-centered level. They described that some women will not take their advice since they are themselves experts in their own story and know what measures to take. The advice will be insignificant if they have already made up their mind.

One of the nurses admitted that the advice they give are nor professional or a part of the nursing duty. Instead it often emerges from feelings of sympathy towards these women as well as a view on the modern woman that does not have to be dependent on their husbands, but can easily get divorced. One of the nurses explained that even though they advise some women to get divorced, it is not because of that they want their family to be separated, but for the sole reason that they should know all of their options. A nurse described:

*"I just give advice because I want her to improve her life and to reduce the violence, the domestic violence. I wish her life would be improved."*

*(Participant 2)*

Some of the nurses expressed feeling curious about the women's future life. They wished they would have gotten the women's phone number so that they can find out what choices the women made after being discharged. They emphasized that it is nowadays easier to call a patient when they want, despite them no longer being at the hospital, as the phone number is recorded in their journal. One of the nurses described that they were friends on social media with one of the women that they had treated and therefore found out that she had gotten divorced later on. A nurse described:

*"I should have had her phone number, but I didn't. But if I would have had her phone number, I would have phoned her later to ask what happened next. At the time we didn't record the patients phone number in our computer. So now it is easier to call the patient when we want."*

*(Participant 1)*

## Discussion

### Methodological Considerations

A qualitative method was chosen as the intent was to study lived experiences (Henricson & Billhult, 2017). The method of semi-structured questions allowed the participants to share their narratives which fitted the aim for the study (Danielson, 2017a). If a quantitative method had been conducted, the authors do not believe that the material would have been as colorful.

The authors had no insight on how the RNs were chosen, but to counteract this, they emphasized to the RNs their right to cancel the interview at any time at multiple occasions. As the authors did not themselves translate the written consent form, it is unclear if it was properly translated. The authors were not familiar beforehand with Vietnam's different nurse education system. This resulted in the participating nurses having widespread education, from two to four years, despite the inclusion criteria. Another inclusion criterion was that they had experience of caring for women with experience of IPV and on some occasions, the nurses had only had a few cases. A positive aspect of the participants demographics was the fact that they had an average of 19 years of nursing experience.

The Vice President from the VNA assisted the authors with the recruitment of the participants and since the VNA is managed by the Government it could have affected the selection. The Vice President also assisted with recruiting the interpreter and the authors have no insight into the competence of that person. A risk that exist with interpretation is that essence in the narratives may disappear (Seale, Rivas & Kelly 2013; Karanja & Musyoka, 2014). The interpreter chose to let the participants talk to point and interpreted sentences collectively which could also have caused important essence getting lost. Although, the authors believed that the translation was successful due to the widespread material that was gathered. Some of the interviews were conducted in the head nurses' office while that person was present and this could have prevented the participants from being fully honest. Since the participants seemed comfortable and open, the authors did not find this to be an issue. The authors had no possibility to ask for a change of room and therefore accepted the situation. Laddered questions (Price, 2002) with a phenomenological approach (Bullington, 2018) in the interviews turned out to be a well-suited method for the aim as the participants answered with openness. There were few breaks between each interview, which caused the authors and the interpreter to become fatigued and this could have affected the outcome of the interviews.

When transcribing, intruding sounds were at times heard which made it difficult to hear what was actually said. When this occurred, the authors relistened and made qualified guesses

on what they believed the content to be. The authors used a latent content approach which can be critiqued since the authors interpreted the participants words in order to find out the true meaning of their narratives and it therefore exists a risk of misinterpretation (Graneheim & Lundman, 2004). However, trustworthiness and reliability were promoted since the authors was transparent to the material, did not over analyze, but tried to understand the essence of it (Polit & Beck, 2017). The entire study was written by both authors together and descriptions for method and analysis were systematically used throughout. They were also aware of their preconceptions before analyzing the raw material as it otherwise could color their interpretation of the material (Graneheim & Lundman, 2004; Malterud, 2014).

## **Results Discussion**

The main findings in the study were the RNs' view of life being central in their view on women with experience of IPV, as well as their perceptions on women's responsibilities in society. The advice the RNs gave emerged out of their central value system and not from their profession which correlated and may be explained by the absence of guidelines in clinical practice.

One of the main findings from the results showed the vital impact RNs' view of life has on their perception on women with experience of IPV and by extension their caregiving. The central value system is a part of the view of life that describes the values that are central for the personality and forms the identity (Andersson, 2008). Ethical, moral and political norms are parts of the central value system which stay relatively constant over time. The nurses described their widely scattered perceptions on women and men's position in society which can be interpreted as parts of their central value system. When healthcare personnel possess these widespread perceptions on gender roles, it is uncertain how it affects the individual RN's caregiving. RNs that possess a clear perception on women's own responsibility when being abused, explained that this perception does not affect the nurse-patient relation or their caregiving at all. However, Watson (2012) describes that caring values and actions towards the patient are highly correlated. With that in mind, it would be impossible for RNs to set aside their own values in the caring moment. On the other hand, The Ethical Standards for Vietnamese Nurses (<http://hoinhap.kcb.vn/>) describe that nurses should be honest in practicing professional care for patients. This could be interpreted as nurses being obligated to be guided by their central value system as it is being truly honest with themselves. One possible solution is having a phenomenological approach in the dialogue with patients since it

enables them to be more sincere with themselves as well as with the nurse (Bullington, 2018). Preconceptions must be dealt with in order for nurses to be open to the patients' spoken life situation, instead of letting it manifest the caring (Wiklund Gustin, 2018; Malterud, 2001). The findings in the study showed that the RNs were often unaware of their preconceptions and therefore unconsciously allowed them to control their caregiving.

Some RNs argued that women have a vital responsibility towards their abusive husband and gave the advice to forgive them and other ways to minimize the abuse. At the same time there exists a risk for violent regression amongst men with a history of abusive behavior (WHO, 2012). Article 3 in the Universal Declaration of Human Rights (<https://fn.se/>) declares that everyone has the right to life, liberty and security of person and it could therefore be argued that this advice was a violation of women's human right to be safe. Furthermore, if someone's human rights are violated, it could also be interpreted as their dignity being violated (Nordenfelt, 2010). Every person obtains human dignity by the unwavering fact of existing as human beings and this must remain inviolable. The Ethical Standards for Vietnamese Nurses (<http://hoinhap.kcb.vn/>) declares that nurses should always respect patients' dignity. It could therefore be interpreted that they violated their patient's dignity when they provided biased advice. With this in mind, these kinds of advice should be avoided in the nursing profession as nurses should promote human rights and human dignity.

This leads to the question where these advices emerge from, since Vietnamese nurses are not responsible for teaching patients how to care for themselves (Pron et al., 2008). The findings showed that the origin for the advice are the RNs deep feelings of sympathy and wishes to improve women's life. Article 8 in the Ethical Standards for Vietnamese Nurses (<http://hoinhap.kcb.vn/>) describes that nurses should be dedicated to the patients care. From this angle, they acted in a rightful manner when they went beyond their profession and gave advice, as it implies that they are dedicated to their patients. Watson (2012) describes that nurses should strengthen human dignity through moral engagement, which correlates with this advice giving. Although, Watson continues to describe that this means that humans should decide themselves what is important for them and what choices to make. It is uncertain if the women are allowed to make choices for themselves when they are only presented with one sided advice. RNs who involved personal opinions in nurse-patient relations to the extent where it was forced on the patient could be understood as emotional power pressuring.

The findings also showed that the RNs experienced absence of guidelines about how to care for women with experience of IPV. Guidelines are an important part of caring for this patient group and it should include routinely assessments even when there are no visible signs

of IPV (Davila, Mendias & Juneau, 2013). Women with experience of IPV also expressed a wish for the nurse to address the topic and follow appropriate guidelines when providing care (Zink, Elder, Jacobson & Klostermann, 2004). It is therefore important that RNs have this in mind in all meetings with female patients and recognize the hidden statistics of IPV as there sometimes are no visible signs of it (Davila et al., 2013; Jayatilleke et al., 2010; Overstreet & Quinn, 2013). Another study showed that only a minority of the participating nurses had been using existing guidelines when caring for women with experience of IPV (Sundborg, Saleh-Stattin, Wändell & Törnkvist, 2012). A majority of global guidelines are not based on findings from qualitative research (Feder et al., 2006), which is noteworthy since qualitative methods are a vital part of human understanding (Henricson & Billhult, 2017). According to Watson (2012), the nurse must be aware and obtain knowledge about the patients care needs in order to provide a person-centered care and to not use guidelines will stand in the way of this. Some of the RNs in the study's findings explained that they are in need for clear guidelines which must emerge from society before being implemented in clinical practices. Article 3 in the Ethical Standards for Vietnamese Nurses (<http://hoinhap.kcb.vn/>) describes that nurses should maintain best practices at work. Watson (2012) clearly states that person-centered care is correlated to knowledge which could be argued is maintaining best practices at work. The ICN Code of Ethics for Nurses (2012) declares that nurses need to be provided guidelines when caregiving in order to not endanger the patient and Ha & Nuntaboot (2016a) describes that secondary educated Vietnamese nurses are not able to care for patients sufficiently. All this together equals a necessary establishment for guidelines without further ado as the care otherwise will continue to be uneven depending on the approach of the individual RN.

### **Clinical Implications**

The findings in the study highlight the need for thorough education of IPV and what kind of care it requires. Education regarding IPV should be implemented in all nursing programs as well as at clinics, initiated by the employer. This knowledge could then be used when meeting women with experience of IPV which includes a sense of sensitivity to if abuse has occurred, providing evidence-based care and guidance. The RNs are in need of guidance themselves to manage the difficult situations presented in the results. They are also in need to discuss their frustration as well as being provided with support from their employers. RNs also need to find a way to become aware of their preconceptions, view of life and how they correlate. In the

meeting with women with experience of IPV, the basis to stand on should be evidence-based guidelines, the ICN Code of Ethics for Nurses or local ethical codes.

The findings could benefit patients through being provided the best possible care. This could benefit the society as they then have the opportunity to elude second and third forms of complications that can arise from IPV which would otherwise financially burden the society. From the nurse's perspective, being able to provide the best possible care could enable them to feel comfortable, confident and capable.

### **Proposals for Continued Research**

Further research focusing on if RNs' clinical education about IPV affects their caregiving from the women's point of view is called for. If a positive effect could be proved, implementing clear guidelines in clinical practice is imperative. For a more person-centered care, these guidelines should be created and defined building on the women's experiences. This type of research would preferably be done through a combination of questionnaires as well as follow-up interviews; use of questionnaires for width and interviews for in depth knowledge.

Further research could also include RNs and how they themselves experience additional education, it's effect on their caregiving and by extension their emotions when providing it. This could be conducted with the same approach as mentioned earlier and if both studies would be conducted, it could become clear what impact education actually has from both perspectives.

### **Conclusion**

The findings indicate that RNs in this study allow their view of life to dictate their caregiving. As a consequence, the individual nurse involves their personal opinions and perceptions when giving care to women with experience of IPV and the care therefore varies widely. At the same time RNs express a wish for guidelines to improve their caregiving and for it to be more consistent. The RNs from this study go the extra mile when caring for this patient group and with proper guidelines in combination with their true desire to help, it could give them the adequate tools for proficient caregiving for women with experience of IPV.

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**Appendix 1. (Consent form)**

**Caring for women with experiences of intimate partner violence**

Nurses perspectives in Hanoi, Vietnam

Consent to take part in research

- I..... voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I agree to my interview being audio-recorded.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

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*Signature of research participant*

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Signature of participant

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Date

*Signature of researcher*

I believe the participant is giving informed consent to participate in this study

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Signature of researcher

-----

Date

## **Appendix 2. (Presentation of the study)**

Hi and welcome to today's interview session. My name is X and this is my colleague X. We are nursing students at Ersta Sköndal Bräcke University College in Stockholm, Sweden. We are writing our bachelor thesis about nurses caring for women with experiences of intimate partner violence. The interview will be audio recorded with two audio recording devices. You are free to answer questions you want and also to quit the interview at any time. This will not affect you negatively in any way.

The aim for today will be to let you tell us about your experiences meeting and caring for this patient group. The main questions that we will ask you, are about your thoughts and feelings.

X will ask you the questions and X will take notes and both of us will ask you follow up questions.

We estimate that the interview will take approximately an hour and if you need a break just let us know.

### **Appendix 3. (Interview guide)**

#### **Start questions**

- What is your age?
- Are you educated as a registered nurse?
- How many years of experience in nursing do you have?
- Can you please tell us about the reason you choose to be a nurse?
- Can you please tell us how long you have been working at this hospital?

#### **Main questions**

- Can you please describe a situation with a woman who experienced IPV?
- Can you please describe experiences of caregiving for these women?

#### **Probes**

- You mentioned... can you tell us more about that please?
- Earlier, when you said... can you elaborate that please?