NURSES' EXPERIENCES CARING FOR CHILD VICTIMS OF DOMESTIC VIOLENCE: A PHENOMENOLOGICAL ANALYSIS

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ABSTRACT: The purpose of this study was to understand the experience of nurses in their care of child victims of domestic violence. Using the phenomenological social approach by Alfred Schütz, 15 nurses who work in emergency, intensive care and pediatric inpatient units were interviewed. Analysis based on the Motivational Theory of Schütz allowed the description of the lived type, supported by three categories that express significant elements of the nurse's experience: contact with the violence, ambivalent reactions and protective professional attitude. The lifeworld of the nurses who care for child victims of domestic violence is composed of various dimensions that generate a constant state of attention, and reactions that cause indignation, anxiety, sadness and a sense of helplessness, which need to be internally managed in the course of his/her care.

DESCRIPTORS: Violence. Child. Family. Nursing. Qualitative research.

VIVÊNCIAS DE ENFERMEIROS NO CUIDADO DE CRIANÇAS VÍTIMAS DE VIOLÊNCIA INTRAFAMILIAR: UMA ANÁLISE FENOMENOLÓGICA

RESUMO: O propósito deste estudo foi compreender a vivência dos enfermeiros no cuidado à criança vítima de violência intrafamiliar. Utilizando a abordagem social fenomenológica de Alfred Schütz, foram entrevistados 15 enfermeiros que atuavam em unidades de emergência, cuidados intensivos e de internação pediátricas. A análise pautada na Teoria Motivacional de Schütz permitiu a descrição do tipo vivido, apoiado em três categorias que expressam aspectos significativos da experiência do enfermeiro: o contato com a violência, reações ambivalentes e atitude profissional protetora. O mundo-vida dos enfermeiros que cuidam de crianças vítimas de violência intrafamiliar é composto de diversas dimensões que geram um constante estado de atenção, e reações que causam revolta, inquietação, tristeza e sensação de impotência, as quais precisam ser internamente manejadas no transcorrer de seu atendimento.

DESCRITORES: Violência. Criança. Família. Enfermagem. Pesquisa qualitativa.

VIVENCIAS DE LOS ENFERMEROS EN EL CUIDADO DE NIÑOS VÍCTIMAS DE VIOLENCIA FAMILIAR: UN ANÁLISIS FENOMENOLÓGICO

RESUMEN: El propósito de este estudio fue conocer la vivencia de los enfermeros en el cuidado de los niños víctimas de la violencia familiar. Basado en enfoque fenomenológico social de Alfred Schütz, se entrevistaron 15 enfermeros que trabajan en las salas de emergencia, cuidados intensivos y unidad de hospitalización pediátrica. El análisis, basado en la teoría de la motivación de Schütz, permitió la descripción de la vivencia apoyada en tres categorías que expresan los aspectos significativos de la experiencia del enfermero: el contacto con la violencia, las reacciones ambivalentes y la actitud profesional de protección. El mundo de la vida de los enfermeros que cuidan a los niños que son víctimas de la violencia familiar se compone de varias dimensiones que crean un estado de atención constante, y las reacciones que causan la ansiedad, la tristeza y la impotencia, los cuales deben ser manejados internamente por los enfermeros en el curso de su cuidado.

DESCRIPTORES: Violencia. Ninõ. Familia. Enfermería. Investigación cualitativa.

INTRODUCTION

Domestic violence against children or adolescents corresponds to any action or omission that harms the well-being, physical or psychological integrity, and right of development of this population. The phenomenon of violence and accidents is considered to be endemic in many countries, including in Brazil, where it is a serious public health problem. In 2009, domestic violence was the third cause of death among the general population, and first in the population from 1 to 39 years.[1] Violence against children and adolescents encompasses specific concepts of physical, psychological, sexual and negligence violence,[2] and is related to personal and social factors. Significant interactions are found between experiences of body punishments during infancy and perceptions of affection, parental support and impulsivity during discipline, and the prediction of attitudes in relation to spanking.[3]

In Brazil, statistics show that rates of violence against children and adolescents are significant. However, the lack of homogeneity in regard to methodology questions and population age range, as well as the concentration of studies done in specific areas of the country, make it difficult to sketch a real and general panorama of the problem in national scope.[4] In the global context, research on this theme has focused on the causes of the problem and the physical and emotional consequences for the child and/or adolescent that experiences the violence, especially when this occurs in the family context.[5]

Treatment of the child victim of violence in the hospital environment, principally when the aggressor is a family member, is a difficult task for professionals, as many cultures maintain beliefs, norms and social institutions that legitimize and therefore perpetuate the violence.[6]

To treat and receive the child victim of domestic violence requires a highly skilled nurse, with knowledge and abnegation of the feelings inherent to the situation, since the family is also inserted into this context of care. An ethical attitude implies impartiality in actions; thus, to be ethical in the treatment of cases of violence against children, the nurse needs to commit to avoid releasing the child to the aggressor, while at the same time not be hostile with family members.[7]

In light of this complex situation, constantly present in the daily work of nurses who care for pediatric populations, this study was driven by the following question: how do nurses experience care for child victims of domestic violence?

In this way, the objective of this study was to understand the experience of the nurses in their care of child victims of domestic violence, in pediatric emergency, intensive care and inpatient units.

METHODS

In order to meet the objective of this study, Alfred Schütz' theoretical-methodological reference of Social Phenomenology was used,[8-12] based on the assumption that peoples' actions are driven not only by psychological motives, but also existential, and that they act based on previous experiences, and typifications in relation to the world and the sum of their knowledge. The beliefs and convictions of the group are real and part of the lived experience.[8]

Motivational behavior is referred to as a group of motives, where the motivations of the individual point to the future (in order to motives) and explain the project as a result of past experiences, the baggage of knowledge acquired by personal experience and transmitted by predecessors (because motives). For the lived type, according to Schütz, only one typical motive exists as far as a typical act, originating from the same context base of meanings. The lived type is always determined by oneself, from the point of view of interpretation [the interpreter], allowing for a new perspective, and will vary according to his/her interests and problems.[9-10]

The study participants were defined as follows: nurses with experience in the care of child victims of domestic violence, in emergency, intensive pediatric inpatient care units in the city of São Paulo. Recruitment of the nurses was done through "snowball" sampling, in which the researcher solicits the first informants, who in turn recommend other participants for the study.[12] The participants were approached via direct contact by the main researcher, who, after obtaining their verbal consent and signature of the Informed Consent Form, performed semi structured interviews for collection of data. All of the interviews were recorded and later completely transcribed for analysis. Fifteen nurses participated in the study, of which 14 were women and one was male, all between the ages of 27 and 48, with time since graduation varying between three to twelve years.

The following guiding questions were used to perform the interviews: how do you experience

care for child victims of domestic violence? What do you expect to accomplish with your care? All of the interviews were recorded and entirely transcribed for analysis.

Based on the theoretical-methodological referential adopted, the analysis phase of the data was done with attentive and careful reading and rereading of the transcribed material, aiming to grasp the motivational context of the nurses in their care of child victims of domestic violence, according to the following steps: a) grouping of the significant elements of the discourses; b) identification of content convergences that compose categories, which encompass participants' acts and meanings of the social act; and c) identification of the discourse typicality of the discourse aiming to obtain the lived typology.

The research was conducted according to the ethical precepts contained in the National Council of Health Resolution (CNS 196/96) and the Helsinki Declaration, and was approved by the Research Ethics Committee of the School of Nursing of the University of São Paulo (Process 798/2009/CEP-EEUSP).

RESULTS

The units of significant results from the analysis, which explained the motivational context of the nurses who care for child victims of domestic violence, were organized into three categories: a) Contact with the violence; b) Ambivalent reactions; and c) protective professional attitude. Each category, in turn, comprises different subcategories, making possible better comprehension of the experience investigated.

Contact with violence

Reflects the context of the experience of the nurse caring for a child victim of domestic violence.

Attention to violence

Everyday contact with violence against children awakens in the nurse a state of alertness, which mobilizes him/her to identify warning signs to detect the violence. Alertness to the violence is related to the professional experience of the nurse, originating from his/her everyday interaction with the child and/or family. Suspected violence requires perception, sometimes subjective, that something is wrong with the child, due to physical changes or suspicious behaviors. This perception requires experience and capacity for observation acquired throughout his/her experience in the care of child victims of domestic violence.

The nurse remains alert to violence in the face of situations such as:

a) Diagnosis that may make detection of the violence difficult, present in situations in which the child presents signs and symptoms associated with some pathology.

I [nurse] *had one case of a child that we* [nursing team] *suspected had osteogenesis imperfecta. After the third hospitalization we* [the team] *saw that it was assault* [...] (N3).

b) Presence of unspecific signs in the child, such as intense crying to physical touch, perception that the child is sad or frightened by questioning done by the team or in the presence of the supposed aggressor.

We perceive [the violence] *by the attitudes of the child, the way in which she treats us, during a conversation we see that she has some problem* [...] *she was a child that liked to play, but when her mother was present she became sad* [...] (N11).

c) Signs indicative of violence, which bring the nurse to perform a detailed physical exam of the child, recognizing the possibility that the child could become very frightened, due to the eventuality of being a victim of constant violence.

We see that [the violence] *is very traumatic* [for the child], [the violence] *influences his living and development a lot* [...] (N14).

Verification of the violence

The nurse seeks to confirm violence to the child through physical alterations, complementary exams and reports from the child and/or a family member. For the nurse, confirmation of this type of violence unchains a lot of worry, since s/he observes the occurrence of these events in a lot of families.

[...] *these days it is difficult to go through one month in which I don't have one or two cases of poor treatment, sexual abuse* [...] (N15)

By believing that the mother should be the one who struggles for the child and constantly cares for him/her, the nurse suffers when trying to comprehend the decision by mothers who, although they know that someone in the family unit is practicing violence against the child, prefers to

remain in silence or risk losing guardianship of the child, due to fear of denouncing the supposed aggressor.

[...] *I have seen cases in which the mother lost guardianship of the child because she did not want to leave the aggressor* [...] (N1).

Ambivalent reactions

Contact with violence to the child simultaneously awakens positive and negative reactions in the nurse.

Empathy

The nurse seeks explanation to comprehend how the violence against the child occurs in the family context, and at the same time, feels uncomfortable with the situation that the child experiences. To understand the practice of violence against the child in the family sphere is a complex task for the nurse, as the family should be the foundation for the child, and should protect, shelter, provide security and comfort throughout his or her growth and development.

To deal with the spontaneity of some families to speak about the practice of violence against the child is also difficult in the nurse's experience, who does not understand when the family deals with this problem in a mundane manner, because s/he believes that such an issue should be discussed with a lot of caution, in order to protect the child.

A lot of times the parents [...] *arrive and talk* [about the violence] *as if it was the most commonplace, natural thing in the world. They talk about it to the entire ward* (N8).

Indignation

The nurse questions the attitude of the adult aggressor, who through a relationship of power violates the rights of the child, who is extremely fragile in relation to him/her. The manner in which domestic violence occurs awakens indignation in the nurse, since s/he perceives this practice as something constant in the family sphere. This feeling of indignation occurs not only from the recognition by the nurse of the child's fragility and incapacity for defense in relation to the adult aggressor, but principally for having been caused by a family member, whose violence will result in irreparable physical and psychological damage to the child's development. Faced with this experience, the nurse continues an internal search for comprehension of the motives that bring the family to commit violence against the child.

[...] *you ask yourself what does the child do to make a person get to the point of hitting? Burning with cigarettes, bites, and sometimes fractures* (N15).

Sadness

The nurse suffers from seeing the lack of value or protection of the child by the family. For the nurse, care of a child victim of domestic violence is to encounter the lack of importance that the family system attributes to the child, and the lack of recognition of the role that it performs for proper child development. Not only to witness, but also to speak about the experience of caring for the child victim of domestic violence causes sadness to the nurse, because to describe how the violence occurs leaves a sensation of emptiness, since s/he is not able to find explanations for such an event, seeing that nothing justifies the practice of this violence.

I [nurse] *felt really sad and began to question things in regard to interpersonal relationships a lot, because if a person that brought a child into the world has the courage to do that* [beat the child], *we have to be really afraid, thinking up to what point people can do bad things to the other* [...] (N5).

The nurse also experiences situations that cause sadness when s/he feels intimidated by the family, seeing that in addition to observing the suffering of the child, s/he has to make the decision to denounce the case of violence, even suffering threats by some family members. The motivating element for undertaking the report is the nurse's desire for a better life for the child.

What most hurt me was that the parents threatened the team. If we denounced, we would pay for this, so it is a complicated situation for the team, because we can't feel intimated. For this our part would need to be done [...] *I* [nurse] *felt a lot of sadness* [...] (N6).

Helplessness

The nurse feels invaded by this feeling when s/he believes that s/he has not been able to do anything or s/he could have done more to help the child. Care of the child victim of domestic violence is also considered a very complex task as it surpasses the nurse's anxieties, who in spite of wanting to do the best for the child, is not always able to carry out what s/he believes to be best.

[...] *I felt helpless. What is it that I could do for this child? I can't do anything; we feel helpless* (N15).

This sensation of helplessness goes beyond the hospital environment, because the nurse would like to be able to contribute to these children beyond this sphere, believing that in order for the child to have a better life, help from other support networks are necessary. In addition to generating indignation, to deal with the family of the child causes a sensation of helplessness in the nurse by not being able to obtain from the aggressor or other family member confession to the act of violence, in addition to not being able to keep these individuals away from the child. The nurse would like to have autonomy to keep the child away from the aggressor, but his/her role as a professional requires certain attitudes that remain beneath his/her desires.

You [nurse] *end up feeling helpless, because your urge is to take the child away from the adult right away and say, 'don't come close, you are a liar!'* [referring to the aggressor] (N12).

The nurse recognizes that in her experience she has encountered institutional strategies to not denounce the violence to the responsible agencies, above all in institutions that aim to preserve the institutional image, keeping it anonymous. In spite of believing that the correct thing to do is to file a report, the nurse feels helpless for not being able to interfere in a process that, in some situations, happen regardless of their participation.

I felt helpless because I didn't only want to be able to treat the child, but also [wanted] *to arrest the parents* [...]. *But when it is a leading private hospital, things take another route and go in another direction, and we, as professionals, cannot interfere* [...] (N5).

Become accustomed to the violence

The nurse ends up not suffering anymore from the impact of the violence experienced by the child. During his/her experience, caring for child victims of domestic violence may become normal and commonplace for the nurse, and the violence may no longer provoke feelings of indignation, sadness and helplessness in the care of the child and family, giving way to indifference, bringing the nurse to become accustomed to, and experience with no impact, the new cases that emerge during his/her professional experience.

[...] *I don't feel much impact, because, it's like, we get so many* [children], *recently there have been a lot, and so before we used to get more* [impacted], *but these days it is hard to go through one month in which you don't have one or two cases of poor treatment, sexual abuse* [...] *I have already had so many* [cases] *that we are beginning to become accustomed with the situation* [...] (N15).

Protective professional attitude

The primary motivation for the actions of the nurse is centered on the creation of a protective environment for the child and moral, human and professional values.

Protect the child

When the nurse is with the child, s/he seeks to protect him or her from domestic violence, doing this through constant surveillance and the offer of a comforting, caring, safe and welcoming environment. The primary motivation of the nurse is to protect the child, because s/he believes that the violence may cause consequences for the child's entire life.

In an attempt to want to help the child victim of domestic violence, seeing to ease the pain and emotional trauma of the child that suffered the violence, the nurse seeks to use strategies to protect it. The significance of this protection is linked to the offer of welcome, safety, care and comfort, surpassing the mechanistic processes present in his/her professional everyday.

S/he [the child] *stays with us for a certain amount of time, and we end up caring about the child, which she certainly doesn't have at home, and we end of giving them what they don't have* [...] (N14).

The intensification of surveillance is translated into attitudes such as how to leave the doors and windows open, since this allows the child to be seen, causing the sensation that s/he is not being left alone with the supposed aggressor. These attitudes are also seen by the nurse as an attempt to demonstrate to the child that nothing bad can happen to him/her.

But, within my capabilities, what I did was intensify surveillance, and try my best to help the child emotionally [...] (N4).

Monitor the families

The nurse recognizes the complexity of the violence in the family sphere, and that the efficacy of the intervention also depends on monitoring of

the families. Monitoring of families that practice violence is seen by the nurse as fundamental to treating the child, by being an attempt to restructure the family system and monitor conditions in which the child is living. They suggest as strategies for this monitoring: carrying out home visits and group meetings with the families at the hospital, monitored by a multidisciplinary team.

[...] *the family has to be monitored, has to have a strengthened relationship, the relationship with the father, mother and child,* [the family] *has to go through a process of therapy to free itself a little from this feeling* [...] (N15).

Family planning is perceived as a preventative measure against domestic abuse of the child, since the nurse observes that the more children and worse financial and social conditions the family has, the greater the chance the child has of suffering domestic violence.

People should have a better culture, and thus, not so many children. [...] *it was one mother who had various children, and you know the reason for this aggression? Because she had nothing to feed them* [...] (N3).

Denounce the violence

The nurse wants to have more autonomy in notification of the violence, with an efficient, specialized support network backed by the institution, with the possibility of participating more actively in the process of denouncing the violence. For the nurse, the process of reporting the violence requires attention, from suspicion of violence to its confirmation. However, to confirm the practice of violence is not always an easy task, as in addition to requiring a sharpened sense of perception of the professional, a network of professional support is needed to help the professional in the treatment of the child and his/her family.

[...] *if the mother does not worry, then I think that we should seek channels that preserve the child, or that leave the child in a state of non-danger, to not suffer anything new, to seek to keep him/her as far away as possible from the aggressor, or whoever is abusing the child* [...] (N1).

The nurse believes that reporting the violence should be done as a way of protecting the child from future and recurring practices of domestic violence, and therefore should not be omitted or ignored. Concern of the nurse to denounce the violence is a concrete desire in his/her experience, and for this reason, s/he seeks to confirm the violence when it is suspected.

[...] *including encouraging and speaking to see if she* [the child] *told me something that was relevant* [...] *to see if something relevant was said to be able to help us* [nursing team] *to call the police, the guardianship council, or anyone responsible for this* (N4).

This struggle requires a long trajectory, since the nurse does not always have autonomy in the institution where s/he performs his/her duties, to further the process of reporting. Thus, it is not enough to identify and confirm the violence, because there are still institutions that insist on not denouncing the violence practiced against the child.

I work in an institution that does not direct things in this manner. I observe that in the public system things are more directed; the guardianship council is called, the father, mother and child are monitored in the family sphere [...] (N5).

Protecting oneself

The nurse tries to protect him/herself from his/her own feelings, in order to not permit his/her reactions and personal opinions about the violence interfere in the care provided to the child and family, because s/he believes that certain behaviors may interfere negatively at work.

As a nurse, we have to be professional, to not let emotion take control of us, because if we let emotion take over, we are not able to work [...] (N8)

In order to protect him/herself from her reactions and personal opinions, the nurse seeks to use specific strategies, such as seeking to not show his/her feelings while caring for the child, and to not think about the future of the child, in the event that it remains under the care of the family.

You try to do the best, do your job, and seek to not think too much about what is going to happen to the child when s/he leaves [...] (N8).

Managing his/her feelings becomes more complex when the nurse is invaded by a wave of personal questions, which vary from inquiries about the motives that bring a family to practice violence, to what the children would like done for them.

[...] *You just wondering how a father, someone from the family, can do something like that to a defenseless person* (N15).

Lived type

Construction of the lived type was a result of retaking the motivations identified and conver-

gences of their meanings. Thus, the lived type of the nurse that cares for child victims of domestic violence in emergency, intensive therapy or pediatric inpatient units is that in which his/her everyday world, in the presence of situations of violence against the child, mobilizes attitudes of suspicion and monitoring to confirm the violence, while at the same time presents ambivalent reactions in front of the child and aggressor, whether the violence is suspected or confirmed. His/her approach to the child victim of violence is motivated by protective professional conduct in relation to the child and his/her professional and personal beliefs. This conduct mobilizes in him/her the desire to denounce the violence, to monitor and save the family aggressor and to protect him/herself, so that his/her personal reactions to not interfere in his/her care.

DISCUSSION

This study made it possible to determine the actions of nurses in a very specific manner, demonstrating that his/her social action is connected to his/her amount of knowledge, aiming to improve his/her way of caring for child victims of domestic violence. These actions are based on his/her lifeworld, and therefore to address various reactions in his/her process of caring is something inherent to his/her experience.

When analyzed from the perspective of social phenomenology, these findings are coherent with some findings in the literature. Among the common evidence, it is highlighted that nurses experience in their everyday world a constant meeting with violence against the child in his/her care in pediatric units.[11] S/he believes that the violence should be denounced, and engages in an effort to confirm it if s/he suspects it. In the assistance of a possible victim of violence, the suspect is the first factor to be considered by the professional, because it from there that a more detailed investigation can be initiated to confirm it.[12-13]

The study points to an important aspect of the lifeworld of the nurse, which is identified as a world of many challenges, in which caring for a child victim of violence is defined as something difficult, generating suffering and which demands great ability in perception and intervention. The professional needs to have abilities to be able to detect possible cases of violence, in order to not overlook unperceived victims of domestic violence.

The report of violence by the professional supports the need for use of protocols of institutional service in order to minimize errors in the identification of these cases and of a network of professional support. Protocols provide safety and support to the professional, assisting in the detection of cases, since the process of investigation is no longer based solely on his or her opinions and personal knowledge.[12] One study shows that reports of suspected or confirmed cases of abuse is the primary way that the health professional works.[14] The importance of complete and correct filling out of the cases attended to is also highlighted, since this can contribute to the quality of the report,[15] and engagement between professionals from various sectors.[16]

In regard to network of specialized support, this can help the professional to identify, care for, evaluate and forward cases of child victims of domestic violence,[11-12] as well as manage feelings of emotional ambivalance,[7] and identify the vulnerability of the family.[17]

The suffering of the nurse from glimpsing the future of the child victim of violence is another highlight of the study that is very important to the ethical dimension of care. While some children exhibit resilience and are not affected by these experiences, for others it may have a negative influence on social, emotional and cognitive development, which may have long-term consequences, interfering in his/her functioning and relationships as an adult.[18-19]

FINAL CONSIDERATIONS

The investigation, based on Social Phenomenology by Alfred Schütz, allowed for the grasping of the typical experience of nurses who care for child victims of domestic violence, in emergency, intensive care and inpatient pediatric units. The lifeworld of the nurses that care for child victims of domestic violence is a world composed of diverse dimensions that generate a constant state of attention, and reactions such as indignation, anxiety, sadness and a sense of helplessness, which need to be internally managed during the course of treatment.

Reflections and discussions about this experience among health professionals, especially between nurses, need to be encouraged in healthcare environments and in spaces of professional training. The magnitude of the problem does not permit the issue to be dealt with from an individu-

alized viewpoint imbued with bias. It is necessary to look at all of the actors involved in the situation, including professional, children and family members, highlighting the importance of the nurse to know the family and context into which the child victim of violence is inserted.

It is necessary to think about support strategies appropriate to the needs of the participants in the situation, with major emphasis on support for the professionals. The nurse needs training, counseling and experience to properly manage all of the complexity that exists in the situation of violence against children, in a way that makes the experience of care for the child victims of domestic violence less painful in his or her everyday world. This is one path to be further explored by investigations and the proposal for interventions that technically and ethically qualify clinical practice in situations of violence.

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