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Experiences of nurses in health care for female victims of sexual violence

ABSTRACT

OBJECTIVE: To understand experiences of nurses caring for women who have suffered sexual violence.

METHODOLOGICAL PROCEDURES: Qualitative-clinical study in which six nurses from a health care service for women who had suffered sexual violence were interviewed in the city of Campinas, Southeastern Brazil, between April and May 2007. Semi-guided interview technique with open questions was used. Data were analyzed following the content analysis technique, based on a psychodynamic framework. The following analytical categories were produced: what they think about, how they feel, how they act and how they react to the work with sexual violence victims.

ANALYSIS OF RESULTS: Interviewees indicated receptiveness as key to provide humanized health care and form a bond with clients. Feelings such as fear, insecurity, impotence, ambivalence, anguish and anxiety were reported, causing behavioral changes and interfering with one's personal life, in addition to feelings of professional achievement and satisfaction. Technical qualification and activities aimed at providing psychological support were mentioned as strategies to help this type of care.

CONCLUSIONS: Although dealing with feelings such as impotence, fear and indignation, the nurses' perception of relief when fulfilling their job tasks and the personal satisfaction felt when helping these women seem to surpass other feelings, as a form of gratification. The desire to "run away" from the health care service and the willingness to do one's best occur simultaneously and are used as inner mechanisms in the sense of minimizing pain and suffering.

DESCRIPTORS: Nurses. Nurses, Male. Nurse-Patient Relations. Battered Women. Humanization of Assistance. Qualitative Research.

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INTRODUCTION

Sexual violence is an underreported crime and a serious health problem due to high rates of female morbidity and mortality.⁶

According to the Brazilian Ministry of Health, sexually abused women need humanized care when interacting with health service professionals.^a However, while caring for women who have suffered sexual violence, these professionals frequently have to deal with their own anguish, facing human limitations, and somehow show their feelings to others.³

A phenomenological³ study showed that such professionals feel powerless. Lack of resolvability might lead to a feeling of impotence, because they confuse their objectives and limitations with those of the people cared for. Authors comment that this impotence causes perceptible tension among professionals, along with sadness and anguish.

The impact on professionals resulting from caring for people who suffer sexual violence may influence the quality of care provided. These professionals start to share the experience that causes a feeling of impotence and to underestimate their own capabilities and knowledge. In addition, they overlook the resources and possibilities of those who have suffered such violence.³

These reactions are not only evident when caring for sexual violence cases. Professionals who care for battered children and adolescents react similarly. They also feel impotent, anguished, indignant, shocked and guilty.¹

In view of the difficulties encountered in their daily routine while receiving and caring for patients, the need to know the nurses' experiences was observed. This happens because caring for this group of women involves ethical, moral and religious issues which could be the cause of psychologically/emotionally-related repercussions. Thus, this study aimed to understand nurses' experiences, while caring for women who have suffered sexual violence, in a university hospital specialized in this type of care.

METHODOLOGICAL PROCEDURES

In 1998, the *Centro de Atenção Integral à Saúde da Mulher* (Caism – Center for Women's Comprehensive Health Care) of the *Universidade Estadual de Campinas* (UNICAMP) created a specialized service aimed at caring for post-pubertal women who suffer from sexual violence, with protocols focusing on humanized care in the municipality of Campinas, Southeastern Brazil. This care is carried out and provided 24 hours a day, being prioritized at the moment of the client's arrival

at the service, in a private and calm environment. The team consists of nurses, health care workers, psychologists, gynecologists and psychiatrists, with specific protocols for each professional category. Therefore, when a woman identifies herself as a victim of sexual violence, a receptionist accompanies her to the gynecology inpatient unit (IU), where the nurse team and the nurse care for her. He/she is the first professional to care for this woman after the aggression. Subsequent to the nursing consultation, this woman is sent to medical, psychological and social care and to the outpatient unit, in order to undergo treatment with the multidisciplinary team for a period of six months.

According to the nursing protocol,⁸ the IU professional collects anamnesis data, executes medical prescription and performs interventions according to the identified nursing diagnoses.

Interviews were conducted from April to May 2007.

Sample selection was intentional and its size established by saturation criterion.⁵ The criteria used to select interviewees were: being a nurse; caring for women who have suffered sexual violence; carrying out professional activities during data collection and accepting that the interview be recorded and literally transcribed at a later date.

A total of six nurses were interviewed (one male and five females). They were responsible for receiving immediate care patients, who had just suffered sexual violence. Interviews were privately conducted in the workplace and lasted 90 minutes on average. Nurses were aged from 29 to 60 years; two of them were married, two were single and two were divorced. They had between six and 32 years of professional experience and had been working in a service aimed at caring for sexual violence victims for a period from two to eight years.

The semi-directed interview technique with open-ended questions⁴ was used, which enables accurate listening. A form including identification data and an interview guide were used to know the experiences of professionals. Verbal and non-verbal expressions, such as personal presentation, general behavior, body expressions, speech alterations and other manifestations were noted down.

The interview guide had the following starter question: "Caring for women who have experienced sexual violence may cause certain feelings. Tell me how it is for you to work with this." It included questions

^a Ministério da Saúde. Secretaria de Políticas de Saúde. Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes: norma técnica. Brasília; 1999.

about situations experienced in their daily routine, receptiveness, professional qualification, psychological support offered to them, reactions and feelings towards the care provided.

Interviews were recorded and transcribed at a later date; treatment of data underwent the content analysis technique and thematic analysis was selected. This analysis consists of discovering units of meaning that comprise a type of communication whose presence or frequency mean something to the analytical objective aimed at.¹⁰

After reading and rereading the corpus of the collected data, discussion among researchers and validation with peers from UNICAMP *Laboratório de Pesquisa Clínico-Qualitativa* (UNICAMP Laboratory of Clinical-Qualitative Research), a research group to whom the project belongs, data were grouped into the following categories: What nurses think about; How they feel; How they act; How they react.

Analysis was based on health psychology, which constitutes a field of psychology that emerged as an answer to a social-sanitary demand. Health psychology “multidisciplinarity” refers mainly to its participation and projection in the institution.¹²

This study followed Resolution 196/96 of the *Conselho Nacional de Saúde* (National Health Council) and was approved by the Research Ethics Committee of the *Faculdade de Ciências Médicas*, UNICAMP (UNICAMP Faculty of Medical Sciences, Protocol 546/2006). Participants signed an informed consent form.

RESULT ANALYSIS AND DISCUSSION

Throughout the interviews, while reporting how they reacted during care, different non-verbal reactions were perceived and some people felt emotional and concerned with what they were saying, unwilling to show insensitivity or fear. One participant affirmed being afraid of mentioning something compromising and asked for the recorder to be turned off. In addition, when asked if he would like to end the interview, he answered “no”. There were interviewees who asked for the recording to be stopped, arguing that they needed to collect themselves to carry on with the interview. Others stated they had much to say or seemed to feel comfortable with the questions.

What they think

All professionals reported that receptiveness is key for humanized and individualized care. Moreover, receptiveness is essential when making a bond and empathizing with the client. To achieve this, it is necessary

to build rapport with women and to show solidarity with their pain and suffering, i.e. an appropriate and vicarious affective response.⁸

“It’s essential to let her feeling reach me and allow my feeling to reach her. It shows that I’m receptive to her pain.” (I1)

“It’s important that I put myself in the victims’ shoes so I can interact with her in a healthy way.” (I1)

One of the factors for humanization of care is personal motivation, which gives rise to the action and transforms itself;¹¹ in other words, it changes one’s acting and humanizes care. Taking technical competence and humanized care into consideration, receptiveness will be an instrument which goes much further than simply receiving the client in a health care unit.⁷

According to the Brazilian Ministry of Health, receptiveness is considered the act or effect of receiving someone and it implies, in its various definitions, an act of approaching, a “being with” and “being close to”. In other words, it consists in an attitude of inclusion, constituting one of the most ethically/aesthetically/politically relevant directives of the *Política Nacional de Humanização do Sistema Único de Saúde* (National Health System Humanization Policy).^a

As a result, receptiveness, understood as the first contact between the professional and the woman who has suffered sexual violence, will provide not only physical, but also emotional safety, and the team sees it as an important factor of adherence to treatment.

Thus, participants of this study were found to understand receptiveness as defined by the Brazilian Ministry of Health.

“Receptiveness is like a blanket that covers the patient, a feeling, a piece of warm clothing, a safe port; they’re positive vibes that embrace her to get her out of this bad and sad place” (I1)

“Her life force is very frail; so, with good receptiveness, she’ll feel safe and confident and the efficiency of this first contact will enable her to be followed by other professionals. But if we make a mistake in this first moment...” (I5)

The nurse needs to organize a coherent set of knowledge and experiences in view of this concrete situation, so that health care for women does not cause suffering and anguish. When caring for them, professionals will certainly face complex emotional tensions which cause personal inner conflicts. Nevertheless, nurses proceed with their actions, as their objective is to care for these women, as shown in the following reports:

^a Abbès C. O Acolhimento como Rede de Conversações. Diretriz e Dispositivo da Política Nacional de Humanização da Atenção e Gestão do SUS. Brasília: Ministério da Saúde; 2006.

“It’s no use forcing a professional who doesn’t fit the profile for receptiveness and doesn’t like this kind of service. Sometimes we can be aggressive towards people who don’t fit the profile so they’ll participate in this program.” (I1)

“The discomfort and uneasiness appear when she describes the rape in detail. It’s never something smooth or easy to do, it’ll always be disturbing. But it’s part of the job and I have to work with this.” (I5)

The gynecology inpatient unit was chosen for this type of care as it is considered of low complexity. Consequently, the multidisciplinary team would be more available to provide immediate care easily and privately.

Personal situations with sexual violence are present in reports; i.e. some professionals have suffered sexual violence themselves, and the care provided may trigger new aggression.

“We’ve experienced some situations of professionals who’d suffered rape; many times they don’t want to deal with this, but it’s not an easy thing to do if you’re in the same workplace where this has happened.” (I5)

“Only those who really want and intend to do something for these victims should care for them. Unfortunately, this is not the case. People are forced to care for them because they work in this unit. There are nurses here who’ve been raped and now have to care for sexual violence victims”. (I1)

What they feel

Providing this type of care may trigger several feelings, according to each individual’s personal and professional experiences.

“It’s complicated to receive patients; we’re not always in the mood and that’s really the worst thing that could happen while we’re on duty.” (I4)

“When I see a woman going upstairs I close my eyes; oh my God, how terrible. If she goes upstairs with the porter, it’s violence. So, I’m unwilling to receive the patient at first. Then, I feel more supportive and humane. She’s been through something so awful that I need to offer her something good to even things out.” (I1)

“The truth is we don’t like receiving them, but we do it. There’re so many things we don’t like doing but we do them anyway. I feel no pleasure receiving patients, but I give them all the care they need”. (I6)

Receiving women who have suffered violence causes feelings related to professional experiences, once it requires interrupting one’s activity at that moment to

dedicate oneself to them exclusively. In such cases, they may not have enough time to care for other hospitalized patients who need the same attention. Therefore, their unwillingness to receive these patients might be associated with a disruption of their daily routine. Another possible factor is the fact that they do not feel prepared for this kind of care.

When an individual faces a dangerous situation without being properly prepared for it, fear becomes evident. Fear is a reaction to a situation of danger or to very intense external stimuli which surprises one who is unprepared. It is a state one is not capable of controlling or protecting oneself from. The difference between fear and anguish lies in the fact that the former is characterized by being unprepared for danger, whereas, in the latter, there is an element which protects the individual from fear.⁹ The following reports show that these professionals experience such feelings.

“That’s what happened, I was afraid that the mother would be robbed and the daughter raped. It was as if everyone around us could be a victim. It’s a reality that affects so many...” (I1)

“It’s something that moves me, no matter the age, but when I see someone who is the same age as my children who are home, I get more worried. It’s hard. I have two daughters and I always think about them at home, I guide them every day and stress how careful they should be.” (I6)

The feeling of impotence towards violence was observed in some cases. The lack of answers as to how to break a family and cultural cycle of violence and what to do to help has caused signs of frailty and indignation to arise in these professionals.

“When you put yourself in the victim’s shoes and you feel vulnerable, there’s a feeling of indignation. It’s so many things mixed up, sometimes you’re touched, other times things pass unnoticed, as if they were normal.” (I4)

“What most shocked me was the time a child was raped by her father. As I couldn’t help and interrupt this cycle, I guess this scar would last forever; and, unfortunately, her mom could be participating in it, because of their socioeconomic situation, so it’s very hard. (I1)

As difficult and painful as this receptiveness may be, it seems that the nurses’ skill for care is present and brings the satisfaction of a job well done as a health professional and gratification as a human being.

“Whenever the patient and the family hold me and thank me, I feel I was able to do a little something. I see something positive coming out of her. So, it makes me feel good.” (I1)

"I'm glad I've done my job. I received her well; I did everything I could. At that moment of pain, despair and anguish, I was there to give her a hand, wipe her tears, and do whatever she needed me to." (I2)

"I go home thinking about what happened, about this mission accomplished, and the fact that she's well. When she arrives at the hospital, she's crying and very upset; when she leaves, she's calm and relieved and so I get more relieved, too". (I3)

When the victim shows signs of relief or joy after being helped, the person who helped may feel happiness. Having experienced "empathic joy"⁹ once, this person may feel motivated to help again to feel this empathic joy once more. This self-reward inherently present in empathy is not a conscious process and it may be an adaptive factor.⁹

How they act

Professionals identified the need of being capable of receiving patients, with lack of professional qualification being considered a factor that may interfere with the several ways of acting.

When confronted with stress, violence, sickness, suffering and death, health professionals are very exposed and, consequently, in great need of care and sensitivity to feel well. Questioning oneself about the representation of oneself is the first step to self-perception, something indispensable for those who intend to communicate better, to interact and behave more adequately towards the other person.¹¹

Raising awareness of the emotional aspects involved in the nursing team's daily routine facilitates and improves caring,¹³ justifying the importance of the support and psychological preparation of professionals who work in the area of sexual violence.

"I'd like to get together with all other colleagues who receive patients and have a discussion and exchange ideas or cases. I think it's a way to gain knowledge and understand what's going on, how I've been affected. It'd be really important to take care of those who provide care and this is something we don't have." (I1)

"I've never been given any kind of psychological support here and I've never looked for it either; we talk and help each other."(I4)

Following the regulations of the Brazilian Ministry of Health, UNICAMP/Caism regularly offers technical qualification and workshops on psychological support to professionals who work in this field. The fact that participation is not mandatory could justify the lack of participation of some nurses. The university's *Serviço de Apoio ao Servidor* (Support Service for Care Workers) provides a psychologist to see all professionals in this

service, including the team responsible for cases of sexual violence.

Probably, greater promotion of and/or information about the importance of participating in these meetings by those responsible for these professionals will result in higher adherence to and search for psychological help and support, when necessary.

Although some nurses have been qualified to provide interaction with clients, aimed at their physical and psychosocial recovery, they presumably have difficulty in receiving victims, due to their inability to deal with the problem in view of their personal beliefs, values and experiences.

"When the qualification came, it was good and profitable. There was an improvement and we became more aware and gentle when caring for and receiving patients." (I5)

In one's role as nurse, the individual will certainly be confronted with emotional and relational tensions of a complex system, which includes the economic situation, hierarchical conflicts or conflicts among multidisciplinary team members and the priority of promoting health care according to the physical and psychological needs of their clients.²

How they react

Nurses reported reacting with fear, described the warning signs in their personal lives and changed these lives in response. Some of them have grown accustomed to the situation and become more careful, while others have begun to fear violence in their daily life. There are several types of reaction to receiving these women and continuing to care for them, as shown in the following reports:

"The first years were of despair, anguish and pain; it was very difficult to receive patients. Nowadays, I still feel their pain and can't help but put myself in their shoes, but I can work in a more detached way, I can understand it and not take this pain as my own." (I1)

"There are some cases that disturb us more; I don't like caring for them, but I've gotten used to the situation". (I3)

"It affects us in many ways; you change when you receive a victim of violence and you bring it to your daily life. For example, I haven't let the guy who delivers water come into my home since I cared for a woman who was raped because she opened her door." (I4)

"I look inside myself and see how much of an aggressor, how much of a rapist there is inside of me; I don't exclude the fact that I'm an aggressor, too." (I5)

As a limitation to this study, those who are responsible for the institution were not consulted about requests of transference of professionals from the unit (something not limited to the nurses interviewed only, once there are 18 employees working in this service); how concerned they were about professionals who had suffered violence; and whether they were aware of this situation. In view of this, it seems adequate to provide professionals who care for these victims with the choice of working with them or not, so that the quality of care given is not compromised, and, especially, to reduce the suffering and anguish caused by such care.

CONCLUSIONS

Professionals interviewed showed different feelings. All of them reported the importance of receptiveness,

empathy and bond with women. The desire of “running away” from care and the willingness of doing one’s best occur simultaneously and inner resources are used to reduce pain and suffering. Technical qualification and activities aimed at providing psychological support are mentioned as strategies that could assist this type of care.

Although dealing with feelings such as impotence, fear and indignation, the perception of relief when fulfilling one’s job tasks and the personal satisfaction felt when helping these women seem to surpass other feelings as a form of gratification. Although the service offers professional qualification and workshops on psychological support with certain regularity, not all professionals have participated. However, those who have later report the importance of these meetings in improving the care provided and in overcoming personal difficulties.

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