THE CAREGIVING PROCESS IN THE VULNERABILITY PERSPECTIVE

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This theoretical article deals with the process of caregiving in the vulnerability perspective, whose condition leads to the need for care. The text analyzes this process, which is characterized by the encounter between the caregiver and the care receiver. The hospitalized patient is an extremely vulnerable being, experiencing something unique. The caregiver plays a very important role in reducing this situation and preserving his or her autonomy and dignity.

DESCRIPTORS: vulnerability; professional autonomy

EL PROCESSO DE CUIDAR SEGÚN LA PERSPECTIVA DE LA VULNERABILIDAD

El presente artículo de naturaleza teórica, aborda el proceso del cuidar bajo la perspectiva de la vulnerabilidad, cuya condición lleva a la necesidad de cuidado. El texto analiza este proceso, que tiene como característica la conjunción entre el ser que cuida y el ser cuidado. El paciente hospitalizado es un ser bastante vulnerable que pasa por una experiencia singular. Por otro lado, la cuidadora tiene un rol fundamental para reducir esta situación y mantener su autonomía y dignidad.

DESCRIPTORES: vulnerabilidad; autonomía profesional

O PROCESSO DE CUIDAR SOB A PERSPECTIVA DA VULNERABILIDADE

O presente artigo, de natureza teórica, trata do processo de cuidar sob a perspectiva da vulnerabilidade, cuja condição leva à necessidade do cuidado. O texto analisa esse processo, o qual se caracteriza pelo encontro entre o ser que cuida e o ser cuidado. O paciente hospitalizado é um ser extremamente vulnerável que vivencia experiência ímpar e a cuidadora exerce papel fundamental no sentido de reduzir essa situação e manter sua autonomia e dignidade.

DESCRITORES: vulnerabilidade; autonomia profissional

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INTRODUCTION

Caregiving is a process understood as the consideration of how caring happens, or how it should happen. This process, to be briefly described in this text, deals with the encounter between the caregiver and the care receiver. Torralba comments on this encounter: "The encounter of two personal universes, two free worlds, two consciences, two unique destinies in history is produced by the action of caring for a human being"[1]. The relations of care that are shared between the protagonists occur during the encounter named moment of caring. This moment of caring is fully concretized when bonds of trust are established from the cared for to the caregiver, and who, in principle, should show responsibility, competence, respect and sensitivity to arouse this trust. It is also understood that the cared for, in the context of a hospital organization, is a vulnerable being.

Therefore, this text aims at analyzing, in a theoretical way, a few important points about the caring process. In this process, the caregiver and the the cared for are emphasized, since both live an experience – the moment of caring – characterized as the encounter of care. This care is visualized in the vulnerability perspective, which is represented in the present text by the disease and by hospitalization, i.e. the condition of being ill and being hospitalized.

CARING: PHILOSOPHIC INTERPRETATION

Caring is a way of being Man; it has meanings that come from Man himself. It includes behaviors, attitudes, values and principles that are experienced daily by people in certain circumstances; however, it primarily regards being or, as Santin prefers, it regards Man[2].

The human being is born with the potential of caring, which means that everybody is able to care. Evidently, this capacity will be more or less developed according to the circumstances it is exerted in during the stages of life.

The human being is a caring being; it is his essence. It exists before the being itself, it is *a priori*, "it is in the frontal root of the constitution of the human being"[3]. It is in caring that the *ethos* needed for human sociability and identification of the essence of being is found.

It is known that human beings need care to develop; in higher degrees in childhood and in the late stages of old age, when they show dependence for the execution of both their physical-social and mental daily activities.

Disease, disability and suffering are some of the circumstances that confer a state of vulnerability, as well as those mentioned before, from childhood to old age, and which are conditions that make caring possible[4].

The caregiver should be sensitive and skilled to help and support in circumstances of vulnerability and, therefore, caregiving has its point of maximum importance, since the efforts in seeking restoration go beyond the physical order, representing support and allowing the other, the cared for, to be by himself, in his own specificity, in his uniqueness. The caregiver ultimately seeks to preserve the integrity of the vulnerable being, regardless of what his condition results in, whether it is healing or relief at a terminal stage. Help is manifested in dealing with suffering, disability and limitations, or even in cases of support in states of fear and anxiety, among other conditions.

The caring process comprehends, more than technical procedures and activities, actions and behaviors that favor not only *staying with*, but also *being with*. Better yet, it is believed that procedures, interventions and techniques performed with the patient are only characterized as care at moments when caring behaviors are identified, such as: respect, consideration, kindness, attention, solidarity, interest, compassion, etc. Caring is an interactive process. It only occurs in relation to the other. The way of caring does not involve a subject-object relation, but one of subject-subject. In the context of the caring process, this relation is characterized as a professional relation, subject-other, based on respect and, if it falls into objectification, it would be seen as a relation of not-caring[5].

Today, there is a redefinition of the meaning of caring, which comprehends, as mentioned before, a much more widespread and integralizing dimension. It includes, more widely, a philosophic-anthropological complexity.

Caring is the human essence of being. It composes nature, the coming-to-be human and, therefore, it assumes an existential dimension. It also has a universal character, although it assumes particular connotations, depending on the cultural context.

Several authors point to responsibility in caring – responsibility and commitment with the other, and it represents the ethical dimension[1,4,6]. In Noddings, this dimension is also found: The response to the impulse of caring results in an act of commitment and composes an ethical ideal[7].

VULNERABILITY IN THE SUBJECT'S PERSPECTIVE

Vulnerability is directly associated with caring, as previously mentioned in a former item, as well as the idea of responsibility. Some of Francesc Torralba y Roselló's ideas will be borrowed to analyze the issue of vulnerability, expressed by the following topics.

Every human being is vulnerable, in all his dimensions, i.e. he is physically vulnerable because he is subject to falling ill, suffering from pain and disability and, for all that, he needs care; he is psychologically vulnerable because his mind is fragile, needing attention and care; he is socially vulnerable because, as a social agent, he is susceptible to stress and social injustice; he is spiritually vulnerable, meaning that his inner self may be object of sectary instrumentalizations[4]. In fact, the pluridimensionality of being, the relational world, life, work, actions, thoughts, feelings, even fantasies, all are vulnerable. Therefore, it can be said that the human being is more vulnerable than many other living beings. However, humans have a better capacity of protecting themselves.

In the present text, the interests cover the analysis of the vulnerability experienced by the human being – disease – which is characterized by being one of the more extreme types, and which demands care.

Torralba also relates philosophy and vulnerability in the sense that, when experiencing vulnerability, the being triggers a philosophical process[4]. In other words, when suffering from some illness, the human being philosophizes, because there is the need to find meaning in the suffering, in falling ill, in death; it is a way of responding to his vulnerability. In this way of thinking, philosophizing and caring are very similar actions, one working at the intellectual level and the other developing fundamentally at the level of *praxis*.

Phenomenologically, ontological, ethical, social, natural and cultural vulnerabilities can be distinguished. The ontological type presents distinct levels; the first, regarding the being, its ontological constitution: a vulnerable being is not an absolute, self-sufficient being. The human being is a dependent being, limited and radically determined by his own finitude.

Ethical vulnerability may present itself in the meaning of emotional instability, which is the being's capacity of succumbing, failing, since he is a finite structure. On the other hand, there is the capacity of acting in the moral sense, protecting the weaker and needy being, and this is related with the other, who in turn is also related with care, as in putting oneself in the place of the other, supporting him. It is an ethical imperative, i.e. a kind of moral duty towards the next-of-kin.

Natural vulnerability means the surroundings, the environment of the human being, subject to changes and transformations. Nature is fragile, especially considering the technical action of the human being. The intervention in the environment is directly reflected in the being and the outcome of his freedom. That is why nature should be well-cared for; deterioration of the natural reality seriously affects the personal structure of being, as well as his way of living, working and loving.

Social vulnerability is about the human being's sociability – he is inevitably a relational being. The interpersonal relation may develop at the level of friendship, love, respect and contemplation; it can also develop at the level of violence and instrumentality. Social vulnerability, therefore, is the possibility that the being has of being object of violence at the heart of society, of losing his social safety.

Cultural vulnerability can have its maximum manifestation in ignorance. For example, in the healthcare relation, the patient does not only suffer an ontological vulnerability; when falling ill, not only his anatomic and physiological structures are affected, but also his cultural vulnerability, represented by not knowing the reasons of his illness or by not knowing which type of care or treatment he is being submitted to. In this sense, the professional has the moral duty of caring for him, and this means not only helping in his recovery, but also providing adequate and pertinent information. In this action of providing information, the professional-caregiver will be using competence, empathy and the art of communication besides, of course, relating respectfully in the preservation or helping him regain self-esteem.

Information should be related to the patient's conceptions of health and disease and, therefore, it is said that the professional is also vulnerable, because he should overcome his own cultural vulnerability through an individualized knowledge of the patient, which will allow treatment to go on with dignity.

When the being falls ill, when he is not capable of developing his usual pace of day-to-day activities, because of somatic, social or psychological pathologies, he empathically perceives the vulnerability of his own being. Perhaps, in these circumstances, the being has the maximum perception of his own vulnerability. When becoming aware of his situation, the being accepts it much better. On the other hand, the caregiver needs to be aware of the vulnerability of the other, i.e. its extension and nature, and then make efforts to help and care. In order to make efforts to promote care, the caregiver should become involved in the working process of healthcare organizations, so that she can seek and perform not only what is her responsibility, but also what is idealized in nursing. Care is inserted in the everyday working activities of nursing, because it represents the core of the transformation processes of human beings' health-disease situations, i.e. it is the final product[8].

CHARACTERIZATION OF THE CARING PROCESS

The caring process occurs within the organizational culture of a hospital, which presents variable components that can be visualized according to what is described and graphically presented in Waldow[9]. Among the components, the environment is highlighted, which in turn includes the physical, administrative, social and technological environment. These components will not be analyzed in this text, since it favors the encounter between the caregiver and the cared for, although it should be mentioned that they play a fundamental role in a satisfactory caring process. The aforementioned environments make up the nursing scene. In her administrative function, she is responsible for the activities of caring, besides educational, organizational, planning and evaluation actions, which cover human interactions among different cultures, feelings and knowledge.

It is considered that the moment of caring has a transforming character, in which both the cared for and caregiver grow, in the sense that the former presents a more positive and serene attitude in the face of his experience with the illness, disability and even death, the result of a calm and friendly relation of trust with his caregivers.

When the patient is considered and respected as a unique person, it is important that all questions about his situation can be clarified. It is also important for him to increase his knowledge of himself, his illness, his existential condition of the moment, so that he can serenely use strategies to face the obstacles presented and engender plans for the future.

The knowledge about himself, his circumstances, limitations and potentialities will aid him in his self-esteem and trust in his situation, preserving his identity and courage. On the other hand, at the physical and emotional levels, pain relief, comfort, tranquility, relaxation and well-being, among others, can be mentioned. Feeling welcomed, protected and well-cared for will considerably influence the patient's experience so that it becomes as mild as possible.

Regarding the caregiver, growth is translated into satisfaction, sense of accomplishment, achievement, improvement of self-esteem, more safety and trust, besides pleasure and well-being. The experience acquired with each new situation and each new encounter adds knowledge to the professional. Every new life history and the experiences of the patient help to know people better, as well as the caregiver herself; her ways of caring become richer with her experiences with the patients, allowing them to evolve personally and professionally.

THE EXPERIENCE OF THE CARED FOR

The patient, when receiving care, experiences something unique, regarding both his illness and his hospitalization*. Feeling ill or being ill causes a disruption in the relation of the human being with the world. He faces a threat (of disease, suffering, disability and death), the unknown (his situation, his destiny, a strange environment, strange people) and

* See chapter 6 in Waldow (2004) and chapter 5 in Waldow (2006)

with a temporary or definitive lack of structure, called ontological crisis by Pellegrino, which affects the individual as a whole in the physical and psychological, social and spiritual sense[10].

All these aspects expose the patient's vulnerability, making him more fragile. His experience of living is interrupted, disarticulated, brought out of the regular rhythm. The relation of the patient with the others is also compromised; his intimacy, his privacy are invaded. His social world is modified and the patient feels oppressed, restrained in his movements and thoughts, humiliated and dependent.

It is common to verify a redefinition of values; the patient reviews what and how he was, and what and how he is now, and questions himself about the future, about how and what could happen. There is a reflection about the meaning of life and the priorities.

Several questions occur because of the disease, during hospitalization and during the caring process, such as: what is happening to me? What are they doing / will they do to me? Will it hurt? Am I going to die? Are these people competent, do they know what they are doing? Will they be able to help me? And so on.

When he becomes aware of his situation, the patient may accept care or not. However, as a rule, he submits to the medical authority in relation to his diagnosis and treatment, and puts himself in the hands of the physician, also accepting and submitting to the other caregivers and their care. Accepting and collaborating are closely related to several items described by Pellegrino and analyzed by Francesc Torralba, regarding the principle of autonomy that will be presented next.

To accept and collaborate with care, it is indispensable to trust the caregivers and the knowledge, i.e. how important the patient is, aware of what is happening with him. He will respond to the treatment and care as the aforementioned trust is preserved, and this corresponds to being aware of the competence, responsibility and attention given by the caregiver. An attentive, interested and respective approach is the key for the patient to respond positively, and this includes tranquility and security.

These answers can be verified through several signs, either by expressing doubts, complaints, even silence. Objective answers can be detected, such as: relaxation, reduction of pain, fever, stable vital signs, added to data perceived by the caregiver as others mentioned before, such as attitude, facial expressions, among others.

THE AUTONOMY ISSUE

Caring for someone means watching over his autonomy, developing his capacities and not opposing or go against his free and responsible decisions. However, there are circumstances like those related to the need for care, because the autonomy of the being is also found to be vulnerable. These circumstances require an analysis of the relation between the act of caring and the limits of the person's autonomy, because this autonomy is not unlimited, it presents distinct degrees and developmental registries. It is, therefore, dynamic and concrete[1].

Still using Torralba's ideas, in a bioethical and philosophical perspective, there are ways to understand autonomy, and, according to him, "Autonomy is said of a reality that is ruled by certain laws, distinct from other laws, but not necessarily incompatible with them"[1].

Autonomy has no direction, differing from freedom, which is fundamentally oriented towards the good. It also differs from free will, because this is related to the human capacity of choosing among several options. This capacity, however, may not be autonomous, may be totally determined or conditioned by exogenous elements of subjectivity itself. Autonomy occurs in the absence of coercion and ability to clarify the presented alternatives. From autonomy's internal point of view, it refers to a deep desire that is expressed through one's decisions, mediated by critical reflection.

On the occasion of illness, the circumstance of the cared for, the patient, is generally characterized by pain, anxiety and fear of the future. Therefore, autonomy is reduced, sometimes severely reduced and even absent. Torralba uses the term circumstance (which this text borrowed), explaining that this philosophical concept, originated from Ortega y Gasset, refers to the being, which is a relational being that is found inserted in history, belongs to a circumstance, i.e. a certain social, cultural, spiritual and linguistic framework. It is part of the personal identity and is determined by the framework of activity and personal decision[1].

The autonomy of the being who receives care presents limits. These limits may be medical, because of uncertainty about his pathological condition; it may be related to the situation of urgency; it may be limited in function of family power; and also because of economic factors, besides the limits imposed by law.

Another aspect about this topic that should be reminded is that the principle of autonomy should not be understood in an isolated way, separately from the principles of dignity, integrity and vulnerability. It should also be visualized in close connection with the principle of responsibility. In this sense, it is said that it is a type of autonomy without responsibility or, better yet, a decision without responsibility that is not able to assume and prevent the consequences of such a decision cannot be considered as autonomy, in its moral sense.

The theme autonomy does not only refer to the scope of the cared for, but also to what is considered as being part of the responsibilities of the caregiving professionals. In the field of health, it is related to the issue of competences, being a wide and complex subject that will not be addressed here.

THE CAREGIVER

It is important for the caregiver to be aware of what is happening, or what may happen with the patients (beings experiencing a circumstance of vulnerability) and, therefore, not only professional competence is required, but also sensitivity, discernment and intuition.

Knowing the patient, his history, his biography, his former experiences, his motivation, expectation, rituals of care and degree of vulnerability will be of great help in the caring process. Knowing the patient allows for the prompter identification and comprehension of his reactions. Being available not only for the patient, but for his family is also a valuable factor. The informed family, well cared for and supported, can greatly collaborate in the care.

A study reveals that, in the view of the nurse responsible for the coordination and planning of care, the concept of caring was perceived as the essence and integrality in the relation with the being, and this especially involves supporting the family[8].

The caregiver should be receptive and aware of what it means to be a patient, to be cared for, to be sick, to be hospitalized, as well as being sensitive to fears, anxieties and insecurities he and his family may present. She should be prepared to help the patient to deal with his new situation, that of being sick, of being hospitalized and needing help; she should ultimately attempt to keep his identity and preserve his integrity.

During the caring process, the caregiver must bring to practice her ability to think critically. All through this process, reflections about what is happening, what is being done and how she should act always need to be present. At each new encounter, she should evaluate the patient and his situation, seeing him as a whole. Several hypotheses and questions will be concocted, such as: What situation is this? Who is this patient? How vulnerable is he? How can I help him? What do I need to know about him? What do I need to know about him and his situation? Among many others.

When identifying what is happening and what the patient needs, the caregiver verifies the available means, so that care can be performed as promptly and adequately as possible. The actions should always be followed by interaction, i.e. talking, listening, touching, expressing interest, availability and acceptance. Attitude, facial and body expression, touching and looks are indicators of such items. Therefore, the patient may, in turn, detect when these behaviors are genuine and lose all trust in the caregiver and her care when these are absent or mismatched. Staying with and being with the other, the genuine presence, is fundamental*.

During and after the actions or procedures, the behaviors of caring should become explicit. The actions at all moments suffer a process of evaluation, such as how the action was performed, who performed it, whether there is the need to reformulate or provide something else for the next time, whether the material and environmental conditions were adequate, and so forth. On the other hand, reflection about her feelings and values is suggested, as well as about the meaning of the experience in relation to the experienced situation, as well as reflection about how she perceived the response of the patient and his family during the encounter. This reflection aids in the caregiver's learning, so that she can always refine her care, providing the patient with well-being.

The evaluation, therefore, is both subjective and objective. The caregiver will monitor the patient's

* This topic is covered in detail in Waldow (2006)

physical-chemical responses and, vital signs. She can also verify the patient's reactions, his behavior, if he is more or less relaxed, apprehensive, tense, among other items. Among the caregiver's variables, her motivation, experience, knowledge, technical skills, capacity of learning and critical thinking are noteworthy.

Therefore, the caregiver, when caring in its truest sense, interacts with the patient, putting her knowledge, technical skills and sensitivity in practice, helping him grow. The patient, in turn, in his genuine experience, shares his own being, experience, rituals of care, characteristics that will contribute positively to the caring process. It is good to highlight that both, caregiver and cared for, should benefit from the moment of caring.

FINAL CONSIDERATIONS

According to the above, it is verified that care, although necessary in all the stages of life and for all types of life on the planet, is fundamental when there is vulnerability. The compulsion to care is highlighted every time the other being presents itself in a state of vulnerability. The patient, due to his illness, is a vulnerable being; hospitalization, in turn, aggravates this state of vulnerability, which, as mentioned before, makes caring possible. During the caring process, the encounter between the caregiver and those cared for is of maximum relevance because, depending on how the relation is initiated, the experience may become less traumatic.

It is also primordial, during the moment of caring, for truth to be established between the cared for with the nurses and all other caregivers; the former will feel safer and calmer, extracting comfort and well-being, and the latter will feel accomplished, grateful and will extract more knowledge, because each new encounter enriches both beings involved in this relation. The role of caregiver is fundamental to reduce the vulnerability and to preserve the patient's autonomy and dignity. In this sense, the nursing professional, in particular, is responsible for obtaining an environment of care, and this involves actions that mobilize both human resources, in their maximum possibility of relating, and material resources. The human dimension favored by the act of caring has a character of transformation, of integrating the world, the environment and the people.

It is thought that the review proposed in this text can contribute to some reflections, focusing on the importance of the experiences of the caregiver and the cared for during the caring process in the vulnerability perspective – a condition that calls for caring.

REFERENCES

1.Torralba FR Ética del cuidar: fundamentos, contextos y problemas. Madrid: Institut Borja de Bioética/Fundacion Mapfre Medicina; 2002.

2. Santin S. Cuidado e/ou conforto: um paradigma para a enfermagem. Texto Contexto Enferm 1998 março; 7(2):111-32.

3. Boff L. Ética e eco-espiritualidade. Campinas(SP): Verus; 2003.

4. Torralba FR. Antropologia del cuidar. Madrid: Institut Borja de Bioética/Fundación Mapfre Medicina; 1998.

5. Waldow VR. O cuidado na saúde: as relações entre o eu, o outro e o cosmo. Petrópolis (RJ): Vozes; 2004.

6. Lévinas E. Totalidade e infinito. Lisboa (PT): Edições 70; 2000.

7. Noddings N. O cuidado: uma abordagem feminina à ética e à educação moral. São Leopoldo (RS): Unisinos; 2003.

8. Borges RF. Humanização da rede pública de Porto Alegre: bases e estratégias das gerências de enfermagem no desenvolvimento do cuidado humano. [Dissertação de Mestrado].Canoas (RS):Programa de Pós Graduação em Saúde Coletiva/ULBRA; 2006.

9. Waldow VR. Cuidar: expressão humanizadora da enfermagem. Petrópolis(RJ): Vozes; 2006.

10.Torralba FR. Filosofia de la Medicina; em torno de la obra de E. D. Pellegrino. Madrid: Institut Borja de Bioética/ Fundación Mapfre Medicina; 2001.

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