

FEELING POWERLESS: A FEELING EXPRESSED BY CAREGIVERS OF SEXUAL VIOLENCE VICTIMS¹

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This phenomenological study aimed to reveal the meaning of providing care to victims of sexual violence. The study was carried out from December 2006 to March 2007 with 12 health professionals. Data were collected through tape-recorded semi-structured interviews, whose analysis followed the phenomenological trajectory. The following theme emerged: Feeling powerless, a feeling expressed by caregivers of sexual violence victims. The feeling of powerlessness is continuously fed by health professionals' daily routines, given the impossibility of solving situations of violence, of problems that emerge from the other's subjectivity, as well as social issues, because these professionals were not trained for that. Thus, it is essential to address the issue both in undergraduate and graduate programs in health and human areas. Institutions should promote continuing education so that these professionals can act properly.

DESCRIPTORS: sexual violence; professional practice; health personnel; professional-patient relations

SENTIRSE IMPOTENTE: UN SENTIMIENTO EXPRESADO POR CUIDADORES DE VÍCTIMAS DE VIOLENCIA SEXUAL

Se trata de una investigación fenomenológica que tuvo como objetivo desvelar el significado de la vivencia de cuidar de víctimas de violencia sexual; fue realizada de diciembre de 2006 a marzo de 2007, con 12 profesionales de la salud. La recolección de los discursos ocurrió mediante entrevista semiestructurada grabada, y el análisis se realizó por la descripción, reducción y comprensión del fenómeno; de este, emergió el tema: sentirse impotente, un sentimiento expresado por el cuerpo de las cuidadoras de víctimas de violencia sexual. El sentimiento de impotencia es alimentado continuamente en lo cotidiano de los profesionales - delante de la imposibilidad de resolver la situación de la violencia, de solucionar problemas que emergen de la subjetividad del otro y de cuestiones sociales - porque no fueron preparados para esas situaciones. Así, es imprescindible que el tema sea abordado tanto en la graduación como en la posgraduación de los cursos de las áreas de la salud y humanas, a fin de que esos profesionales puedan actuar adecuadamente, y que las instituciones promuevan capacitación permanente.

DESCRIPTORES: violencia sexual; práctica profesional; personal de salud; relaciones profesional-paciente

SENTIR-SE IMPOTENTE: UM SENTIMENTO EXPRESSO POR CUIDADORES DE VÍTIMAS DE VIOLÊNCIA SEXUAL

Trata-se de pesquisa fenomenológica que teve como objetivo desvelar o significado da vivência no cuidar de vítimas de violência sexual. Foi realizada de dezembro de 2006 a março de 2007, com 12 profissionais de saúde. A coleta dos discursos ocorreu mediante entrevista semiestructurada gravada, e a análise se deu pela descrição, redução e compreensão do fenômeno. Dessa, emergiu o tema: sentir-se impotente, um sentimento expresso por corporeidades cuidadoras de vítimas de violência sexual. O sentimento de impotência é alimentado continuamente no cotidiano dos profissionais, diante da impossibilidade de resolver a situação da violência, de problemas que emergem da subjetividade do outro, bem como de questões sociais, porque não foram preparados para isso. Assim, é imprescindível que o tema seja abordado tanto na graduação como na pós-graduação dos cursos da área da saúde e humanas, a fim de que esses profissionais possam atuar adequadamente, e que as instituições promovam capacitação permanente.

DESCRIPTORES: violência sexual; prática profissional; pessoal de saúde; relações profissional-paciente

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INTRODUCTION

Violence is a complex and global phenomenon with multiple forms of expression in all societies and in diverse scenarios. It is currently the keynote of daily life⁽¹⁾ and is undoubtedly the main problem faced, as it is no longer a fact exclusive to the police. Instead, it has become a social problem⁽²⁾ that affects the population in general in different age ranges, regardless of social class and economic status.

There has never been more discussion on violence and how to fight it and yet, a feeling of powerlessness has increased⁽¹⁾. A factor that contributes to powerlessness is its morbidity, which is difficult to measure, be it due to the scarcity of data or imprecise information generated through police occurrence reports or by the little visibility of certain types of injuries and the multiplicity of factors involving violent acts⁽³⁾.

Regarding sexual violence against women, the Ministry of Health recommends that they should be attended by an interdisciplinary team, composed of physicians, psychologists, nurses and social workers, each with a specific role. For that to happen, all should be sensitized to violence issues and be able to welcome and offer support to the main demands⁽⁴⁾.

The Municipal Secretary in Curitiba, PR, Brazil has developed, through the *Mulher de Verdade* [Real Women], a protocol to attend women victims of violence in the attempt to offer health professionals methods to detect signs and symptoms of aggression, approaching and welcoming strategies, and information to orient women who seek help in health units.

When health professionals develop this protocol, they are exposed not only to signs detectable through sophisticated equipments for clinical diagnosis that are conducive to the expression of complains and symptoms revealing evident health problems, but they also share the suffering, pain, fear and sorrow triggered by violence and store the experiences of sexual violence victims in their bodies, which can also affect them.

Based on the above, this study aimed to: reveal the meaning of the experience of care delivery to victims of sexual violence.

METHOD

This is a phenomenological study based on concepts of body, corporeality and perception⁽⁵⁾.

Phenomenology was chosen because it permits going beyond the world of appearances and theoretical knowledge. The investigation seeks to approximate the human experience under a new perspective so as to understand it based on its existence.

The phenomenological proposal is to directly investigate human experiences to understand them without getting tied to causal explanations or to generalizations and aims for direct observation and description of phenomena, which are sensed by consciousness⁽⁶⁾. For that, the researcher has to give up assumptions, hypotheses or explicative theories to reach the "go-to-the-thing-itself", that is, to seek the individual's unique and personal conscious experience, contained in the subjective world of each person and which can be acknowledged through what is revealed⁽⁷⁾.

The experience happens in the body, the first and only place of human experience⁽⁸⁾, it is the expressive space, set of experienced meanings, vehicle of the being in the world, which is capable of seeing, suffering, thinking and expressing. Thus, the body is concrete of human existence and its multiple forms of expression are revealed in the corporeality. It is what permits, by perception, access to the world, to knowledge. Perception is the encounter of the subject with the world and is presented as a mosaic of "a set of different objects", due to the "recollection of past experiences"⁽⁵⁾.

This study was set in hospitals, reference centers that attend sexual violence victims in Curitiba, PR, Brazil. Data were collected between December 2006 and March 2007, involving 12 health professionals with a bachelor's degree who attended sexual violence victims: four nurses, three physicians, two psychologists and three social workers.

Regarding ethical aspects, the research project was evaluated and approved by the Ethics Committee (CAAE No 0049.0.091.00-06), whose report was forwarded to the ethics committees of the institutions involved in the study for their information.

Aiming to assure anonymity of participants, Arabic numbers from 1 to 12 following the order of interviews were used to identify the obtained statements.

Data were collected through semi-structured interviews, tape-recorded and fully transcribed, to seek the expression of experiences, considering the following question: tell me about your experience in care delivery to victims of sexual violence.

Some difficulties were faced to obtain the statements: reduced number of professionals who work with violence victims in reference centers, refusal of two professionals to participate in the study, participants did not have much time to attend the interviews and impossibility to arrange another time, out of the work environment, to carry out interviews.

Discourse analysis followed the following steps: description, reduction and phenomenological understanding⁽⁹⁾. Phenomenological description is the exposure of a phenomenon in a contextualized way that aims to seek the essence of transcendence through its analysis, interpretation and understanding⁽¹⁰⁾. It is an investigation of what is showed and can be discovered, though it is not always seen. It happens through the interviewee's naïve discourse, as from his(er) lived experience, which indicates how the individual perceives a given phenomenon, it is "the individual's position in the world of his(er) meanings"⁽⁵⁾.

The reduction step consists in returning to the description to question it, and aims to determine and select which parts of description are considered essential from those that are not. What one wishes is to find exactly which parts of the experience are truly parts of consciousness, selecting them from those that are simply supposed⁽⁹⁾. It is at this moment that the participant's expressions are transformed in the researcher's language, creating, therefore, units of meaning in the attempt to understand the phenomenon. When the researcher assumes the result of reduction as a set of units of meanings that show the individual's consciousness of the phenomenon, the third moment emerges: phenomenological understanding.

Phenomenological understanding is the moment when units of meanings are summarized and the individual's consciousness regarding the phenomenon is unveiled through the interpretation of his(er) discourse, in language that supports what the researcher is looking for⁽¹⁰⁾. Therefore, it is nothing more than an exercise of inter-subjectivity and hermeneutics that permits capturing the subjectively lived experience without explanations.

At the end of this trajectory, the following theme emerged: feeling powerless – a feeling expressed by caregivers of sexual violence victims.

RESULTS

Nothing can happen out of one's body because it is what is concrete in our existence and the place where all experiences are stored during our existential trajectory in the personal, social and professional dimensions. It is the space where "everything remains: of making one see and talk and where everything is showed"⁽⁵⁾.

Health professionals who attend sexual violence victims frequently deal with their own anguish in view of human limitations and also with health system limitations because, somehow, everyone needs to be exposed. This exposure implies showing fragilities, vulnerabilities and limitations, and can be illustrated by the following discourse excerpt:

I guess that the limitation is really this thing of I'm going to sit with you and cry together, you know, it's difficult to keep up with the reports. You feel like crying, screaming. You learn about your limitations during care. Attending these women meddles with your limitations, you know. How far can I go, to what extent am I being professional, to what extent am I letting the professional aside, am I going to get angry or cry with this woman? (Interviewee 7).

Being with the other so (s)he can show his(er) world, the experience lived, so that the professional can capture it, is done by perception. It is constructed with states of consciousness, based on perceptions, reason for which it is considered a human act.

Perception is the sense that inaugurates the opening to the world as the *outward projection of a being*. When the human being is faced with something that is presented to his(er) consciousness, s(he) first notes it and perceives it in total harmony with its form, as from his(er) perceptive consciousness. Aiming to perceive it, the human being feels it, imagines its fullness and is able to describe what it really is. This way, knowledge regarding the phenomenon is generated around the phenomenon itself. Thus, "any consciousness is perceptive, even consciousness about ourselves"⁽⁵⁾, that is, consciousness that we are body.

The body is unique and mediates the human relationship with the world, being in the world, and the human being relates with this and the other by its corporeality, that is, his(er) form of expression. Thus, attendance to sexually violated bodies is carried out by living bodies, and it consists in corporeality and by corporeality, where professionals consider the care delivered to human beings as their existential project. In this perspective, caregivers' bodies have their

"being" involved with bodies that need care, because they experience a moment of existential fragility, generated by violence, which they share during care delivery.

Violence is a complex problem with severe consequences because it affects the individual's multidimensionality. Health professionals are concerned with the use of the protocol to treat victims because it does not consider issues that involve the other's subjectivity and social problems. This rush in care delivery can produce a result opposed to what is expected, that is, other violence, since it can disrespect the victim's trajectory and lead to frustration. Thus, they might feel they have little "problem-solving capacity" in resolving the problem⁽¹¹⁾, and professionals feel this little "problem-solving capacity" as expressed in the following discourse.

There are several kinds of violence, such as chronic violence [...] committed by the partner or husband, it is a profile in which I think that my interference, my participation is small, because it involves other things in the patient's social and family context about which we don't have much "problem solving capacity" (Interviewee 2).

Patients who suffer chronic violence (...) I feel that they are forced to come here; but, like, I feel that it's something that will not be quickly resolved because that is a continuum, you know. But, like, these are things that are out of my league. And then I see there is no resolution. It's why people get anxious, including myself (Interviewee 3).

The feeling of not solving things can lead to the feeling of powerlessness, which many times is installed in the work environment and can occur when professionals confound their objectives and limitations with those of the other corporeality, the one who asks for help⁽¹²⁾. This feeling was constantly present in the discourse of the interviewed professionals, which was unveiled as one of the feelings that affect them as professionals.

I think that oftentimes the feeling of powerlessness makes you anxious, you look to the person and think: 'what am I going to do?'. Many times I feel powerless. Many times I want to do something (...). So there're things that bother me, powerlessness and also the fact that the woman who is there represents violence (Interviewee 7).

The feeling of powerlessness also emerges when professionals are clinically attending a child or an adolescent and are obliged to discharge them and get them back to their legally responsible adults. Thus, they have to ignore what the future might bring to these clients⁽¹³⁾. This situation was perceived in the excerpt of the following discourse:

The most difficult thing for me is children and chronic (sexual) violence. Because they're unprotected, because children don't have experience or conditions to get out of the situation; we can even see the social imposition of values that are very strong. I feel so powerless (Interviewee 2).

What a person (phenomenon) perceives occurs in an area which (s)he is part of. The identity of the perceived world occurs through one's own perspectives and is constructed in movements of resumption of the past and opening to the future, and new perspectives are always possible⁽⁵⁾. Professionals are marked by these experiences, recall each of them in detail, even when they happened in a distant past. They do not make it explicit, but feel they have caused an evil, feel co-responsible for not being able to act out of their scope of work, because even when they do, nothing results⁽¹³⁾. In these cases, powerlessness causes perceptible tension in the interviewees, which is accompanied by anguish and sorrow, stored in their bodies, as explained in the following:

There was a case I wanted to adopt two girls who were (sexually) violated by their parents, they were even the same age of my daughters, but we have to work on this too. I got devastated, even got sick and then you get that feeling of powerlessness (interviewee 11).

The feeling of powerlessness, sometimes "uselessness", other times of violence or incapacity to relieve all of the patient's pain at that given moment, appears to be remnant of our biomedical training. It is not about pain as the fifth vital sign but the pain that transcends the physical and seems to remain in the body's essence. It comes to light when one shares the being and being in the world as corporeality, that is, when the invisible is unveiled. The invisible becomes visible when one exposes his(er) own subjectivity to the other who captures it by perception, since this is the way to access the world⁽⁵⁾. The biomedical model does not address the knowledge of the other's subjectivity; this kind of training makes the professional value practical results in the short term. Thus, when it does not occur, there is a false feeling that not much is being done for the client, as verified in the following.

Many times there's that feeling of powerlessness, that you're doing nothing, you know! I can't give you an aspirin to alleviate pain, there isn't a remedy you can give and say it'll go away. You can't put a serum, give an injection and everything is gone. It's different, it won't pass, it won't. It's a life mystery. It's like the pain of loss, pain of death, of passion. But I think this pain is worse (Interviewee 8).

Health professionals who attend victims of sexual violence share the experience that generates the feeling of powerlessness, which makes them underestimate their own abilities and knowledge, and do not perceive clients' resources and possibilities.

It is important that sexual violence victims are able to share their experience with professionals, because this is a possibility, a pre-condition to reconstitute a world with meaning. Helping them to found a new meaning in their existence means entering subjectivity. In this perspective, the need of the health team to get in contact with their suffering and reality is evident, helping them to reconstruct a more reliable and less threatening inner world⁽¹⁴⁾.

At the moment the caregiver's bodies assume the care of sexually violated bodies, they start to be-with-the-other and this relationship affects their existence. Apparently, professionals are not prepared or do not have proper tools to deal with feelings of powerlessness, anger and anguish, among others. Dealing with these feelings will favor and facilitate their work. For that to occur, however, getting in touch with their own preconceptions, moral values and feelings in relation to sexual violence victims is needed, bringing these issues to the "consciousness" so that they are better elaborated, avoiding negative interference in their professional life. Thus, one should consider that everything presented by a client is pertinent and appropriate, who cannot be charged for reviving the professionals' issues or emotionally "touch" them.

FINAL CONSIDERATIONS

It is important to constantly pay attention to the body so as to perceive its signs, acknowledge and understand it better and oneself. Self-knowledge is essential to grasp the other who needs care during consultation.

Understanding the other in his(er) multidimensionality means perceiving the other. When it occurs, one is faced with the possibility of helping the other to reconstitute his(er) self-image, self-esteem, transcending his(er) here and now, which emerged from a past in which sexual violence left

visible and invisible scars in one's body and made him(er) to experience an existential vulnerability.

Health professionals not only see to a body that presents signs and symptoms and needs treatment that can be found in the care protocol. Many times, they face social problems, which they are not prepared for, because emotions, feelings and suffering emerge during care delivery. Discourse or reports victims of sexual violence bring to the consultation are dense and put professionals in a delicate and fragile position in the face of their impossibility to resolve the problem because it is out of their scope of competence, which can generate the feeling of powerlessness in these professionals.

The feeling of powerlessness is continually fed in these professionals' daily life and is stored in their bodies in the same way the victims' dense reports are, which also affect them. That is why strategies need to be devised and implemented in the services so as to provide for and guarantee the health of workers as well, since they do not receive proper training to deal with issues that involve the sexual violence phenomenon.

The institution needs to construct and assure a welcoming and safe routine for health professionals, since they take care of the other, but not always take care of themselves properly. The care of professionals is related to the creation of emotional conditions to help them deal with their problems. This way, the mental suffering inherent in their activity can be transformed in personal development and construction of knowledge, if daily understood and elaborated by its actors.

Therefore, it is essential that this issue be addressed in undergraduate and graduate programs in the health and human areas, so as to train future professionals to take care of sexual violence victims. Institutions also need to implement continuing training, create groups guided by specialized professionals so that health professionals who deliver care to these victims can address not only their feeling of powerlessness but also accumulate experiences and suffering that are shared by the victims, which can affect them in their multiple dimensions. In addition, an institutional ethics policy that values workers' health is needed.

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