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CHILD AND YOUTH VIOLENCE UNDER THE PERSPECTIVE OF NURSING VIOLÊNCIA INFANTO-JUVENIL SOB A ÓTICA DA ENFERMAGEM VIOLENCIA INFANTO-JUVENIL SOBRE LA ÓPTICA DE LA ENFERMERÍA

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ABSTRACT

Objective: to analyze the nurses' knowledge about the types of child and youth violence, identifying the conduct, the difficulties and possible actions of prevention and health promotion that have been developed in the Family Health Strategies. **Method:** descriptive and exploratory study, of a qualitative approach, developed with 18 nurses through semi-structured interviews. The treatment of the data was performed through the Content Analysis technique. **Results:** nurses do not feel able to deal with violence, report the existence of numerous difficulties in confronting it and there is still a great resistance from these professionals to make the notification, mainly because they are afraid of suffering reprisals. **Conclusion:** nurses' performance is full of challenges. So, it is necessary for municipalities to invest in training and in the safety of their professionals. **Descriptors:** Child Abuse; Nursing; Children; Adolescent.

RESUMO

Objetivo: analisar o conhecimento dos enfermeiros acerca dos tipos de violência infanto-juvenil, identificando a conduta, as dificuldades e as possíveis ações de prevenção e promoção à saúde que são desenvolvidas nas Estratégias Saúde da Família. **Método:** estudo descritivo e exploratório, de abordagem qualitativa, desenvolvido com 18 enfermeiros, por meio de entrevistas semiestruturadas. O tratamento dos dados foi realizado por meio da técnica de Análise de Conteúdo. **Resultados:** os enfermeiros não se sentem capacitados para lidar com a violência e relatam a existência de inúmeras dificuldades diante do seu enfrentamento. Nota-se ainda uma grande resistência desses profissionais para realizar a notificação, principalmente por terem medo de sofrer represálias. **Conclusão:** a atuação dos enfermeiros é repleta de desafios. Portanto, é necessário que os municípios invistam em capacitações e na segurança dos seus profissionais. **Descritores:** Maus-Tratos Infantis; Enfermagem; Criança; Adolescente.

RESUMEN

Objetivo: analizar el conocimiento de los enfermeros acerca de los tipos de violencia infanto-juvenil, identificando la conducta, las dificultades y las posibles acciones de prevención y promoción a la salud que son desarrolladas en las Estrategias Salud de la Familia. **Método:** estudio descriptivo y exploratorio, de enfoque cualitativo, desarrollado con 18 enfermeros, por medio de entrevistas semi-estructuradas. El tratamiento de los datos fue realizado por medio de la técnica de Análisis de Contenido. **Resultados:** los enfermeros no se sienten capacitados para lidiar con la violencia y relatan la existencia de innumerables dificultades frente a enfrentamiento. Se nota también una grande resistencia de esos profesionales para realizar la notificación, principalmente por tener miedo de sufrir represalias. **Conclusión:** la actuación de los enfermeros es repleta de desafíos. Por lo tanto, es necesario que los municipios invierten en capacitaciones y en la seguridad de sus profesionales. **Descriptors:** Maltrato a los Niños; Enfermería; Niño; Adolescente.

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INTRODUCTION

Violence is a global problem, and children, adolescents and young people are among the human groups that are most vulnerable to violent events. Although home is considered a protection area, it is in the family environment that most cases of violence occur.¹

The World Health Organization (WHO) defines a child as the person aged up to 9 years, 11 months and 29 days, and the individual aged between 10 and 19 years is considered as an adolescent. For the Statute of the Child and Adolescent (ECA in Portuguese), the child is the person up to 11 years old 11 months and 29 days of age, and the adolescent are the ones between the complete ages of 12 and 18 years.²

In line with the ECA, the Ministry of Health developed the Notification of Injury Information System (SINAN), whereby the Municipalities, States and Federal District should mandatorily maintain notification records³. The purpose of the notification is to disrupt violent attitudes and behaviors within the family and by any aggressor, thereby inhibiting their recurrence.⁴

In Brazil, numerous cases of violence against children and adolescents were recorded in 2014, totaling 62,645 reported cases, of which 5,648 were against children under 1 year of age; 8,546 against children aged 1 to 4 years; 8,212 against children aged 5 to 9 years; 15,963 against individuals aged 10 to 14 years; and 24,276 against young people aged 15 to 19 years. In the state of Pernambuco, there were 3,824 cases.⁵

Between 1981 and 2010, in Brazil, there were 608,462 occurrences of external causes that victimized children and adolescents. In 2010, there were 8,686 homicides of people included in these age groups, of which 594 murders occurred in the state of Pernambuco.⁶

In the health services, it is usually the nursing area that receives the victims of violence. So, these professionals are of fundamental importance to overcome the problems related to it. The care provided by professionals in the Family Health Strategy (FHS), including by the nurse, should be based on the principles of bioethics, reducing the consequences of injuries and acting for the defense and protection of the client. It is up to these professionals to work on this theme with actions aimed at health promotion and violence prevention, as well as to identify warning signs and predisposing factors, recognizing even the most subtle forms of

violence against children and adolescents and reporting them.^{7,8}

It is necessary that nurses be trained, especially during their undergraduate course, to deal with situations of violence.⁹ In developing care, education and research activities, nurses must be aware that they are essential agents in the transformation of this problem, and should be able to develop self-help groups and workshops involving families in order to encourage and strengthen healthy family ties.¹⁰

In view of this, this study aimed to analyze the nurses' knowledge about the types of child and youth violence, identifying the conduct, difficulties and possible actions of prevention and health promotion that are developed in the Family Health Strategies.

METHOD

This is a descriptive, exploratory study of a qualitative approach, developed with nurses who work in the FHS of Alagoinha and Pesqueira, municipalities in the Agreste region of Pernambuco. These municipalities have, respectively, six and 16 Family Health Teams, totaling 22 FHSs, of which twelve are located in urban areas and ten in rural areas. All the nurses from the FHS of the municipalities of Alagoinha and Pesqueira who agreed to answer to the data collection instrument and who were willing to sign the Informed Consent Form (ICF) totaled 18 nurses. Two nurses who were on vacation, medical leave or bonus leave during the period of data collection were excluded, and two other nurses were removed from the sample, as they participated in the pilot test that served to verify the quality of the collection instrument. Each of the subjects was identified with the letter N, and numbered from 1 to 18 (N1, N2, N3, etc.), in order to preserve their anonymity.

The data collection took place between July and October 2015, through semi-structured and individual interviews, after the prior authorization of the Municipal Health Secretaries, with the aid of a audio recorder, in order to guarantee reliability. The interviews were transcribed as soon as possible so that other impressions present in the interaction were preserved, after approval of the project by the Ethics and Research Committee on Human Beings of IMIP (CEP/IMIP), under CAAE no. 44951015.3.0000.5201 and opinion no. 1,102,202 and after clarifying the research, reading and signing the ICF by the interviewees, respecting the ethical and legal principles set forth in the Guidelines and

Norms Regulating Research involving human beings, in compliance with CNS Resolution No. 466/12, in force in the period of the research.

The sociodemographic data of the study were tabulated in Excel 2007 and arranged in figures and tables. Considering the qualitative methodological design adopted in this study, the authors sought a support for a better understanding through the Bardin’s Content Analysis technique that interprets the data through three stages: pre-analysis, material exploration and treatment of results obtained and interpretation.

A total of 18 nurses working in the FHSs of two municipalities in the interior of Pernambuco participated in the study. As Table 1 shows, 94.4% were female and 55.6% were in the age range over 35 years. Regarding vocational training, 72.2% of the sample have between 5 and 10 years of training and 55.6% have been working for less than two years in the FHS. Among all participants, 88.8% stated that they have some specialization focused on Primary Care (Public Health, Collective Health or Family Health).

RESULTS

Table 1. Sociodemographic profile of the nurses of the FHS of Alagoinha and Pesqueira, municipalities of the Agreste of Pernambuco. Pesqueira (PE), Brazil, 2015.

Sex	n=18	%
Female	17	94.4
Male	1	5.6
Age	n	%
20 to 25 years	2	11.1
26 to 30 years	4	22.2
31 to 35 years	2	11.1
> 35 years	10	55.6
Time of work in this service	n	%
< 2 years	10	55.6
2 to 5 years	1	5.6
6 to 10 years	5	27.7
> 10 years	2	11.1
Year of graduation	n	%
< 2005	4	22.2
2005 to 2010	13	72.2
2011 to 2014	1	5.6
Specialization	n	%
Primary Care (CH*, PH** or FH***)	16	88.8
Obstetrics	1	5.6
Occupational Nursing	1	5.6

*Collective Health; **Public Heath; ***Family Health.

According to Table 2, 44.4% of the sample reported having identified and reported some cases of violence during their professional activity. Among the cases, 75.0% were identified as sexual violence, 12.5% were physical violence and 12.5% % as negligence. Regarding the identity of those who identified the violence, the CHW (Community Health Worker) was responsible for identifying 50.0% of the cases. As for the identity of the aggressors, 12.5% corresponded to the parents, 25.0% to the victim's stepfather, 25.0% to unknown people, and 37.5% to other subjects.

Table 2. Characteristics of the cases of violence against children and adolescents accompanied by the nurses of the FHS of Alagoinha and Pesqueira, municipalities of the Agreste of Pernambuco. Pesqueira (PE), Brazil, 2015.

Identification or suspected cases	n=18	%
Yes	8	44.4
No	10	55.6
Notification of at least one case	n=18	%
Yes	8	44.4
No	10	55.6
Type of violence identified	n=8	%
Sexual	6	75.0
Physical	1	12.5
Negligence	1	12.5
Psychological	—	0.0
Identity of the person who identified it	n=8	%
Community Health Worker	4	50.0
Parents	2	25.0
The victim himself/herself	2	25.0
Identity of the aggressor	n=8	%
Parents	1	12.5
Stepfather	2	25.0
Unkown	2	25.0
Others (neighbors and friends)	3	37.5

According to Table 3, the notification of violence after confirmation of the case is performed by 61.1% of the nurses. Thus, only 38.9% of the professionals make a notification based on a suspicion. Regarding training in

face of violent events, 77.8% of nurses do not feel able to do so. However, 55.6% of them carry out some type of educational action aimed at preventing the occurrence of violence.

Table 3. Performance of the FHS nurse in the face of child and youth violence of Alagoinha and Pesqueira, municipalities of the Agreste of Pernambuco. Pesqueira (PE), Brazil, 2015.

Situation in which the notification of violence is carried out	n=18	%
Only after confirmation of the case	11	61.1
In face of the suspicion of a case	7	38.9
Do you feel empowered to provide care to victims of violence?	n	%
Yes	4	22.2
No	14	77.8
Do you carry out actions to prevent violence and encourage a culture of peace?	n	%
Yes	10	55.6
No	8	44.4

DISCUSSION

Violence is a global problem that is defined by WHO as:

The intentional use of physical force or power, threatened or actual, against oneself, against another person, or against a group or a community, that either results or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation of freedom.^{11:5}

This is a social phenomenon that can be triggered by several factors. Among the main types of violence suffered by children and

adolescents there are physical violence, sexual violence, psychological violence, negligence and/or deprivation.¹¹

The nurses participating in the study conceptualized violence according to their conceptions. The forms of violence that were listed were restricted to physical, psychological violence or deprivation, as verified in the following speeches:

For me, violence is all that is done in a way that is not allowed, from the moment you do not have the consent [...] Violence is a mother who does not take the child to take

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vaccine at the service, as she is violating the child's rights. (N2)

Any kind of aggression, any denial of a right. (N9)

Violence is any kind of physical or psychological aggression that someone suffers from family members or from people of the community. (N18)

Health professionals must be aware of all forms of violence in order to promote early identification, individualized care and also actions to prevent and discourage violence. So that they can act in the face of violent events, nurses need to delve deeper into this issue, knowing its peculiarities and acting with knowledge to intervene in this scenario.

Children/adolescents subjected to situations of violence face serious consequences, of which the main one is psychological suffering, which can impede a good physical, mental, emotional and cognitive development.¹² Thus, professionals should also be alert to signs that are poorly associated with violence, such as weight changes and developmental delays.¹

Both physical and psychological violence cause behavioral changes and damages to the child's/adolescent's mental health, but the former may cause more damage to child development. These damages include inability to learn, inability to build and maintain a satisfactory interpersonal relationship, depressed mood, aggression, tendency to develop psychosomatic symptoms, isolation and fear.¹²

A study with Norwegians states that exposure to childhood violence has a significant association with the presence of anxiety and depression in adults, which is more common in individuals subjected to neglect and psychological violence than in those exposed to sexual abuse.¹³ Also, abused and neglected children are more likely to engage in sexual intercourse and criminal behavior earlier than those not exposed to these situations.¹⁴

So, the nurse must be able to identify the suggestive signs of violence, keeping an eye on them to act in a situation of suspicion. The following speeches highlight the signs identified by nurses in children and adolescents who are victims of violence.

First, we need to verify the general state of the child, whether or not they are interacting; they may be ashamed [...] check for bruises, scrapes. (N1)

If the complaint is vaginal or rectal bleeding, we may already suspect of sexual violence [...] I also observe the psychological aspect, because when the child suffers some kind of violence, they get

irritated, crying, or they can remain silent. (N7)

Usually, it is how the child behaves, the child is introspective or is always crying, with lack of appetite, does not want to interact with the group, even in the school they exclude themselves. At home, they are aggressive. (N16)

The nurses emphasized that the child victim of violence behaves differently than usual and tends to be irritated or isolated, which reaffirms that the effects of violence are mainly behavioral and psychological.

Violence has a multicausal origin, resulting from the interaction between individual, relationship, social, cultural and environmental factors.¹¹ Corroborating with other studies,^{12,15,16} many nurses stressed in their speeches that the main vulnerability factors are individual and social problems, such as alcohol and drug use, family dysfunction, mental disorders, low socioeconomic conditions, and media influence.

I think family dysfunction, misery, parents' addiction of alcohol, lack of care for the child, parents who do not bring children to the health service, who do not know the concept of family. (E4)

The environment itself, the level of education of those involved. (N12)

I believe that after the rights and duties of the citizen were extinguished from curriculum, violence has increased greatly [...] and there is also the media that brings a lot of disrespect between parents and children. So, they absorb and reproduce what they see. (N14)

I think that a person who has a good family base, a good family relationship, has a lower tendency to violence, both within and outside the family. (N18)

Violence can be influenced by numerous situations. However, unbalanced family relationships are considered as important factor in the emergence of violent acts. This reinforces the importance of a good family relationship.

The first step in the care to the user should be the reception, in which the professional must perform a qualified listening. The second moment must include anamnesis, physical examination, planning, conduct of the therapeutic conduct and follow-up. The following steps are notification and follow-up of cases within the network. In this context, the FHS team should work together, emphasizing specific actions, encouraging a culture of peace, ensuring the privacy and confidentiality of the appointment.¹

Furthermore, the FHS team should be multidisciplinary. It should have among its members a generalist nurse or a Family Health

specialist.¹⁶ The nurse must have a specialization focused on the family health, because, in this way, this professional will be able to have a more comprehensive view on the peculiar issues existing in the community and thus provide quality care.

Nursing care should include anamnesis and physical examination, injury repair, prophylaxis against Sexually Transmitted Infections (STIs), emergency contraception, STI/HIV testing and notification through the Notification Form/Individual Investigation (FNI in Portuguese) of Domestic, Sexual and/or Other Types of Violence. Nursing should also offer psychological care and promote measures to strengthen the victims of violence, helping them to deal with the problems arising from the situation they are experiencing. In addition, during such care, necessary guidance must be provided and the Guardianship Council or the Childhood Court should be notified.¹⁷

There are many actions that nurses must take when faced with a child/youth violence case. However, these professionals tend to suppress their actions when they take into account the age of the client. This fact may be associated with the fear of being exposed, as well as because there is a high incidence of cases in which the perpetrator of violence is a member of the family.

Most of the time, the behavior adopted by the nurses consists in the notification and referral of the case to the child and adolescent protection organs.⁹ These characteristics can be observed in the following speeches.

We notify and call the other sectors that are connected to the child and the adolescent to take the appropriate measures and solve the problem. (N5)

First, I would talk to the person in charge. Then, I would approach the child and make an appointment, provide a more specialized care, and go to a NASF (Family Health Support Nucleus) psychologist to see if this is really happening. And then, I would seek the guardianship council. (N6)

We can only investigate, report and forward, the rest is with the legal authorities. We do not have the power to come and intervene. (N16)

In 2009, the Ministry of Health included domestic violence, sexual violence and/or other types of violence in the list of compulsory events and diseases.^{6,18} In this way, any suspicion or confirmation of violence, both in the primary care service and in the hospital, must be registered in the FNI.¹⁸

Health practitioners must make the notification from the moment that there is a

suspicion of violence. Notification is an instrument of paramount importance in the intervention of violent behaviors. However, even with the obligation to notify, nurses still have doubts as to how accomplish it.

I have never done it. In case of a suspicion, I will seek the CRAS (Social Assistance Reference Center) and the Guardianship Council. (N1)

In the case of violence, we have to notify it. It is different of some types of diseases that we notify only with the suspicion. (N8)

Notification of such events has to be made, only after confirmation, not in case of suspicion, because we have to be sure before we do something headfirst. (N14)

Despite participants' experience, the doubt about the notification and conduction of cases is a recurring situation. In short, they consider it imprudent to notify without having a confirmation of the occurrence of violence. This thought is a result of the lack of professional qualification of these individuals.

Lack of knowledge about what should be reported or the low value given to neglect and psychological violence are recurrent situations among nurses.¹⁹⁻²⁰ Among the interviewees, only a small portion (38.9%) stated that the nurse must notify based on a suspicion.

For this purpose, there is the discarded and the confirmed notification. So, if we suspect a case, let's investigate it. If we realize that it is only a matter of lack of understanding of the parents, we discard it. And if we find out that this has really happened, we complete the notification. (N6)

We went through a training course and there is a model of notification of violence. Any suspicion that we have, we can make this notification. (N7)

Education is a primary function of the nurse, and should be exercised whenever possible.²⁰ At any time, they should carry out activities that favor collective reflection, such as lectures with newlyweds and parents, especially for risk groups (chemical dependents), based on the adoption of actions aimed at reducing sequelae and avoiding recurrences in individuals that had already suffered abuse, disclosing the rights of the child and the adolescent, as well as encouraging the protection of this population group.¹⁵

Actions of prevention and fight against violence must be implemented in health services, promoting behavior changes and favoring the reflection of individuals in order to discourage violence.

We do not have an action aimed at preventing violence, but I think it should be carried out together with the NASF [...] educational lectures[...] including rights and

duties of the citizen and, especially, of children. (N1)

Since we have the PSE (School Health Program), we always try to give lectures at school. (N4)

Here, we work hard on the sexual issue, but now we are addressing domestic violence [...] we do it mainly in schools together with the NASF. (N7)

Actions of prevention of violence should be addressed whenever possible, as this is a problem that affects all of society. Thus, fighting against these behaviors must be stimulated within the communities.

However, there are many obstacles that nurses face in addressing and intervening in the situation of violence.²¹ The CHW, in most cases, is responsible for identifying situations that suggest the occurrence of violence.^{8,19} The FHS team is often informed through community people, such as neighbors and teachers. This is because the family is responsible for the aggressions or for wanting to keep the fact only within the family environment, as seen in the speeches below:

Sometimes it is the school teacher who perceives something strange or the CHW in the course of the visits. (N4)

In another situation, the neighbors advised the health worker and he got in touch with us. (N7)

Usually, when violence exists in the family, they try to hide it. So, there needs to be much confidence in the team to someone reports it. (N9)

Violence is a problem of great proportions and so that it is identified, professionals must notify in face of any suspicion. However, notifications are often not performed, generating assistance without solvability.

Notification is essential for coping with violence, as well as to ensure the protection of the rights of children and adolescents. This attitude favors the interruption of abuse and the triggering of assistance to victims and relatives.²²

The practitioner's decision to carry out or not the notification of a case of violence may be strongly influenced by cultural aspects. Often, families deny information that substantiates suspicions, as they feel threatened in face of the notification.²³

Among the reasons for underreporting, there are professionals' fear to expose themselves and to suffer reprisals by aggressors, the belief that what happens in the family environment should be restricted to this environment (and not to the social environment), the disregard by public authorities, as well as the fact that professionals do not receive a return of the measures adopted, which makes them believe

that it is not worth notifying, contributing to the feeling of failure of their part in these situations.^{21,24-5}

Many people see violence and are afraid to notify it [...] It is difficult to notify a violence in a rural area and stay there without any protection. (N2)

Depending on the family, there may be a bad reaction against the professional [...] The child gets ashamed, afraid of being beaten by their father if they say something. (N7)

We try to do as much as we can, but we have to be careful [...], sometimes, it must be understood that the information did not leave here, so as not to have the connotation that the nurse was the one who detected and denounced it. (N3)

Nurses who receive a good academic background and experience training programs are the ideal professionals to provide care to individuals victimized by violence, as well as to promote educational actions in which issues on this theme are raised, in order to discourage this practice.²⁶ However, nurses do not feel empowered to deal with situations of violence, and lack the skills that go deeper into this issue. Notably, there is a large gap in the training of these professionals regarding issues related to aggressions, mainly in childhood and adolescence.

I do not think I am qualified to do this service. When I identify it, I immediately forward to a professional as the psychologist or the social worker. I think it is necessary to invest in professionals working in public health, there should be courses more targeted to those who work in FHS. (N4; N14; N17).

The nurse faces many difficulties in dealing with violence: the identification that requires a differential look, the family that does not want to expose the child or expose themselves, the lack of qualification of nurses and the overload of duties. All this can contribute to the cases remain veiled.

It is difficult because, often, the professional does not have adequate support to deal with the situation. (N8)

The competent bodies take a long time to arrive and make things happen. (N16)

There are many things we have to deal with, there are many duties. (N1)

Sometimes, it is the family that hinders. (N11)

The lack of training for those who work in the health area makes it difficult. (N4)

Unfortunately, it is still people's fear of denouncing. (N7)

The difficulty is for us to identify it. (N13)

In order to address issues related to child and youth violence and overcome the challenges encountered, support actions are needed to promote health and prevent risks

and harms, organize discussions on the issue, articulate the lines of comprehensive care that qualify health services, make the actions dialogue with public policies and seek the integration of actions with other sectors, thus collaborating to ensure the protection and fulfillment of the rights of children and adolescents.³

As mentioned above, nurses' work is surrounded by numerous difficulties. So, it is necessary that measures be implemented to modify this scenario, contributing to quality of life and improved care.

CONCLUSION

Child and adolescent violence has affected the whole society since ancient times. However, this is still a very neglected problem often due to the fear that people have to report it and because notifications are no longer made by health professionals. In this context, the nurse, as a member of the multidisciplinary team and responsible for the nursing appointment, still has a number of limitations when it comes to the approach in the situation of violence. The conduct adopted by the nurses present in this study is predominantly based on the activation of the child and adolescent protection organs. As for the performance in the support to the confrontation and to the appointment for identification of situations of violence, these professionals fall far short of what is planned and recommended.

There is a need to address violence in the groups existing in the services, in conversation groups, in home visits, as well as in any situation that allows this dialogue, so that the community reflects and becomes aware of the breadth of this problem.

Therefore, there are several gaps that need to be fulfilled in order to prevent and combat violence in childhood and adolescence in an effective and resolute manner. For this purpose, municipalities must invest in courses and training for nurses and other health professionals working in the FHS, who must join forces with other sectors to ensure that the problem is solved. Furthermore, institutions must give greater emphasis on combating and preventing violence during nurses' training, thus improving the care provided to the client and increasing the incentive of a culture of peace.

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