ORIGINAL ARTICLE

Children in Situation of Intra-Family Violence: Concepts, Personal Experiences and Feelings of Undergraduate Medical Students

Crianças em Situação de Violência Intrafamiliar: Conceitos, Vivências e Sentimentos de Graduandos de Medicina

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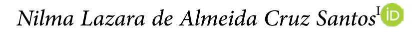
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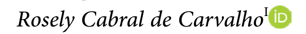

KEY-WORDS

– Child.

– Violence.

– Health.

– Higher Education.

– Medical Training.

ABSTRACT

Introduction: *The objective of the study was to learn about the concepts of violence among medical undergraduate students in the state of Bahia, their personal experiences with the phenomenon and advice regarding case referral.* ***Method:*** *a qualitative research was carried out with 20 undergraduate medical students from public institutions in the state of Bahia. The data were collected via the web through an electronic file made available by Google Forms. The students were informed about the page address through an e-mail.* ***Results:*** *Most of the students said that the topic of "Violence against Children" was addressed during their undergraduate years. Shared conceptions by most of the students on the subject are related to the definitions of violence as physical injuries inflicted on the victims, but broader definitions of social and subjective perception, encompassing different dimensions of the phenomenon were also identified. The most frequently cited feelings experienced in situations of violence were the following: helplessness, fear, sadness, unpreparedness, compassion, empathy, anger and rage. The difficulties that the students encountered in approaching the victims of violence stem from the lack of preparation in the training and from the positions related to the physicians themselves, such as fear of involvement and accountability. The inherent characteristics of children and distrust in protective services were also mentioned.* ***Conclusion:*** *Although the students reported having contact with the topic during graduation, most of them evaluated the training as insufficient. The lack of professional preparation to approach the medical-social issues, such as violence, has been partially attributed to the biologicist bias of the medical training. In this sense, we highlight the understanding of violence as an essentially social and historical phenomenon, to the detriment of the different dimensions of the illness that imply in the health-disease process. From this perspective, this bias obscure the recognition of the different manifestations of violence as objects of healthcare work, suggesting a need for a broader approach in medical education, which can help to contemplate the complexity of the subject.*

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PALAVRAS-CHAVE

– Criança.
– Violência.
– Saúde.
– Ensino Superior.
– Formação Médica.

RESUMO

Introdução: *O objetivo do estudo foi conhecer as concepções de violência entre acadêmicos dos cursos de Medicina do estado da Bahia, suas vivências com o fenômeno e orientação quanto ao encaminhamento dos casos.* ***Métodos:*** *Trata-se de uma pesquisa qualitativa realizada com 20 graduandos de cursos de Medicina de instituições públicas do estado da Bahia. Coletaram-se os dados por meio de um formulário eletrônico via web, disponibilizado no Google Forms, e os discentes foram informados sobre o endereço da página por meio de e-mail.* ***Resultados:*** *A maioria dos discentes afirmou que o tema violência contra a criança foi abordado durante a graduação. Concepções compartilhadas pela maioria dos discentes sobre o tema estão relacionadas às definições da violência como agravos físicos infringidos às vítimas, porém identificaram-se, além de aspectos subjetivos, definições mais amplas da percepção social, contemplando diferentes dimensões do fenômeno. Os sentimentos vivenciados em face de situações de violência mais frequentemente citados foram impotência, medo, tristeza, despreparo, compaixão, empatia, revolta e raiva. Para os discentes, as dificuldades encontradas na abordagem das vítimas da violência decorrem da falta de preparo na formação e de posicionamentos relacionados ao próprio médico, como medo de envolvimento e responsabilização. Mencionaram-se ainda características inerentes às crianças e descrença nos órgãos de proteção.* ***Conclusão:*** *Embora os discentes tenham relatado contato com o tema durante a graduação, a maioria avaliou a formação como insuficiente. O despreparo profissional para a abordagem de temas médico-sociais, a exemplo da violência, tem sido atribuído em parte ao viés biologicista da formação médica. Nesse sentido, destaca-se a compreensão da violência como fenômeno essencialmente sócio histórico, em detrimento das diferentes dimensões do agravo que implicam o processo saúde-doença. Nessa perspectiva, tal viés obscurece o reconhecimento das diversas manifestações da violência como objeto do trabalho em saúde, sugerindo a necessidade de uma abordagem ampliada na formação médica que possa contemplar a complexidade do tema.*

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INTRODUCTION

The inclusion of violence in the global public health agenda, the movements towards the recognition of children and adolescents as subjects of law and the development of social public policies aimed at this population contributed to the visibility of abuse against children as a problem global.

Although childhood has traditionally been conceived as a phase of life characterized by vulnerability and innocence, it has been demonstrated that this phenomenon is part of the daily lives of thousands of children[1]. Article 19, of the Convention on the Rights of the Child highlights the governments' responsibilities regarding the protection of children against all forms of mistreatment. The protection referred to in this article includes a wide range of actions and omissions, such as sexual, physical and emotional abuse, neglect and exploitation[2].

Historically, violence against children is a chronic phenomenon. In opposition to the principles of human rights and child development imperatives, it has been documented in all countries of the world, regardless of culture, social class, education, income and ethnicity[3]. Worldwide, in the most varied living spaces, children are exposed and subjected to several manifestations of violence, that is, physical, sexual, emotional or psychological abuse and neglect, which can result in physical psychological damage, and growth, development and maturation impairment [4]. Among the perpetrators, parents and other family members or caregivers stand out, in addition to teachers, employers, law enforcement officers through punitive measures and peers.

Corroborating the magnitude of the problem, Hillis et al.[5] point out that more than half of this population worldwide experienced some form of violence in the year prior to the study. However, case underreporting has been reported by researchers, such as Gonçalves and Ferreira[6] and Chen et al.[7]. The silence surrounding violence against children has been attributed to the multidimensional presentation and its occurrence in the privacy of the family context, being perpetrated very often by individuals who should provide protection and care. The fear that children have of reporting violence against them, the social and cultural acceptance of violence, the lack of an explicit legal prohibition against corporal punishment and of safe or reliable ways to report it further contribute to the phenomenon's lack of visibility[3].

Doctors play an important role regarding the opportunities to identify children in situations of violence during routine childcare consultations, as well as in emergency services. For Wirtz et al.[8], these professionals should not be limited to identifying children in situations of vulnerability, but also have the skills to presume, even in less evident circumstances, even when the complaint apparently is not related to violence, abuse or neglect. In this context, it is noteworthy that legal normative instruments require these professionals to report suspected cases, in addition to the ethical precepts that guide them to use their skills to promote health, safety and well-being to patients[9].

The difficulty found by the physicians to identify victimized children, the reluctance observed in reporting a suspected abuse case and the discomfort with the management of the child and the family have been attributed to the lack of training and education on the problem. In this sense, medical education must prepare these professionals during their training to identify child abuse, notify suspicions to the competent authorities and collaborate with the interpretation of medical information, in addition to dealing with the consequences of physical and psychological trauma, offering support to families in situations of violence[10-12].

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In Brazil, the 1988 Constitution redefined the position and representation of children in society, recognizing them as a subject with rights and an object of full protection, anticipating the guidelines of the International Convention on Children's Rights, approved the following year, in 1989[13]. From 1990 onwards, with the Statute of the Child and Adolescent (ECA, *Estatuto da Criança e do Adolescente*)[14], this age group had its rights recognized and guaranteed. In the context of the support and defense structure of this population, it became mandatory to notify suspected or confirmed cases of abuse treated in the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*). In 2006, Ordinance N. 1,356 was published, establishing the Violence and Accident Surveillance System (VIVA, *Sistema de Vigilância de Violências e Acidentes*). As of 2009, VIVA's continuous surveillance component was incorporated into the Notifiable Diseases Information System, adapting to its specific norms of data collection and submission standardization[15]. In 2011, violence became a compulsory notification event across the country, through the completion of the Notification Form in a confirmed or suspected situation of violence [16].

For Souza et al.[17], despite the recognized efforts in the field of public health, by recommending the actions and practices of diagnosis, treatment and prevention of intra-family violence and the establishment of guidelines regarding the training of human resources in relation to the implementation of the specific policy, the curricular modifications towards this direction are still slow, isolated and little known.

Particularly, medical training at the undergraduate level for the care of children in situations of violence, Brazilian studies are scarce. Koifman et al.[18], in a study on the approach to Violence against Children in undergraduate medical school at Universidade Federal Fluminense (UFF), point out that for most students the topic was approached, however insufficiently, since doubts and insecurity persisted.

In view of the above mentioned facts and considering that medical training will have an impact on the health care of children in situations of violence, in different contexts of health care, the present study aimed to understand the concepts of violence among undergraduate medical students from the state of Bahia, their experiences with the phenomenon and advice regarding the referral of cases.

METHOD

This is an exploratory, qualitative research aimed at understanding the perceptions of undergraduate medical students on the theme of Violence Against Children in medical education. The research scenario was constituted by medical higher education institutions (HEIs) in the state of Bahia, Brazil. All public and private institutions that had already graduated at least one undergraduate medical class were invited to participate in the study. Nine HEIs met this inclusion criterion, but only seven granted a letter of consent for inclusion in the study.

The research instrument, constructed to apprehend conceptions about the topic of Intra-family Violence and the approach during medical training, comprised an electronic file, available on Google Forms, consisting of a Free and Informed Consent Form (FICF), sociodemographic data, in addition to 14 open and 11 closed questions. The students were invited to participate in the study through e-mail, which explained the study objectives and the authorization for their participation was requested. To answer the questions, the participant had to access the form homepage and mark their agreement with the FICF and, at the end, send the information to the researcher. It should be noted that the study confidentiality character was guaranteed, since the respondents were not given the option to identify themselves.

The electronic form has been increasingly used by researchers in different areas of knowledge, such as the social sciences, psychology, economics and education. Vasconcellos-Guedes and Guedes [19] point out that among the advantages of this resource, the fast data sending, collecting and storing, in addition to easy access for populations living in different regions and its low cost, stand out. Regarding the limitations, they mention impersonality and privacy issues, the possibility that the respondent considers the e-mail as unwanted, an invasion of privacy or junk e-mail, and the low rate of responses.

A total of 314 students were invited through weekly emails, totaling six deliveries from September to November 2018, according to the experience reported by Barros [20]. Twenty students answered the invitation, corresponding to 6.37% of the total, a lower percentage than that reached by this author, who obtained 10% of responses in the aforementioned study.

Content Analysis was chosen for data organization and analysis, which, according to Bardin[21], consists of multiple techniques in order to describe the content produced in the communication process, whether through discourses or texts. Operationally, the Thematic Content Analysis [22] was carried out, aiming at defining the nuclei of meaning that denote "relevance, reference values and behavior models that are present or underlying the discourse" (p.316) and their main categories. This phase was organized into three stages, following the sequence recommended by the author: pre-analysis, exploration of the material and treatment of the obtained results and interpretation.

The study was approved by the Research Ethics Committee of Universidade Estadual de Feira de Santana (REC Opinion N. 2,776,388), on July 18, 2018.

RESULTS AND DISCUSSION

Characterization of subjects

Twenty students from public institutions in the state of Bahia were included in the study, of which ten were from State Higher Education Institutions (HEIs) (S1 to S10) and ten from Federal HEIs (F1 to F10). The age of the participants ranged from 23 to 41 years (mean age 27.3 years), 11 of which were females and nine males, all single. About half (11/20) claimed to have experienced situations of violence in their personal lives. The majority (18/20) reported providing care in cases of violence and (19/20) reported that the topic was addressed during their undergraduate years; however, only one student reported knowing the VIVA form. All considered that the topic of violence concerns the physician and that the approach to violence against children is important for the training of these professionals.

Based on the discourses of students from different HEIs, the nuclei of meaning that represented the speeches emerged, and through the analytical units that were created, two empirical categories were outlined for analysis: 1 - Violence: concepts, experiences and feelings among medical students and 2 – The (in)visibility of violence against children in medical training.

Violence: concepts, experiences and feelings among undergraduate medical students

Misse[23] points out that the category of violence encompasses multiple meanings in contemporary times. For the author, the term cannot be used

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in the singular, because “there is no violence, but multiple, plural, types of violence, under different degrees of visibility, abstraction and definition of its otherness” (p.43). In this sense, Minayo and Souza [24] point to the complex, polysemic and controversial nature of violence. In this sense, it is a multifaceted phenomenon of global distribution, which permeates the social fabric, disclosing contradictions and forms of domination, whether within the family or society. Ribeiro and Silva[25], in a research on the compulsory notification of violence, observed a lack of clarity in the conceptualization of this phenomenon among primary care health professionals. For these authors, this gap may have an impact on their performance when caring for children in situations of violence.

In the present study, when asked about the concept of violence, the study subjects stated that violence is comprised, above all, of acts of physical, psychological, and sexual aggression or neglect. These aspects can be illustrated in the following answers:

> *“Any act that violates someone’s physical, moral and psychological integrity” (S3).*
>
> *“An act of cruelty, whether physical or moral” (S5).*
>
> *“Physical or psychological torture” (F5).*
>
> *“Physical, psychological, sexual abuse or neglect” (F9).*

The conceptions presented by the students are in line with the World Report on Violence and Health, published by the WHO[26], in which it defines the problem as “[...] the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (p.5).

Although for most students the concepts of violence are associated with the physical injuries inflicted on the victims, broader and more subjective definitions, covering different dimensions of the phenomenon were identified:

> *“Any and all forms of coercion or abuse, mediated by an imbalance of power, intentionally used to harm others physically, psychologically, morally or financially, whether it is an individual or a community” (S4).*
>
> *“Any act that violates the physical, mental, social integrity or any human dimension” (S7).*
>
> *“An aggression against the dignity of the individual” (F1).*
>
> *“Any aggressive or intimidating act to force someone to do something they do not want” (F10).*

These concepts refer to the understanding of violence as a violation of human rights. In this sense, Piovesan[27], when discussing the contemporary conception of human rights, points to the universality and indivisibility of rights. Thus, every human being is conceived as being essentially moral, endowed with existential unity and dignity, with the guarantee of civil and political rights being a condition for the observance of social, economic and cultural rights, and vice-versa. Such understanding converges to the approach to violence based on rights through an expanded health perspective, which considers any harm that affects the person’s multidimensionality, whether it is a threat to life, to working conditions, to interpersonal relationships and quality of life as part of the performance of the health sector [28].

The phenomenon of violence is capable of generating multiple feelings in those who experience it, both in their personal lives and in the approach of individuals in situations of violence. Different researchers have reported ambiguous feelings of disgust, anger, helplessness and fear[29,30].

Regarding the experiences, in the practice scenarios in the teaching / learning context, most students declared to have participated in the care of individuals in situations of violence. Such care triggered different feelings, with helplessness, fear, sadness and unpreparedness being more frequently reported.

> *“Sadness and discomfort” (S3).*
>
> *“Sadness and insecurity to deal with the situation” (S4).*
>
> *“Unpreparedness” (F2).*
>
> *“Feeling of helplessness” (F4).*
>
> *“Need to intervene in some way. Without knowing how” (F8).*
>
> *“Despair. Anxious to help” (F9).*
>
> *“I felt deeply unstructured and unprepared to deal with the patient in such a vulnerable situation” (F10).*

These results are in agreement with the study carried out by Rosa et al.[11] with undergraduate students from different health courses (Nursing, Medicine and Dentistry), whose predominant feelings in the face of situations of violence were helplessness and fear.

Other feelings, such as rage and anger in the face of severe types of violence, notably sexual violence against children and adolescents, have been highlighted by different researchers [31,32]. Among the students participating in the present study, such feelings were also reported:

> *“Angry” (S8).*
>
> *“Repulsion for the inappropriate human behavior” (S9).*

Emotional mobilization in the face of situations of violence produces feelings such as empathy, pity and compassion, denoting the professional’s humanized posture[33]. Empathy has been recognized as a key element in care-related professions. Schweller[34] points out that, currently, the multidimensional concept of empathy is the most often used one, encompassing the affective and cognitive components. According to this author, the affective dimension refers to the individual’s ability to be sensitized to the experiences of the other, whereas the cognitive dimension represents the ability to understand the other and communicate this understanding, associated with the intention to help. These feelings were experienced by the subjects of the present study:

> *“Compassion” (S1).*
>
> *“Empathy for the victim” (S10).*
>
> *“Pity / empathy” (F5).*

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Arratia[35] lists the acknowledgment of the individual's dignity, respect for the other and humanistic values as being the essential ethical components for the confrontation of violence by health professionals. For Florêncio et al.[36], such components could be summarized in the word "empathy".

The (in)visibility of violence against children in medical training

Most medical students stated that the topic of violence was addressed during undergraduate school. The most often mentioned curricular components involved were Pediatrics, Ethics and Collective Health, in addition to medical consultations held during internship. However, regarding the flow of notification and the activation of the child protective agencies for those victims of violence, only one student declared to know the Violence and Accident Surveillance System (VIVA) and eleven mentioned Child Protective Services when asked about referrals of cases.

In Brazil, the principles from the 1988 Constitution and the promulgation of ECA (1990) represented a milestone in the acknowledgment of children and adolescents as subjects of law. In this context, the Child and Adolescent Rights Guarantee System (SGDCA, *Sistema de Garantia de Direitos da Criança e do Adolescente*) was structured to guarantee and protect the universal rights of children and adolescents. It is worth mentioning that Brazilian law requires that cases involving violence against children or adolescents be notified to the Child Protective Services of the respective location. In the absence of this organ, the case should be referred to the Child and Youth Court [37].

From this perspective, knowledge of such a system is essential for physicians to fulfill their ethical and legal role when caring for victims of violence. Regarding this issue, most medical students claimed little or no knowledge:

> *"I have no knowledge" (S1).*
>
> *"Almost nothing" (S2).*
>
> *"I don't know how to talk about it" (S7).*
>
> *"I don't know the system very well" (F7).*
>
> *"That the specific rights of children and adolescents are addressed in ECA" (F8).*
>
> *"I don't have much information. I know the Child Protective Services, but I don't know exactly how it works" (F10).*

Although they demonstrated lack of knowledge about the SGDCA, medical students were unanimous in recognizing the doctor's role in protecting and guaranteeing the rights of children and adolescents:

> *"The doctor can contribute so that a vicious circle of violence is broken, and that child or adolescent can have a dignified life" (S2).*
>
> *"To identify situations of violence suffered by the individual, to carry out comprehensive monitoring of the demands generated by this problem, to offer psychological support and appropriate treatments, and to provide assistance to the investigation by competent organs" (S4).*
>
> *"To guarantee the rights, advising family members, demand them if they are not being guaranteed ..." (S6).*
>
> *"As it is a profession that values life and quality of life, we have the role as one of the agents aimed at protecting these rights through the observation of signs of violence and letting the authorities know about it to deal with the case" (F2).*
>
> *"To advise parents and guardians. Active search for problems related to violence. Ensure the child's safety through Child Protective Services, when necessary" (F9).*
>
> *"The doctor can identify traumas, mistreatment, abuse and neglect in the child's family and seek help for the patient" (F10).*

Case notification and referral are crucial procedures in addressing violence against children. In addition to the possibility of interrupting this cycle and triggering protective measures at the individual level, this action favors the visibility of the phenomenon, since these records allow its assessment from an epidemiological point of view and can contribute to the development of public policies focused on the problem.

Regarding the role of doctors in the care of children in situations of violence, it is crucial that these professionals know their responsibilities and obligations in the context of the health team. The students' opinions about the causes of the difficulties that doctors experience to diagnose and refer patients who are victims of violence, converged to the lack of preparation during academic training (55%), followed by questions related to the physicians themselves (40%). Characteristics inherent to this period of the life cycle and distrust in the protection organs were also mentioned.

> *"Due to the deficiencies in the curricular bases of medical schools, in which they approach this topic superficially" (S1).*
>
> *"Caution when raising suspicion of violence and fear of being involved in a situation of violence with the possible aggressor" (S7).*
>
> *"Lack of preparation" (S10).*
>
> *"Because we are not well prepared in the academic environment to deal with this type of situation" (F7).*
>
> *"Children often do not express their thoughts directly; Distrust in the children's speech; Distrust in Social Services / Child protective Services; Believing that 'the best thing for the children is to be with their parents'; Increasingly shorter consultations, focused on specific problems, which are easily resolved"(F9).*
>
> *"Because we are not properly trained, since undergraduate school. And because most doctors are little concerned with treating beyond organic disorders" (F10).*

Such results are inconsistent with the findings of the study by Rosa et al.[11], in which the difficulties of the health professional in identifying victims of violence during their activities, according to the view of undergraduate students in the health area, are associated to the professionals themselves, followed by factors inherent to patients and, only for 22.8%, it is associated with training. However, the difficulties listed by the subjects of the present study have been reported in Brazilian and international studies.

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Gomes et al.[38] reported that among the explanations for the lack of visibility of violence against children and adolescents by health professionals, gaps in professional training stand out, especially among doctors and nurses.

Similarly, Bannwart and Brino[39], in a study about the difficulties found by pediatric doctors in identifying and reporting cases of abuse against children and adolescents, they observed that the professional was not prepared to deal with victims of violence. At the international level, Vullimay and Sullivan[40] reported the lack of relevant training on the subject, among the reasons mentioned by doctors for failures in case identification and, consequently notification. Gilbert et al.[41] alert to the need for the training of professionals to manage children in situations of violence, especially in the context of primary care, in view of the small number of referrals made by this sector to Child Protective Services, despite constant contact with the families. Corroborating such studies, researchers in different contexts point out that physicians who received adequate training in the identification of violence against children showed better practice regarding case notification[42,43].

The results found in this study point to the need, in medical training, for practical contents and experiences aiming to understand and deal with situations of suspicion and diagnosis with reflective, ethical and legal capacity, seeking the multidisciplinarity, with a sense of responsibility and commitment to guarantee the full protection of children.

FINAL CONSIDERATIONS

The need to have professionals trained to recognize and respond to the violence that affects children and adolescents has been widely recognized. Results of different studies indicate that in the curricular matrices of undergraduate medical courses, regarding the different theoretical and practical teaching scenarios, the incorporation of the topic has been modest and isolated.

The lack of professional training to address medical and social issues has been attributed in part to the biologicist bias of medical training, to the detriment of raising awareness of disorders of different dimensions that imply the health-disease process. From this perspective, such bias obscures the identification of the several manifestations of violence as an object of health work.

As limitations of the present study, of which data collection occurred through a self-administered electronic form, a low response rate was observed, restricting the scope of possible generalizations. However, the results suggest gaps in medical training related to the topic of violence against children. It was interesting to note that although the students reported having had contact with the topic during their undergraduate years, most of them considered the training insufficient.

The medical students' discourses point to the existence of blind spots in the training to be recognized and disclosed. Barriers that limit the possibility of identifying children in situations of violence need to be further evaluated. Between the routine and the demands that interweave the structures of doing, between the visibility and invisibility of the phenomenon in the daily lives of health professionals, expanding their listening and observing efforts at the care process can be decisive in identifying cases of violence against children.

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AUTHORS' CONTRIBUTION

The authors equally participated in all phases of the study development, including bibliographic research, initial planning, selection and creation of data collection instruments, carrying out data collection, collected data preparation, review and manuscript submission for publication.

CONFLICTS OF INTEREST

The authors declare there are no conflicts of interest.

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