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Care for chidren and adolescents victims of violence: feelings of professionals from a psychosocial care center

Atendimento a vítimas de violência infantojuvenil: sentimentos de profissionais de um centro de atenção psicossocial

Atención a las víctimas de violencia infantojuvenil: sentimientos de profesionales de un centro de atención psicosocial

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Abstract

Objective: to unveil the feelings experienced by health professionals working at a Child and Adolescent Psychosocial Care Center (*Centro de Atenção Psicossocial Infanto-Juvenil*) in the care for children and adolescents victims of violence. **Methodology:** qualitative, descriptive and exploratory research, carried out in a Child and Adolescent Psychosocial Care Center (*Centro de Atenção Psicossocial Infanto-Juvenil*). Data were collected through a semi-structured interview with ten professionals from the multidisciplinary team between May and June 2017. Data interpretation was based on the thematic analysis. **Results:** there were two themes: *Contact with violence: feelings that emerge*; and *Between reason and emotion: contact with the perpetrator of violence*. It was evidenced a multiplicity of feelings that affect the professionals involved in the care for children/adolescents victims. **Conclusion and implications for practice:** from the results, it is identified that professionals have difficulties in caring for children/adolescents victims of violence, with a need to devise strategies to deal with the range of feelings that emerge when performing this. In order to do so, it is believed that it is necessary to improve attention in the care network in order to reduce emotional levels overload and improve quality of life of victims and professionals, in order to solve problems for a healthier working process.

Keywords: Violence; Child Abuse; Adolescent; Health Personnel; Care.

Resumo

Objetivo: desvelar os sentimentos vivenciados pelos profissionais de saúde, atuantes em um Centro de Atenção Psicossocial Infanto-Juvenil, no cuidado à criança e ao adolescente vítima de violência. **Metodologia:** pesquisa qualitativa, descritiva e exploratória, realizada em um Centro de Atenção Psicossocial Infanto-Juvenil. Os dados foram coletados por meio de entrevista semiestruturada, com dez profissionais da equipe multidisciplinar, entre maio e junho de 2017. A intepretação dos dados ocorreu com base na análise temática. **Resultados:** apresentados em dois temas: *O contato com a violência: sentimentos que emergem*; e *Entre a razão e a emoção: o contato com oautor da violência*. Evidenciou-se uma multiplicidade de sentimentos que acometem os profissionais envolvidos no cuidado à criança/adolescente vitimizada. **Conclusão e implicações para a prática:** a partir dos resultados, identifica-se que os profissionais possuem dificuldades na assistência à criança/adolescente vítima de violência, necessitando elaborar estratégias para lidar com a gama de sentimentos que emerge ao realizar esse. Para tanto, acredita-se ser preciso melhorar a atenção na rede de assistência, visando diminuir os níveis de sobrecarga emocional e melhorar a qualidade de vida das vítimas e dos profissionais, em prol da resolutividade dos casos e de um processo de trabalho mais saudável.

Palavras-chave: Violência; Maus-Tratos Infantis; Adolescente; Pessoal de Saúde; Cuidado.

Resumen

Objetivo: desvelar los sentimientos vivenciados por los profesionales de salud, actuando en un Centro de Atención Psicosocial Infantojuvenil (*Centro de Atenção Psicossocial Infanto-Juvenil*) en el cuidado a niños y adolescentes víctimas de violencia. **Metodología:** pesquisa cualitativa, descriptiva y exploratoria, realizada en un Centro de Atención Psicosocial Infantojuvenil (*Centro de Atenção Psicossocial Infanto-Juvenil*). Los datos fueron recolectados por medio de una entrevista semiestructurada con diez profesionales del equipo multidisciplinario, entre mayo y junio 2017. La interpretación de los datos ocurrió con base en el análisis temático. **Resultados:** se presentaron en dos temas: *El contacto con la violencia: sentimientos que emergen*; y *Entre la razón y la emoción: el contacto con el autor de la violencia*. Se evidenció una multiplicidad de sentimientos que acomete a los profesionales involucrados en el cuidado de niños/adolescentes victimizados. **Conclusión e implicaciones para la práctica:** a partir de los resultados, se identifican que los profesionales tienen dificultades en la asistencia a los niños/adolescentes víctimas de violencia, necesitando elaborar estrategias para lidiar con la gama de sentimientos que emergen durante su realización. Para ello, es necesario mejorar la atención en la red de asistencia con el fin de disminuir los niveles de sobrecarga emocional y mejorar la calidad de vida de las víctimas y los profesionales, en favor de la resolución de los casos y de un proceso de trabajo más sano.

Palabras clave: Violencia; Maltrato a los Niños; Adolescente; Personal de Salud; Cuidado.

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INTRODUCTION

Violence against children and adolescents is defined as any conduct of action or omission, aggression or coercion that causes harm, embarrassment, limitation, physical, sexual, moral, psychological or social suffering. It is understood that no form of violence against children and adolescents is justifiable and that all can be prevented. However, this type of problem still prevails in all the countries of the world, regardless of race, culture, social class and level of schooling, characterizing itself as a serious global public health problem.[1]

According to the *Sistema de Informação de Agravos de Notificação* (SINAN - Notification of Injury Information System), in 2011, 39,281 cases were recorded, in the age group from zero to 19 years of age, by the Brazilian Unified Health System (*Sistema Único de Saúde*), in cases of violence. In Brazil, the age group with the highest attendance rate is that of children under one year of age, with 118.9 to 100 thousand children. The age group from 15 to 19 years old counts 84.6 visits for each 100 thousand adolescents.[2] In 2014, there were 62,645 cases of violence against children and adolescents. Of these, 5,648 in children under one year; 8,546 in children from one to four years; 8,212 in children aged five to nine years; 15,963 in adolescents aged 10 to 14 years; and 24,276 against adolescents aged 15 to 19 years.[3]

Given the magnitude of the statistics and the complexity of situations of violence, it is necessary to have an expanded view of the whole context involved, health professionals, children/adolescents and the family as a whole. However, health professionals need to be qualified for care, so that actions are adequate and resolute, taking into account the whole network involved in practical interventions, seeking to make the experience of violence less painful and traumatic for children and adolescents.

However, most health professionals do not feel capable of attending to these cases, since many feelings are involved in the process of caring for children and adolescents victims of violence, a fact that impacts the approach of the cases by the professionals involved. Moreover, these professionals are exposed to suffer reprisals from the perpetrator of violence, which often already has a history of perpetrating violence.[4] Fear arises as a recurring feeling in professionals involved in care, by exposing them to risk situations, when the perpetrator of violence is a member of the child's family. However, some professionals do not keep quiet about cases of violence and confront the dangers to help the victim leave the cycle of aggression.[5]

Studies[6-7] have focused on issues of violence, especially those involving the family of children and adolescents, in order to reflect on the life-world of health professionals, especially nurses. This world is composed of several dimensions that generate a constant state of attention and reactions that impose a range of feelings, such as revolt, restlessness, sadness and feeling of impotence, which need to be internally managed in the course of their care. However, professionals relate to the actors in this context, in challenging questions that involve the management of emotions, often without support, feeling affected in their abilities, which makes it difficult to protect the victim of violence.[6-7]

Thus, professionals involved in the care for children and adolescents exposed to violence need to know the situation, in which these people and their families live so they can contribute with care in an attempt to help improve this condition. In order to achieve this, a harmonious and healthy dialogue is essential in order to promote attitudes and behavior without violence.[8]

Thus, it is evident the need for a look aimed at the professionals who act in cases of violence, considering the intense emotional load to which they are subjected,[9-10] developing feelings that deeply impact them. Professionals need preparation to deal with highly complex issues so that this care can embrace the individuality and emotional suffering of each chlidren and adolescents in their life and family context. In addition, professionals should be trained in the detection of maltreatment, notification and referral to protective and support networks; in order to guarantee children their rights, a dignified and more decisiveness.

Among the places that host children victims of violence, there is the Child and Adolescent Psychosocial Care Center (CAPSI - *Centro de Atenção Psicossocial Infanto-juvenil*), which is part of the Municipal Mental Health Care Network and serves children with a diagnosis of mental disorder before or after the abuse situation. EThe children are referred by the *Centro de Atenção à Saúde Escolar* (CASE - School Health Care Center), Guardianship Council, Schools, Public Prosecutor's Office and Basic Health Units.

Psychosocial Care Centers (CAPS - *Centros de Atenção Psicossocial*) are strategic points of attention of the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*), which comprise open and community health services that operate from an interdisciplinary point of view. They are composed of a multiprofessional team, performing, primarily, care for people with mental suffering or disorder, aiming to guarantee the exercise of citizenship and social inclusion of the family. This team works together with the Family Health Teams and the Community Health Agents.[11]

From this perspective, the present study aims to reveal the feelings experienced by health professionals working in a CAPSI, caring for children and adolescents victims of violence.

METHODOLOGY

This is a descriptive and exploratory research, with a qualitative approach, carried out between May and July 2017. Data were collected in a CAPSI located in a city in the southern state of Rio Grande do Sul (RS). This service has, on average, 200 regular users, and the entry into the CAPSI occurs through referral by CASE, Guardianship Council, Schools, Public Prosecutor's Office, Basic Health Units or people arriving at service seeking

care without prior referral. It should be noted that this service is part of the Mental Health Care Network of said municipality. The researchers' approach to the field occurred during the final curricular stage of the nursing faculty of one of the authors.

Professionals working in the unit were a psychiatrist, a general practitioner, a pediatrician, two nurses, a nursing technician, two social workers, five psychologists, one physical educator and two teachers of artistic education. Of these, ten professionals participated in the study, being a psychiatrist, two nurses, a social worker, three psychologists, a physical educator, a superior technician in arts and a technician in music. The approach of these was through direct contact of the principal researcher who, through verbal acceptance and signing of the Free and Informed Consent Term (FICT), carried out the information collection through a semistructured interview.

As criteria of inclusion were respected: to be a professional that composes the multiprofessional team of the service; be active in the service during the research period; allow the interview to be recorded; and agree to participate in the research, signing the FICT, thus authorizing the use and publication of the data. Professionals who were on health leave or on vacation during the collection period were excluded.

To answer the research objective, the following guiding question was used during interviews: how do you feel about caring for children/adolescenst victims of violence? All interviews were recorded and then transcribed in full for the analysis. They occurred individually, in a private room in the institution, and had an average duration of 30 minutes.

To delimit the number of participants, the data saturation criterion was followed[12]. To do so, we first transcribed the interviews, extracting the initial codes. After this step, the codes were categorized by prevalence and type. Then, it was identified that each code obtained depth and complexity enough to understand the studied question. Thus, saturation should consider data richness derived from each question, which contributes to the understanding, not just the presence or frequency of a problem[12]. Therefore, in this study, saturation was achieved with 10 interviews, with the understanding that the data provided sufficient depth and complexity to understand the phenomenon of interest.

For the interpretation of the data, the thematic analysis of Braun and Clarke was used, which is a method to identify, analyze and report patterns (themes) within the data, organize and describe the entire data set in detail, besides to interpret aspects of the research topic. The research is structured in six phases: 1st phase: familiarizing with its data; 2nd phase: generating initial codes; 3rd phase: searching for themes; 4th phase: reviewing the themes; 5th phase: defining and naming themes; 6th phase: producing the report[13].

The following is a table illustrating the steps followed in the analysis:

Text	Initial codes	Intermediate Themes	Final theme
Fear, afraid to be taking some action, because all this implies not only in my acting [...] it implies what other institutions will do and we are afraid to actually expose the child and ourselves too. So that's it, fear, anxiety, frustration [...] (P1)	Feelings experienced	Feelings when caring for children/ adolescents victims of violence	Contact with violence: feelings that emerge
There are times when we get very angry [...] (P6).	Feeling experienced	Feelings about the aggressor	Between reason and emotion: contact with the perpetrator of violence

It is highlighted that the codes and themes were validated by two researchers.

The research was conducted, respecting the ethical precepts defined by Resolution 466/1214 of the National Health Board (*Conselho Nacional de Saúde*) of the Ministry of Health, approved by the Research Ethics Committee of the College of Medicine of the *Universidade Federal de Pelotas*, under Opinion 2,014,644 and *Certificado de Apresentação para Apreciação Ética* (CAAE - Certificate of Presentation for Ethical Consideration) number 67048217.4.0000.5317, on April 12, 2017.

RESULTS

The results of the analysis of the data, related to the feelings experienced by the health professionals in the care for children/ adolescents victims of violence, were organized in two themes: a) *Contact with violence: feelings that emerge*; and b) *Between reason and emotion: contact with the perpetrator of violence*.

Contact with violence: feelings that emerge

This theme refers to the professionals' feelings about violence in relation to children, adolescents and their families. Thus, by giving voice to the participants, it was possible to perceive a multiplicity of feelings that surround the care process on the part of the professionals directly related to the victims of violence.

Among them, the impotence in relation to the resolution of cases of violence is highlighted, evidenced in the statements that follow.

> *We can solve some things here, but they are few, so* [...] *I feel powerless about violence of all kinds* [...] *this feeling* [...] *is really strong.* [...] *because we have this set of personal tools, team, network and everything, but we can not forget that we are dealing with people, with children, with adolescents.* [...] *you are listening to the mother speak, "ah I already asked for protection, he already left the house", but they are here, she is telling me that he passed by car, that was at school* [...].*I feel powerless, in the sense of resolutiveness* [...] (P5).

> *I feel powerless, because we're not really in there, he's going back home.* (P8).

> *I feel really bad, because you are going to take action to help and you see that it did not help there at all, even worse.* [...] *I often feel powerless to be unable to help them because, in fact, they* (referring to the family) *need a treatment.* [...] *I will not be able to be inside their house to be talking, "look, let's think, let's see how we will solve this"* (P9).

Another point identified in the speeches was the fear regarding the exposure of the child and the adolescent as well as of himself as a professional involved in the care for these.

> *Fear, afraid to be taking some action, because all this implies not only in my acting* [...] *implies what other institutions are going to do, and we are afraid to actually expose the child, to expose ourselves too, so that's it, fear, anxiety* [...].*There have been cases in which we pass on the information and the anonymity of the person making the complaint is not maintained,* [...]*, then, ends some situations coming to the knowledge of the family who made the complaint* (P1).

> [...] *knowing that you have to make a decision and that decision will affect her* (child) *and will often hurt* [...]. *So I'm very scared of these things to involve tutelary advice, and forwarding to other services is worrisome, because I do not know how that care thing is* (referring to shelter institutions) [...]. *Sometimes the decisions you make to get advice and seek a better solution,* [...] *are things that will not help at all and even harm* [...] (P9).

Another point highlighted by professionals refers to their concern about the consequences of violence in the life of children and adolescents.

> [...]*depending on the type of symptomatology that the child and the adolescent have, aggression can aggravate the picture.*[...] *aggression does not help anyone, much less the one who picks up and also does not help the one who knocks because he will not feel better because he hit the child. The child will not improve, will not have her problems solved* [...] *by spanking them* (P3).

Frustration, given the outcome of the cases after the identification and performance of the team, appears as a feeling pointed out by the participants.

> *Frustration at times, because things sometimes do not go the way we want, do not have the outcome that we expect* (P1).

> *Frustration, sometimes, we see how difficult it is to change, for there are little violence, if I may say that term, that happens inside the family, that aggression, that tug of the ear, that sometimes we try to talk to the father, try to talk to her mother, but it's hard to change that* (P2).

Moreover, professionals also reported feeling an emotional overload for dealing daily with situations of violence against children and adolescents.

> *We have to deal with it and try to do our best, but it is a very heavy burden to work with children and adolescents who are victims of violence* (P2).

> *Sometimes we cry, I cry sometimes, on that boy's day I went to the bathroom to cry* [...].*There was a situation of the child arriving and being very agitated, so she came close to me with that marquinha in the shirt, a little of the mark and then I suspected. I asked them to go to a room, I asked him to examine him and I asked him to take off his tunic and such, with the agreement of his mother, and he had marks on the back, flanks, legs, near the buttocks, on the thigh, he was all marked* (P5).

Speeches refer to the emotional overload of the professional in dealing with cases of child violence, given the difficulty of managing the child and the adolescent and the family, as well as the concern to provide comprehensive care that guarantees the safety and well-being of the child and the adolescent, removing the victim from the violent cycle. Some interviewees reported feeling angry and sometimes astonished at situations of violence, since they consider violence against children and adolescents to be unacceptable, especially when committed by family members.

> *Knowing that a child, that a user of ours often is spanked because he is sick. It's very complicated to hear, or chil-*

dren who are sick because they pick up, from so much they are spanked, it's very difficult to hear [...]. *I feel really mad about it* (P4).

In addition to the revolt when faced with cases of violence against children and adolescents, it is perceived that some types of violence accentuate this feeling, since they mobilize personal questions that refer to the value judgment before the experiences of the human being, as expressed in the following you speak:

I deal better with issues of physical violence than sexual violence, but it's something that shocks me a lot.I find it very difficult, it is not an easy thing to work with. The reports are very hard; they are issues of aggression, a lot of experience of these children, which impress me greatly. [...] *physical violence is difficult too, but for me it is already easier to deal with, to talk about, more than sexual violence* (P2).

[...] *we have a hard time understanding why it does, especially sexual abuse, I think the worst is the worst, you know? From the worst of the types of violence to me, it's the hardest job* (P5).

Yeah, I think it depends on the type of violence, some people make us more angry (P6).

It is perceived that regardless of the type of violence suffered by the child or the adolescent, the professionals feel overwhelmed when taking care, once they perceive themselves powerless and frustrated due to the lack of resolution of most of the adopted actions.

Between reason and emotion: contact with the perpetrator of violence

This theme sought to bring the reports that reflected the professionals' feelings about the author of the violence. It was identified that the majority of participants reported feelings of anger and misunderstanding. However, they realize that they can not let these feelings interfere with the care for the child, the adolescent and his family.

Sometimes it is inevitable that you feeling angry [...], *some moments we stay like this, I do not know if it's feeling, but it's the person's misunderstanding* (P1).

There are times when we get very angry [...] (P6).

Ah, it is complicated because [...] *you do not agree with their actions and even understand what is behind a whole reality, but we do not like these people. I try to understand what happned. Okay, that's the context in which you did what she did, but you do not like the person because she did it. So I do not stand with the person...* [...] (P8).

The abuser is already more complicated, you are there in front of the abuser and he will deny all life, the abuser is never, he is the perfect, he does not know anything, he did not see anything. So, there are hours that I think I feel like jumping, but we cannot, because he's going to answer everything for justice (P10).

Speeches refer to negative feelings regarding the author of the violence, considering the professionals' incomprehension regarding the acts of physical and psychological violence to which the victims are subjected. Despite this, the interviewees understand that their feelings can not interfere in the attendance to these cases, because from the moment the emotional begins to act, 'reason loses space', impairing the adequate assistance to the victims and their families, according to the following lines:

[...] *we cannot show this much because we know that the family member will close in a way that we will never be able to hear from them the information they need.* [...] *people try not to appear and try to listen in a way that we do not show the astonishment and repulsion that causes us* [...]. *So we have to try to show serenity and report this and transcribe in their records without our judgment of value, try to transcribe the fact without interpreting* (P4).

We do the management, we try to deal with it, help the family in the confrontation and try, because, right? [...] *I will assist her in coping with a violence she is committing* [...]. *I cannot just judge her and say she's guilty and she's solved the problem* [...] *I am not God, who descended on earth and do justice. So I think we have to be impartial, sometimes we even need to distance ourselves from some value judgments* (P5).

[...] *no one likes to see the miseries of the world, but at that moment the psychic mechanism, thus, can be turned off, because if I enter, "ah father hit the child is a monster". Feeling bad, angry, angry or pitiful does not give, the care will not work* [...]. *I try not to make value judgments like this, then it's something else, then I can have my revolt, but at that moment I think I can separate* (P7).

In this context, there is a lack of understanding regarding violence against children and adolescents, considering that, in most of the cases experienced within the service, violence is part of a family member.

But it is incomprehension of that person (author of violence). *Because that person does it, you know? You do not find an answer* (P1).

> *As much as the child and the adolescent have done something wrong, nothing justifies him being attacked due to the error. Then, the moment I see an aggression, aggression is usually a reaction to something that happened, and then you no longer have one, you have two mistakes, one aggression leads to another, leads to another, and there becomes a snowball* (P3).

> *Because all the kids have is running to the mother, it's running to the father. If they can not run to them, they will run to whom?* (P4).

Speeches refer to the lack of understanding of the interviewees about intrafamily violence, especially when violence departs from a member with a great degree of closeness to the child and the adolescent, such as the mother and the father. Thus, professionals cannot assimilate the reasons that may lead to violence, considering this situation unacceptable, since parents are culturally expected to protect their children.

Most of the interviewed professionals did not allow themselves to form judgments regarding the perpetrator of violence, although this contact refers to feelings, such as anger and incomprehension, consider that judging only disturbs the care provided to children, adolescents and their families. On the other hand, one of the interviewees mentioned feeling the pain of the perpetrators of violence, considering that the family is overburdened with issues of economic and social vulnerability, sometimes lacking understanding of the harm they cause to the victims.

> [...] *I feel sorry for these people because they do not know, they have no idea what they are doing. They are very vulnerable people and also have problems that need to be solved. So my feeling for them is a feeling of pity because they so losing a good part of their lives* [...] *turning everything into chaos, they have no notion of the evil they do to people* (P9).

In this speech, it is observed that the participant understands violence as part of a context of adversity, in which the family suffers high levels of overload in chlidren and adolescents care, having limited conditions for both.

DISCUSSION

The impotence felt by the professionals is largely related to the lack of resolution of the cases, considering that after the identification of violence, the child and the adolescent return to the environment in which it occurs. In this way, it is possible to intervene significantly in the family and social environment of the victims. Professionals often feel powerless in the face of the precariousness of the health network within the SUS due to delays in referrals and the ineffective approach of chlidren and adolescents protection agencies, in cases of violence against this population.[15]

For the study[8], there are also difficulties related to the lack of articulation of the protection network and chlidren and adolescents care. This sensation also refers to the inability of the professional to completely cease the pain of the victims, but not only physical pain, but also that which exceeds the physical limits of the body and reaches the essence of the human being.[6] Professionals who experience this sense of impotence end up underestimating their knowledge and their competence to act before the cases, a fact that may harm the care provided.[16]

At this point, it is difficult for practitioners to find meaningful results so that they feel really helping the chlidren and adolescents overcome the aftermath of violence. Added to this is the feeling of impunity of the aggressor in front of the cases, a fact that makes the professionals can not understand their assistance as effective.[5] Complementarily, legal barriers of the country accentuate this feeling, since, often, the children and adolescents, victims of violence, return to the environment in which violence occurred, without being responsible for the perpetrator of the violence.[17]

Professionals also fear that their actions may have a negative impact on the daily lives of these children and adolescents, considering that notification can increase children's exposure to risk situations when the perpetrator is a member of their family and sometimes lives in the same place as the victim.[5] Therefore, notification often does not work positively for the well-being of children and adolescents.[5], because they return to the environment in which violence occurs and thus may suffer some form of repression by the family, after exposing the situations of violence to the professionals of the service.

For another study[18], fear and insecurity of professionals are also related to the lack of confidentiality of the Guardianship Council that sometimes exposes the complainant to the family, leaving him susceptible to some form of repression. In this way, the non-secretive flow of the notification causes fear to those who carry it out, exposing the victims and also the professionals who are in contact with the case.

In this sense, it is understood that the feelings of impotence, frustration, fear, helplessness and insecurity of health professionals are part of a context that often goes beyond their possibilities. However, it is necessary for professionals to maintain an ethical commitment, establishing care relationships with the victim and the family in the sense of cooperation, especially with the primary caregiver of the child or adolescent.

Another point highlighted in the interviews is related to the professionals' understanding of the consequences that violence brings to the life of the child and the adolescent. This is related to the prevalence of severe mental disorders due to child violence. A study[19] relates childhood violence to the emergence of psychic illnesses. Thus, violence against children and adolescents is an important risk factor for the emergence and aggravation of mental disorders.[20] In this context, it is necessary for those involved to be supported by an interdisciplinary network that enables conditions of prevention and psychosocial and cultural adjustment within the family context, strengthening relationships

among family members and raising awareness about ways of educating, without differentiating between adult to child, with regard to physical strength.[21]

Speeches also highlight the frustration of the interviewees in the face of the lack of resolution of their actions in situations of violence, considering the difficulty in promoting changes in the cultural and social habits of the families of the victimized children, a fact that makes it impossible for them to act effectively in the cases. From this perspective, it is up to the health professional not only to take care of the consequences that violence brings to the child and the adolescent, but also its ethical and professional role before the protection of the victims and their families. Therefore, the focus is not to seek guilty in the situation, but, rather, to seek alternatives for the resolution of cases.

Care for children and adolescents who are victims of violence generates emotional overload for the professional, since he has to deal with these cases, not stigmatizing those involved, even revolting with the situations experienced. Health work is considered, by its complexity, a strong factor for the appearance of emotional overload in health professionals, in view of its responsibility sense for the well-being of children and adolescents who, although satisfied, also burden them, causing stress in professionals.[7]

In this study, professionals emphasized the greater difficulty in dealing with certain types of violence, such as sexual violence. This may be related to the revolt and misunderstanding that situations of sexual violence cause. This feeling is more pronounced when it comes to violence against children and adolescents, since they are individuals who do not have the power to defend themselves against the condition imposed on them. Some professionals suffer more when faced with cases of sexual violence against children and adolescents, as they find themselves amidst cultural and ethical conflicts, considering the obscurity that permeates the violation of all victims' rights, in these cases, especially the right to the body itself.[22] Thus, in confronting sexual violence against children and adolescents, professionals cannot deal with the complexity that the cases require, since they include moral and cultural issues that, if not addressed, can make it difficult to care for victims and families.[23]

Studies[6-18] report that caring for children and adolescents who are victims of violence generates a variety of negative feelings among health professionals, given the complexity of the cases and the emotional vulnerability of the victims. Thus, many professionals have difficulty managing their own feelings, which results in emotional overload.[6-18] In addition, it is believed that this overload may compromise care for victims in the context of CAPSI, hampering the care for children or adolescents and their families, causing damage to the health of the professionals who are submitted to this demand of expressive complexity.

The fact that the family is involved in caring for and often departing from violence requires professionals to deal with their incomprehension and their judgment, thus providing full assistance to the victim and his family, which can increase stress levels and emotional overload.[22] Misunderstanding, judgment and overload are challenges that professionals face. Thus, it is understood that besides the technical/scientific preparation that the professional needs, it is also fundamental the continuous education and the psychological accompaniment to attend to these complex cases, favoring the elaboration of more effective strategies of care.

The trial of perpetrators of violence is one of the main obstacles to care for victims of child violence, given the inability of professionals to strip themselves of their prejudices.[6] Therefore, health professionals need to be able to work with families, aiming at reducing the levels of caregivers' overload and, consequently, helping to maintain the quality of life of children and adolescents, as well as their family cycle.[24]

Still, it can be observed in the interviews the feeling of sorrow that the professionals have of the families in which the cases of violence occur. They understand that these situations are often generated by a condition of socioeconomic vulnerability where perpetrators do not understand the extent of the negative impacts caused by violence for both children and adolescents.

In these situations of violence, health professionals need to develop strategies to act to understand the life history of the people they attend, as well as their social and family networks, and the vulnerabilities related to each case. In this way, it is necessary to create spaces for reflection on the practice, based on the situations experienced, providing multiprofessional action with shared decisions and networking.[25]

In addition, a study indicates the establishment of the bond as an essential strategy to provide a more adequate assistance to the needs of children and adolescents and their families, since it favors a more human and singular connection.[8]

CONCLUSION AND IMPLICATIONS FOR THE PRACTICE

Considering the proposed goal, the research revealed several factors that may directly interfere with the quality of care provided, identifying the feelings that emerge in health professionals when they provide care for children who are victims of violence, including impotence, fear, frustration, revolt and anger. Moreover, the emotional overload to which they are exposed due to ethical, cultural and legal conflicts is also evident. However, positive feelings and professional and personal satisfaction have also been revealed, in which professionals perceive themselves as promoters of changes in the lives of children and adolescents and their families.

As implications for the practice, it can be considered that this study points to the need to devise strategies that qualify professionals to face difficulties in assisting victims of violence and their families. In particular, for the nurse, who, like other health professionals, has an important role in the prevention, reporting and coping of cases. In this context, it is necessary to increase the investment in actions that favor the prevention and recognition of chlidren and adolescents violence, especially, based on strategies articulated in a network, between the health and education sectors. It is necessary to insert the theme, both in the process

of continuing education and in the academic formation, from the inclusion of the subject in the minimum undergraduate curricula.

The lack of legal support to the professionals by the protection agencies, as well as the dismantling of the care network of children and adolescents victims of violence, which presented as obstacles in comprehensive care fo these individuals, was also evidenced in this study. Thus, the multiplicity of feelings produced by professionals in face of exposed situations comes to the fore, hindering their work process and emotional contribution.

The study presents limitations regarding regional peculiarities, since it represents a specific reality, encompassing only one health service. It is believed that more research with professionals working in other network services, such as the tutelary council, social services and schools, can contribute to increase the visibility on the subject, pointing to possible articulations in the network of chlidren and adolescents care.

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