

THE MEANING OF CARE FOR CHILD VICTIMS OF VIOLENCE FROM THE PERSPECTIVE OF HEALTH PROFESSIONALS

Luciana Vilma Oliveira Quintino AMARAL^a, Annatália Meneses de Amorim GOMES^b,
Sarah Vieira FIGUEIREDO^c, Ilvana Lima Verde GOMES^d

ABSTRACT

The aim of this study was to describe the significance of the care attributed by professionals in attending child victims of abuse. This descriptive study, using a qualitative approach, was developed with 14 professionals in the pediatric emergency unit of a hospital in Fortaleza, in the period between March and June of 2010, by means of semi-structured interviews. The results identified two categories: 'Feelings and suffering of the health professional' and 'Limitations of the professional practice in the care of abused children'. The emotions expressed included compassion towards abused children, which was a motivation for professionals. Negative feelings included rage and anger against the aggressor. In conclusion, the care of child victims of violence is a challenge for health professionals from emergency services, as it involves biopsychosocial aspects that go beyond the injury itself and the hospital universe.

Descriptors: Child abuse. Child care. Delivery of health care. Emotions.

RESUMO

Objetivou-se descrever os significados do cuidado atribuídos por profissionais na atenção a crianças vítimas de maus tratos. Trata-se de pesquisa descritiva de natureza qualitativa, realizada com 14 profissionais em uma emergência pediátrica de hospital de Fortaleza, no período de março a junho de 2010, por meio de entrevista semiestruturada. Nos resultados, identificaram-se duas categorias: "sentimentos e sofrimento do profissional de saúde" e "limitações à prática profissional no cuidar de crianças violentadas". Entre os sentimentos expressos, estava a compaixão em relação às crianças maltratadas, sendo esta um motivador profissional. Aqueles considerados negativos foram indignação e ira contra o agressor. Concluiu-se que o cuidar de crianças vítimas de violência constitui um desafio para os profissionais de saúde dos serviços de emergência, por envolver aspectos biopsicossociais que ultrapassam a lesão corporal propriamente dita e o universo hospitalar.

Descritores: Maus tratos infantis. Cuidado da criança. Assistência à saúde. Emoções.

Título: Significado do cuidado às crianças vítimas de violência na ótica dos profissionais de saúde.

RESUMEN

Descripción de los significados atribuidos por profesionales de la salud en su práctica profesional con niños maltratados. Estudio descriptivo y cualitativo realizado con 14 profesionales de la salud de una sala de emergencia pediátrica en un hospital de Fortaleza, Brasil, entre marzo y junio de 2010, a través de una entrevista semiestructurada. Los resultados identificaron dos categorías: Los sentimientos y sufrimientos de los profesionales de la salud y las limitaciones a la práctica profesional en el cuidado de los niños maltratados. Entre los sentimientos expresados tomó la palabra sobre la compasión hacia los niños abusados, al ser un motivador profesional. Aquellos considerados negativos fueron rabia e ira contra el agresor. El tratamiento de niños maltratados es un desafío para los profesionales de la salud en los servicios de emergencia, ya que involucra aspectos biopsicosociales que van mucho más allá de las lesiones físicas y del entorno hospitalario.

Descriptores: Maltrato a los niños. Cuidado del niño. Prestación de atención de salud. Emociones.

Título: Significado del cuidado de los niños víctimas de la violencia desde la perspectiva de los profesionales de salud.

a Teaching Hospital Wálter Cantídio and Hospital Distrital Nossa Senhora da Conceição. Clinical nurse. Master in Public Health, State University of Ceará (UECE). Fortaleza, Ceará, Brazil.

b UECE. Psychologist and Social Worker. PhD in Health Sciences, Federal University of Rio Grande do Norte (UFRN). Professor at the Professional Master's Programs in Family Health and Education in Health and Public Health Scholar at UECE. Consultant to the Ministry of Health for the National Humanization Policy. Fortaleza, Ceará, Brazil.

c UECE. Registered Nurse. Student of the Academic Master's Program in Public Health at UECE. Registered Nurse at Waldemar de Alcântara General Hospital. Member of the Research Group for the Health Care of Children and Adolescents and Nursing (CNPq) (National Research Center). Fortaleza, Ceará, Brazil.

d UECE. Registered Nurse. PhD in Health at the State University of Rio de Janeiro (UERJ/IMS). Professor at UECE, Academic Master in Public Health and Professional Master in Child and Adolescent Health. Registered Nurse at the General Hospital of Fortaleza (Committee of Ethics in Research and Continuing Education in Health). Fortaleza, Ceará, Brazil.

INTRODUCTION

Violence is an increasing cause for concern for society in general, following the whole history and transformation of humanity, and present in various spheres of social life. The number of victims of this offense has increased significantly in recent years, being among the leading causes of morbidity and mortality worldwide, and with children being one of the major targets⁽¹⁾. Among the leading causes of mortality among children, external causes (accidents and violence) were responsible for over 120,000 deaths in Brazil, in 2006, constituting the leading cause of death among children and adolescents over one year of age⁽²⁻³⁾.

Thus, the increase in violence against children in recent years stands out as a serious public health problem, yet health services are unprepared to meet this demand comprehensively, sensitively and competently⁽⁴⁻⁵⁾.

Considering that abuse victims need care in health services, health professionals must be able to serve them and their families, in technical and emotional aspects, with structural conditions as well. Thus, the appropriate knowledge and resources must be used to broaden the degree of co-responsibility of the professionals', and the instances of management, legal entities, and safety and support networks⁽⁶⁾.

This comprehensive care includes the embracement of the singularity and emotional distress of each child in their context of life and family, the detection of abuse, the reporting and referral to protection and support networks, to ensure children their rights, dignified care and more solvability^(4,7).

Despite the implementation of public policies intended to deal with this phenomenon, the establishment of legal apparatus and the progress in the achievements of children's rights, notably from the 1990s, through the realization of the Statute of the Child and Adolescent (ECA, as per its acronym in Portuguese), there still remains a certain distance between official discourse and the practices⁽⁸⁾.

Although it is legally and ethically imperative for health professionals to report abuse cases, studies indicate omission, which hinders the implementation of the law and contributes to keeping children vulnerable to this abuse; in addition to the lack of technical and emotional preparedness of the staff in dealing with social problems and the

dismantling of the services network, which does not provide the necessary support^(4,7,9).

In this context, the hospital emergency environment, due to the fact that it consists of a gateway to the health care network, is the *locus* where violence becomes visible and announced⁽⁹⁾. It is therefore necessary to develop institutional arrangements for the care of abused children.

In this perspective, the following question arose: what significance have healthcare professionals assigned to the care of child victims of abuse? Studies in this field are incipient, since much of the scientific research on the subject only addresses the epidemiological aspects of abuse and its repercussions on infant growth and development. Therefore, the importance of investigations that provide strengthening and subsidies for improvement in the care of children and adolescents who are victims of abuse is noteworthy⁽⁹⁾.

In support of the above, the relevance of studying this phenomenon has been demonstrated, in order to describe the meaning that professionals attribute to the care of children victimized by abuse.

METHODOLOGY

This is a descriptive study, originating from the dissertation entitled "*Maus tratos infantis: significados e experiências de profissionais de saúde*" (Infant abuse: meanings and experiences of health professionals); using a qualitative approach, since it allows the researcher to reveal people's thoughts and feelings regarding how they live and relate to the world^(3,10). It was carried out in the pediatric emergency department of a public hospital in the city of Fortaleza, in the period between March and June of 2010, once the project was approved by the Research Ethics Committee of Ceará State University (No. 09554117-9). All of the ethical principles of Resolution 196/96 of the National Health Council were respected.

The study included 14 professionals, who have voluntarily signed the Free and Informed Consent Form, and were selected according to the following inclusion criteria: health professionals, with experience of at least one year in the care of children victimized by abuse, working in the hospital emergency unit. Professionals who were on leave, vacation or away from the institution were excluded from the sample. In order to assure anonymity, all respondents were identified by the letter E, fol-

lowed by a number, arranged sequentially for ease of identification.

For data collection, systematic observation was employed and the interview with a semi-structured script was recorded. The systematic observation was performed by entering into the daily lives of healthcare professionals and the users, in three shifts at the hospital; the entire journey was recorded in the field diary. To conduct the interview, a script with semi-structured questions was followed, with one item for the identification of the subjects and the other with a guiding question (What does it mean for you to take care of a child who has suffered abuse?).

In an attempt to better understand the meanings and experiences, the data were analyzed according to Minayo's thematic content analysis technique, through exhaustive reading of the speeches, clippings of the excerpts and confrontation of the speeches with the observations made⁽¹⁰⁾.

RESULTS AND DISCUSSION

Characterization of the participants and the study scenario

Among the 14 health professionals interviewed, women prevailed, five were registered nurses, five assistant nurses, two social workers and two physicians, all with higher education, as the nursing assistants completed undergraduate degrees in Public Health Management. As for age, 64.3% were over 40 years old. Twelve were public servants and the rest rendered service to the institution. As regards the duration of training, 85.6% had completed the course at least 13 years ago, and 14.4%, had recently graduated. At this stage of their professional and personal life, conquering some emotional maturity is expected, which could contribute to greater balance in the care of children in emergency departments as regards situations of violence.

The emergency pediatric unit of the studied institution had two consulting physicians, a room with five cribs and ten chairs, for children who need to remain some time under observation, and another one only for the administration of drugs and sprays. There were two beds in the Emergency Care Unit (ECU), where the most serious cases were treated and stabilized, and subsequently transferred to a tertiary care hospital. This number of beds did not meet the demand of the population in the area.

Feelings and suffering of the health professional

The care of a child victim of abuse mobilized several feelings and emotions in the professionals. In emergency care, the relationship with these helpless and vulnerable children awakened a sense of compassion:

[...] First we feel sorry because this child is abused. Sometimes we even comment: "how could anyone dare to mistreat a little thing like that, of that size, who is totally helpless [...]. (E1)

[...] but sometimes I feel compassion for the very situation of the child. (E12)

These feelings of pity and compassion towards those assisted are widely discussed and identified as motivators for actions in institutionalized health. This "pious compassion" leads to the glorification of the suffering of others, because it legitimizes inequality, isolates individuals, and excludes dialog. Indeed, when mobilizing these feelings, professionals need to be alert to realize that a child who suffers is a singular, close and autonomous subject, not labeled, therefore, as a generalized condition of a "helpless wee thing", because immediate and thoughtless help can almost inevitably turn into an excuse to legitimize violence or exclusion, contributing to aggravate the condition of violence imposed on the children⁽¹¹⁾.

Solidarity is what allows effective action from the professional, also being beneficial to the child and family as autonomous individuals. This requires human plurality and the mediation of the dialog as being necessary to take the place of the sufferer and claim the right to be cared for; with the other one needing to be recognized as someone similar in dignity, thus, making the therapeutic relationship possible⁽¹¹⁾.

Indeed, the care of children who are victims of violence requires much more than carrying out technical procedures and bandages, with subjective care being indispensable, involving the uniqueness of each child, i.e., emotional care and support, which can often be what the child yearns for the most⁽⁷⁾.

Professionals also revealed sadness and anguish in caring for these children, according to their statements:

[...] A feeling of sadness. I find it very sad when a child, especially these days, is mistreated. (E4)

[...] I feel anguish when seeing the suffering of that helpless person, who does not know how to react. (E12)

[...] I feel very sad [...] What I feel the most is anguish, for not being able to monitor the situation and not being able to do anything. (E6)

These feelings and suffering generated in serving the children, demand that these professionals have a lot of tolerance and sensibility, in order to provide humane and effective care for the victim and family. Among the respondents, feelings of indignation and anger also emerged, against the child's situation and the violent attitude of the perpetrator. With similar results, a survey showed the feelings of outrage as the most common among health professionals⁽¹²⁾.

[...] As healthcare professionals, when we assist a child who has been the victim of abuse or violence, we are left with a feeling of outrage. (E3)

[...] I keep thinking that they are helpless beings, and yet people are abusing this lack of having a way to react, this weakness [...] my greatest feeling is anger at the perpetrators. (E4)

[...] Bewilderment and outrage in knowing that children who are unable to defend themselves are the victim of abuse by those who should protect them. (E7)

Understanding the causes of family violence against children is not an easy task and requires that professionals avoid prejudices and know better their daily life. Disorders related to the aggressors, as well as those associated with the social environment in which they live, may predispose the occurrence of abuse. Therefore, when dealing with families, considering the multifaceted nature of violence is one of the important steps for comprehensive care and prevention⁽¹³⁾.

Based on the view that situations involving abuse are permeated by social, economic and cultural aspects, training based on the biological side of things is not enough to provide answers to solve these problems⁽¹⁴⁾.

The respondents were perplexed by the behavior of adult aggressors, especially when the violence had been committed by relatives or acquaintances, believing that, based on their ethical views, the family environment should be as safe and welcoming as possible for these children.

[...] it's shocking, especially when you are talking about people in the family [...] they're not looking after them, they're maltreating them. I've seen several horrible cases here [...] death by asphyxiation, for another type of maltreatment. I've already seen a body totally burned, cigarette burns, physical aggression. (E11)

[...] The initial moment is of great importance, because the child is extremely fragile, without any defense, they need the support of other people, mainly from the family, which is, quite often, the actual aggressor [...] one doesn't understand why this was done. (E3)

A study conducted with professionals in a Family Health Unit identified that, for some of them, violent acts against children in the household are part of an intergenerational cycle, resulting from violent experiences that their parents experienced in the family context, and that are unconsciously repeated in the aggressive behavior with their children. It was also notable that behind every case of violence against children there is a context that needs to be seen and evaluated, so that the service is not focused only on the victim but on the whole situation and all of the agents involved in the violent act⁽¹⁵⁾.

Indeed, it is observed that the abuse of a child by the family has socioeconomic influences, often pervaded by a culture of power between parents and children, in which the adult is abusing this power through violence. Therefore, due to the complexity of this phenomenon, greater coordination and joint work between the various sectors of society in search of the most effective solutions in situations of violence against children becomes necessary⁽⁵⁾.

Thus, the healthcare team need to be aware of all the aspects involved in the occurrence of child abuse, in order to try to understand the reality in which each the family is inserted, to thereby better cope with the feelings that emerge, which allows for dignified and respectful care to the child and the family.

It was also perceived that the intense emotional load that professionals are subjected to in the hospital emergency unit, with situations of child abuse, and the difficulty in dealing with the feelings produced in this encounter, produce suffering, which influences the therapeutic relationship.

In addition, the emergency unit can be considered one of the environments where professionals are subject to greater psychological distress, mainly

due to the dynamics of the service, which runs continuously, and for being a place where user demand is spontaneous, with different health problems, often uncontrollable, which escape therapeutic limits⁽¹⁶⁾.

Hence, workers in these sectors need to be professional and prepared emotionally to deal with the different demands and feelings arising during the act of caring, because, in this space of the health system, the most serious cases of child victims of violence abound. Nevertheless, in the scope of the hospital, a social and historical construction prevails, which forms a social imaginary situation enrolled in the valuation of a technological rationale with emphasis on specialized equipment and knowledge. Consequently, in the production of healthcare, technical talk, the work focused on standards and protocols is privileged at the expense of space for talk on anxieties, fears, conflicts and issues experienced in the daily work, which impact on the manner of being in the world and dealing with emotions⁽¹⁷⁾.

This defends the argument that it could be less threatening for professionals dealing with abused children, if there were a work environment conducive to the sharing of ideas and feelings, where an interdisciplinary team could expose their emotions, allowing for a learning opportunity, maturity and collective decision making. In addition, relationships with other professionals and groups can trigger changes in the singular manner of being and acting for each worker, because producing things and services, such as health care, the subject produces itself, and thus gains greater ability to intervene in the reality, being the protagonist of social, collective and individual changes.

The importance of recognizing feelings by the staff is needed to prevent the robotization of child care, because disregarding them in practice leads to the dehumanization of care. Furthermore, by exposing and managing their emotions, they can give rise to a creative and non-immobilizing response faced with such a scary service, reacting with more humanized care.

Limitations to professional practice in the care of abused children

The main limitation to the care relationship with abused children involves dealing with the barriers imposed by the social, family and legal reality of the country, which is reflected in the mood of

professionals, who surrender themselves as helpless faced with macro-structural issues. Concerns and tensions are expressed by health professionals that, after clinically assisting a child, often return them to the family environment, a place where their very aggressors may be, and thus repeating the cycle of violence against the child.

[...] Who will enter the family to discover the family dynamics that made this happen? It's complicated [...] but making sure that it doesn't happen again is something that we really cannot do. (E9)

[...] we don't know if they have gone back to the same place to suffer the same aggression [...]. (E6)

Indeed, there is a public and political accountability that must be assumed by the state and society, with a view to promoting social equity and the effectiveness of the rights of children and all citizens.

Impunity, as present as it is in the Brazilian system, is another limit to professional performance to ensure the rights of children and it interrupts this repetitive mechanism of violence, which keeps the child in a prison of aggression, without defense and protection. Therefore, from the same importance as the diagnosis and proper care of the child, the unfolding of the processes in the branches of childhood and youth and in the criminal courts also favors the reduction of violence, for determining measures to protect children and punish the perpetrators, avoiding new violent acts⁽¹⁸⁾.

[...] At first you just think about assisting them and alleviating, but then you keep it in mind and think from that moment on there should be a punishment already. (E8)

The frequency of abuse cases and delays in punishment have been observed in a study conducted in Rio de Janeiro, where the authors found that a significant number of cases were still in progress, despite the passing of five years from the date of its opening. The delay in resolving the cases was assigned to the deficiency of human resources, the volume of accentuated backlog and the dragged out progress throughout the process⁽¹⁸⁾.

The impotence caused by this whole situation was unanimous among professionals, especially for perceiving themselves as responsible for the protection of the child and they considered the violence against them a social problem with a difficult solu-

tion, which goes beyond their possibilities in the quality of healthcare professionals.

[...] *All of a sudden she arrived in a bad state, tomorrow she might even arrive dead and the nurse who was previously on duty might even feel responsible [...]. (E3)*

[...] *it's a social sphere. We will try to overcome the physical damage, and at least the emotion of the moment, but not the social part. It creates a feeling of helplessness. (E9)*

These expressions are similar to findings from a study that evaluated the emotions of psychosocial professionals faced with child sex abuse, during psychosocial analysis which subsidizes judges in their decisions. The children were also seen as being unprotected and defenseless, in need of protection, and professionals assigned themselves to this task, producing suffering and a sense of helplessness in the case of failing to meet this expectation and preventing further abusive situations⁽¹⁹⁾.

Furthermore, in the training of health professionals, the idea that they have a duty to save lives and solve the situation of the patient still rules, in a clear statement of omnipotence. This may contribute to exacerbate feelings of helplessness, producing intense suffering in the care of child victims of violence if they do not achieve this goal⁽²⁰⁾. On the other hand, the work process in the production of health care is mostly open to the presence of live work in action, so that the permanent creativity of the employee may invent new work processes and even create new directions not previously thought for challenging situations⁽¹⁷⁾.

Thus, health services, despite showing an important role in working with child abuse, express limits in their actions. The role of health professionals is that of co-responsibility with other sectors of attention to violence, through the practice of quality and humanized care to the child and the family, and the notification of this offense⁽⁹⁾. Based on this prerogative, various services and sectors should assume the continuity of care and protection, thus revealing an interdisciplinary and interdepartmental professional action.

FINAL CONSIDERATIONS

The feelings of the professionals express a contemporary understanding of children who are

victims of violence, which are consistent with current policies for the complete protection of children and adolescents, as the conception of the integral rights of the subject in health care is increasingly prevalent. They perceived themselves as powerless, as they cannot stop the violence against children, although they recognize that this depends on factors transposed to their capabilities.

Thus, the care of child victims of violence is a challenge for health professionals in the emergency services, as it involves biopsychosocial aspects that go beyond the injury itself and the hospital universe. Furthermore, when dealing with the child and the family, professionals also deal with their own feelings and emotions that arise during care, according to their own preconceptions, knowledge and education as people.

The limitations of this study derive from the fact that it does not include the participation of child victims of abuse and their families. Therefore, targeting a broader range of discussions, further studies must be developed, so that different perspectives on violence against children can be shown, in order to better contribute to the creation of strategies for its prevention, its combat and to better assist the victims.

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**Author's address / Endereço do autor /
Dirección del autor**

Ilvana Lima Verde Gomes
Rua J. da Penha, 631, ap. 1003, Centro
60110-120, Fortaleza, CE
E-mail: ilverde@gmail.com

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