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Social representations of nurses concerning domestic violence against women: study with a structural approach

Representações sociais de enfermeiras acerca da violência doméstica contra a mulher: estudo com abordagem estrutural

Representaciones sociales de enfermeras acerca de la violencia doméstica contra la mujer: estudio con enfoque estructural

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ABSTRACT

Objective: To analyse the structure and contents of the social representations of nurses concerning domestic violence against women.
Methods: This is a qualitative study conducted with 100 nurses between May and September 2014 in two hospitals of Rio Grande, RS, Brazil. Data were collected through evocations and semi-structured interviews. The data were processed in Evoc software and subjected to contextual analysis, respectively.
Results: A negative representation was identified with core elements alluding to forms of violence and its judgment, expressed as "physical aggression" and "contempt". In the periphery, "fear" is how the professionals and the victims feel toward the aggressor and "submission" is mentioned as a cause of violence. The term "verbal aggression" in the contrast zone suggests the possibility of a subgroup with a different representation.
Conclusions: A centralised view regarding physical injuries and the culpabilisation of domestic abuse victims can limit care actions, revealing the need to discuss this subject with health workers.
Keywords: Violence against women. Nursing. Delivery of healthcare. Nursing care.

RESUMO

Objetivo: Analisar a estrutura e os conteúdos das representações sociais de enfermeiras acerca da violência doméstica contra a mulher.
Métodos: Estudo qualitativo realizado com 100 enfermeiras entre maio/setembro de 2014 em dois hospitais de Rio Grande/RS. Colheram-se os dados por meio de evocação-livre e entrevistas semiestruturadas. Foram tratados pelo software Evoc e análise contextual, respectivamente.
Resultados: Observa-se uma representação negativa com elementos nucleares aludindo às formas de violência e ao seu julgamento, expresso em "agressão física" e "desrespeito". Na periferia, "medo" revela tanto o sentimento das profissionais quanto das vítimas frente ao agressor, e "submissão" é pontuada como causa da violência. Infere-se a possibilidade de um subgrupo com representação diferenciada, frente ao termo "agressão verbal" na zona de contraste.
Conclusões: A visão centralizada nos agravos físicos e na culpabilização da vítima pode limitar as ações de cuidado, portanto é fundamental problematizar este objeto com profissionais da saúde.
Palavras-chave: Violência contra a mulher. Enfermagem. Assistência à saúde. Cuidados de enfermagem.

RESUMEN

Objetivo: Analizar la estructura y el contenidos de las representaciones sociales de los enfermeros sobre la violencia doméstica contra las mujeres.
Métodos: Estúdio cualitativo cumplido em dos hospitales de Río Grande/RS. Los datos fueron recolectados entre mayo/septiembre de 2014 a través de entrevistas semi-estructuradas, cumplido con 100 enfermera, y evocaciones com 34. Fueron tratadas por un software Evoc y análisis contextual, respectivamente.
Resultados: Se observa una representación negativa con elementos nucleares en alusión a las formas de violencia y su juicio, como "agresión física" y "falta de respeto". En la primera periferia, "miedo", revela tanto la sensación de profissonais como las víctimas contra el agresor, y "sumisión" se califica como una causa de la violencia. Se deduce de la posibilidad de una representación del subgrupo diferente, a través del la presencia del término "agression verbal", en la zona de contraste.
Conclusiones: Una visión centralizada las lesiones físicas y culpabilidad a la víctima puede limitar las acciones de atención, por lo tanto es fundamental discutir este tema con profesionales de la salud.
Palabras clave: Violencia contra la mujer. Enfermería. Prestación de atención de salud. Atención de enfermería.

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INTRODUCTION

Domestic violence against women is configured as a problem of epidemic magnitude and has consequently become a subject of interest of the public and the scientific community. This is not a new subject of study and its historic roots permeated by cultural beliefs, traditions, and values underpin the interpretation of this phenomenon, including in healthcare.

Discussions on this subject are partly based on gender issues, which is an analytical category that addresses the male and female as a social construct based solely on biological aspects[1]. This differentiation leads to relations of power, force, and domination that can culminate in the various forms of violence against women. These unequal and asymmetrical relations are expressed in the norms and conduct expected of men and women, making certain violent behaviour naturalised by common sense.

In contrast, there is some interest in analysing the implications of violence on women's health[2-4]. Given the evident negative effects of violence on health, health workers must provide relational and sensitive care beyond physical boundaries and free of the gender stereotypes and prejudice that still permeates professional practices[5-6].

According to epidemiological data, most violence against women is practiced by the intimate partner in the household[2], causing many cases to be silenced. One in every three women in the world has been beaten, forced to have sex, or subjected to some other form of abuse[2].

In Brazil, more than 92,000 women were murdered between 1980 and 2010, and 43,700 of these women were murdered in the last decade alone[7]. An analysis of the circumstances of murders in general reveals that fire guns are the most common weapon among men; however, when the victim is a woman, the most common weapons are cutting, penetrating, blunt, and suffocating objects, suggesting that most of these episodes are crimes of passion[7].

Conceptually, the term "domestic violence against women" covers many forms of violence, including physical, sexual, psychological, moral, and patrimonial, practiced by someone with consanguineous ties or somehow related to the victim. The revealed cases, however, are usually the most serious, requiring hospitalisation[8] or involving death threats to the women or their families.

The emergency room is considered the point of access of these women to support services. Studies show that most of the women assisted in the emergency rooms are young, with contusions, especially in the arms, head, and face caused by physical abuse, knives, and fire arms[8], or burns[9]. In milder cases, they claim that their partners are good, hard-working people[3] or that they are encouraged by their families to remain in the relationship, which reinforces women's subjection for the sake of the marriage tradition[10].

Based on the information shared in the social and hospital setting, nurses build their representations on this phenomenon to provide a more or less humane and emancipatory care. Hospital nurses can be important allies in the detection of cases, adoption of preventive measures, and in the treatment and rehabilitation of users who seek care, especially in acute cases. To provide this support, they must perceive domestic violence against women as a serious social and public health phenomenon and overcome their beliefs, labels, and prejudgments to ensure a more effective professional performance.

In the field of healthcare, studies of social representations provide insight into social knowledge to guide and justify care practices. The recognition of this object in a concrete and representational manner exposes the problem in terms of hospital care. Thus, the aim of this paper is to analyse the structure and content of the social representations of nurses regarding domestic violence against women.

METHODOLOGY

This is a descriptive, exploratory, and qualitative study grounded on the structure theory of social representations or the Central Nucleus Theory[11]. This theory argues the need to work the idea of structuring and centrality in the organisation of the social representation because it justifies thought and its relationship with practice.

The study participants were nurses working at two mid-sized hospitals in the municipality of Rio Grande, RS, Brazil. After obtaining a list from the nursing coordination office of the two hospitals with the names of the nurses of each unit, the nurses who had been working at the unit for at least two months were invited to participate in the study. The selected units were likely to admit women who are victims of domestic violence: maternity clinic, obstetrics centre, intensive care unit, surgery clinic, medical clinic, burn unit, trauma unit, and emergency service. Nurses who were on leave or on holidays were excluded.

Data were collected between May and September 2014 by means of the Free Evocation of Words technique and a semi-structured interview. The first technique consists of asking all the subjects to evoke words or expressions that come to mind immediately after hearing the inductor term, which in this case was "domestic violence against women". This method allows the relaxed and spontaneous apprehension of cognitions that would otherwise be masked in discursive productions[12].

The interviews were guided by a script containing open-ended questions about the perception and personal and professional experiences of the subjects with domestic violence against women. The interviews were recorded and transcribed in full. Of the 100 nurses who participated in the free evocations, one to three of each unit were invited to the interviews, totalling 34 subjects. Both stages were individual in a transit-free room in the workplace, as chosen by the subjects.

The evocations were analysed using EVOC 2005 software, which conducts a statistical analysis of the words according to frequency and the average order of evocation (O.M.E), serving as a base for the four-quadrant chart. In this chart, the quadrants are divided into the central nucleus (CN), in the upper left quadrant; the contrast zone (CZ) in the lower left quadrant; and the peripheral system (PS) in the upper and lower right quadrants, called the first and second periphery, respectively.

The central nucleus contains the most readily and frequently evoked elements, that is, those that give meaning to the representations because they are connected to the collective memory and history of the group[12]. The contrast zone contains the variations of the representations according to the subgroups without modifying the core elements or the least evoked elements. Finally, the peripheral system contains the most flexible and heterogeneous elements, possibly revealing the influence of the current context in the representation[12]. The first periphery is the most significant because it contains the most readily and frequently evoked elements.

The interview transcripts were subjected to content analysis using the unit of context to encode the data[13]. Subsequently, the sentences containing the words that construct the four quadrants were selected. The subjects were identified with the letters PH and UH depending on whether they worked in the philanthropic hospital or the university hospital, respectively, followed by an Arabic numeral corresponding to the order of the data collection. The research project was approved by the healthcare research ethics committee of Universidade Federal do Rio Grande, opinion No. 80/2014.

RESULTS AND DISCUSSION

Of the 100 professionals who participated in this study, only four were men, 54 worked in the university hospital and 46 in the philanthropic hospital. The average age was 36, ranging from 20 and 59 years, and 68 of these subjects had companions. The time working at the unit varied from 2 months and 20 years.

For the four-quadrant chart, the natural order of evocation of the terms was considered to know the most spontaneous elements of the representations. In all, 495 words were evoked, of which 93 were different, meaning that the analysed corpus is homogeneous, considering the low frequency of different words. The four-quadrant chart was built with the average frequency of words of 18, a minimum of 10, and an average order of evocation of 3.0 in a ranking of one to five. The terms distributed in the quadrants enabled analysis of the structure and contents of the representation formed by the central nucleus, peripheral elements (first and second peripheries), and contrast zone.

Avg. Freq.	O.M.E < 3.0			O.M.E ≥ 3.0		
≥ 18	physical aggression	36	2.222	fear	28	3.500
	contempt	24	2.875			
	aggression	21	1.905			
	humiliation	18	2.889			
< 18	verbal aggression	17	2.235	family	11	3.545
				submission	11	3.273
	cowardice	13	2.000			
	pain	13	2.000			
	abuse	12	2.333			
	unacceptable	10	2.500			

Figure 1 - Structure of the social representation of the nurses for the inductor term "domestic violence against women". Rio Grande/RS, 2014

Source: Research data, 2014.

In the evocations for the inductor term "domestic violence against women", the distribution of the terms varied. In the upper left quadrant, **physical aggression**, **contempt**, **aggression,** and **humiliation** indicate the possible core elements of representation, given the high frequency and readiness of evocation. The lower left quadrant contains the elements of the contrast zone **verbal aggression**, **cowardice**, **pain**, **abuse**, **unacceptable**, which can strengthen the first periphery or the core or even reveal the presence of a subgroup with a different representation[12].

Despite the high frequency, the term **fear** is part of the first periphery, in the upper right quadrant, as it was evoked in the last positions. The terms **family** and **submission** in the second periphery reveal the interface of the representation with the practices. The periphery allows an interface with reality, guiding the actions and reactions of the subject regarding the representation[11]. To better understand the content of the analysed representations, the element of the four-quadrant chart were contextualised from the

units of entry, selected from the interviews, grouped according to the position in the quadrants.

Elements of the Central Nucleus

The most frequent element of the central nucleus was "physical aggression", with 36 evocations, followed by "contempt" evoked 24 times, and the words "humiliation" and "aggression", the latter of which was evoked more readily. Given the cognitive, imagery, and attitudinal dimensions of the structure of social representations[14], the words "aggression" and "physical aggression" express the concept of the nurses regarding domestic violence against women.

"Physical aggression" is all types of violence that causes physical harm to the victim. In this study, it includes kicking, punching, beating, bruising, mutilating, burning, and the use of knives and firearms, as exemplified in the entry units.

The first thing that comes to mind is that person all bruised, beaten, with a knife or gun, with hot water, with fire, physical violence. (PH; 025)

[...] We suspect physical violence when there is bruising, something sort of visible, a mark on the face, something you can see in the body. When there are marks it is easier because sometimes the person is withdrawn, shows some aspects of depression, we might even suspect it, but that doesn't it's that. (UH; 029)

We had one patient whose partner set her on fire. She came here, but as it was a large burn, it was evidently aggression, the police arrested him and everything. We ended up focusing more on the care. (PH; 018)

This form of violence is the most easily recognised by the healthcare workers when the women access the services[8, 15]. It is generally reported and valued by society because it leaves explicit marks. Moreover, it also refers to the imagery of the representation associated with marks on the victim's body.

It appears that the elements of the symbolic universe of nurses are linked to their professional activity at the hospital since the meanings of physical aggression are related to the care provided to the victimised women. This relationship gains even greater meaning when the primary care workers perceive this phenomenon as being linked to other factors, such as drug use, unemployment, and lack of dialogue, revealing the sociocommunitary influence, together with the workplace, in their conceptualisation of violence[16-17].

Bruising, facial oedemas, burns, and other physical signs serve as "support/certainty" for the workers to identify and interrogate patients on the subject[18-19]. The absence of these signs creates a deadlock in communication that masks the phenomenon, without observing the subjectivity of these women. In the absence of this "marker" of violence, the workers ask no questions and the women reveal nothing, which restricts the possibility of comprehensive care.

The central nucleus also contains elements indicating the attitudinal dimension, embodied in the words "humiliation" with the lowest frequency and highest average order of evocation, in order to question its centrality. Along with "contempt", they express a negative judgment of the nurses regarding domestic violence against women.

Domestic violence against women is a form of contempt of a person who tries to demonstrate a power he does not have, coercing the less favoured in terms of strength. Sometimes it can be in the cultural, intellectual sense, in the self-esteem; it is a relationship between who is coercing and the one who is coerced. (UH; 049)

The nurses have a greater understanding of the actions that characterise violence. Thus, the centrality of this representation is based on the negative evaluation content and the elements allude to violent acts or to the conducts of the aggressor.

Elements of the contrast zone

The analysis of this quadrant reveals a different meaning to the central nucleus since the term "verbal aggression", evoked 17 times, emerges as a descriptive conception of the object. It refers to a dimension that is not found in the other quadrants of the chart and suggests the possibility of a subgroup with a different representation of the object and a central nucleus that includes verbal aggression in addition to the physical aggression.

[...] Because regardless, there can be verbal violence. You do not necessarily abuse physically, just physical violence, she can be assaulted by a friend or by someone verbally and that hurts people deeply and causes bitterness, preventing them from growing as a person. That wound that remains turns into a scar. (PH; 07)

Violence against women starts first with verbal violence, it starts with start the name calling, with arguments. Women are generally more fragile than their partners, and the men try to produce this aggression, sometimes it does not solve the problem and they resort to physical violence. (UH; 029)

Verbal aggression leaves no physical marks, so it is not always recognised as a violent act; however, it is an expression that marks the beginning of the cycle of violence[3] as noted in the interviews. This form of aggression leaves indelible scars in the soul, affects the victim´s self-image and self-esteem, and causes isolation from society and the support network. Verbal aggression is only considered important to others when it becomes palpable, when home imprisonment or the onset of mental disorders caused by the psychological torture are involved[1]. This expression does not generally occur in isolation and often intensifies the violence.

The women who suffer this form of violence seldom seek external help and prefer to accept and justify the actions of the aggressor[3]. They hide the aggression until they experience a life-threatening situation or attempt suicide, which is when they are forced to seek hospital services[10]. The help they seek in the healthcare institutions does not merely solve the physical harm, but also the physiological harm they suffer[4]. It is therefore essential to train hospital workers so they can identify and manage these cases beyond the physical marks and medicalisation of the bodies.

The readily evoked element "pain" reveals affective evaluative content in the representation of domestic violence toward women since it can refer to the consequences of injuries[9] and the suffering caused when someone is assaulted by an intimate companion. In terms of inpatient care, the pain mentioned by the nurses expresses the acute consequences that require immediate intervention.

She [woman victim] told us really late at night, she arrived with abdominal pain, said her companion had jumped on top of her, but she was reluctant to talk; ruptured her spleen. (UH;041)

After a few days in the ICU of the hospital, I didn't even recognise her from the day she arrived; because she was very edematous, she moaned with pain when she arrived, eyes, mouth, nose. It was suspected head trauma and she was pregnant. (SC, 048)

She was burned and said she was trying to kill himself, couldn't bear to live anymore. After a while, she decided to tell us it was him again and we contacted the police station because she wanted to report it. (SC, 012)

When the situations of violence are not identified in primary care, they are identified in the emergency units, such as hospitals, where these women seek care due to the gravity of the injuries[18]. Victimised women often have thoughts of ending their lives and suicide[20] and frequently use medication[4] to reduce the pain and suffering caused by the marital conflicts. Therefore, understanding the consequences of domestic violence goes beyond the conceptual, attitudinal, and imagery dimension. In practice, it means looking beyond the findings of clinical investigations and incorporating holistic and humanising professional practices into care.

"Cowardice" and "abuse" demonstrate the negative attitude of the nurses on the studied object and the actions of aggressors, who express dominance against the fragility of women.

The first thing that comes to mind is the image of a cowardly man, a scared women, with low self-esteem; and the man uses his physical strength to embarrass and totally humiliate her. (UH; 035)

These meanings are based on the social imaginary of female inferiority because of a more fragile body[16, 19]. At first sight and considering common thought, this means gender issues are the backdrop in the interpretation of this phenomenon. Cultural and historical conditions have contributed and still contribute to the legitimacy of women's subalternity and the superiority of men who still use their hierarchical status to exercise power over their wives and children[1].

Finally, the term "unacceptable" also refers to a positive attitude towards the phenomenon. From the perspective of social representations, attitudes are positive or negative positions toward a given object. Consequently, opinions as attitudes acquire a predictive characteristic in relation to action and guide behaviour in the relationship network of the object[14]. Thus, repudiation toward the object can contribute to a more welcoming and understanding care that targets women's empowerment.

I find it completely unacceptable. I see that these problems have a lot to do with how people are raised, with the mother and father, present or not; with the models of roles they learnt [aggressors] since childhood; with the personality that was built in relation to this. It depends a lot on what they have experiences, but there are definitely deficiencies in several points for them to be that way. (PH; 012)

Although the nurses judge the actions of the aggressors, they acknowledge the influence of the social environment as a catalyst for violence. According to the discourses, the main cause of violence is men's socialisation, revealing the influence of macrosocial issues in individuals. Learning about the catalysts of violence can support the rethinking of interventions for victimised women, their families, and of the aggressor and address the issues of equal relationships and the socialisation of men and women, as well as prevent the judgment of victims in healthcare.

Peripheral elements

The peripheral elements, located on the upper and lower right quadrants, are flexible and mutable since they are more associated with the immediate context in which the subjects are inserted[11].

In the upper left quadrant or the first periphery, the word "fear" was reported 28 times. Fear is an umbrella term that expresses mixed feelings of both the victim and the health professional in relation to the aggressor[4, 18]. Moreover, in this study, the affective sphere is linked to the lack of preparation of the health workers, the fear of criticism from their colleagues, and the feelings of the victims during care.

> *They are afraid of them, they are scared of the reaction, afraid of the criticism they will receive. It's not just the aggressor; they are afraid of us, health workers, of what we are going to say about it; what we are going to do; what type of protection to give or not. (PH; 012)*

> *[...] Maybe it would be better if we knew more about it, if we felt more support to take action. It can be a little scary, when you are there in the moment, when you see that situation you are going to get involved with. Fear of reprisal, fear of what your own colleagues will say: what you got into, what you said. Or of the actual aggressor saying: What you want to know? Why did you stick your nose in? Because you're nothing. (UH; 034)*

In relation to the victims, fear is the consequence of domestic violence and prevents them from reporting the aggressor[20]. According to the workers, the women are afraid of being blamed, revealing the importance of providing receptive healthcare with active listening and the need to rethink the traditional model of care.

As for the health workers, fear is not restricted to male domination. The findings confirm that the study object is part of the daily routine of the respondents and triggers discussion and concerns regarding women's care, especially the possibility of being criticised by colleagues about their conduct in situations of violence. The abundant national and international literature on the lack of professional training[5, 19] often translates this deficiency as impotence.

Care for women victims of domestic violence goes beyond the technical and scientific skills of the heath workers. Evidence clearly shows the need for investments in professional training by the managers of health institutions. Fear of the aggressor extrapolates the scope of work; however, fear of the attitudes of colleagues should not cause inertia of the workers regarding their responsibility to provide care for women in situations of violence. The disease-based care model must be replaced with a care model based on social problems permeated by humanising relations among the workers in a team and between the health workers and users.

The nursing team, which remains by the user's side at all times, can easily identify cases of violence and help break the silence of victims by suggesting support services and enabling the empowerment of these women and the families. Discretion and listening strengthen the bond, enable communication, and have a positive effect on care. In relation to the legal aspects, notifying suspected or confirmed cases of violence should be obligatory and is considered fundamental to increase the visibility of this phenomenon. The approval of the victimised women is not needed to complete the notification form.

The second periphery, lower right quadrant, contains the terms "submission" and "family" with low frequency and the least number of evocations. This quadrant has the most changeable elements that create the interface with reality[11]. The understanding is directly linked to gender issues, roles, and the legitimised behaviour of men and women in society. Submission is the inverse pole of domination-exploration and can be understood as a cause or a consequence of aggression.

> *I realise that there is not much information and I don´t see a way out for this. There may even be a way out, but maybe she cannot see it or she doesn't have anyone to help her see. Also, somehow she must think she deserves it because some of them think they deserve [to be battered] (HU; 027)*

> *Of course, the culture has that, woman's submission, the chauvinism that is rooted in men, in children, it is cultural, it is in our society. (UH; 032)*

The "submission" enunciated by this group maintains the image of women as subjects of men as a result of cultural issues. This passivity is considered a model of the social behaviour of women in relation men, which may be caused by financial and emotional dependence and hopes of maintaining the nuclear family or even that the partner will change[3-4, 16].

Women victimised by their partners can perceive violence as a chronic illness given the extended duration of the situation. They naturalise the phenomenon and prefer to view it as punitive and may even blame themselves for the violence, seeking answers where there are no questions, as they believe they are good mothers who wash and cook[3]. The fear, shame, and silence contribute to their permanence in the home, thus initiating a cycle of violence.

The term "family" reveals a negative and positive meaning. It is negative because domestic violence against women affects all the members, causing the family nucleus to become fragile and contributing to intergenerational violence; and it is positive because in the family these women can find the support they need to break the cycle of violence.

> *The first thing that comes to mind is the suffering, of the family and the relative of the victim; because it shakes the whole structure, the family; the children who are watching. Imagine how it affects her, and that is why a lot of these women have depression, really low self-esteem, I think it's because of that. (PH; 020)*

> *If you have this support, that's enough; you can turn your life around, but sometimes they don't. It's one of the things they said: I have nowhere to go, I don't have my family, nobody in my family wants me. (PH; 017)*

In the interviews, the nurses recognise that violence also affects the children and other relatives. Therefore, health services must provide a linear service model as a framework of interdisciplinary and intersectoral care to protect and promote the health of women, children, and families[5]. Moreover, they mention the importance of a primary care network composed of family, friends, and neighbours.

The main reasons women remain in a position of submission and violence are the lack of family support and the lack of awareness of the healthcare services they should seek to protect their rights. In contrast, the protection provided by people close to them is one of the main forms of support in cases of violence, and these women generally tell their mothers, aunts, and friends about the violence they are suffering because they think the healthcare services will not solve their problem[10]; on the contrary, they will only increase their exposure or the risk of being attacked again.

FINAL CONSIDERATIONS

Rooted in collective memory, physical aggression in the central nucleus also has meaning in the professional practice since it is the most common way for the nurses to recognise the victimised woman. Care can assume a clinical nature and give priority to treating injuries without observing the subjectivity of women. The perceptions of health workers regarding the object, however, gain expression and visibility in a more amplified conception of the phenomenon, through the use of the words "contempt" and "humiliation", and open the possibility of a different representation in the contrast zone, embodied in the term "verbal aggression".

Fear must be confronted by the victims and by the nurses in their daily work. The results reveal the importance of training health workers to prevent inertia regarding the unknown and the fear of being criticised by colleagues. The conception of the actors of violence is linked to social relations based on inequality between the sexes and submission versus domination.

It is believed that the articulation between primary care, exemplified by the family, and care services for the women victims of domestic violence can enable emancipatory practices and protect the healthcare workers. Studies such as this one do not conclude the need to investigate this phenomenon. On the contrary, they raise questions on the organisational dynamics of health services and the responsibility of managers to provide and encourage training for professionals in the field.

Nursing, which is jointly responsible for the health of women who suffer domestic violence, must assume a care model that is not restricted to clinical findings and favours the establishment of interpersonal relations with the staff, as well as the biopsicossial dimension, individuality, and subjectivity. The ability to view this phenomenon as a problem that affects the health-disease process is essential to increase the visibility of humanised care practices, rather than merely curative practices, in hospitals.

The limitation of this study was the impossibility of comparing the representation according to gender since most of the participants were women. It is, therefore, necessary to conduct research on the representations of both sexes and the influence of nursing care on the victims of domestic violence.

REFERENCES

1. Saffioti HIB. Gênero, patriarcado, violência. São Paulo: Perseu Abramo; 2011.
2. World Health Organization [Internet]. Geneva: The Organization; c2013-2017 [cited 2015 Jun 14]. Violence against women as a 'global health problem of epidemic proportions' [about 8 screens]. Available from: http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/
3. Fonseca DH, Ribeiro CG, Leal NSB. Violência doméstica contra a mulher: realidades e representações sociais. Psicol Soc. 2012;24(2):307-14.
4. Dillon G, Hussain R, Loxton D, Rahman S. Mental and physical health and intimate partner violence against women: a review of the literature. J Fam Med. 2013 [cited 2015 Jun 16];2013:313909. Available from: http://www.hindawi.com/journals/ijfm/2013/313909/
5. García-Moreno C, Hegarty K, Oliveira AFL, Koziol-McLain J, Colombini M, Feder G. The health-systems response to violence against women. The Lancet. 2015 Apr [cited Jun 16];385(9977):1567-79. Available from: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61837-7.pdf.
6. Almeida LR, Silva ATMC, Machado LS. The object, the purpose and the instruments of healthcare work processes in attending to gender-based violence in a primary care service. Interface (Botucatu). 2014;18(48):47-59.

7. Waiselfisz JJ. Mapa da violência 2012: atualização: homicídio de mulheres no Brasil. [Internet]. Rio de Janeiro: FLACSO; 2012 [citado 2015 jun 14]. Disponível em: http://mapadaviolencia.org.br/pdf2012/MapaViolencia2012_atual_mulheres.pdf.
8. Ilha MM, Leal SMC, Soares JSF. Women interned due to aggression at an emergency hospital: (in)visibility of violence. Rev Gaúcha Enferm. 2010 Jun;31(2):328-34.
9. Arruda CN, Braide ASG, Nations M. "Carne crua e torrada": a experiência do sofrimento de ser queimada em mulheres nordestinas, Brasil. Cad Saúde Pública. 2014;30(10):2057-67.
10. Santi LN, Nakano AMS, Lettiere A. Percepção de mulheres em situação de violência sobre o suporte e apoio recebido em seu contexto social. Texto Contexto Enferm. 2010 jul-set;19(3):417-24.
11. Abric JC. A abordagem estrutural das representações sociais. In: Moreira ASP, Oliveira DC, organizadoras. Estudos interdisciplinares de representação social. Goiânia: AB; 2000. p. 27-38.
12. Oliveira DC, Marques SC, Gomes AMT, Teixeira MCTV. Análise das evocações livres: uma técnica de analise estrutural das representações sociais. In: Moreira ASP, organizador. Perspectivas teórico-metodológicas em representações sociais. João Pessoa: UFPb Ed. Universitária; 2005. p. 573-603.
13. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.
14. Moscovici S. A psicanálise, sua imagem e seu público. 2. ed. Petrópolis: Vozes; 2012.
15. Vieira EM, Ford NJ, De Ferrante FG, Almeida AM, Daltoso D, Santos MA. The response to gender violence among Brazilian health care professionals. Ciênc Saúde Coletiva. 2013;18(3):681-90.
16. Hesler LZ, Costa MC, Resta DG, Colomé ICS. Violence against women in the perspective of community health agents. Rev Gaúcha Enferm. 2013;34(1):180-6.
17. Costa MC, Lopes JM, Soares JSF. Representações sociais da violência contra mulheres rurais: desvelando sentidos em múltiplos olhares. Rev Esc Enferm USP. 2014;48(2):213-21.
18. Gomes NP, Silveira YM, Diniz NMF, Paixão GPN, Camargo CL, Gomes NR. Identificação da violência na relação conjugal a partir da Estratégia Saúde da Família. Texto Contexto Enferm. 2013 jul-set;22(3):789-96.
19. Nascimento EFGA, Ribeiro AP, Souza ER. Percepções e práticas de profissionais de saúde de Angola sobre a violência contra a mulher na relação conjugal. Cad Saúde Pública. 2014;30(6):1-10.
20. Correia CM, Gomes NP, Couto TM, Rodrigues AD, Erdmann AL, Diniz NMF. Representações sobre o suicídio para mulheres com história de violência doméstica e tentativa do mesmo. Texto Contexto Enferm. 2014 jan-mar;23(1):118-25.

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