http://dx.doi.org/10.1590/0104-07072018001680016

PROFESSIONAL PRACTICES THAT SILENCE DOMESTIC VIOLENCE AGAINST CHILDREN AND ADOLESCENTS[1]

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[1] This article is the result of the thesis – Professional pratices that silence domestic violence against children and teenagers: a study institutional contexts, presented to the *Programa de Pós-Graduação em Enfermagem* of the *Universidade Federal do Rio Grande* (FURG), in 2016.

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ABSTRACT

Objective: The objective of this study is to identify practices that silence domestic violence from the discourse of professionals who work in children and adolescent protection services.

Method: This is a qualitative study, carried out with fifteen professionals, being six nurses, two psychologists, two physicians, two community health agents, two child protective council workers, and one social worker. The data were collected between November 2013 and March 2015, using semi-structured interviews. For the process of organization, analysis, and interpretation of the data, we used a theoretical matrix built from Institutional Ethnography, and the technique of analysis used was the textual discourse.

Results: We have identified three categories: the reductionist action in relation to the domestic violence against children and adolescents; referrals as the transfer of the responsibility to protect; and, the exclusion of the aggressor from the intervention process.

Conclusion: The practices developed by the professionals of this study can contribute to the recurrence of domestic violence against children and adolescents, highlighting the weaknesses of the services that make up the child and youth protection network. Therefore, this study proposes to reflect on new ways of acting against domestic violence, in order to ensure that children and adolescents have their rights guaranteed.

DESCRIPTORS: Domestic violence. Child. Adolescent. Nursing. Professional practice.

PRÁTICAS PROFISSIONAIS QUE SILENCIAM A VIOLÊNCIA INTRAFAMILIAR CONTRA CRIANÇAS E ADOLESCENTES

RESUMO

Objetivo: identificar, a partir do discurso dos profissionais que trabalham em serviços de proteção a crianças e adolescentes, práticas que silenciam a violência intrafamiliar.

Método: estudo qualitativo, realizado com 15 profissionais, sendo seis enfermeiros, dois psicólogos, dois médicos, dois agentes comunitários de saúde, dois conselheiros tutelares e um assistente social. Os dados foram coletados entre novembro de 2013 e março de 2015, utilizando entrevistas semiestruturadas. Para o processo de organização, análise e interpretação dos dados foi utilizada uma matriz teórica construída a partir da Etnografia Institucional e a técnica de análise foi a textual discursiva.

Resultados: foram identificadas três categorias: o agir reducionista frente à violência intrafamiliar contra criança e adolescentes; os encaminhamentos como transferência da responsabilidade de proteger; e a exclusão do agressor do processo de intervenção.

Conclusão: as práticas desenvolvidas pelos profissionais deste estudo podem contribuir para a reincidência da violência intrafamiliar contra crianças e adolescentes, colocando em evidência as fragilidades dos serviços que compõem a rede de proteção infanto-juvenil. Diante disso, este estudo propõe refletir sobre novas formas de agir frente à violência intrafamiliar, com vistas a assegurar que crianças e adolescentes tenham seus direitos garantidos.

DESCRITORES: Violência doméstica. Criança. Adolescente. Enfermagem. Prática profissional.

PRÁCTICAS PROFESIONALES QUE SILENCIAN LA VIOLENCIA INTRAFAMILIAR CONTRA NIÑOS Y ADOLESCENTES

RESUMEN

Objetivo: identificar, a partir del discurso de los profesionales que trabajan en servicios de protección a niños y adolescentes, prácticas que silencian la violencia intrafamiliar.

Método: estudio cualitativo, realizado con 15 profesionales, siendo seis enfermeros, dos psicólogos, dos médicos, dos agentes comunitarios de salud, dos consejeros tutelares y un asistente social. Los datos fueron recolectados entre noviembre de 2013 y marzo de 2015, utilizando entrevistas semi-estructuradas. Para el proceso de organización, análisis e interpretación de los datos se utilizó una matriz teórica construida a partir de la Etnografía Institucional y la técnica de análisis fue la textual discursiva.

Resultados: se identificaron tres categorías: el actuar reduccionista frente a la violencia intrafamiliar contra niños y adolescentes; las referencias como transferencia de la responsabilidad de proteger; y la exclusión del agresor del proceso de intervención.

Conclusión: las prácticas desarrolladas por los profesionales de este estudio pueden contribuir a la reincidencia de la violencia intrafamiliar contra niños y adolescentes, resaltando las fragilidades de los servicios que componen la red de protección infanto-juvenil. Este estudio propone reflexionar sobre nuevas formas de actuar frente a la violencia intrafamiliar, con miras a asegurar que niños y adolescentes tengan sus derechos garantizados.

DESCRIPTORES: Violencia doméstica. Niños. Adolescentes. Enfermería. Práctica profesional.

INTRODUCTION

Domestic violence against children and adolescents is a serious public health problem because of the physical and psychological consequences left on the victims that may manifest themselves in childhood or in adulthood. Research studies developed in the field of health reveals that, in the short term, children and adolescents subjected to violence tend to develop problems such as depression, aggression, anxiety, and difficulties in social interaction and learning.[1-4] At the same time, they are at increased risk for the development of heart, pulmonary, metabolic, and autoimmune diseases that may manifest in adulthood.[5-6]

Such problems require interventions able to remove children and adolescents from the condition of victims. However, we can observe in the context of protection services that professional practices are not always capable of offering protection to young victims. This fact instigates the questioning about the professional practices developed in the children and adolescent protection services, considering that they can both protect and silence the violence that occurs within the family. We consider as practices that silence domestic violence those that, although taking care of the physical and psychological problems resulting from violence, are not able, in fact, to protect children and adolescents, even if this is the purpose of the social and health services, made explicit in the guidelines of official documents that regulate the organization of these spaces.

Specifically, in this study, the emphasis is placed on professional practices that silence domestic violence, which may be institutionalized precisely in the services that have the responsibility of caring for victims and families, such as General Hospitals, Basic Health Units, Child Protective Councils, and Reference Centers Specialized in Social Care (CREAS). In these spaces, interventions can be limited to the timely and immediate assistance to victims, disregarding the fact that, after leaving these services, children and adolescents return to their homes where they remain vulnerable to further aggression and abuse. Of those children and adolescents who have been victimized and who have received some type of specialized treatment, few continue to be monitored by the services, in order to ascertain if the interventions were effective in terms of protection. The lack of communication between professionals working in referral and counter-referral services is pointed out as one of the factors capable of compromising the protection of victims, as many cases are archived and considered as solved.[7-9]

In order to give visibility to and understand the professional practices that silence domestic violence against children and adolescents, we used the Institutional Ethnography (IE) as theoretical reference, since it allows us to explore and analyze the daily life of services, starting from the concrete experiences of the professionals inserted in these spaces.[10]

With this perspective, we can examine, from a dynamic model, the issues related to the identity and signification of individuals,[10] that is, how professionals conceive the protection of children and adolescents, their responsibilities within the service where they act, and how they relate to families in situations of violence that daily seek their care. These issues allow us to highlight the main actions developed, in order to prevent children and adolescents from going through new (re)victimization.

The theoretical framework adopted presents a critical posture in relation to the objective forms of construction and organization of professional practices in the institutional context.[10] Specifically regarding the problem of domestic violence against children and adolescents, it can sometimes be widely recognized within the services that make up the protection network. As a consequence, the practices adopted in these situations fail to meet the specific and individual needs of the victims.

With this theoretical perspective, this study aims to identify practices that silence domestic violence from the discourse of professionals who work in children and adolescent protection services.

METHOD

This is a qualitative study carried out with fifteen professionals who met the following inclusion criteria: having cared for children and adolescents as a result of domestic violence, presumed or confirmed, and being employed for at least 12 months at the service where they work.

The professionals were recruited in services that comprise the protection network for children and adolescents, including Emergency Care Units and Pediatrics of a University Hospital, a Basic Health Unit, a Reference Center Specialized in Social Care, and a Child Protective Council, based in a medium-sized municipality, located in the extreme south of Brazil. The option to include these services is due to the fact that, as a whole, they portray the itinerary usually traversed by families in situations of violence in the municipality.

The University Hospital serves the population from the Brazilian Unified Health System (SUS). It has 189 beds for hospitalization, distributed for different purposes, and two units stand out for the care of children and adolescents: the Emergency Care Unit, which treats approximately thirty children and adolescents daily, and the Pediatric Unit, with the capacity to admit twenty patients.

The Basic Health Unit consists of three Family Health teams, with doctors, nurses, nursing technicians, and community health agents. Each of the teams serves approximately 4,500 families, and their duties are to welcome users, facilitate access to the other services that make up the network, and implement care activities, prioritizing individuals, families, and groups at greater risk and vulnerability.

The Child Protective Council is a permanent, autonomous, non-jurisdictional public agency charged by society to ensure the rights of children and adolescents. Among its attributions we can mention: attendance to situations that involve threat or violation of the rights of the child or adolescent, application of protective measures, care and counseling of parents or guardians, and requesting of services and referrals to the service network. This institution has twenty workers distributed into three teams responsible for the annual care of approximately one thousand children and adolescents victims of domestic violence.

The Reference Center Specialized in Social Care is responsible for providing specialized care to individuals or families in situations of personal or social risk, because of the violation of rights. Weekly, it treats approximately thirty cases involving domestic violence against children and adolescents. Of these, 95% are referred by agencies such as the Child Protective Council, Police Station, and Child and Youth Court.

Data were collected between November 2013 and March 2014 from semi-structured interviews that followed a script oriented to identify the practices and routines adopted in the care of children and adolescents victims of domestic violence and the reasons that led the professionals to take such decisions. The professionals were interviewed in the services where they work, previously scheduled. Each of the interviews lasted, on average, 1 hour and 15 minutes. To preserve anonymity, professionals were identified by the letter "P", followed by the order in which they were interviewed. For example: $P_{1,}$ $P_{2.}$ The study was approved by the Research Ethics Committee of the institution to which it is affiliated, with registration under number 066/13 and Certificate of Presentation for Ethical Consideration under number 11230413.1.0000.5324.

The data were organized, analyzed, and interpreted with the aid of a theoretical matrix, built from Institutional Ethnography,[10] which considers the institutional context as a dynamic space where work processes are developed and where victims, families, and professionals establish social relationships. The technique of analysis was the textual discourse,[11] following the steps: identification of the statements related to professional practices developed against domestic violence against children and adolescents, and disassembling of interviews, identifying and coding each highlighted fragment, forming the units of analysis. Then, the construction of the relations between these units was carried out, grouping the elements into a process named categorization, which resulted into three categories: the reductionist action in relation to the domestic violence against

children and adolescents, referrals as the transfer of the responsibility to protect, and the exclusion of the aggressor from the intervention process.

RESULTS

Of the fifteen participants in the study, six were nurses, two psychologists, two physicians, two community health agents, two child protective council workers, and one social worker. Of these, fourteen were females and one was male, all aged between 28 and 64 years. The time of employment varied between 12 and 240 months. Twelve of the professionals have complementary training, with special emphasis in the areas of Public Health and Family Health.

The three categories that, together, identify the professional practices that silence domestic violence against children and adolescents in the context of the protection services investigated are described below.

The reductionist action in relation to the domestic violence against children and adolescents

The reductionist action in relation to situations of domestic violence against children and adolescents encompasses a set of professional practices that engage in meeting only the physical needs presented by the victims, excluding, from the intervention process, the legal aspects that involve the handling of these situations, among them the obligatory notification of suspected or confirmed cases with the Child Protective Council. The practices adopted by some professionals, in relation to a victimized child or adolescent, are to check vital signs, dress wounds, and apply medication as necessary. *I will be very sincere, when they* [victims] *come here we check the vital signs, we weigh this child and medicate when necessary. Of course the doctor will do the anamnesis, but basically this is what we, the nursing professionals did* (P_3).

The reductionist action against domestic violence still includes the lack of official records regarding the care that is performed. Although they have the opportunity to record, professionals report that, if during the care they perceive that it is a suspected or confirmed case of domestic violence, they choose not to formalize this information, giving it verbally to other colleagues. *If I suspect any situation, I go to the doctor's office and comment on it, but I don't usually record it. Maybe when the child is under observation the colleague will record it* (P_4).

In social services, the reductionist action against domestic violence is translated into professional practices that strictly follow the routines pre-established in these spaces, regardless of whether they are suitable or not for the different situations treated. *Our routine here is to establish a bond with the family. For this end, we bet on the welcoming. There are people who come to the service and don't form a bond because they don't feel welcome; then we can't do much. I can't chase after the family.* (P_{10}).

Asked about the reasons that led them to adopt such actions regarding the cases attended, professionals reported that they only followed what they believe to be their attributions in the face of situations of domestic violence. Thus, we can see that the problem of violence is sometimes treated in a generalized way, with pre-established institutional routines that do not always fit the needs of victims and families.

The referrals as the transfer of the responsibility to protect

Referring victims and families in situations of violence to the care or follow-up of other staff members and services was the most expressed practice by professionals. These referrals seem to take on the meaning of transferring the responsibility of protecting victims and exempting professionals from other actions that must be carried out, such as notifying suspected or confirmed cases of domestic violence and monitoring victims and families while they do not reach the services to which they were referred to: [...] *I receive the child, I give the first care, and I refer him to a physician, because in relation to the violence itself, it is the physician who notifies it, as it he is the one who fills the final report* (P_4); [...] *if I receive a case of domestic violence I refer them to the psychologist because I believe it is her who does this part of protection* (P_1). In addition to believing that physicians and psychologists are primarily responsible for conducting situations involving domestic violence, some professionals also delegate a great responsibility to the Child Protective Council and the Family Health Support Center (NASF): [...] *once I called the Child Protective Council and I said, 'look, I'm sending you the case that I've treated', so if there is ever a problem, the phone secrecy can be lifted and they'll see that I've given you the case* (P_7); [...] *in relation to domestic violence we call the Child Protective Council or the NASF, because if someone has to put the gun to the head it will have to be them* (P_{11}).

Furthermore, we need to emphasize that, although the professionals adopt the practice of referring the situations to other professionals and services, most could not inform if these referrals were effective and contributed with the process of protection of the victims, as evidenced in the following speech: [...] *after the case leaves the service we do not know what happens to the child, it is difficult to have this information* (P_1). On the other hand, some professionals recognize the inefficiency of the referrals made, as they daily observe the relapse of the cases that are treated in their daily life: [...] *we took a case here of a child suspected of sexual violence. We referred to the Child Protective Council, but then what? Nothing was done, because some time later she came again with the same problem* (P_3).

These discourses highlight the fact that the protection of victims is an attribution of the other (professional and/or service), reflecting the difficulty of many professionals in seeing themselves as an integral part of a network of services that legally aims to promote articulated practices capable of promoting the protection of children and adolescents.

The exclusion of the aggressor from the intervention process

Of the practices adopted in relation to situations of domestic violence against children and adolescents, reported by the professionals, none of them provides assistance to or follow-up of the aggressor. Some professionals reported that they cannot even approach the aggressor, given that these are situations that generate a great emotional load, which many are not prepared to face. *I feel very angry, contempt for the aggressor* (P_8); *I already had to treat a person who assaulted the wife and children, but, it was difficult, I could not even look at him right* (P_6).

It was evidenced that the exclusion of the aggressor seems to be institutionalized, as none of the institutional routines that were verbalized by professionals seek to welcome or understand him or her as an integral member of the family in situations of violence. Thus, professionals understand that providing care to the agent of aggression is something that is not part of their assignments: [...] *when I started to work here, the first thing they told me is that we don't treat the aggressor* [...] *we have the responsibility to treat only the victim* (P_{13}).

It is worth noting that domestic violence is a problem that is not seen from the victim-aggressor dyad, and although many children and adolescents receive the necessary care/follow-up, when they return to their homes, they will remain living with the aggressor who will likely continue to commit aggressive, abusive, and negligent acts.

DISCUSSION

The results of this study make it possible to highlight that professional practices developed in relation to situations of domestic violence do not always constitute protection, contributing to keep the suffering of many children and adolescents anonymous.

Although the creation of the Child and Adolescent Statute represents a step forward in the protection of children and adolescents, in this study, the guidelines of this important document were not put into practice. Although mandatory,[12] the reporting of suspected or confirmed cases is still not a very expressive practice. Faced with the situations treated, the professionals who participated in this study seem to produce a reductionist care, only aimed at meeting the physical needs of the victims. These results are in accordance with those evidenced in a research that aimed to identify the care strategies adopted by professionals against situations of violence against children in the hospital context. In it, 58.82% of the interviewees identified as main strategies the verification of vital signs, dressing, and administration of medication.[13]

In addition, the absence of educational and preventive actions in relation to violence is discussed, which could be linked to the activities developed by professionals working in primary care services. For some authors, this model of care may be a result of the biomedical model established in a large part of the Brazilian services, as well as the academic training of health professionals, in which we can observe more attention in the care processes related to the cure of diseases to the detriment of prevention-oriented knowledge.[14]

The discourse of the professionals interviewed highlighted the lack of records regarding the care provided to victims of domestic violence. Although the professionals have a screening record and the medical record of the patient, where they could record their impressions in response to the situations treated, they choose not to formalize such information, which is eventually passed on verbally among the team.

Thus, the reductionist action of the professionals of this study regarding situations of domestic violence may be due to practices that seem to be intrinsic to pre-established institutional routines,

even if they prove to be ineffective in some situations. The professionals reported that the welcoming is the main tool used to approach the services to victims and families. If on the one hand there is the recognition that this practice is not always effective, as some persons do not feel welcomed and therefore do not attend services, on the other, there was no interest in assessing how this welcoming has been developed and what are the points to be improved.

The lack of interest of the professionals in assessing their daily practices can be justified, considering that many assume the role of spectators in situations involving violence against children and adolescents. They are professionals who cannot see themselves as an integral and essential part of the management of these situations.[15] In addition, it should be noted that pre-established routines can sometimes generate some feelings of convenience or immobility regarding the changes needed to improve the care for victims.

It is necessary to understand domestic violence as a complex phenomenon,[16] which requires professionals to constantly assess and change their daily practices. Interventions against violence requires professionals to act in a dynamic way that fits the needs and specificities of each family.[16]

Regarding the referrals reported by the professionals of this study, we observed that this practice assumes the function of transferring responsibility for the situations to other professionals and services, especially to the Child Protective Council. These results are in accordance with research carried out with nursing professionals who work in primary health care, who have identified as their main attribution, in the care of victims of violence, the referral of the situation to agencies such as the NASF and Child Protective Council.[17] It is noteworthy that the professionals follow, in part, the guidelines described in the Child and Adolescent Statute,[12] that is, they communicate the cases of violence to the Child Protective Council. However, this attitude does not exempt them from the other responsibilities that these situations require.

Furthermore, researchers[18-20] have highlighted the main obstacles of this practice in the daily network of services that provide care for victims of violence, among them, lack of care flow charts, non-coordination of referral and counter-referral services, and lack of follow-up of victims and families receiving the referrals. These are factors that contribute to cases being forgotten, filed, and thought as solved.[18-20]

In this study, no professional practices were identified focused on the provision of care and/or follow-up of aggressors, a reality similar to English services,[21] in which the lack of interventions with aggressors is currently one of the main inadequacies of the protection network for children and adolescents. The main reason for the exclusion of aggressors from intervention processes is the fact that, culturally, society and professionals tend to underestimate the ability of the aggressor and their willingness to change their behavior.[21]

In order to prevent many cases of domestic violence from being silenced and forgotten, authors suggest regular audits within the services that provide care to victims, given the need to continuously assess the care and interventions provided to them. The discussion about new ways of caring for victims and families is also necessary, contributing to the enhancement of singular and specific professional practices capable of covering not only the physical and immediate needs of the victims, but also the social and legal aspects involved in the management of these victims.[22-24]

Although this study has important limitations that hinder the generalization of its results, both from its qualitative nature and the sample size, its results allow us to recognize the institutionalization of professional practices capable of silencing domestic violence against children and adolescents. In addition, the results highlight the need to discuss and rethink new ways of acting in relation to the phenomenon, as failures in intervention processes can contribute to many children and adolescents suffering in anonymity.

CONCLUSION

In this study, we identified that the practical practices developed against domestic violence against children and adolescents, although concerned with addressing physical and psychological problems, are not effective in terms of protecting the victims. We observed that such practices are expressed by a reductionist action, by the professionals, in relation to the situations of violence seen in their daily life, that is, they are limited only to the care of the physical injuries presented by the victims, without care records and without notification of suspected or confirmed cases of violence.

Regarding the practice of referrals, as it has been developed by the professionals of this study, we believe that it may contribute to children and adolescents having their suffering forgotten or kept anonymous, as professionals end up transferring

the responsibility for the protection of victims to colleagues and even to other services. The lack of formal records on the conduct carried out prevents victims and families from being monitored, even after receiving the referrals deemed necessary by the professionals.

Finally, the exclusion of the aggressor from the intervention processes is also one of the inadequacies of the services and contributes to silence the violence, as without the provision of a treatment and/or follow-up, the probability of aggressors changing their attitudes is reduced, which further compromises the health and development of children and adolescents, as they will probably continue to live with constant aggression and abusive and negligent acts.

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Recived: May 10, 2016
Approved: October 25, 2016