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Care delivered to victims of domestic violence: social representations of nursing students

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ABSTRACT

Objective: To describe the contents of social representation of domestic violence against women, according to undergraduate students in the initial and final years of nursing education. **Methods:** Data were collected between August and November 2014, by means of interviews analyzed by the *Alceste* software. Among the six classes obtained, the largest one was selected, with 27% of the corpus and 212 units of elementary context. Protocol No. 109/2014. **Results and Discussion:** The representational contents showed that in the initial years, care delivered for a victim is based on common sense knowledge, with informal conversation and personal advice predominating. In the final years, the reified approach predominates, which is described in the form of welcoming, bonding, teamwork and referrals. **Conclusion:** Common sense knowledge was mainly demonstrated among the students in the initial years and the reified knowledge predominates among those in the final years.

Keywords: Domestic Violence; Violence against women; Nursing students; Nursing care.

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INTRODUCTION

Violence is a universal phenomenon that affects populations of several cultures, religions and socioeconomic levels. Around 30% of women suffer intimate partner violence worldwide[1]. In Brazil, Law 11.340, known as Law Maria da Penha, has been in force since 2006, which conceptualizes domestic and family violence against women as "any gender-based action or omission that causes them death, injury, physical, sexual or psychological suffering, and moral or patrimonial damage"[2:5].

The Law also defines that violence occurs various forms: physical, psychological, moral, sexual and patrimonial[2]. Based on this classification, in 2014, the Women's Call Center (*Ligue 180 – [Call 180]*), recorded 31,432 reports of physical violence, 19,182 reports of psychological violence, 4,627 reports of moral violence, 3,064 reports of sexual violence and 1,382 of patrimonial violence [3].

In order to expand the range of *Ligue 180*, the service was extended to Brazilian women living in Spain, Portugal and Italy. Also, the Women's Policy Secretariat launched the campaign "*Violência contras as mulheres – eu ligo"* [V*iolence against women - I care*"] and the mobile app "*Ligue 180*" in 2014. With this new option, the violence records increased by 52%. In the same year, the media, mainly television, contributed to making the Center known by the victims, accounting for 47% of the demand for the service[3].

Between 2013 and 2014, the Center had a 50% increase of records of forced confinement, and a 20% increase in records of sexual violence, including rape, harassment and sexual exploitation, reaching an average of four records per day[3]. In 82.53% of them, the aggressors had an affective bond with the victims, were current or former partners, spouses, boyfriends or lovers[3].

This bond, fear, shame, and other factors can inhibit reporting by women. Sometimes women find themselves in a situation of family helplessness, loneliness and lacking the courage to break away from violent acts. Even because of ignorance or misinformation about their rights, they endure their condition of victims. In this sense, health professionals should be alert to the signs of a possible occurrence of domestic violence against women (DVAW) and should be scientifically supported to provide care.

Nevertheless, health care professionals, including nurses, consider themselves unprepared to act in situations of DVAW. This feeling is justificated by the superficial approach or lack of debates on the subject during undergraduation, as well as by the small availability of courses, seminars and conferences[4-5]. Other factors such as the belief in the male superiority, culture, religion and representations can also be obstacles in the establishment of public policies, development of preventive and caring actions to the victim.

Higher education institutions have a social commitment to educate professionals capable of acting responsibly and committed to the problems and health/disease situations prevalent at the national level[6]. In this sense, we believe that the undergraduate nursing course enables students to develop a reified knowledge, which is added to the commonsense knowledge and can modify the social representation about DVAW. Thus, the objective was to describe the contents of

social representation of domestic violence against women, according to undergraduate students in the initial and final years of nursing education.

METHODS

This was a descriptive, qualitative research grounded on the Theory of Social Representations (TSR). The first three years and the final three years of the nursing program were chosen because we believed that reified knowledge acquired during the undergraduate nursing program can modify the representation of DVAW, because when entering the course, students opinions are based mainly on commonsense knowledge .

It is emphasized that TSR experts agree that 30 interviews is the minimum amount to recover the representations in a group[7]. Thus, all students were invited, trying to reach the minimum of five students per year. Those who missed classes during the data collection period were excluded, which occurred between August and November 2014. First, a questionnaire containing personal, social and academic information was administered. Next, individual interviews, previously scheduled, were performed. A script was developed, with open questions related to the pre-university experiences, with the theme and the approach during the theoretical-practical courses.

The interviews were conducted in a private room in the academic area of the School of Nursing, and recorded with permission. The mean time was 30 minutes. Data processing was performed using the *software Lexical analysis of a set of text segments in the context (ALCESTE),* proposed by Max Reinert in 1979, which enables a content lexical analysis.

This software identifies the contents present in a set of texts using statistical techniques. It divides the corpus, formed by the total of interviews, into classes according to the relationship between the reduced forms. This relationship is found through the value of Khi², calculated from the intersection between presence and absence of the word in an Elementary Context Unit (ECU). This consists of corpus segments with different sizes[8]. For this study, the class that had the largest percentage of the corpus analyzed was selected.

To ensure anonymity, participants were identified by the letter S (students) and the order of the interview. The research complied with Resolution 466/2012, obtaining approval from the Health Research Ethics Committee, under Protocol No. 109/2014.

RESULTS

Thirty-three nursing students participated, 16 of the initial years and 17 of the final years. Only two participants were male and four had children. Regarding age, 18 were between 17 and 23 years old and 15 were between 24 and 50 years old. Twenty-five reported that they had not attended any discipline addressing DVAW during the course, whereas four mentioned the women's health discipline and four mentioned the epidemiology discipline.

The class analyzed corresponds to 27% of the corpus (figure 1). It is composed of 212 ECUs, which have a mean of 29 words analyzed. The variables age range 24 to 50 years (khi²=2) and children (khi²=2) were statistically associated with this class. Confirming the as-

sumption that the undergraduate-nursing course enables students to develop reified knowledge, the variable related to women's health discipline (khi²=8), which addressed the subject, was statistically associated with the class. Similarly, the final year variable (khi²=6) included five of the six interviews that compose the class.

The class has 168 major reduced forms, which showed greater statistical association. Among these, the ones with the highest Khi² values and which indicated meanings present in the class are: *follow-up*(khi²=38), *help*(khi²=32), *bond*(khi²=29), *patient*(khi²=27), *preparation*(khi²=25), *acting* (khi²=23), *appointment*(khi²=22), *symptoms* (khi²=22), *primary healthcare*(khi²=21), *conversation*(khi²=19), *referral*(khi²=18), *difficult* (khi²=16), *nurse* (khi²=16), *professional* (khi²=16).

The reduced forms showed that the representational contents were related to acting with the victim, characterizing it as a difficult task that requires professional preparation, highlighting the care by means of bonding, monitoring, appointment in the primary healthcare, help and referral to other services. These contents constitute two categories, developed from the analysis of the set of semantic contexts. The first refers to the victim care based on commonsense knowledge and the second addresses care based on reified knowledge.

Care delivered to DVAW victims based on commonsense knowledge

The social representation about DVAW, as a *difficult* matter (khi²=16) to be worked in the professional daily life, showed that nursing students recognize the dimension and severity of the problem. Those in the early years of school related the difficulty to their desire of giving their personal opinions about the situation while providing care to the victim.

> *If I had to deal with this situation, it would be hard for me not to comment on anything. Of course, as we go along the course we become more mature, and maybe in the end it will be different, to be able to behave*

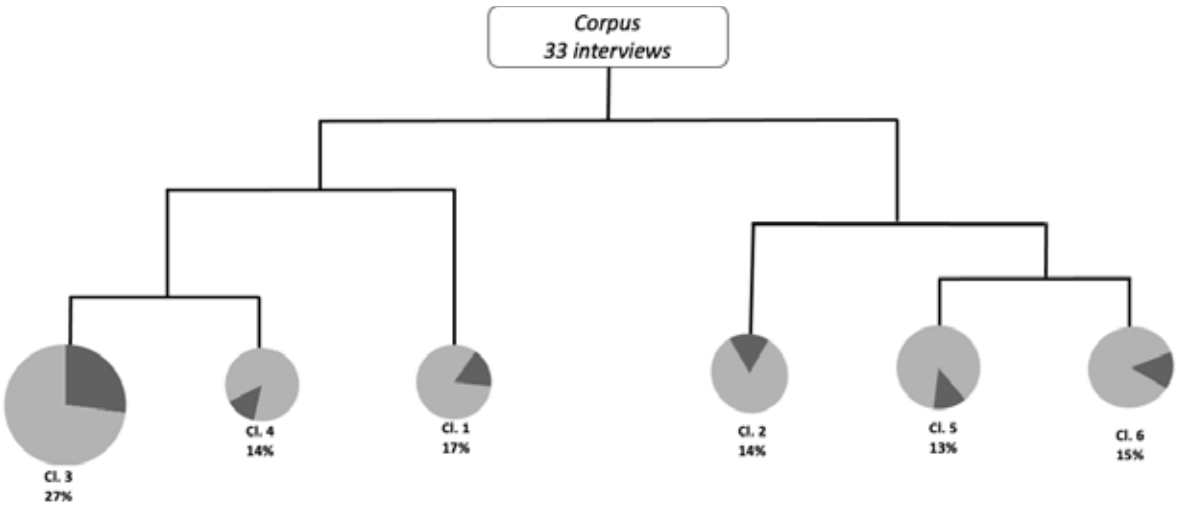

Figure 1. Descending Hierarchical Classification of the class "Professional performance in the face of DVAW". Rio Grande/RS. 2014
Source: author.

> *differently in these situations and try to help other women and children not go through it. (S23)(2014)*

The representation of DVAW among the students in the first years is based on common sense, because, although recognizing the need for professional *preparation* (khi²=25) and knowledge about what steps should be taken, they still showed lack of arguments to guide their *acting* (khi²=23) in caring for victims.

> *I don't feel well prepared, there are some things that I still need to improve a lot, I think that only with daily routine I will learn, because a case like that and try to solve ... I think we first have to try to do things, ask a colleague for help. (S24)(2014)*

On the other hand, these students had the expectation of overcoming their unpreparedness to work throughout the undergraduate course. Thus, they recognized the construction of knowledge by means of the development of internships and professionalizing disciplines, as well as qualified teachers. Even so, they still could not understand the applicability of basic nursing instruments previously learned. In this sense, a student reported using the nursing assessment, but did not perceive it as an appropriate tool to investigate the occurrence of DVAW. Another student from the early grades restricted their acting to the hospital environment, unaware, as the general population, that nursing can and should act in primary care, aiming at both the prevention and the combat of DVAW.

> *I feel unprepared. One is not prepared for that, as I am in the third semester and for us this is very recent, we do not have much contact with the hospital, I do not know if it is common to see. (S124)*

> I have hope; we have professionals, teachers, who are well grounded, who have a lot to offer us. As I'm just starting the hands-on clinical learning, because the first stages we do are more directed at data collection. *(S24)(2014)*

Based on commonsense knowledge, nursing students expressed the need to provide care to the victims. Those in the initial grades, with little scientific basis, focused the care on informal *conversation* (khi²=19) with the victim, and on the *follow-up* (khi²=38), declaring the nurse's intervention with the *patient* (khi²=27) as unnecessary in a first contact.

> *Talk serenely, that we will try to solve her situation in the best way, even for her to start talking, talking about what's going on. I think that what the nurse can do is, at this moment, not to interfere, there is no way [...], I would say that she could reach me to talk, to try to clarify. (S124)(2014)*

Among the care activities provided to the victim, students in the initial years indicated seeking *help* (khi²=32) from family members and close people. Some mistakenly indicated to go to the police only if they have evidence of the violence. One student listed care regarding the psychological impairment generated by violence. The nurse is inadequately

associated with the assignment of giving personal advice to the victim.

> *I would tell her to talk to her partner, try to alleviate the situation and, if it was not possible, then look for someone, some family member of her, who could help and welcome her. (S127)*

> *I'd try to tell her to get help, get help from her father, family, and go to the police if she's really being assaulted, if it's proven by a witness that she's being assaulted. (S63)*

> *Everyone knows how to deal with the physical, injured part ... but the psychological part, to guide, seek the hospital psychologist, go to therapy, give advice to divorce the husband, who is assaulting... (S126)(2014)*

We highlight the statement of a student from the initial years, who witnessed a situation of violence in his family environment. The compulsory notification was mentioned as a nurse's assignment and that could subsidize public policies for victim care. This fact caused strangeness, because such knowledge is usually acquired during the final years of the course, as it constitutes a reified knowledge.

> *The nurse needs to welcome, listen to that person because she arrives so desperate, she does not know what to do, what action to take. I think the first thing is talking to the family, guiding, making compulsory notification of cases so that some public policy can be developed, due to underreporting of cases. [...] As the case of my aunt, who had no one, but if she had help from a health care professional ... (S65)(2014)*

Care delivered to DVAW victims based on reified knowledge

The students in the final years also represent the DVAW as a *difficult* matter (khi²=16) to be worked on in the daily professional life. Based on the reified knowledge, they stated the difficulty to provide care to the victim, especially to break the cycle of violence.

> *She often opens up to you, cries, gets desperate, and the next day she comes back, and nothing happened. It is very difficult to make her have the courage to report, it is a difficult situation to deal with, for the nurse is also not easy. (S51)(2014)*

Some students stated they were prepared to deliver care to the victims. However, due to the near conclusion of the nurse education, they stated a feeling of insecurity, which is recurrent among undergraduates. Thus, they sought to take advantage of the latest academic experiences and participated in the delivery of care for the victim with the nurse supervisor of curricular internship in primary healthcare. Relying on more experienced colleagues was identified as an alternative to lessen insecurity.

> *Being with the teacher supporting, then you will be alone and have to make the decisions. We are afraid to make a wrong decision. A woman arrives, will not report directly, we have to talk first to acquire confidence*

> *and be able to act. I feel prepared, but with a little fear, I always smell a rat. (S13)*

> *In the clinical here in primary healthcare we deliver care with the nurse. The patients have confidence in nurses, very much. I saw that everything the nurse said she welcomed, and said she would do. I felt confident with the situation. (S36)*

> *I would feel very insecure, ask someone more experienced for help. We don't know, at first, how to handle most things and a case of violence against women is pretty complicated. (S35)(2014)*

Representing the DVAW as a fear-generating situation can lead the student to feel unprepared to provide care. Another factor that triggers the feeling of unpreparedness is the lack of approach to the subject during undergraduate education. Some reported that discussions provided during professional disciplines, in extra-class activities, or in the form of courses and research groups were insufficient. They also stated the need for debate using a realistic simulation to make learning more concrete.

I feel completely unprepared to act, very afraid, like that situation of the lady who was raped, I never expected to hear that. (S119)

> *I don't feel prepared at all, because we have no contact, we are not prepared for it in undergraduation. I think that it could be addressed in the undergraduate disciplines. (S34)*

> *I would be very apprehensive, because we are not prepared during undergraduation for this type of conduct, in relation to violence [ ]. These things of compulsory reporting, which are in our ethics code, I have a slight idea because I participated in a research group that works on violence against women. We have no basis during undergraduation; we should have at least some preparation for it, hypothetically, live these situations in simulations to understand how we would act.* As we do in other cases, *realistic simulation that they use a lot in the disciplines. It's a very difficult thing, because we know that the woman is suffering. (S49) (2014)*

Students in the final years recognized the importance of professional experience in providing care. Faced with the scarce opportunities to experience victim care and the lack of specific knowledge on the subject, they stated the applicability of basic nursing instruments in working with the victim.

> *We only feel prepared to act as we acquire more experiences in the area. I haven't seen it often, and I don't feel very prepared. I use the basic principles of undergraduation learning and that are part of the nurse knowledge, know how to listen, what to ask, how to express myself in the best manner possible. But I feel unprepared, I would try to write as many things as possible that she [the victim] would be telling me, so that nothing would be lost and that would be recorded. (D132)(2014)*

Reified knowledge is also evidenced by the professional confidentiality, stated by the senior student regarding team performance.

> *Keep everything just between the nurse and the patient. Try to tell it only to the individuals who are getting involved, who will take care of her. I also think the details that will be told to other professionals, some the nurse should try not to say, otherwise it will more disturbing. (S92)(2014)*

The representation of students in the final years is based on reified knowledge, because, unlike the initial years, care is associated with instructing on the victim's rights, as well as *referral* (khi²=18) of the *patient* (khi²=27) to others services. Examples include the psychology service, the police station, primary healthcare (khi²=21) and the family health support center.

> *To support and make her leave the hospital as knowledgeable as possible ... (S39)*

> *I should investigate well, talk to her and sometimes even refer her to do the exams, for a psychological follow-up; in this case here in the primary healthcare that has Expanded Nuclei of Family Health and Primary Care appointments. (S35)*

> *The nurse has to give all psychological support to the woman to reach the police station, and also later, to be able to leave her house. (S51)(2014)*

In the delivery of care for victims of violence, students in the final years cited *bonding* (khi²=29) as an essential factor between the *patient* (khi²=27) and the *professional* (khi²=16). Approaching to the victim facilitates obtaining information and approaching the subject. A student of the final year mistakenly stated that the nurse should act with the victim only in the second occurrence of violence, and that this first occurrence should be the moment to make only the complaint and not the compulsory notification.

> *I would try to make a home visit, to demonstrate that we are paying attention, develop the bond, because here the patients only talk when a bond is established. (S36)*

> *In the first time, I would not make the compulsory notification, I would make it in the second occurrence, I would first try to get as much information, even because she does not know me yet, I would try to establish a bond, in which she could talk to me, with no problem. (S13)(2014)*

The students of the final years recognized the importance of the nurse's role in the care delivered to the victims, as well as of other health professionals, especially for the accomplishment of teamwork.

> *Nursing is the profession that has the most close contact with the woman, who can reach and maybe have some positive effect on the woman to take some action ... it requires a whole multidisciplinary team, the psychologists, who can make referrals and they will be very important in this process. (S51)(2014)*

DISCUSSION

Social representation can be understood as "a form of knowledge, socially elaborated and shared, having a practical orientation and contributing to the development of a common reality to a social group" [9:22]. It is through representation that "the existing symbolic reality can be captured,[...] which has a strong power to mobilize and explain the reality, guiding the actions of social groups" [8:393].

By representing DVAW, the nursing students recognized the dimension of this phenomenon. Authors highlight violence against women as a serious public health problem, as it affects victims regardless of culture, religion, education and financial status[10-11]. Students stated that DVAW is a difficult issue to be addressed. We highlight the reified knowledge among the students of the final years, which focused on the complexity of the process of caring for the victims, qualifying it as difficult. A survey conducted in Canada with health professionals found that, considering the abusive tendency of the aggressor, a difficulty in acting is his permanence with the woman during the course of the nurse's appointment. Another difficulty is the frequent reconciliation of the victim with the aggressor after the occurrence of violence, perceived by professionals as lack of action of the victims[12].

Students in the early grades stated a feeling of unpreparedness to act in cases of DVAW. However, they expected that this reality could be modified throughout the undergraduate nursing course. Some students of the final grades also listed the feeling of unpreparedness, justifying the small experience in the area, the fear generated by the situation and the scarce approach throughout the course. A research conducted in São Paulo with health professionals showed that fear is a common feeling among workers, possibly associated with the feeling of helplessness in front of the aggressors[13]. The lack of addressing issues related to domestic violence during undergraduation program was also identified in another survey conducted with nurses and physicians in 2010, in the state of São Paulo[14].

A study conducted in 2009 with nurses showed that these professionals express interest in learning about violence, indicating the development of attractive approaches, such as the use of real-life scenarios, role playing, conversations with colleagues, discussions with surviving women, visits to women's shelters, as well as working with more experienced colleagues[12]. Continuing education can be used as a strategy for nurses to develop skills and feel prepared to identify and act in situations of DVAW.

Due to the proximity of the undergraduate degree, the students of the final years mentioned the feeling of uncertainty because they no longer had the presence of the teacher or the nurse. A study conducted in São Paulo, aiming to analyze the students' experience in the development of supervised curricular internship activities, identified that the nurse is perceived as a model to follow. Thus, the nurse should be aware of his/her responsibility as a reference for the undergraduate. The internship is a unique opportunity in the academic education, a period in which it can be an inspiration on the identity and profile of the future professional [15].

Care determined by the students in the early years was based on common sense, as they emphasized the importance of informal conversation, follow-up, seeking for help from family members, and police reporting only if there is proof of violence. On the other hand, students in the final years referred care by means of instructions on the victim's rights, as well as referral of the patient to other care services.

In this sense, a study conducted in Bahia, with nurses, nurse technicians and community agents, pointed out that professionals facing a DVAW situation call the support of their teammates, rely on referral to the women's police station and social assistance. However, the authors emphasize the importance of the team prioritizing listening and dialogue and, only after all possibilities are exhausted, refer the victim to other services. This prevents situations in which professionals delegate responsibility for other services just to get rid of the problem [16].

Another indispensable piece of care is professional confidentiality, emphasized by the students of both groups. Students of the final years emphasized the exchange of information about patients among the health care team members. On the other hand, they mistakenly stated that violence must occur more than once for the nurse to make the police report. There is confusion between the concept of police reporting and compulsory reporting. Such confusion is also identified in a study in Minas Gerais with primary care health professionals, who cite them as synonyms[17].

It should be elucidated that the compulsory notification consists in the organized and systematic registration, in a proper form, of known, suspected or proven cases of violence against women[18]. For this registering, the health professional does not need to know the aggressor. Failure to comply with the compulsory notification recommendations is a violation of public health legislation, and health professionals are subject to penalties related to their Professional Ethics Code[18]. A survey conducted with health care professionals, especially nurses, identified that they recognize the purpose and importance of compulsory reporting, although it is not reflected in their professional performance. Thus, underreporting prevails among health services. The authors associated the professionals' difficulty in providing care to the victim to the education and qualification process of health team members [19].

CONCLUSION

The representation can be a guide to the actions of social groups, so, in view of the representational contents, the care to the victim based on knowledge of common sense occurs in both groups, but predominantly in the representation of students in the early grades. On the other hand, reified knowledge underlies the care of victims among students of the final years.

The students of the initial years presented representational contents of DVAW related to the nurse's performance restricted to the hospital environment, family resources, informal conversations, opinion and personal advice, seeking police support only if there is concrete evidence. A lack of arguments was found to drive the actions towards the DVAW, however the students had the expectation

that reified knowledge can be acquired during the undergraduate education.

Students in the final years revealed representational content based on reception, bonding, confidentiality, teamwork, women's rights, and referral to other services for victim care. It was noted that, although there are gaps in knowledge, the students sought to overcome them by relying on care models of nurses of the basic network. A professional preparation was evidenced in the statement of students who participated of undergraduate disciplines that addressed the theme. However, they also reinforced the need for more diversified and in-depth approaches during undergraduation, mainly by means of realistic simulation.

Although the objective of the study was achieved, the findings constitute a first analysis of a specific group, requiring further researches to be extended to other areas of health and social contexts. It is expected from research that the representational contents of DVAW guide the academic and professional performance in the prevention, identification and intervention of cases of violence. Still, it is expected that the research can alert those responsible for undergraduate health courses, sensitizing those responsible for related disciplines to the inclusion of the theme in the syllabus, attractively and problematizing ethical, political and legislative issues.

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