RIASE
REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

NURSES' ASSISTANCE NARRATIVE OF WOMEN VICTIMS OF DOMESTIC VIOLENCE

Irene Santos Cristina – Barreiro-Montijo Hospital Center. Nossa Senhora do Rosário Hospital. Barreiro, Portugal

Sandra Risso – Barreiro-Montijo Hospital Center. Nossa Senhora do Rosário Hospital. Barreiro, Portugal. ORCID: https://orcid.org/0000-0002-7169-5570

Margarida Sim Sim – Department of Nursing, University of Évora. Évora, Portugal. ORCID: https://orcid.org/0000-0002-0028-2664

VOL. 5 NO. 3 DECEMBER 2019

ABSTRACT

Background: Violence is a problem which affects society, and individual and collective health.

Objective: To describe the victims' experience on the nurses' attendance in health units following an episode of violence.

Method: Cross-sectional study with a qualitative approach, configuring an interpretative paradigm. Convenience sample of 27 women resident in a shelter-house. Age between 22-64 years (M=41.15; SD=11.7). The questionnaire collected demographic data, type of aggression and narrative on the nurses' attendance on the health unit's admission episode. The data was analysed using WebQDA software. The ethical procedures were complied.

Results: The majority is of Portuguese nationality (n=21), cohabited with the aggressor (n=24). In 18 of the cases, the time between the admission in the health unit and the secure place ranged from 1 to 48 hours. All suffered psychological violence. In the narrative analysis, three major categories emerge: a) retelling the violence, b) deprivations in care and c) beneficence in care. In the first category the participants describe the victimization, in the second category they point the attendances' frailties and in the third category the attendances' favourable aspects. A fourth category emerges, resulting from the reflective attitude on the predecessors, denominated here by rebirth of losses and bereavements, on which some of the participants anticipate a positive future.

Conclusion: Although sexism is identified by some participants, overall, they are gratified by nursing care.

Descriptors: Domestic violence; violence against women; nursing care; qualitative research.

INTRODUCTION

Violence consists in the behaviour or the omission of the same, which practiced intentionally, harm, cause injury, compromise development, deprive of opportunities and can cause death by murder or associate to suicide. Violence is exhibited through threat, coercion or consummation of physical or psychological aggression.

The World Health Organization (WHO) recognizes domestic violence (DV) as a public health problem. Through WHO's successive reports it is stated that DV, although carried out in different ways, has no geographical barriers, nor of social status or culture, being observed as much in developed countries as in developing countries[1]. In trying to face

the problem, legislation is created, programs are developed, movements take place, social protests, resources are organized[2,3].

DV occurs between people who share common or familial spaces, and the most denounced happens between the pair who anchors their relationship in a previous affective commitment. In the couple, the most frequent victim is the feminine figure. Violence against women, or gender-based violence, reports to violence directed towards the woman because she is a woman or affects the woman in a disproportional way[4]. The concept of DV also includes sexual violence, persecution, coercion or impediment to freedom. In a broader look, it extends itself to kidnap[5], genital mutilation[6], honour vengeance[7].

In the emergency department, the victim's admission occurs in a critical moment, sometimes inserted in an escape from home and, not rarely, in an emotional crisis. When admitting a victim, healthcare and security personnel identify DV situations in a broad sense and/or violence from the sexual partner, question facts, collect evidence[8,9]. These are the professionals who provide support in crisis and referral to the shelter-house.

Considering that the victim's future is anchored in the professionals' referral, the evaluation of attendance, in the victims' perspective, is important. Past the acute episode of violence and already in a safe place, the woman, now more serene, recalls, not rarely, the completed route. This recalling can offer data on the professional attendance. Due to the confidential nature of the cases, the maintenance of the woman's safety and the woman's emotional condition, data collection is difficult, therefore the lack of studies. They are, however, important, for, starting from a victim-centred perspective, the attendance can be improved. Therefore, the objective of the actual study is to describe the experience of the survivors of domestic violence on the attendance offered by nurses following the violence episode.

METHOD

It is an exploratory study, with a qualitative approach through discourse analysis, configuring an interpretative paradigm. The study was carried out with survivors of domestic violence temporarily residing in a shelter-house in Portugal. From 12 shelter-houses contacted, 6 responded. The inclusion criteria of the participants reported to a) an age superior to 18 years, b) read and write in Portuguese and c) last violence episode occurred more than one month ago. The data collection occurred through a self-filling instrument. It was performed throughout intermediate of psychologists who assist these women, after

an evaluation regarding the emotional status. Regarding the ethical principles, all invited women, who agreed to participate, signed the informed consent, after being informed about the characteristics and purpose of the study. Therefore, it resulted in a convenience sample of 27 women, aged between 22 and 64 years old (M=41.15; SD=11.7).

The study is part of a broader academic project, which obtained a positive ruling from the Ethics Committee for Research in the Human Health and Welfare Areas of the University of Évora, under register number 16001.

Data collection instrument

The data collection instrument exhibited a section with demographic variables (i.e., age, nationality, marital status, family household), a section which collected data on suffered violence (i.e., type of aggression, victimization duration). In the third section, through an open answer question, an evaluation on the nursing personnel attendance was asked. Due to safety reasons regarding the victims, the places where data was collected were not mentioned.

The quantitative data were processed through descriptive statistics, using Statistical Package for the Social Sciences®, version 24. The narrative observation was based on the analysis of the thematic content, following the data organization, categorization and inference (10). Web Qualitative Data Analysis (WebQDA) was used for categorization.

RESULTS AND DISCUSSION

Most women are Portuguese (n=21; 75%), possess the 3rd cycle of studies (n=10; 35.7%) and are unemployed (n=13; 48.1%). Regarding marital status 12 (42.8%) are married or live in a non-marital partnership. The majority has children (n=26; 92.9%). The most represented family household is composed of husband and children (n=11; 39.3%). Data is shown in table 1.

Table 1 – Demographic data.

	Categories	n	%
Age	19-25	4	14.8
	26-35	5	18.5
	36-45	9	33.3
	46-55	5	18.5
	>55	4	14.8
Marital status	Single	10	37
	Married/Non-marital partnership	12	44.4
	Divorced	5	18.5
Family household	Alone	6	22.2
	With partner	6	22.2
	With partner and children	11	40.7
	Other	3	11.1
	Doesn't answer	1	3.7
Professional status	Employed	4	14.8
	Unemployed	12	44.4
	Student	2	7.4
	Retired	4	14.8
	Housekeeper	1	3.7
	Incapacitated for work	2	7.4
	Temporary job	2	7.4

Although the actual study is not of epidemiological character, we must stress that the demographic profile of the participants is similar to the one described in a recent report by a non-governmental organization[3].

Through a multiple answer analysis, it can be observed that 96 mistreatment episodes were pointed out. The psychological aggression is referred by all, and the physical aggression is presented in several ways of sexual violence as stated in table 2.

Table 2 – Analysis of Multiple Answers on type of violence suffered.

	Responses		
	n	Percentage	Percentage of Cases
Physical aggression	21	21.9%	77.8%
Psychological aggression	27	28.1%	100.0%
Sexual Aggression	13	13.5%	48.1%
Sexual Abuse	9	9.4%	33.3%
Harassment	8	8.3%	29.6%
Negligence	10	10.4%	37.0%
Rape	6	6.3%	22.2%
Gun threat	2	2.1%	7.4%
Total	96	100.0%	355.6%

Note: Dichotomy group tabulated at value 1.

Results highlight the psychological aggression, concurring to studies which underline the same type of violence, as much in the perspective of the professionals who assist victims, as in the women's[11]. The fact that all participants refer this type of aggression, suggests a high exposure to humiliation acts, threat, coercion, control, placing her in an inferior level, as a subordinate person with little value in the conjugal relationship. The social aspect of the woman as a dependent, fragile being, concurs to an image of a human being subordinated to the partner, who, by protection, gains authority, thus uneven the conjugal figures' positions. Some studies underline this attitude, recognize cultural factors, where female roles are dramatically stigmatized, imposing identity inferiority[12]. These are perspectives which place the conjugal partner in an educator role, extending the paternal roles. In most of the cultures, marriage ceremonials transmit the message that the woman belongs to a man (i.e., the father) and is delivered to other (i.e., the groom), through social applause, by the new matrimonial bond. Concomitantly, the negligence, referred in 37% of the cases (i.e., 10 participants), enhances psychological violence, as it does not recognize the woman's dignity as an element of the couple, in the equitable distribution of goods. Thus, the woman is placed as a figure, who, subjected to care, is neglected by the partner, by not providing her needs.

Regarding the discussion of the results of the multiple answers' analysis, the idea that psychological violence frequently precedes physical violence, is concurred[13]. They both potentiate the aggressor's perpetration in the sexual intimacy moments, consequently originating a violated intimacy experienced by the victim (i.e., sexual aggression, sexual

abuse, harassment, rape). Violence exerted by the intimate partner, in non-consented or coerced sexualized acts, is therefore one of the most difficult situations to be assumed by the woman or even to perceive as violence. In the normal couple, sexuality is experienced as an "us", through shared bodies with desire and emotion with permission of them both. Elements of the couple express themselves through intercourse, in human condition acts which justify the human condition itself. They surrender themselves in a satisfactory eroticism, not one losing the decision to agree or deny proposals of intimate interactions. In couples where there is sexual violence, the woman has no autonomous expression of her sexuality. She becomes a manipulated and used object. She lacks dignity, which is inherent to the self-willed animated human existence. Contexts of sexual violence take, sometimes, to a low self-esteem, a serious obstacle to the search for help and a high risk to depressive scenarios, self-flagellation and suicide[13,14]. A hard to interrupt cycle is installed. It is sometimes a dramatic episode, which leads to an emergency of relief, initialising contact with healthcare services, causing the development of the assistance process, which leads to the shelter-house[11, 15].

The emerging meanings of narratives

Assuming the corpus of the participants' narratives, the analysis was performed. The open nature of the narrative eased the experience revelation, which, being analysed and interpreted, resulted in several major categories, designated as a) (Re)telling the violence, b) Deprivations in care and c) Beneficence in care (figure 1).

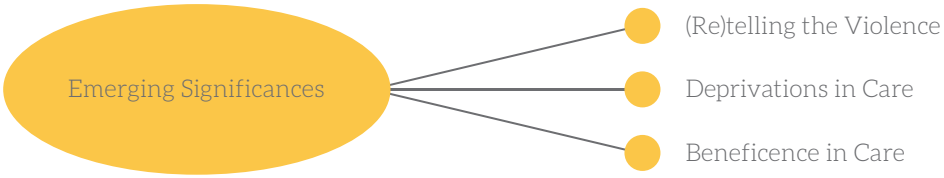

Figure 1 – Emerging Significances in the narratives.

CATEGORY 1

The category "(Re) telling the violence", reports the memory of the personal history. It is from the aggression incidents that the participants explain their experiences. They transmit a highly negative recollection, exhibiting remaining grievances. The women's statements were organized in four sub-categories: "domestic captivity", "demanding justice", "marianismo supports machismo" and "shelter and help".

In subcategory "domestic captivity", the participants reveal a hard quotidian through statements such as *"(...) my home companion didn't let me go (to the healthcare centre)"* (E7). The statement is suggestive of an imprisoning matrimony, denying access to healthcare, in a dominating attitude. Complaints traduce themselves in genuine coercion experiences. In statements such as *"stopping aggressors to imprison their women and minor children at home"* (E19), the urgency of personal freedom felt by these women is observed. The domestic captivity through DV is studied by authors who define guidelines to be given to the victim. For instance, to know signs of alert or of imminence of an aggressive crisis by the partner and to know where to recur[2]. The identification of the aggression and the immediate response of the victim may surprise the partner and provide protective effects on the woman. However, in face of the inaugural aggression or when women are not aware of services where to recur, the inefficacy of these strategies is superimposed, as the aggravation of captivity. Such is illustrated by the participants when they affirm *"I had no knowledge that the Health Services could help victims"* (E23). Or, as the participants recognize, asking for the attention of competent entities through affirmations such as *"not only divulge in the social communication, but to also appeal in villages and cities where all these situations happen"* (E3). It is necessary to break the DV cycle, bringing the problem to the public dominion and congregating multi-sectorial efforts. Although the dominant social culture may be an obstacle to denounce an aggressor, the development of multi-sectorial programs has shown progresses[3].

In the continuity of the narratives' analysis, it can be observed that the participants refer mistreatment by the sexual partner, but also inter-gender social incomprehension, here categorized with the expression "Marianismo supports machismo". That is, by the cultural connotation and by having a masculine blame-exonerate effect, relativizes the gravity of actions which attempt the dignity and the life of the human being who is each woman. In these narratives there is a conscience that an asymmetric conjugality model dominates. A prevalent social understanding is highlighted, as inter-gender conflicts, which emerge from statements as *"there is machismo in certain women who let themselves be quiet and condemn others who suffer, but who have the courage to make a decision"* (E2) or even *"there are women who don't support this situation (present a charge for mistreatment) and are favouring the aggressors"* (E27). These statements reproduce sexist characteristics which sustain control and humiliation of the feminine figure of the couple[16]. They reveal how attractive the exhibition of power can become, which enslaves the feminine conjugality. In other words, some women consider as positive the forms of interaction of the couple, which are not favourable and reproduce contrary values to the conjugal papers' symmetry. Attitudes of support from professionals, counteracting sexism, are fundamental[17].

In subcategory "demanding justice", are included expressions such as *"nurses must be good, all of them (...) it is necessary... to be more severe with everyone and all the aggressors"* (E15) and *"DV is a public crime, needs to be denounced to authorities whomever they are"* (E21). For some women, presenting complaints to the authorities, means to take to public intimacy stories. However, is important that they recognize themselves as targets of violent acts, as this is a step in order to search for help[8,14]. Demanding justice is a logical attitude, but the victim does not always press or maintain charges. Not seldom women express ambiguous feelings about the partner and give up the charge due to economic, social or cultural reasons[18]. Considering the amplitude of the participants' victimization time (i.e., from 1 to 34 years), one can suppose that the demand for justice possesses different times to the various women.

Considering the subcategory "shelter and help", the statements collected in the narratives are discussed next. The participants are reacting and setting off towards life positive experiences. Such reaction may eventually occur in result of the safety that the shelter--house provides. The temporary residence, which succeeds the admission in the health services, provides the relief that the victim needs[3]. This sub-category "shelter and help" is illustrated in statements such as: *"if I knew how shelter-houses were, I would have left home sooner"* (E13). Shelter-houses are refuges with a relevant role in the acute crisis. WHO describes them in the models from different developed or developing countries, as social centres who provide advice, emotional support, legal information, mental health guidance, programs directed to children, between others[19]. In Portugal, they are legally governed by Law no. 112/2009. The resource to shelter-house, with a concealed destiny, places a legal resolution evident, to the victim and her significant ones, but especially to the aggressor, that, by imposing alienation, highlights criminalization and feminicide.

Shelter-house, in its mission, possesses limits, when the internment time is extended. In the actual study such was evident in the statements, that, recognizing its benefits, also demonstrates consternation. Some of the participants express themselves in these moulds: *"there should be shelter-houses for men so we could stay at home with our children"* (E1). Violence deprived women from domestic spaces built/created by themselves, aspects which cause injustice feelings. Shelter-houses protects and stops the aggressor from making hostages. However, it makes these women captive from technically secure places, but absent from the unique familiarity of their own home. Statements such as *"victims don't have to be the persons to move out"* (E11), reveal the ambivalence between the need for living in real security *versus* the need to live in their home. Results concur to other studies, where the women's resistance to shelter-houses is referred[13]. The shelter-house will be, in its best option, a temporary place. Extending the residence, frequently depends on the

delay of the criminal/legal process. Although it provides a secure environment, it adds dissatisfaction to the victims' emotional life, as it is an institutionalization which interrupts life. The actual participants transmit the idea of a high loss, through leaving the familiar space, which is their home.

CATEGORY 2

In the category "Deprivations in care", are reunited the aspects which are identified by the participants as unsatisfied needs during attendance. The terms in which the participants express themselves were organized in sub-categories "caring interaction", "support regulation", "professionals' sexism" and "wait".

The statements in sub-category "caring interaction" suggest that there are communication gaps with the professionals. Such is illustrated by the statements *"more interest and sensibility during the facts approach is needed"* (E18) or *"it is needed (...) to properly clarify confused and disoriented victims"* (E7) or even *"they ought to be better prepared for these circumstances, because they still aren't"* (E8). Lack of knowledge or of sensibility to deal with the cases is a denounced theme by the victims and recognized by the healthcare personnel. Statements such *"consultations should have a longer duration for they are very brief, which takes professionals to have a lesser perception that something isn't right with the client and family"* (E8) exemplify a need of a therapeutic relationship with the victims. The knowledge on DV confers a higher cohesion to attendance and therefore an effective organizational management, even in the network relationship with other victim support organisms[20]. In fact, people exposed to violence need sensible services to gender-related questions[1].

The sub-category *"support regulation"* shows the role that the participants attribute to the health services, as a formal source of information. Statements such as *"there should be more information in the healthcare centres for the victims"* (E22) or *"healthcare centres should provide more support"* (E18) shows, in particular, that DV is a transversal matter for some of the participants, where health, social security and law cross themselves. The statements suggest that they attribute, to the health units, the mission of providing help to the victim. Such is perceptible in statements such as *"there should be visits of the healthcare professionals to their children's' schools, that could also help women"* (E9) or *"exist more information in healthcare centres (...) in a way that the aggressors wouldn't find out when the victims are there"* (E19). The understanding of the participants concurs to Portuguese studies conducted a decade ago (i.e., Lisboa, Vicente e Barroso, 2005; Saúde e violência contra as mulheres. DGS), subsequently reaffirmed and internationally recognized[1]. The occurrence of this type of statement makes clear the lack of projects voted for the preven-

tion of the DV in some healthcare units. Being in progress attendance programs, it will be useful to develop investigation which regularly monitors the perception of the women who use these services. In fact, the victims hope to find answers in the mission inherent to the health institutions, which particularly means to find answers in the professionals' attendance.

In some women's narrative, statements appear, which can be interpreted as "professionals' sexism". These are statements such as *"there is still a lot of chauvinism in the healthcare personnel"* (E20) or *"I would like that the healthcare professionals of the male sex had a higher sensibility for the violence matters"* (E8). Sexism is the healthcare context is identified in some studies[21,22]. It demonstrates itself in a hostile and benevolent sexism aspects, being the first the most exhibited by professionals of the male sex[22]. Benevolent sexism includes positive attitudes regarding women in traditional roles. Therefore the professionals, regarding the women, exhibit a protective paternalism, an idealized vision of the woman and a heterosexual kindness. Hostile sexism refers to negative attitudes and the professional exhibits a dominative paternalism, depreciative beliefs and a heterosexual hostility[21]. Two of the participants referred sexism in their narrative saying *"they (nurses) were not totally by my side (...) I saw it from their words (...) from their face"* (E5; E8). In a physically and emotionally critical moment, one would expect professionally correct attitudes. If the attendance of the victims is recognized as sexist, a need for training should be considered.

In the category "Deprivations in care", sub-category "Wait" appears lastly, in face of the narrative's statements such as *"the time that my criminal complaint against the aggressor took was too long"* (E7) or *"the wait time in hospital is too long"* (E14) or even *"(...) a faster attendance in hospital, one waits too long"* (E10). In the victimization processes, women are not always aware of the precariousness of the relationship with the partner and sometimes minimize mistreatment, delaying the healthcare and adequate resources[23]. Therefore, in the moment in which victims search for help, it will be necessary to act quickly. Nowadays the removal from home should be quicker *"(...) the waiting time to move out was a bit long"* (E14).

CATEGORY 3

The category "Beneficence in Care" organizes the valorisation of the professionals' attendance, through the positive statements of the participants. The first sub-category "provide support", expressed through terms such as "they gave me all information and help to move out (E12)" suggests satisfaction of the women's needs, in the critical moment of preserving survival. In these circumstances the healthcare professional's help is widely

valued. These results concur to the authors' study[24] where it is verified that the almost entirety of the participants refer having received care which was sensible to their situation and which were necessary for the moment. On the other hand, the expression *"I am enjoying the attendance I have been given"* (E16), suggests gratitude for the attendance. The expressions remember the interpretation by other authors, who recognize the construction of the victim's trust by the longevity of the contact with the professional[20]. In the sub-category "pay attention", illustrated by the expression *"may they continue to be understanding"* (E12) suggests that some participants identified the singularity of the victim-professional relationship. Active listening is one of the truly important characteristics in the dialogue between beneficiary and carer[1,11]. Nurses, by centring their attention in the victim and by genuinely trying to understand the woman's drama, directs their attention to the singularity of the case. Simultaneously, the victim, by identifying an attention posture regarding her state or history, will tend, perhaps, to develop ties to the professional and become loyal to the healthcare system. The possibility to recur to the services in subsequent victimization episodes grows. The "pay attention", besides the immediate effects of emotional comfort to the victim, may bring long term benefits. Having a memory of a good attendance is an immediate factor for the search for healthcare, avoiding aggressions of greater severity or even feminicide. In fact, WHO recommends, firstly, to pay attention and provide practical support to the woman who reveals having suffered violence, recognizing *a posteriori* effects[1]. In the same sub-category, expressions such as *"the work made by (...) was very good"* (E26) is suggestive of correct and adequate attitudes and professional practices to the physical and emotional situation of the woman. The steps and requisites for a good attendance will have been fulfilled. In this area of care, the international institutions define parameters or guidelines which become universal[1]. Lastly, in the category "Beneficence in Care", appears the sub-category "safety for the children". Expressions like *"they helped in going to a place where I feel my son and I are protected and safe, in safety now"* (E3), suggest that children constitute an increase of worries. The participants' expression demonstrates satisfaction with the provided care, for they recognize the need to avoid children's exposure to violence. This is one of WHO's concerns, for life stories which include this kind of experiences during childhood can lead to a violent behaviour in the adult age[1]. However, the end of the sentence *"(...) in safety now"* (E3), brings a note of sorrow to the statement. It is necessary not to forget that the participants are in the shelter-house, in a temporary safety situation. In a longer term, past the acute mistreatment crisis, with the return to work, to the everyday life, the sense of security can diminish. Some authors' reflection shows that, when one shares children's custody, sometimes there is lack of guidance and concessions given to the couple, what emotionally undermines the woman[25]. To entrust the children, which is the great-

est affective richness, even for a small period, to a partner who violated the symbolic commitment of the greatest gift which is marriage/non-marital partnership, can bring suffering. On the other hand, it is possible to defend the idea that a violent husband/partner won't necessarily be a bad father. This will probably be one of the potential dilemmas of the women during their children's childhood in the shared custody regime.

Given the open nature of the narrative, several statements emerge, which waive from the initial proposition centred in the nurses' attendance. The categorization of these answers resulted in the expression "Rebirth of Losses and Bereavements". The statements suggest that these women, past a concentration and reflection time on the violence they were subjected to, are willing to a restart. In a refugee condition in the shelter-house, they forge their future, through statements such as *"we should look after ourselves, we cannot allow to be mistreated"* (E24) or *"to restart a new life without looking back, a life without the suffering of feeling one goes away, but to have peace of mind and some joy within us"* (E17). Therefore, they possess the great capacity to start a positive story on themselves. Health personnel's positive attitudes are fundamental for a life reconstruction. The interpretation of the participants' narrative is presented through a diagram in figure 2.

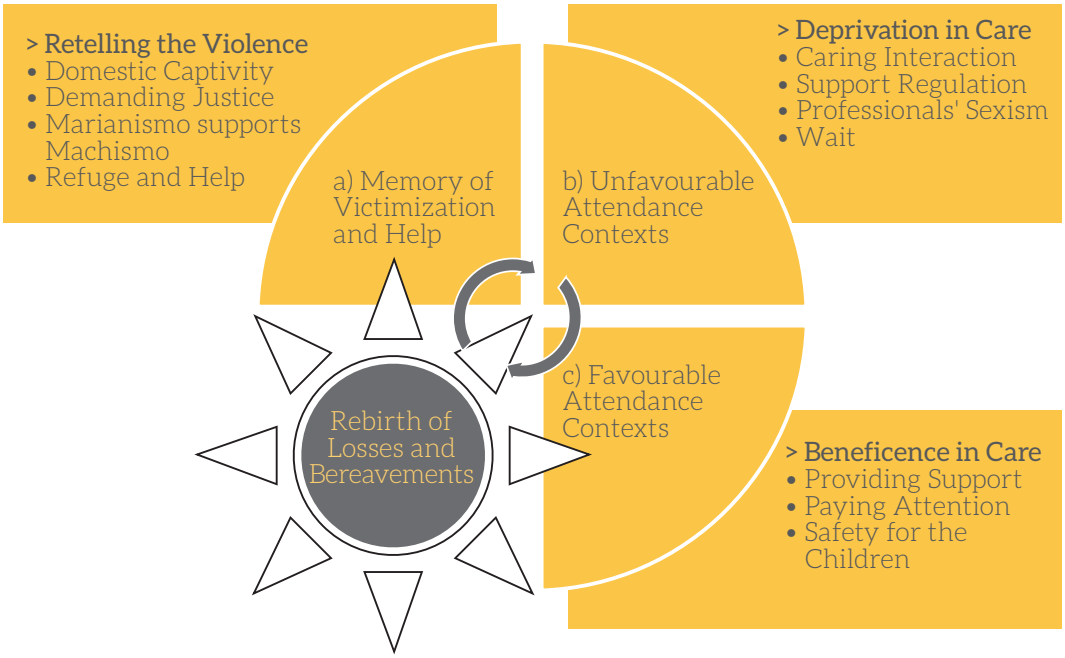

Figure 2 – Diagram of global interpretation.

Overall, the diagram based on the interpretation of the narratives suggests that participants, a) from individual memories of victimization/help become b) critical of unfavourable contexts and c) favourable health care pathways. The narrative feeds itself, in the rebirth of the mistreatment processes which include losses and bereavements. Therefore, they affirm themselves as women, perhaps as ex-victims, in order to provide a continuity to their lives.

The configuration of the diagram initially encloses the dramatic idea of a circle, which repeats and closes, in memories that attenuate, but do not forget, the repeated pathways to health care that improve-but-not-heal. However, breaking the dramatic circle, the chaos of these lives robbed of affection, lacking safety, needy of the future, the image of a sun, appears through the chaos. A sun, still in eclipse, has rays behind the black circle. Rays that offer different directions which may direct these women into the light of their lives, as their statements suggest in narratives categorized as "Reborn of Loss and Mourning".

CONCLUSIONS

The study anchors itself in the descriptions of women who suffer victimization from the intimate partner. Demographic data show a high amplitude of age. A variety of mistreatment is recorded, being the psychological aggression referred by all the participants. The narrative categorization shows the will of the women in (re)telling the experience of victimization. They wrote, spontaneously, excerpts on their personal history. Regarding the unfavourable or deprived aspects, in the victim's attendance, narratives arise, the need of genuine interest of the professionals on the cases, abandoning sexist attitudes, expediting processes in time and clarifying or regulating the support procedures. Regarding the favourable aspects beneficent to care, the participants understand, as fundamental, the active listening and the availability of support. In face of the narrative's meanings and the unpredictability of cases, it is desirable a larger comprehensiveness of health units with DV programmes, and more training of the healthcare personnel.

Perhaps reaching in Portugal, a specialization in forensic training, since postgraduate training in Forensic Nursing is a reality in some academies in Portugal, USA, Italy, among others. Not infrequently, nurses are the health professionals who have more opportunities to identify cases. They follow protocols according to legal guidelines, but it is necessary to be aware, for the DV destroys lives in short and long term.

REFERENCES

1. WHO. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneve: World Health Organization; 2016. 64 p.

2. Newswire PR. Domestic Violence Expert Dr. Ludy Green Provides "Road Map" For Womens' Independence In "Ending Domestic Violence Captivity: A Guide To Economic Freedom". DC-DR-LUDY-GREEN-book: Y; 2014.

3. APAV. Estatísticas APAV. Relatorio anual 2017. Lisboa; 2018.

4. UN-WOMEN. Convention on the elimination of all forms of discrimination against women 2009. Available from: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

5. Kaukab IS, Shad TJ. Violence against women: a case study of kidnapping in the Punjab, Pakistan. Science International. 2014;26(5):2549-52.

6. Muteshi JK, Miller S, Belizán JM. The ongoing violence against women: Female Genital Mutilation/Cutting. Reproductive Health. 2016;13:1-4.

7. Kulwicki AD. The practice of honor crimes: a glimpse of domestic violence in the Arab world. Issues Ment Health Nurs. 2002;23(1):77-87.

8. Shamu S, Abrahams N, Temmerman M, Zarowsky C. Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe. Cult Health Sex. 2013;15(5):511-24.

9. Doran F, Hutchinson M. Student nurses' knowledge and attitudes towards domestic violence: results of survey highlight need for continued attention to undergraduate curriculum. Journal Of Clinical Nursing. 2016.

10. Silva K, Almeida M. Combined use of software that supports research and qualitative data analysis; potential applications for research in education In: Costa A, Reis L, Sousa F, Moreira A, D L, editors. Computer supported qualitative research. Coimbra: Springer; 2017. p. 25-37.

11. Signorelli MC, Auad D, Pereira PPG. Violência doméstica contra mulheres e a atuação profissional na atenção primária à saúde: um estudo etnográfico em Matinhos, Paraná, Brasil. Cadernos de Saúde Pública. 2013;29:1230-40.

12. Da Silva N, Verdejo TR, Dillon FR, Ertl MM, De La Rosa M. Marianismo Beliefs, Intimate Partner Violence, and Psychological Distress Among Recently Immigrated, Young Adult Latinas. J Interpers Violence. 2018:886260518778263.

13. Rakovec-Felser Z. Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective. Health Psychology Research. 2014;2(3):1821.

14. Avdibegovic E, Brkic M, Sinanovic O. Emotional Profile of Women Victims of Domestic Violence. Materia Socio-Medica. 2017;29(2):109-13.

15. McGarry J, Nairn S. An exploration of the perceptions of emergency department nursing staff towards the role of a domestic abuse nurse specialist: a qualitative study. International Emergency Nursing. 2015;23(2):65-70.

16. Stanley N, Barter C, Wood M, Aghtaie N, Larkins C, Lanau A, et al. Pornography, Sexual Coercion and Abuse and Sexting in Young People's Intimate Relationships: A European Study. J Interpers Violence. 2016.

17. Femi-Ajao O, Kendal S, Lovell K. A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK. Ethnicity & Health. 2018:1-15.

18. Jong LC, Sadala MLA, Tanaka ACDA. Desistindo da denúncia ao agressor: relato de mulheres vítimas de violência doméstica. Revista da Escola de Enfermagem da USP. 2008;42:744-51.

19. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. Lancet. 2002;360(9339):1083-8.

20. McGarry J. Domestic violence and abuse: an exploration and evaluation of a domestic abuse nurse specialist role in acute health care services. Journal of Clinical Nursing. 2017;26(15/16):2266-73.

21. Vecina ML, Pinuela R. Relationships between Ambivalent Sexism and the Five Moral Foundations in Domestic Violence: Is it a Matter of Fairness and Authority? J Psychol. 2017;151(3):334-44.

22. Özerdogan N, Coskun, A., Ergin A, Özdilek R, Merih Y. Sexism among healthcare professionals working in women's health in patient care. ASOS Journal. 2017;5(57):21-39.

23. Francis L, Loxton D, James C. The culture of pretence: a hidden barrier to recognising, disclosing and ending domestic violence. J Clin Nurs. 2017;26(15-16):2202-14.

24. Du Mont J, Macdonald S, White M, Turner L, White D, Kaplan S, et al. Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. J Forensic Nurs. 2014;10(3):122-34.

25. Ogunsiji O, Foster J, Wilkes L. Experiences of African women who migrate to a developed country and encounter domestic violence: a systematic review protocol of qualitative evidence. JBI Database of Systematic Reviews and Implementation Reports. 2016;14(12).

Correspondence: irene.cristina@sapo.pt