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## Caring for women facing domestic violence: Grounded Theory

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### ABSTRACT

**Aim:** To understand the meanings attributed by health professionals about the care of women facing domestic violence as they are supported by the Family Health Strategy (FHS) program. **Method:** This is qualitative research, with the use of a method based on Grounded Theory. 52 professionals from health units of the Brazilian state of Santa Catarina were interviewed. **Results:** The management of FHS, in order to provide assistance to women, must give more importance to the words of the users, the development of bonds, the creation of spaces for discussion about domestic violence and the intersectorial and university articulation. **Discussion:** Health professionals must give some answers to the problems faced by the population, and therefore, they need to know more about domestic violence and how it is inserted in marital experience. **Conclusion:** While nursing, as a science, is focused in mixing the understandings and the practices, it is also essential in the process of organization of health units, above all by integrating the team and taking part of management positions inside the FHS.

**Descriptors:** Violence against Women; Domestic Violence; Family Health; Health Management; Nursing.

## INTRODUCTION

Violence, which is present in interpersonal relationships, is a violation of human rights and affects the health, and can even lead to the deaths of the people involved. An act of violence represents a threat to life and it can be followed by a silence on the part of the victim. Unfortunately, women are one of the groups most vulnerable to this situation.

Violence against women is more frequent within the area of influence of family relationships, thus identified differently as family violence<sup>(1)</sup>, when it involves relatives in a location other than where they live. When violence occurs in the space known as “home” it is described as domestic violence, and it involves the people that live in this environment, who do not need to be relatives, such as maids and other domestic workers. In the case of women, marital violence, a type of violence provoked by their spouses<sup>(1)</sup>, can be described by both domestic violence and family violence.

In regards to the legal effect, domestic and family violence against women is understood as any action or omission based on gender that may generate physical, sexual, psychological, moral, heritage damage, or even death<sup>(2)</sup>. Besides the problems linked to health, violence has an impact in the working conditions of women, thus generating an important social problem to be solved. A study with women that suffered physical aggression from their partners shows that the incapacitation rate for any paid work is around 16%.<sup>(3)</sup> Besides that, the general costs of violence against women, consisting of the use of the public health system, the treatment of health problems, the implementation of police and judicial processes, and medical leave, amount to 10% of Brazil’s Gross Domestic Product (GDP)<sup>(4)</sup>.

It is worth mentioning that, usually, women involved in marital violence do not report

such situations, even when they look for health services to treat the damage generated by these experiences. Such situations are worsened when health professionals have little or no understanding about the steps to take during these moments, which is a deficiency of health services in general<sup>(5)</sup>. In Family Health Strategy (FHS), this reality is the same, despite some studies showing that this is the most privileged scenario to recognize the seriousness of the aggression and the care needed by the victimized woman, especially due to the bond created between the service user and the professional<sup>(6-7)</sup>.

With the objective of improving coverage and the extension of the actions in basic care, as well as the prospect of resolution, the Support Center for Family Health (NASF, in Portuguese), which teams are composed by professionals of different areas of knowledge has been created. They must work together, supporting the professionals from the Family Health teams, sharing their best practice and understandings about health<sup>(8)</sup>.

Therefore, it is necessary to improve the capacity for intervention for the actions of promotion of health, which must include fighting domestic violence. For such movements, it is essential that health team understands what marital violence is, its impact on women, family and the health of the collectivity, and the articulation of a strategy for the prevention and confrontation of this phenomenon on all its many levels of complexity within the health system<sup>(9)</sup>.

Based on what was shown, a question came up: What are the meanings given by the professionals that work in FHS about the management of care of women dealing with marital violence? This question was derived from the main question of this study: What are the meanings of the interactions and actions experienced by the

professionals regarding the practices of nursing care and health to the women experiencing marital violence in the area of FHS?

This study aimed to understand the meanings given by health professionals during care management to women experiencing marital violence within FHS.

## METHOD

This is a research with a qualitative approach, linked to a post-doctoral project sponsored by the Research Support Foundation of Bahia State (FAPESB, in Portuguese). As a method, the Grounded Theory (GT) was used, which permits the researcher to find new hypotheses, concepts and theories based on the data collected, instead on using predetermined information.<sup>(10)</sup>

The research took place in a municipality located in the Brazilian state of Santa Catarina, in one of its five health districts, which is served by 16 family health teams. To select the actors, some criteria of inclusion were adopted: to work in the FHS; to have at least six months working in the unit, and to be present during the period of data collection. According to the standards of GT, the following sample groups were created: the first one was composed of 17 nursing technicians, 13 nurses and 12 physicians; the second group, composed of two psychiatrists and one social worker; and the third group, composed of five health coordinators; a total of 52 actors.

The project was approved by the Ethics in Research Committee, of Santa Catarina Federal University (Protocol 21560/2012). When contacting the professionals, they were informed about the relevance of the study, and then invited to collaborate with the research. Ethical aspects described in the Ordinance 196/96 were

followed, such as: the right to decide to participate in the study and withdraw from it at any time, the guarantee of confidentiality of data and anonymity of the actors, which were later identified by the capitalized initial letter of the professional category, or the letter C, followed by a number. If they agreed to participate in the study, the actors were asked to sign a Free and Clear Consent Agreement.

The interviews were previously scheduled in the units, and occurred between May and August 2012, in a room selected previously by the unit manager or chosen by the professional. The testimonies were recorded on a portable audio recorder, later fully transcribed and its data were codified with the support of the software NVIVO 8.0<sup>®</sup>. The analysis of data occurred at the same time it was being collected, and there was an opened coding, axial coding and selective coding, according to the standards of GT.

Open coding facilitated the creation of preliminary categories, which are part of the conceptual data. In axial coding, these codes were regrouped, resulting in the subcategories. In selective coding, the subcategories were further analyzed and related among each other, based on the structural concepts: context, causal condition, intervening condition, strategies and consequences<sup>(10)</sup>. From the use of this methodology, five categories were found, which are filled with the subcategories defined up to now.

The relationships, associations and interactions between these categories that represent the structural concepts continued until a central category was found, also known as substantive theory, explaining conceptual model or referential matrix, a representation of the studied phenomenon. The model was validated by professionals from the studied units, and by 10 researchers with experience in GT.

## RESULTS

From this study five categories emerged related to the context, causal condition, intervening condition, strategies and consequences that are articulated with the phenomenon described: Recognizing marital violence as a public health issue and the necessity of management of women's care (Figure 1).

From the interpretation of the meanings given by the professionals that work at the FHS, the following concept arose: "Unveiling marital violence as a public health issue and women's care". Such context reveals that the professionals interviewed by this research understand the importance of marital violence, being able to point out the damage to women's health, the

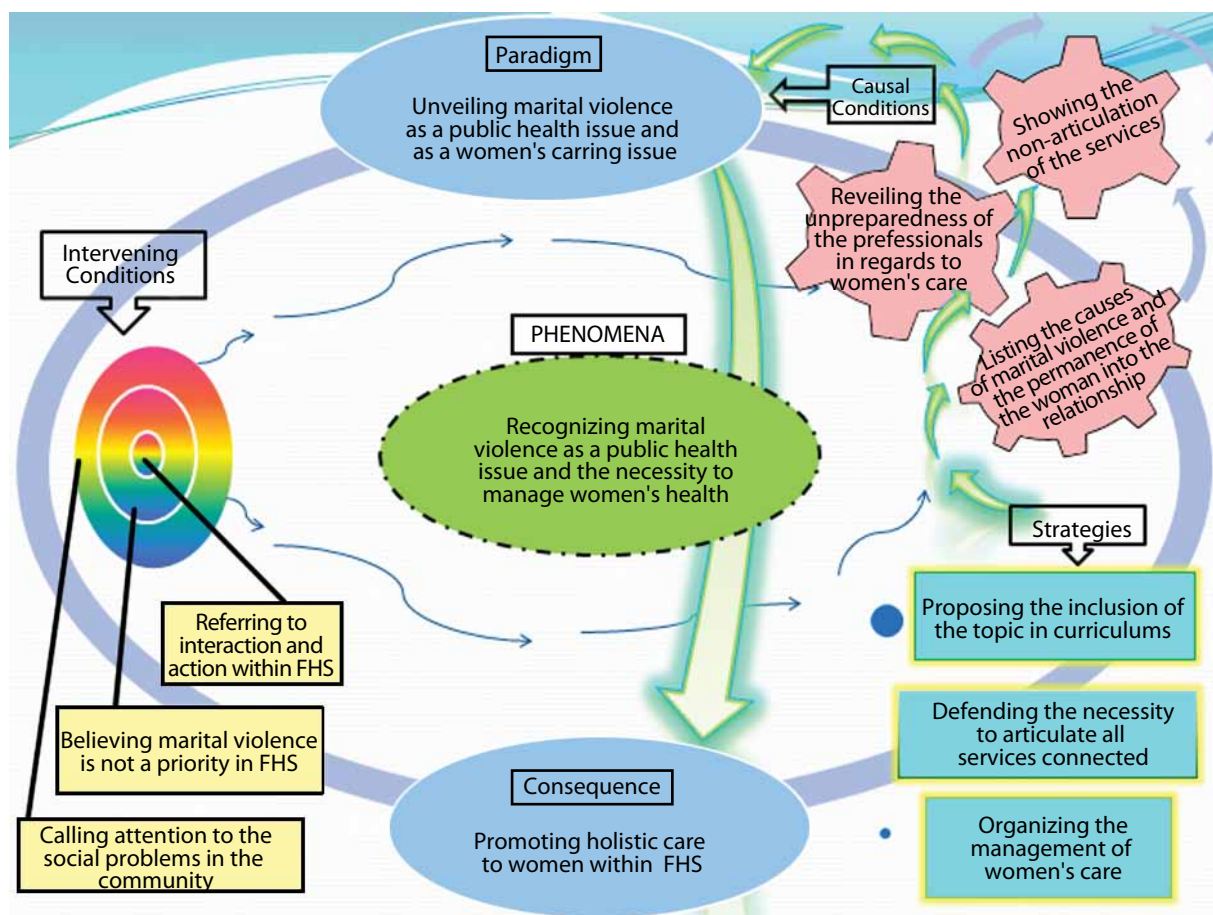
repercussions for the whole family and also for economic productivity.

The categories and subcategories related to causal conditions, intervening conditions, strategies and consequences are presented as follows, all of which circulate between the theoretical model and allow the understanding of how the management of care to the woman under marital violence within FHS is carried out.

### *Revealing the unpreparedness of professionals in women's care*

The professionals that work in FHS, including the local health unit managers, singled out situations that compromise the care of women experiencing marital violence in the area of

**Figure 1.** Theoretical model of the Substantive Theory



Source: Designed by the authors

coverage of FHS. These situations are seen in the causal conditions of the theoretical model, because they represent events that act upon the context, helping it or harming it<sup>(11)</sup>.

It is seen that, from the testimonies of the interviewees, there is a professional unpreparedness to identify marital violence associated with the search of women for health services:

[...] it is very hard for us to see signs of violence if the woman doesn't say a thing about it. (E-2)

Probably many things can go on without us even noticing. They don't come and talk about it openly. (E-10)

Besides the difficulty of recognizing the aggravation, the professionals of the reference team feel unprepared to take care of these women:

[...] we don't get any support to deal with it: which attitude to have in these situations. We are not prepared [...] we don't have much to do in these cases. (TE-10)

[...] if we knew how to deal with, it would be much easier to take care of a case like that. It is so hard! I don't know if the health clinics have these facts in sight. I don't think so. (TE-7)

### *Showing events that interfere in the women's care*

The time established for the consultations and the frequent rotation of the professionals were mentioned as situations that create some difficulties in caring for women experiencing marital violence. These events are part of a sub-category "Believing that marital violence is not a priority in FHS", which then become intervening

conditions, seen as happenings or events that facilitate, limitate or hamper the action/interaction strategies towards a change of paradigm<sup>(11)</sup>.

For the professionals that are part of the reference team, which means, the ones responsible for the caring itself, the time defined for a consultation limits the approach to marital violence, thus inhibiting its further investigation:

[...] the question is that we have a structure already set with an inadequate time frame. If you see the consultations, in one day, you'll see there is not enough time. And a situation of violence demands more time so to let the person feel confident to start to talk. (M-5)  
[...] we have too many consultations every day [...] and we don't have time. Maybe if the consultation was longer, with more time, it would be possible to see what was going on. (M-4)

According to the interviewees, the work dynamics of the unit are also influenced by the rotation of the professionals. The following testimonials express how this situation compromises the care within FHS:

Worst of all is the rotation: either because of the qualification of the professionals, or because of the unit or the district itself, or even the local city health department. Then the new ones come, and while they were not fully trained and qualified [...] (C-4)

[...] there is always someone missing in the team [...] then many things are left behind, such as follow up; sometimes what is left undone or done wrongly, not as holistic as it should have been. [...] it makes our work much harder and also the caring for these women (TE-6)

## *Organizing to manage women's care*

Considering the strategies as interactions or actions performed or to be implemented in order to change the paradigm<sup>(11)</sup>, the interviewed professionals mentioned actions that, if implemented or intensified in the units, will help in the caring of women. These strategies are organized in the following subcategories:

### *Presenting the prevalence of marital violence to the team*

Based on the visualization of a health issue, the professionals work towards getting prepared to provide effective professional care. It is, therefore, important to present this context within the community to the members of the health teams. Below, a testimony that better exemplifies this situation:

I think that, in a first moment, this data of violence should be exposed to the whole team: when does it happen, what is the percentage of women that suffer these aggressions, when does it effectively happen [...] so that based on this information we can have permanent education events that bring these elements to the team, facilitating the team to detect this mode of aggression. (C-2)

### *Empowering the voice of women during consultations*

The watchful listening to women during the consultations was mentioned as an important resource to identify the grievances:

[...] I always try to talk to them, to listen to them because sometimes we see

they have the need to talk. (E-8)  
We need to listen to the patient. I think it would be very important. (TE-6)

### *Creating a bond with the female patient*

The creation of a bond between the professionals and the female patients was mentioned as something that helps to identify the problem and the caring of women:

[...] there is a consultation for the birth control pills, their regular monthly consultations during pregnancy, so they end up having a link and I think we should be prepared to improve this connection, making it easier to identify if the female patient is going through any sort of problem. (E-12)  
We have to have some sort of approach, creating a situation, a bond, so they can speak up. (E-13)

### *Interacting with professionals from other areas*

The multiprofessional environment of the FHS, especially the presence of NASF members, permits a learning process that can be managed by the team itself. The importance of the interaction with professionals from the other areas can be seen in the following testimonies:

The NASF professional participates in our team meeting, and on this day she either shows a situation or we show her a situation: those are case studies and elaboration of strategies for a certain patient. [...] here we are instructed in how to deal with the situations. (E-7)  
We didn't discuss – all the professionals – about a certain topic. Today, with the

Family Health Program, there is some time to meet and discuss how to help one specific patient. (E-6)

### *Institutionalizing the space to discuss the topic*

Based on the recognition of the difficulty of identifying violence as a threat to the health of women, as well as to provide direct care based on their demand, the interviewed professionals, including unit managers, supported the necessity of creating spaces for the discussion of the topic, especially in the moments of interaction between the professionals of the reference teams and the members of NASF. Some testimonies reinforce this idea:

[...] we started to have one group to discuss the topic. (C-5)

[...] this is a thing we are still developing together with the coordination: to have some space to discuss this matter. (Pc-2)

### *Getting prepared for referral of women*

Caring for women leads to the need for referrals, which require professionals to understand the services available and the combined work of the areas involved:

[...] one thing that would help us is to have a general view of each part of the organization. [...] it is to reinforce the bond between these bodies with the Family Health Program. (E-2)

In think it would be more important to establish a flow of procedures that is more reliable and less painful, so we could use it in those cases. (M-7)

### *Informing women about their rights and other supporting services*

The professionals consider essential the fact that female victims of violence must know their rights and be aware of other supporting services that can help them in dealing with the situation. The testimonies reveal that awareness of these questions supports the professional during their time with the female patient, and signal the importance of disseminating such information in health spaces:

[...] we have to be informed about what we can do with that person who is a victim of violence, how we can say something, how we should conduct the whole process [...] so she doesn't go back to the situation of aggression again. (TE-1)

I think they should be better informed about their rights [...]. Maybe some posters around the health clinic talking about it, with some guidelines, rights and places she can look for help. (TE-4)

### *Establishing partnerships with universities*

As a way to manage the process of professional education to ensure proper care for 1 female victims of marital violence within FHS, the professionals point out to the importance of partnerships with universities, also reporting for the awareness brought by this research in their routine work practices:

Suddenly, this research is making them stop and think about this specific topic.

[...] the researches that help us in our daily practice are good. (C-4)

The specific group coordinators that are there in the department, such as



women's health, could create a partnership supported by the universities, with the support of the people inside the university studying and improving themselves [...] to help in our practice, our daily routine. (E-1)

### *Promoting holistic care to women within FHS*

Consequences are seen in the results or expectations of the implemented action/interaction strategies<sup>(11)</sup>. The professionals understand that the strategies listed will make their professional preparedness more suitable to recognize the difficulties, as well as the caring for women experiencing marital violence:

As in any other topic, if we are more prepared we could investigate more. [...] we would have a more proactive approach to ask, to approach, to see evidence [...] maybe the incidence of interventions would be higher too. (M-8)  
[...] we would have a correct approach so she wouldn't leave and never come back. If I approach her in the wrong way, she may never come back. She will continue to suffer from the violence and no one will be able to help her. (E-13)

## **DISCUSSION**

The meanings given by the professionals that work in FHS to marital violence signal their understanding about the magnitude of the problem. However, as seen in the phenomenon "Recognizing marital violence as a public health issue and the necessity of management of women's care", this study showed that the professionals, including unit managers and pro-

fessionals of NASF, point out their professional unpreparedness to identify women experiencing marital violence and respond adequately to this situation.

This unpreparedness is expressed through reports about the difficulty of recognizing or suspecting that the female patient experiences violent episodes in her marital relationship, and also in what procedures to take when identifying such scenario. This situation is taken as causal, one that occurs based on a certain context, which makes it even worse, once the non-recognition of the problem makes women even more vulnerable in a relationship filled with violence.

A research done with 57 women with facial traumas corroborate with the findings by reaffirming that the experience of violence creates serious health problems, compromising the self-esteem and well-being of the woman. Another study also confirms that women hardly report in the environment of health services in general the experience of domestic violence, and the health professionals have some difficulties in identifying such grievances. Based on the perception of the researchers, such situation has a strong link with the limited preoccupation of the educational institutions with the inclusion of the topic in their curricula, with a special emphasis on those for nurses and physicians<sup>(6)</sup>.

A study performed within FHS also found the lack of preparedness related to domestic violence, showing that the professionals feel powerless towards the female patient in such situations. The professionals recognize this as a reality that exists in the provision of services, as do nurses who work in family health units, who also reported that they don't feel prepared to take care of this clientele<sup>(7)</sup>.

Considering that FHS is an important entry door to recognize such problems and give support to women experiencing domestic violence, nursing professionals – as well as other health

professionals – must find more professional strategies to provide holistic care to women, which requires interdisciplinary discussions and intersectorial actions<sup>(5)</sup>.

Besides the professional unpreparedness, the interviewees showed there are intervening conditions within FHS that also compromise the caring process: the limited time of consultation and the rotation of professionals. These situations interfere in the strategies of action/interaction planned or developed to transform the actual paradigm.

Research performed with nurses and physicians of 31 family health teams of 25 municipalities in the Brazilian state of Rio Grande do Sul confirmed the high rotation of these professionals. Considering the multicasuality that provokes this rotativity in FHS, which also include the fragmentation of the educational background, precarious work contracts and poor working conditions, the authors see these as harmful to the effectiveness of the teams' actions in health<sup>(12)</sup>.

In regards to the period of consultation, physicians that work in FHS in the city of São Paulo, Brazil, mention that it is not enough in terms of individual consultations, considering the necessities found in the area of coverage of their units. More than 50% of the interviewees believed the estimated time for consultations does not match the directives of Family Health<sup>(13)</sup>.

Despite the situations that impede the recognition of the grievance are listed as the high rotativity of the professionals and the limited time for the consultations, thus also causing disturbance in the attention to women, the professionals defended the importance of the bond established between the user and the professional and the evaluation of the presented complains; these are considered strategies against marital violence. Therefore, the professional that works in FHS must valorize each and every opportunity

to make contact with women in consultations, educational activities, homecare visits, etc.

Research with women carried out by the Institute of Forensic Medicine into domestic violence defends the creation of a bond and a careful listening to support women. This listening means to understand the individual as a whole, listen with sensibility and solidarity, which is the characteristic of quality care. The caring, from a welcoming attitude that is shown in the moment of receiving, listening, touching and treating, permits a holistic assistance<sup>(5)</sup>. Therefore, the interest of the professional for the health of the patient, for the life and for their care is enough to mobilize this professional in order to give more importance to the words and gestures of women, and then, to recognize the problem. Such attitudes transcended the problems related to the structure of the health system, such as the limitation of time during consultations, mentioned by some professionals.

Another strategy revealed by the professionals in order to help the recognition of the problem and the care for the female patient is linked to the comprehension of the prevalence of marital violence. On the point-of-view of the interviewees, to know the epidemiologic spectrum and the repercussions of marital violence mobilize the professionals to search for technical and theoretical support in order to know how to proceed on the phenomena.

It is important to highlight that the data related to domestic violence confirm the dimension of the problem. According to the Brazilian National Secretary for Policies to Women, 38,020 women suffer some type of aggression everyday in Brazil, and in about 68% of the cases, the offenders are spouses or ex-spouses. In the Brazilian state of Santa Catarina, the number of notifications of violence against women grows every year: a recorded number of 49 cases, in 2009, to 262 cases registered only

during the first semester of 2012<sup>(14)</sup>. However, it is known that this number is far from the reality of the cases that are not reported and are silenced by the victims and/or not recognized by the professionals, who normally do not notify them to the authorities. This paradigm does not permit a real epidemiologic dimensioning of the problem<sup>(6)</sup>.

In regards to the complexity of the phenomena, a study showed that health professionals recognize the importance of multidisciplinary work to take care of women. The interaction, especially with NASF professionals, is a factor that strengthens work processes, being considered very important to enrich the discussions of the topic, mainly because of NASF interdisciplinary characteristics. Thus, this group works side-by-side with its main objectives, which are to contribute to the holistic care of SUS users, helping to increase the capacity of analysis and intervention of the problems and necessities in health.

According to the principles and general directives in basic care, amongst the many actions performed by the NASF professionals, there are: discussion of cases, combined development of therapeutic projects, permanent education, interventions in the territory and in the health of populational groups and of the collectivity, intersectorial actions, preventive actions and promotion of health, discussion of work processes of the teams, among others<sup>(8)</sup>. The importance of institutionalized discussion spaces come from the discussion of the work processes, with integrates all professionals that work in the area of coverage of the FHS. Research demonstrates the necessity for professionals to go deeper in their discussion of the topic to a higher awareness and understanding of the existing references, both from the legal, police, social and psychological frameworks, and the supporting networks<sup>(5)</sup>.

Hence, it is imperative to know the service network for women experiencing violent situations in order to assist these patients with higher quality. Knowing the services and developing the ability to identify the cases of violence, it is necessary that services are connected with the specialized referral centers, among which, the shelters, specialized police stations and other centers of reference, as while the Primary Health Care units are responsible for referring and following the female patient. The Brazilian National Policy Confronting Violence against Women defends the creation of specialized services (Shelters, Reference Centers, Rehabilitation and Education Centers of the Aggressor, Domestic and Family Violence Court against Women, Women's Public Defender); the strengthening of the Service Network; and the continuous education of public and community agents<sup>(4)</sup>.

In regard to the necessity of education in service, this study calls attention to the necessity of the professionals to know the support network of women under violence, as well as their rights, in order to guide them and/or send them to the services, considering their demands. These services are essential so they can provide some continuity to the care of women, and then strengthen it in a constant search for alternatives to solve the problem<sup>(5)</sup>. Health professionals, especially those working in FHS, must respond to all types of health problems found in the population. In order to do so, they must understand the legal and social background to these problems<sup>(7)</sup>.

According to the interviewed professionals, such information can be made feasible in partnerships with universities. The "Maria da Penha" Bill also included the necessity of further studies and research into the topic as a strategy to confront domestic and family violence against women<sup>(2)</sup>, of which marital violence is a part.

## CONCLUSION

This study shows the necessity of management within FHS of the care of women experiencing marital violence. The meanings attributed by health professionals reveal the importance of professional preparation in recognizing such problems and for caring for the female patient in such a way as to empower her to stop the cycle of violence.

Among the strategies, there is: the creation of a bond and valuing what women say; institutionalization of spaces to discuss the topic, involving professionals of the reference team and of NASF; the understanding about the services that are part of the caring network for women facing violence and follow ups; and partnerships with higher education institutions.

We signal the necessity of caring management within FHS to permit the creation of spaces for permanent education in service, and intersectorial articulation and educational institutions, with the objective of guaranteeing holistic care. For the actors involved in the study, the incorporation and/or the intensification of such strategies can help them to provide holistic care to women facing marital violence within FHS.

Nursing has a fundamental role as a science focused on articulating the knowledge and practices needed to provide individual and collective care. In addition, a nurse is often a member of the reference team in family health, and many times this professional works in managerial positions in health units.

We highlight that the professional formation in health and the processes of permanent education must include, among its priorities, the transversal approach of violence as part of the complete human right to health, equipping health professionals with the relative competences and interpersonal abilities necessary to give the

subjectivities inherent to a humanized care their appropriate value.

It is worth to consider that, as only social actors linked to FHS were heard by this study, more studies are necessary on other levels of complexity in the health system, and also in other sectors beyond the area of health, in order to better understand the process of confrontation of marital violence.

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