Revista de Enfermagem
do Centro-Oeste Mineiro
2017;7:e1630
DOI: 10.19175/recom.v7i0.1630
www.ufsj.edu.br/recom

RECOM
REVISTA DE ENFERMAGEM DO CENTRO-OESTE MINEIRO

Original Article

REPRESENTAÇÕES SOCIAIS DA VIOLÊNCIA DOMÉSTICA CONTRA A MULHER ENTRE PROFISSIONAIS DE SAÚDE: UM ESTUDO COMPARATIVO

SOCIAL REPRESENTATIONS OF DOMESTIC VIOLENCE AGAINST WOMEN AMONG HEALTH PROFESSIONALS: A COMPARATIVE STUDY

REPRESENTACIONES SOCIALES DE LA VIOLENCIA DOMÉSTICA CONTRA LAS MUJERES ENTRE LOS PROFESIONALES DE LA SALUD: UN ESTUDIO COMPARATIVO

Daiane Broch[1], Camila Daiane Silva[2], Daniele Ferreira Acosta[2], Marina Bisio Mattos[3], Cristiane Lopes Amarijo[4], Vera Lúcia de Oliveira Gomes[5]

RESUMO

Objetivo: identificar e comparar as representações sociais da violência doméstica contra a mulher entre profissionais que atuam em Unidades de Saúde da Família das zonas urbana e rural. **Métodos:** pesquisa qualitativa, baseada na Teoria das Representações Sociais. Colheram-se os dados entre julho e novembro de 2013 pelas técnicas de evocações livres e entrevistas, que foram tratadas pelo software EVOC e análise contextual, respectivamente. **Resultados:** comparando o núcleo das representações dos profissionais das áreas urbanas e rurais foi observada uma conotação negativa do objeto, bem como a presença de elementos comuns como "agressão" e "covardia". A representação também comportou diferentes dimensões entre os profissionais, provavelmente influenciadas pelo contexto de trabalho dos profissionais de saúde. **Conclusão:** espera-se que os resultados sirvam de subsídio para um repensar sobre as práticas dos profissionais que atendem diariamente vítimas de violência, com destaque para a sua prevenção e identificação dos casos.

Descritores: Violência doméstica; Saúde; Estratégia saúde da família.

ABSTRACT

Objective: to identify and compare the social representations of domestic violence against women among professionals working in Family Health Units in urban and rural areas. **Methods:** qualitative research based on the Social Representations Theory. Data were collected between July and November 2013, by the techniques of free evocation and interviews, which were treated by the EVOC software and content analysis, respectively. **Results:** the comparison of the core of the representations of professionals from urban and rural areas revealed a negative connotation of the object, as well as the presence of common elements such as "aggression" and "cowardice". The representation also had different dimensions among the professionals, probably influenced by the work context of the health professionals. **Conclusion:** we hope that the results serve as a subsidy for a rethinking of the practices of professionals who assist victims of violence in the daily routine of the services, with emphasis on prevention and identification of cases.

Descriptors: Domestic violence; Health; Family health strategy.

RESUMEN

Objetivo: identificar y comparar las representaciones sociales de la violencia doméstica contra la mujer entre profesionales que actúan en Unidades de Salud de la Familia de las zonas urbanas y rurales. **Métodos:** investigación cualitativa, basada en la Teoría de las Representaciones Sociales. Se recogieron los datos entre julio y noviembre de 2013 por las técnicas de evocaciones libres y entrevistas, que fueron tratadas por el software EVOC y análisis contextual, respectivamente. **Resultados:** comparando el núcleo de las representaciones de los profesionales de las áreas urbanas y rurales se observó una connotación negativa del objeto, así como la presencia de elementos comunes como "agresión" y "cobardía". La representación también comportó diferentes dimensiones entre los profesionales, probablemente influenciadas por el contexto de trabajo de los profesionales de la salud. **Conclusión:** se espera que los resultados sirvan de subsidio para un repensar sobre las prácticas de los profesionales que atienden a víctimas de violencia, con destaque para su prevención e identificación de los casos.

Descriptores: Violencia doméstica; Salud; Estrategia de salud familiar.

[1]Graduada em Enfermagem. Mestranda em Enfermagem pela Universidade Federal do Rio Grande do Sul. [2]Graduada em Enfermagem. Doutora em Enfermagem pela Universidade Federal do Rio Grande. [3]Graduada em Enfermagem pela Universidade Federal do Rio Grande. [4]Graduada em Enfermagem. Doutoranda em Enfermagem pela Universidade Federal do Rio Grande. [5]Graduada em Enfermagem. Doutora em Enfermagem pela Universidade Federal de Santa Catarina. Professora titular na Universidade Federal do Rio Grande.

Como citar este artigo:
Broch D, Silva CD, Acosta DF, et al. Social Representations Of Domestic Violence Against Women Among Health Professionals: A Comparative Study. 2017;7:e1630. [Access_____]; Available in:_____. https://doi.org/10.19175/recom.v7i0.1630

INTRODUCTION

Domestic violence against women has been identified as a serious public health problem regardless of culture, religion, schooling, socioeconomic status or geographical location[1-2]. This is the main grievance by external causes affecting women, ahead of assaults, rapes by strangers and car accidents[3]. It is conceptualized by Law 11,340/2006, as "any act or conduct, in the form of action or omission which causes death, injury, physical, sexual or psychological distress and moral or property damage"[4].

Epidemiological data from 83 countries show that El Salvador ranks first in the *ranking* of femicides, with a rate of 8.9 per 100,000 women, while Brazil ranks fifth with a rate of 4.8. In this survey, countries such as Anguilla, Bermuda, Tunisia and the Cayman Islands did not present a record of this type of violence, which does not necessarily mean the inexistence of occurrences, because these may in many situations be silenced by the family environment[5].

Violence affects the different spheres of society, causes family disorder, leaves physical and psychological marks on the victim, and has repercussions on the health-disease process. A survey carried out in the Women's Police Station of a municipality in the state of Paraná showed that 93.4% of the victims of violence lived in the urban area, while only 6.6% lived in rural areas[6]. This evidences the need for investments in both cases, since domestic violence is multifactorial and affects both rural and urban areas[6]. Domestic violence is possibly worsened in rural areas by the fact that the geographic location, the distance from urban centers, poses a difficult access to resources of protection and social attention, favoring the invisibility of violence[7].

In this sense, the work of the Family Health Strategy (FHS) team in the identification and care of victims of violence is of great importance. The FHS is basically composed of nurses, physicians, nursing technicians and Community Health Agents (CHA). Among the activities assigned to professionals, the home visits make it possible to learn particular traits of the homes, facilitating actions in cases of domestic violence against women[8].

However, FHS professionals may have different perceptions about domestic violence against women; some focus mostly on the physical form of violence, while others do not recognize it at all, even blaming the victims. The imaginary based on biological models[9], interferes with the diagnosis of violence and, consequently, referral of the victim to the support network, a fundamental factor to avoid revictimization.

Considering domestic violence against women as a social problem that does not belong to the health area inhibits more effective care actions that contemplate the subjectivities and individualities of the offended women. In certain situations, professionals do not investigate the violence practiced because of uncertainties and concerns with the procedures and referrals that must be adopted[10]. In these cases, a holistic look on the part of professionals is necessary to help women to build a life project and get out of the violent situation.

It is known that the actions of health professionals who provide assistance to women victims of domestic violence are rooted in values, judgments and affective dimensions that can positively or negatively influence their professional practice. Such conceptions are built on day to day work, influenced by the media and shared in social life[10], generating the social representations of these professionals.

Social representations of domestic violence against women may trigger different forms of care[11]. Based on this, the Theory of Social Representations (TRS), which if characterized as a set of beliefs, opinions and knowledge capable of explaining a phenomenon social, was used in this study. Social representations are the result of the social interaction between the subject and the social object[12].

For health professionals, domestic violence against women is a reality in the workplace or even in the personal sphere. It is a phenomenon that carries cultural-historical gender-based characteristics, making this social construction to reflect on care practices. Moreover, as a phenomenon that happens in urban and rural centers, violence implies that health professionals need to be ready to provide comprehensive assistance to victims, for which they have to weigh their beliefs, opinions and knowledge of the context in which they are inserted.

In this sense, the present study was carried out with the objective of identifying and comparing the social representations of domestic violence against women expressed among professionals working in Family Health Units in urban and rural areas

METHODS

This is a qualitative research based on the TSR. The municipality of Rio Grande, Rio Grande do Sul, has 13 FHUs in the urban area and 7 in the rural area. The multiprofessional team consists of at least 1 general physician, 1 nurse, 1 nursing assistant or technician and 4 to 6 Community Health Agents (CHA). The FHU of Rio Grande do Sul counts with 29 nurses, 24 physicians, 40 nursing technicians and 178 CHA.

The inclusion criterion was: to be a health professional working in the FHU of the municipality. Those who were away on vacations, on break or on leave were excluded, as they did not return to the unit after the end of the leave. It is noteworthy that one team from the urban area refused to participate in the study, justifying great demand and lack of time. Thus, 19 FHU - 12 in the urban area and 7 in the rural area - participated in the research.

Data were collected during July and November 2013, through the techniques of free recall and semi-structured interview. Two hundred and one professionals working in the FHU of the urban and rural perimeter of the municipality participated in the free evocations. In this technique, the participant is asked to spontaneously mention words, phrases or expressions that come to mind from an inducing term[13]. In this study, participants were asked to verbalize the first five words recalled before the inducing expression "domestic violence against women".

A semi-structured questionnaire prepared to bring to light the content of the social representations of the participants was used in the interviews. Due to the large number of professionals and also the large geographic dimension of the municipality, 4 urban FHUs and 6 rural FHUs were drawn for the interviews. Aiming at representativeness of all the professions of the team, at least 1 physician, 1 nurse, 1 nursing technician and 2 CHA from each unit were invited to participate in the interview, totaling 64 professionals. Interviews were carried out in the unit itself, in a room far from the circulation areas and had an average duration of 40 minutes. The interviews were recorded and transcribed verbatim. The professionals who accepted to participate in the study signed the Informed Consent Term.

Data were analyzed using two different techniques, one for evocations and the other for interviews. The words or phrases evoked were organized and processed in the Ensemble de Programmes Permettant L'analyse des Evocations - EVOC 2005. This software has a program called "Rangmot" which displays a list of all the words spoken in alphabetical order, indicating the overall frequency and the overall mean of each word[14]. A four-quadrant chart was generated by this analysis, where the words were distributed according to frequency criteria (how many times the word was evoked) and average order of evocation (A.O.E.)[15-16]. The value of 1 is assigned to the most readily evoked word. The second most evoked word receives the value of 2 and so on with the other words. The words are distributed by the *software* into the different quadrants of the chart[17]. The four-quadrant chart is composed of Central Core, Peripheral System and Contrast Zone[15].

In the upper left quadrant are the most relevant and significant terms evoked by the subjects, probably constituting the Central Core of the social representation[16-18]. The terms present in the Central Core are those more readily evoked and more frequently mentioned by informants[14-19]. In the upper and lower right quadrants, the elements of the first and second peripheries, respectively, are the less prominent but still meaningful ones[14,15,19]. The peripheral system constitutes the "most accessible and liveliest part of the representation"[20]; one of its functions is to prescribe behavior[20].

The words in the first periphery also have a frequency that is greater or equal to the average frequency and an equal or greater *Rang* than that established by the EVOC. Therefore, "peripheral elements of a given social representation establish the *interface* between the Central Core and the concrete reality upon which the representations were elaborated and where they function" (p.591)[16]. The words located in the lower left quadrant constitute the Contrast Zone; these are the less frequently mentioned, but more readily evoked words[14,15,19].In turn, the words of the second periphery "present low frequency and order of evocation more distant from 1"[16], that is, they have a lower frequency than the average and a *Rang* that is greater than or equal to that established by EVOC. This construction makes it possible to analyze the structure of the representation.

Content Analysis was used to analyze the data produced in the interviews[21]. This technique consists of three steps: pre-analysis, material exploration and treatment of results,

allowing the choice of context unit for coding. The pre-analysis consists of the organization of the material and has "the objective of systematize and make the initial ideas operational" (p.125)[21], so as to accurately develop the other steps of the plan of analysis. In the material exploration, raw data are gradually and systematically transformed into units of record. These can be words, phrases or even paragraphs. Analytical categories are created based on the criteria of relevance or frequency of appearance of the units of record. These categories represent the faces of the object of study that were grasped. And finally, in the treatment of the results we try to highlight the results obtained, presenting them in a discursive manner[21].

In order to ensure anonymity, nurses, physicians, nursing technicians and community health agents were identified by the initials of the profession N, P, NT and CHA, respectively, followed by the initials of urban and rural areas, UA and RA, respectively. The project was approved by the Research Ethics Committee of the Federal University of Rio Grande, under Opinion nº 020/2013.

RESULTS AND DISCUSSION

A total of 146 professionals from the urban area and 55 from the rural area participated in the free evocations, distributed into 26 nurses, 21 physicians, 39 nursing technicians and 115 Community Health Agents. Sixty-four professionals participated in the interviews, specifically 13 nurses, 12 physicians, 12 nursing technicians and 27 CHA.

The *corpus* formed by the evocations of the professionals of the urban zone before the inducing expression "domestic violence against women" totaled 730 words, being 222 different words. On a scale of one to five, the average order of evocation (A.O.E.) was three, the minimum frequency was ten, and the mean frequency was eighteen. The analysis of this data set resulted in the four-quadrant chart shown in Figure 1.

Figure 1 - Four-quadrant chart formed by the evocations of health professionals of the urban area before the inducing expression "domestic violence against women" - Rio Grande, Rio Grande do Sul, 2013.

Frequency ≥ 18 / Rang < 3			**Frequency ≥ 18 / Rang ≥ 3**		
	Freq	**Rang**		**Freq**	**Rang**
Agression	27	2.000	Low self-steem	20	3.700
Physical aggression	21	2.429	Fear	33	3.333
Cowardice	24	1.625	Submission	20	3.050
Lack of respect	30	2.700			
Frequência < 18 / Rang < 3			**Frequency < 18 / Rang ≥ 3**		
	Freq	**Rang**		**Freq**	**Rang**
Abuse	16	1.875	Professional support	11	3.636
Power abuse	14	2.857	Impunity	12	3.250
Pain	10	2.300			
Humiliation	14	2.857			
Revolt	17	3.000			
Suffering	11	2.818			
Sadness	14	2.857			

Source: Research Data, 2013.

In the upper left quadrant are the most relevant and significant terms evoked by the subjects, probably constituting the Central Core of the social representation[16-18]. Among professionals in the urban zone, "cowardice" was the term most readily evoked, followed by "aggression". The elements of the first and second periphery are placed in the upper and lower right quadrants. These are regarded as less important by deponents, because they are more flexible elements[14,-15,19].In the first periphery, the terms reveal an affective dimension, with "fear" being the most frequent word. In the second periphery, "professional support" reveals the pragmatic character of representation (Figure 1).

The *corpus* formed by the evocations of the professionals of the urban area before the inducing expression "domestic violence against women" totaled 272 words, containing 121 different words. The A.O.E. was three, the minimum frequency was five and the average frequency seven. The analysis of this data set resulted in the four-quadrant chart shown in Figure 2.

Figure 2 - Four-quadrant chart formed by the evocations of health professionals of the rural area before the inducing expression "domestic violence against women" - Rio Grande, Rio Grande do Sul, 2013.

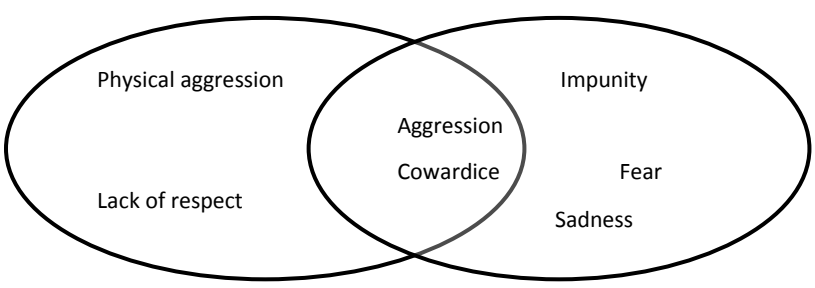
Frequency ≥ 7 / Rang < 3			**Frequency ≥ 7 / Rang ≥ 3**		
	Freq	**Rang**		**Freq**	**Rang**
Agression	16	1,750	Revolt	9	3,111
Cowardice	10	2,200			
Impunity	7	2,286			
Fear	10	2,700			
Sadness	7	2,571			
Frequency < 7 / Rang < 3			**Frequency < 7 / Rang ≥ 3**		
	Freq	**Rang**		**Freq**	**Rang**
Power abuse	6	2,667	Abuse	6	3,167
Physical aggression	5	1,600	Lack of dialogue	6	3,333
Low self-steem	6	2,500	Submission	5	4,200
Pain	5	2,400			
Lack of respect	6	1,500			
Suffering	5	2,400			

Source: Research Data, 2013.

The centrality of the representation of the professionals working in the rural area is marked by the terms "aggression" and "cowardice", similar to the Central Core of the representation of professionals of the urban area. However, in the first and second periphery, the terms point to the reality of these professionals who live in a constext where the "submission" of women, "lack of dialogue" within homes, and the "revolt" for impunity predominate, revealing the influence of the sociocultural context where they work.

The comparison of the Central Core of the representation of domestic violence against women among professionals working in urban and rural areas (Figure 3) makes it possible to distinguish, through intercessions, the elements common to those representations. Thus, it is observed that, although the compared groups operate in different areas, on the one hand they maintain the centrality of representation, marked by the same terms, i.e. "aggression" followed by "cowardice", located in the upper left quadrant of Figures 1 and 2.

Figure 3- Comparison of the Central Core of the representation of professionals from urban and rural areas about domestic violence against women - Rio Grande, Rio Grande do Sul, 2013.



Source: Research Data, 2013

This is a representation with negative and structured connotation defined by the three dimensions portrayed by Moscovici,[22]: namely, concept/information, attitude/judgment and image/field of representation. The concept consists of the information, that is, the knowledge that a certain group has about an object. The attitude is the opinion, the judgment that the group has about the object in question. The image, or mental sensations, represents the impressions that people or objects leave in the brain[22]. Considering these three structuring dimensions of social representation, the word "aggression" assumes the conceptual and imaginary dimensions of violence, while "cowardice" demonstrates the judgment of these professionals towards this phenomenon. These two terms reinforce the homogeneity of the group in relation to the representation, whose determination is relatively linked to the historical and social context.

On the other hand, there are variations in the centrality of the representation; the Central Core of the representation of the professionals who work in the urban area also includes the terms "physical aggression" and "lack of respect" (Figure 1). The latter expression together with "cowardice" point to the value system of the group, revealing the normative dimension of the core[23].

The element "physical aggression" is the main form of violence recognized among professionals in the urban area. This term was also part of the Central Core of the representation of municipal managers and health professionals about violence against rural women in a study conducted in the south of Rio Grande do Sul[24]. Traditionally, violence against women has been closely related to physical aggression. Besides being the most recognized for of violence, it is socially considered the most dangerous and has high prevalence[1]. Marks left in the body of victims by physical violence favor their visibility and detection, leading to greater social notoriety[25].

As for the elements of the probable Central Core of the representation of the professionals of the rural area, "fear" and "sadness" (Figure 2) point to the affective dimension of this representation, demonstrating the fragility of the situations of domestic violence against women. The word "impunity" (Figure 2) refers to legal aspects of the problem or yet to the fact that the victims, often moved by fear, keep in the relationship with the aggressor, preferring silence about the incident.

These differences reflect on the influence of the work context on the representation. In order for "two representations to be different, they must be organized around two different central cores"[15]. Otherwise, they are "differentially activated states of the same representation, depending on specific situations in which the two groups are"[12].

In order to contextualize the probable elements of the Central Core, we present excerpts extracted from the interviews. "Domestic violence is a disrespect to the whole, to the human being. For me, violence is a disrespect because it is not only about beating, it is about verbal action, a disrespect of the human being toward the partner, toward a mother". (NT, UA) "Violence against women, I think it is an example of gross impunity. We witness that issue of impotence, I think this is the most important of all terms to be used, because those who suffer have a great feeling of being powerless in the face of that situation, pain, suffering and all the consequences that come from this type of violence". (N, RA) "Sadness as a human being, sadness to see something that could be resolved with dialogue becomes physical aggression". (N, UA) "The teams, because they are in the same community of the attacker, they are afraid. Especially if it is a violent person, a head of traffic gang, bandits who got out of the jail, fugitives. There is the fear of the threat, of the fact that everybody knows where you live, the car you drive, who is your family [...] There is a lot of fear, by the way she is very afraid to follow our recommendations, for fear of retaliation from her husband". (P, RA)

A study that sought to analyze the care practices of health professionals provided to rural women who had been victims of violence[7] evidenced that the location of health units in rural areas contributes to the distance and difficulty for victims to access services of protection such as the women's police station, defenders, and courts. Thus, it is evident that without this immediate support, it is more difficult to take a stance. The professionals feel vulnerable to the domestic violence practiced against women.

In the representation of professionals in the urban area, the sentimental sphere indicated by the term "fear" is the most frequent (Figure 1). In turn, the terms "submission" and "low self-

esteem", had the same frequency of evocation (Figure 1). These words highlight the image that the professionals create of the victims, who are immersed in a detrimental behavior to health. Low self-esteem may be associated with the consequences of violence and social isolation[3].

Research studies[26-27] have given evidence that, in the view of health professionals, it is difficult to understand why women subject themselves to episodes of violence. Even so, they recognize that the permanence in the home may be tied to a diversity of factors such as economic dependence, fear of threats by the aggressor, fear of losing the children or by the valuation attributed to the marriage[26-27], which reinforces male domination in marital relations.

In the representation of professionals of the rural area, the first periphery was composed of the term "revolt" only (Figure 2). This feeling may express the professionals' judgment regarding the reconciliation of the victims with the aggressors, despite the support and encouragement they give for women to flee from the violent context. The following are excerpts extracted from the interviews to contextualize the elements of the first periphery of the urban and rural areas. "Violence against women is an abuse, it is aggression, it is heartbreak. On the woman's part, it's a lack of self-esteem". (N, UA) "Here, the culture of the community that I attend is quite different. People do not report, but we notice that men have that patriarchal culture. Sometimes men dominate women, and the women are more submissive". (NT, RA) "We get revolted because she wanted to go to the police station, we took the car and took her there. From this moment she started to deny that it had been the husband". (P, UA)

In the Contrast Zone, located in the lower left quadrant, the terms "pain" and "suffering" appear in both four-quadrant charts (Figures 2 and 3), showing that both urban and rural professionals see the suffering and pain that violent acts can cause to the victim. Still in common in the contrast zone of the two four-quadrant chart, the term "power abuse" refers to the judgment of the professionals towards the abusive actions of the aggressor. Power has been, historically and culturally, instituted as a possession of men to dominate women. Violence is sustained by these inequalities, often naturalized in the marital relationship. The victim herself, for fear of further assaults or death threats[28], indirectly ends up reinforcing the vertical relationship, permeated by a game of strength and domination. The following excerpts characterize the dimension belonging to the Contrast Zone. "So we had no action, it would be very quiet, thinking that it was normal, the owner of the house, the man to have power and we women, we do not have, we accepted that as if it were normal". (CHA, RA) "It is really about discrimination, because they do not know what the woman suffers, they think men deserves more because they provide food". (CHA, UA)

In the lower right quadrant are the infrequent terms and those considered less important by the subjects of the research. This quadrant constitutes the closer *interface* of the representation with social practices[23]. In the representation of the professionals of the urban zone (Figure 1), the term "professional support" means the commitment of the team to support the victim. Among rural workers, the term "lack of dialogue" (Figure 2) was identified by professionals as one of the reasons why violence is unleashed.

The lack of dialogue signals the lack of communication between victim and aggressor, which can trigger the practice of violence. This term may also reveal the difficulty of the victims in expressing exactly what happened to the professionals that assist them, that is, the lack of communication between victim and professional, aggressor and professional and between the health team itself. The silence and the invisibility that surround this problem are protected in the scope of private life and family relations[28]. Factors such as the use of drugs by the aggressor may also make it impossible to establish a dialogical relationship, potentializing violent events[29].

The professional support and the limited communication between the professional who provided care and the woman who suffered violence was evident in the excerpts from the interviews presented below. "We called [the victim] because she wanted to file a complaint. We brought her to a private room, we talked, but that's it, that's the most we can get involved. We support, we talk, we host, because we have to receive the person. She wanted to report, I think at the time, we talked to the Family Health Support Center (NASF), with the psychologist, and we sent her to the social worker". (NT, RA)

Linked to the FHU, there is the NASF, a service that is listed as a coadjuvant in the care provided to victims of violence. This shows that,

in social representations, domestic violence against women is described as a complex health problem, which needs to be addressed through the articulation of a multiprofessional support network. Although the importance of the articulation between services is acknowledged, a study carried out with medical workers at a FHU found that they did not know the referral sites, delegating this function to nursing workers[26].

It is noticed that, besides knowing the social representations of health professionals about the domestic violence against women, transcendental and holistic care requires investment in the restructuring of an articulated support network. The lack of time, the reduced number of employees[8,26] and the unpreparedness to act in the face of the phenomenon[8] are also considered obstacles for the health team to develop preventive and educational actions regarding domestic violence against women in the community.

CONCLUSION

The comparison of the social representation of domestic violence against women revealed that the representation among health professionals who worked in urban and rural areas presented common characteristics and, at the same time, variations depending on the specific situations of the daily life and scenario of the professionals' performance.

Both groups evoked the terms "aggression" and "cowardice" in the Central Core, indicating the concept or image and the judgment of professionals towards violence. Therefore, this is a structured representation with negative connotation.

We highlight in the comparison of the social representation that the professionals of the rural area expressed the affective dimension of the representation, supported in the sensation of vulnerability both of the team, and of the rural women. Regarding the action/performance of the professionals towards the victim, it was observed that the only term "professional support" was evoked only by the workers of the urban area, possibly because they are inserted in urban units which the access to protection services to women is easier. Domestic violence against women is still not viewed as an object of the health area. The innumerable consequences to the victim revealed in the literature reinforce the importance of health professionals to view it as a social problem articulated with health.

The other representational elements point to contents anchored in common sense, considering that they portray subjective aspects related to the victims such as pain, humiliation, low self-esteem, suffering, sadness, fear. There is a need for management of services aimed at women who are victims of violence and of training professionals, not only to identify cases of violence, but also to promote the empowerment of women through guidance on their rights. The problematization of this theme in different spaces would also make it possible to dilute gender inequalities existing in society, contributing to prevent the phenomenon.

The present study has limitations due to its development in a single socio-cultural context, pointing to the need to expand the approach to other realities and experiences involving professionals of both Basic Health Care and other levels of care. We hope that the study serve as a subsidy for rethinking the professional practices towards women who are victims of violence, especially in areas of FHU where the work dynamics allows to know and act on the particularities of the affiliated community.

REFERENCES

1 - Moura MAV, Albuquerque Netto L, Souza MHN. Perfil sociodemográfico de mulheres em situação de violência assistidas nas delegacias especializadas. Esc. Anna Nery Rev. Enferm. 2012;16(3):435-42. https://doi.org/10.1590/S1414-81452012000300002

2 - Rodrigues DP, Gomes-Sponholz FA, Stefanelo J, Nakano MAS, Monteiro JCS. Violência do parceiro íntimo contra a gestante: estudo sobre as repercussões nos resultados obstétricos e neonatais. Rev Es. Enferm USP. 2014;48(2): 206-13. https://doi.org/10.1590/S0080-623420140000200002

3 - Kulwicki A, Asward B, Carmona T, Ballout S. Barriers in the utilization of domestic violence services among arab immigrant women: perceptions of professionals, service providers & community leaders. J Fam Viol. 2010;25:727-35. https://doi.org/10.1007/s10896-010-9330-8

4 - Brasil. Lei Nº 11.340, de 7 de agosto de 2006. Diário Oficial União. 9 ago 2006.

5.Waiselfisz JJ. Mapa da violência 2015: homicídio de mulheres no Brasil. Brasília, DF: Flacso; 2015 [Acesso em 8 mar 2016]. Available in: http://www.mapadaviolencia.org.br/pdf2015/MapaViolencia_2015_mulheres.pdf

6 - Raimondo ML, Labronici LM, Larocca LM. Retrospecto de ocorrências de violência contra a mulher registradas em uma delegacia especial. Cogitare Enferm. 2013[Acesso em 27 de jun 2017];18(1):43-9. Available in: http://revistas.ufpr.br/cogitare/article/viewFile/26539/20012

7 - Costa MC, Lopes MJM. Elementos de integralidade nas práticas profissionais de saúde a mulheres rurais vítimas de violência. Rev Esc Enferm USP. 2012;46(5):1088-95. https://doi.org/10.1590/S0080-62342012000500008

8. Gomes NP, Erdmman AL. Violência conjugal na perspectiva de profissionais da "Estratégia Saúde da Família": problema de saúde pública e a necessidade do cuidado à mulher. Rev Latino-am Enfermagem. 2014;22(1):76-84. https://doi.org/10.1590/0104-1169.3062.2397

9 - 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. Cad Saúde Pública 2013;29(6):1230-40. https://doi.org/10.1590/S0102-311X2013000600019

10 - Vieira EM, Ford NJ, Ferrante FG, Almeida AM, Daltoso D, Santos MA. The response to gender violence among Brazilian health care professionals. Cienc Saúde Coletiva. 2013;18(3):681-90. https://doi.org/10.1590/S1413-81232013000300014

11 - Borges MS, Queiroz LS, Silva HCP. Representações sociais sobre cuidar e tratar: o olhar de pacientes e profissionais. Rev Esc Enferm USP 2011;45(6):1427-33. https://doi.org/10.1590/S0080-62342011000600021

12 - Sá CP. A construção do objeto de pesquisa em representações sociais. Rio de Janeiro: Ed UERJ; 1998.

13 - Magalhães EMM, Maia H. O trabalho docente por professores de curso de Pedagogia. Rev Múltiplas Leituras. 2009;2(1):189-206. https://doi.org/10.15603/1982-8993/ml.v2n1p191-206

14 - Machado LB, Aniceto RA. Núcleo central e periferia das representações sociais de ciclos de aprendizagem entre professores. Ensaio Aval Pol Publ Educ.. 2010;18(67):345-64. https://doi.org/10.1590/S0104-40362010000200009

15 - Abric JC. A abordagem estrutural das representações sociais. In: Moreira ASP, Oliveira DC, organizadoras. Estudos interdisciplinares de representação social. Goiânia: AB; 2000. P. 27-38.

16 - Oliveira DC, Marques S, Gomes AMT. Análise das evocações livres: uma técnica de análise estrutural das representações sociais. In: Moreira ASP, Camargo BV, Jesuíno JC, Nóbrega SM, organizadores. Perspectivas teórico-metodológicas em representações sociais. João Pessoa: Ed. Universitária; 2005. p. 573-603.

17 - Wachelke J, Wolter R. Critérios de construção e relato da análise prototípica para representações sociais. Psic Teore Pesq. 2011;27(4):521-6. https://doi.org/10.1590/S0102-37722011000400017

18. Costa TL, Oliveira DC, Formozao GA, Gomes AMT. Análise estrutural das representações sociais da terapia antirretroviral entre pessoas que vivem com HIV/AIDS: possibilidades de convivência, normatividade e ressignificação. Psicol Saber Social. 2013 [Acesso em 30 out 2016];2(1):104-14. Available in: http://www.e-publicacoes.uerj.br/index.php/psi-sabersocial/article/view/6931/4904

19. Sá CP. Núcleo central das representações sociais. Petrópolis: Vozes; 2002.

20 - Abric JC. Abordagem estrutural das representações sociais: desenvolvimentos recentes. In: Campos PHF, Loureiro MCS, organizadores. Representações sociais e práticas educativas. Goiânia: UCG; 2003. P. 37-58.

21 - Bardin L.. Análise de conteúdo. São Paulo: Edições 70;, 2011. Capítulo 3: A codificação; 103-114.

22 – Moscovici S. A psicanálise, sua imagem e seu público. Petrópolis: Vozes; 2012.

23 - Oliveira DC, Gomes AMT, Acioli S, Sá CP. O Sistema Único de Saúde na cartografia mental de profissionais de saúde. Texto Contexto - Enferm. 2007;16(3):377-86. https://doi.org/10.1590/S0104-07072007000300002

24 - Costa MC, Lopes MJM, Soares JSF. Representações sociais da violência contra mulheres rurais: desvelando sentidos em múltiplos olhares. Rev Esc Enferm USP. 2014;48(2):214-22. https://doi.org/10.1590/S0080-623420140000200003

25 - Arruda CN, Braide ASG, Nations M. "Carne crua e torrada": a experiência do sofrimento de

ser queimada em mulheres nordestinas, Brasil. Cad Saúde Pública. 2014;(10):2057-67. https://doi.org/10.1590/0102-311X00175713

26 - De Ferrante FG, Santos MA, Vieira EM. Violência contra a mulher: percepção dos médicos das unidades básicas de saúde da cidade de Ribeirão Preto, São Paulo. Interface (Botucatu). 2009;13(31):287-99. https://doi.org/10.1590/S1414-32832009000400005

27 - Gomes NP, Erdmann AL, Carneiro JB, Paixão GPN, Santos JAS, Bettinelli LA. Profissionais de saúde significando a permanência da mulher na relação de violência conjugal. Rev RENE. 2013;14(3):558-67. https://doi.org/10.15253/rev%20rene.v14i3.3433

28 - Vale SLL, Medeiros CMR, Cavalcanti CO, Junqueira CCS, Souza LC. Repercussões psicoemocionais da violência doméstica: perfil de mulheres na atenção básica. Rev RENE. 2013;14(4):683-93. https://doi.org/10.15253/rev%20rene.v14i4.3523

29 - Vieira LB, Cortes LF, Padoin SMM, Souza IEO, Paula CC, Terra MG. Abuso de álcool e drogas e violência contra as mulheres: denúncias de vividos. Rev Bras Enferm. 2014;67(3):366-72. https://doi.org/10.5935/0034-7167.20140048

Note: Funding agency: National Council for Scientific and Technological Development (CNPq), Call Notice nº 032/2012. Research Report.

Received in: 12/11/2016
Approved in: 18/10/2017

Mailing address:
Daiane Broch
Rua Miguel Tostes, 905, apartamento 33
CEP: 90430-061 Porto Alegre/RS - Brasil
E-mail: daiane_broch@hotmail.com