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Intentionality of the action of caring for women in situations of violence: contributions to Nursing and Health

Intencionalidade da ação de Cuidar mulheres em situação de violência: contribuições para a Enfermagem e Saúde

La intencionalidad de la acción de cuidar a las mujeres en situación de violencia: contribuciones a la salud y enfermeira

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Abstract

Objective: To investigate the reasons for the nurse's action when caring for women in situations of violence. **Methods:** Qualitative Research based on the Phenomenological Sociology of Alfred Schutz, performed through ten interviews with nurses who had cared for these women in a hospital and Emergency Department of the public network in Rio Grande do Sul, Brazil, in January to April 2013. **Results:** The intentionality of the action showed the initial search to restore these women's physical health, permeated by the expectations to understand the situation; and to provide emotional well-being, support and continuity of care, such that these women are able to build a life without violence. **Conclusion:** The typical action reveals urgency to broaden the focus of care for the subject in their unique biographical situation. The promotion of actions aimed at deconstructing natural attitudes towards the violence experienced is aimed for.

Keywords: Women's Health; Violence Against Women; Health Services; Nursing; Professional Practice.

Resumo

Objetivo: Apreender as motivações da ação da enfermeira ao cuidar de mulheres em situação de violência. **Métodos:** Pesquisa qualitativa, fundamentada na Fenomenologia Sociológica de Alfred Schutz. Realizaram-se dez entrevistas com enfermeiras que haviam cuidado dessas mulheres em um Hospital e, Pronto Atendimento da Rede Pública do Rio Grande do Sul, Brasil, no período de janeiro a abril de 2013. **Resultados:** A intencionalidade da ação desvelou a busca inicial da recuperação da saúde física das mulheres, permeada pela expectativa de compreender a situação; proporcionar bem-estar emocional, apoio e a continuidade do cuidado, para que as mulheres possam construir uma vida sem violência. **Conclusão:** O típico da ação revela a premência de se ampliar o foco do cuidado para o sujeito em sua situação biográfica singular. Vislumbram-se ações que visem desconstruir as atitudes naturais em relação à violência vivida.

Palavras-chave: Saúde da Mulher; Violência contra a Mulher; Serviços de saúde; Enfermagem; Prática Profissional.

Resumen

Objetivo: Comprender las motivaciones de la acción de la enfermera en la atención a las mujeres en situación de violencia. **Métodos:** Investigación cualitativa, fundamentada en la Fenomenología Sociológica de Alfred Schutz. Se realizaron diez entrevistas con enfermeras que habían cuidado de estas mujeres en un Hospital de Emergencia de la red pública de Rio Grande do Sul, Brasil, entre enero y abril de 2013. **Resultados:** La intencionalidad de la acción ha develado la búsqueda inicial de la recuperación de la salud física de las mujeres, permeada por la expectativa de comprender la situación; proporcionar bienestar emocional, apoyo y continuidad del cuidado, así que ellas puedan construir una vida sin violencia. **Conclusión:** El típico de la acción revela la necesidad de ampliación del foco del cuidado para el individuo en su situación biográfica. Se vislumbran acciones dirigidas a la deconstrucción de las actitudes naturales con respecto a la violencia que vivieron.

Palabras clave: Salud de la Mujer; Violencia contra la Mujer; Servicios de Salud; Enfermería; Práctica Profesional.

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INTRODUCTION

Violence against women (VAW) is configured as one of the main forms of violation of human rights, affecting women in their right to life, health and physical integrity. In this study, the concept of VAW is understood as any act or omission based on gender which causes them death, injury, psychic, sexual or psychological suffering or moral damage or patrimonial harm in either the public or private ambit[1].

In 2014, on the Notifiable Diseases Information System (SINAN), in Brazil, 223,796 attendances to health, relating to violence, were recorded. Of these, 147,691 were women, that is to say, two out of every three cases. The scenario of the situations was at the woman's residence, while the aggressors were the spouse or boyfriend (current or previous)[2].

In the health sector, the issue was included officially as a demand for care in 1990, due to the impact which it has on the lives of people, families and society, which entails the need for attention and care from the health services[3]. It is emphasized that the consequences for women's physical and mental health result from ocular injuries, gastrointestinal disorders, anxiety-related disorders and depression which can lead to the abuse of alcohol and other drugs[4]. Due to these repercussions, the women seek the health services, which indicates the important role that the professionals have in their embracement and in the listening, thus being strategic for confronting the violence[5]. In this regard, the Health Area is a pioneering field for the identification of the situations and for critical-reflexive production regarding the phenomenon[6], being part of the route traveled by many women[7].

A large proportion of the cases is not identified by the professionals, contributing to the phenomenon's invisibility. One reason for this is the lack of training for detecting situations of violence in the complaints presented by the women, and the professionals' understanding being based in conceptions of gender and in an understanding that this is a private matter. Generally, the professionals concern themselves purely with the physical symptoms, not taking into account the psychosocial aspects, there being a strong tendency to medicalization[5,8,9], judgment and blaming of the women themselves[10]. This shows that the health sector has not yet incorporated into its care models the problems of people's lives and those which are not typical illnesses. The language of the symptoms and the diagnoses are insufficient in the multifactorial universe of violence[9]. Generally speaking, the care for these women takes place in a fragmented and piecemeal way, being restricted to the treatment of the physical injuries, demonstrating a lack of preparedness for developing networked care, capable of resolving the issue, and with a view to comprehensiveness[6,9,11]. However, it is emphasized that in many cases these are the professionals who provide the first care measures and who need to know and understand the women's needs.

This study considers the work of the nurse based in caring as an action experienced individually and contextualized in the world of the social life, being signified and re-signified based on the type of relationship established with the other[12]. The world of life, also termed the social world, routine world or commonsense world covers the routine experiences, directions and actions through which the individuals deal with their interests, conceptualizing and realizing plans[13]. The professional care adds the technical-scientific dimension to the factual care, differentiating it from that which is practiced through commonsense[12]. This understanding supported the need to investigate issues which seek to grasp the professionals' actions, in particular those of the nurses in caring for these women. In this regard, this article is the clipping of a dissertation* which had as its guiding question: "What is the intentionality of the professional action of the nurse in caring for women in situations of violence?". Thus, the study aimed to investigate the motivations of the nurse's action in caring for women in situations of violence.

THEORETICAL FRAMEWORK

Considering nursing care as an action, and that when one carries out the care, one has something in mind, in this study, the decision was made to use the theoretical-methodological framework of the Sociological Phenomenology of Alfred Schutz, whose field of thinking is based in the sociology of action, proposing a method of capturing the social reality and the set of social actions, based on which it is possible to understand it[13]. As a result, in order to undertake nursing care which aims for comprehensiveness, it is necessary to grasp the motivations for undertaking this. Such that these may support the development of skills for interdisciplinary and interdepartmental care which aims to confront the violence and the understanding of this as a requirement of these women and a question of public health.

Alfred Schutz was born in Vienna in 1899 and died in New York in 1959. He studied Law and Social Sciences, forming his bases of thought based on the works of Edmund Husserl and Max Weber. In investigating the subjective impulses which surround human action, Schutz developed the theory of motivation, in which the action in the world of life is seen as a process based in functions of motivation, such as reasons and objectives, guided by anticipations in the form of planning and projections. In this way, human action is planned based on a project which is aimed to be realized, and each individual acts with a view to some purpose. Its meaning is understood through the motives for the action: the *reasons why* and the *reasons to*. The former will determine the project according to the availability of knowledge of the agent of the action, contextualizing it. They refer to the past, as they may be observed based on the action already undertaken. The *reasons to,* the intentionality, may be grasped during the action underway and refer to the project to be realized, what one intends in undertaking a determined action, to the purpose[13].

In this study, it was sought to grasp what the nurses have in view in caring for women in situations of violence, that is, the *reasons for* the professional action. It is emphasized that these professionals, as representatives of a social group, are inserted in a system of knowledges inherited from ready-made cultural patterns, their reserves of experience. In this way, they

act in accordance with practices and habits which constitute the profession's social inheritance[13]. It is considered that the knowledge accumulated by the professionals in the course of their lives has as its reference actions of clinical care, which, furthermore, are permeated by the biomedical model. To this end, one of the study's objectives is to reflect based on this way of acting so as to outline possibilities for extending this care to these people.

The decision was made to choose this framework as it makes it possible to grasp the *typical of the action*, the representation of the group's actions, that which is common for these professionals, which represents the essence[12,13]. It is understood that for the nurse to undertake actions of care, it is necessary to begin with the context of these women's needs, considering them as a whole, covering their uniqueness and deconstructing natural attitudes in relation to the violence experienced[14]. Thus, it is necessary clearly to understand their personal and professional motivation for caring for these women. In this regard, using Sociological Phenomenology as an approach makes it possible, in the different situations of care, to group characteristics which allow people to recognize them as such, due to the fact that they have experienced them preliminarily[12].

METHODS

This is a qualitative study with a phenomenological nature[14] which made it possible to understand the intentionality of the subjective action of the nursing professional in caring for women in situations of violence, as it made it possible to think, base and undertake the action of investigating and caring in Nursing, based in the social relationships established in the world of life. This framework valorizes the intersubjective dimension of the care, translating it as the most primary of the relationships existing among human beings[12].

The scenarios were the health services linked to the public network and referral network for attending these women, in the interior of the Brazilian state of Rio Grande do Sul, namely: the Obstetric Center and Emergency Room of a large-size hospital, and the Municipal Emergency Room. The participants were ten professional nurses who worked in these services and the choice of these was justified mainly by the need to strengthen the center of knowledge of this profession for acting in cases of violence against women. The following inclusion criteria were established: to be a nurse in these locales and to have attended at least one woman in a situation of violence. The exclusion criteria was to be on holiday or any type of leave from work in the period of the production of information. The selection of professionals was random and the number of participants was not predetermined, as in phenomenological studies the number of interviews to be undertaken is determined by the sufficiency of meanings converging with the research objectives[15], which was possible in the 10th interview.

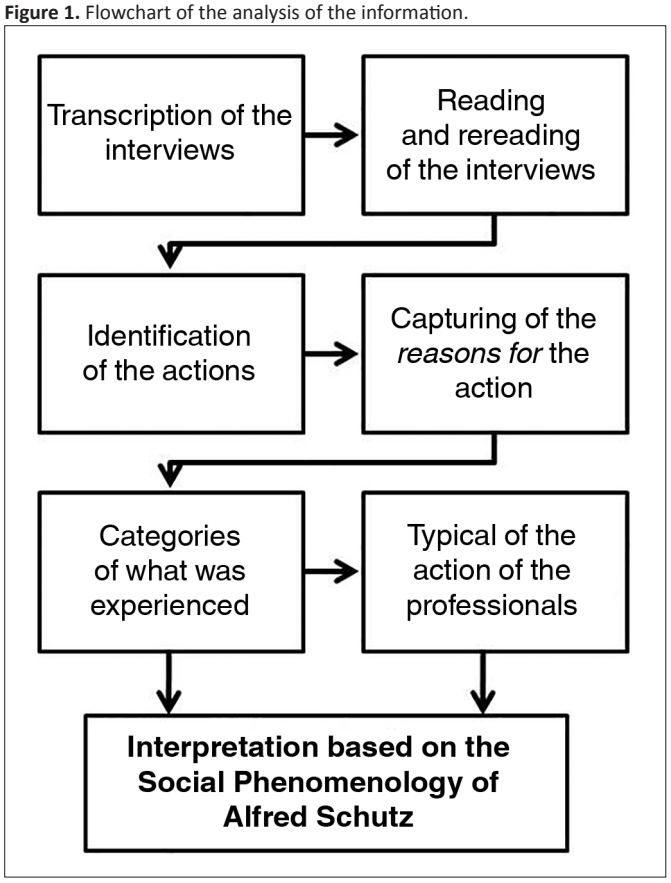
Entrance into the research scenarios for the production of information took place following the project's approval by the Research Ethics Committee (Certificate of Presentation for Ethical Consideration: 12224212.2.0000.5346). The ethical considerations were effected according to the provisions of Resolution Nº 466/2012 of the Brazilian National Health Council. Subsequent to the authorization of the services involved, and after the making of contact and adaptation in the scenarios, at an appropriate moment the professionals were invited by the researcher to participate in the study. In order to capture the participants, previous contact was made in order to arrange a date and time to carry out the interviews. The Terms of Free and Informed Consent were presented and explained to them, and two copies of these were signed voluntarily after the understanding and agreement with the explanation of the ethical questions. The participants' anonymity was ensured through the use of the letter "N" for 'Nurse', followed by a number (N1, N2, N3, N4...).

The production of the information was undertaken during the morning and afternoon shifts, in January - April 2013. Phenomenological interviews were used, which are considered to be a social meeting, in which empathy and intersubjectivity are fundamental. Hence, it requires the researcher to decenter herself from herself, in order to direct herself towards the understanding of the subject and her social-phenomenological perspective. There is no prescription of steps to follow, as this is a meeting of subjectivities[16]. The interviews were held in a private room made available by each service, were recorded using a digital recorder, and the interview's length was determined by each participant.

The interview script was made up of questions on these professionals' characteristics and whether they had ever attended women in a situation of violence; they were also questioned in relation to the care actions and a guiding phenomenological question was posed: *What do you have in mind when you care for women in situations of violence?*

The analysis of the information followed the following steps (Figure 1): the first was the careful transcription of the interviews; following that, the same were read and reread with a view to identifying the actions carried out by the professionals and to capture the *reasons for* the nurses' action. For the capturing of the *reasons for*, an excerpt was made of the responses which were aligned with the study's central question. Once the common ideas reflected in these excerpts had been identified, each interview was read and reread in full in order to confirm whether these ideas were expressed throughout the accounts. The careful reading and the critical analysis of the content made it possible to identify and describe the social processes, which were categorized for understanding of the phenomenon investigated. The categories are termed concrete as they make up objective summaries of the different meanings of the action which emerged from the subjects' experiences[12]. Finally, in the data analysis, the categories' relations between themselves were identified, thus obtaining the typical of the professional action. The results were interpreted in accordance with the fundamentals of the Sociological Phenomenon of Alfred Schutz and dialogue between the scientific evidence related to the issue was studied[12].

Figure 1. Flowchart of the analysis of the information.



RESULTS

The analysis of the information made it possible to organize the results of the experiences experienced by the professionals into two concrete categories relating to the intentionality of the nurses' action:

They initially expect the recovery of the women's physical health and well-being and to minimize the health problems resulting from the violence

The nurses, in carrying out the care for women in situations of violence in their care practice, intend to provide the initial care for the injuries, the trauma; they hope for the women's clinical well-being, that is to say, their physical recovery. They demonstrate their intentionality in the health attendance conditioned to the biological issues of the injuries, of the risk to life. The care provided is technical, sometimes, recorded in the work, considered normal, and often restricted to biological issues. At some second point, they talk with and listen to the women, hoping for their emotional well-being.

> *The first thing is to ascertain the signs, and then begin to talk with the person, I ask what the main symptoms are [...]. the main thing here is the physical, mental, clinical and psychological well-being as well, because it is very good for you to talk with people. (N1)*

> *For the initial care, what we think about is the physical part of the subject, of the woman [...]. the beginning, as it is characteristic of the emergency, is to try to save her life, and we work on the rest afterwards. (N7)*

> *The care is provided as usual, it is care that is provided regardless [...] The person who is caring for this patient may not even know that she has suffered violence. There is an injury [...] We attend to what is clinical, and not the rest. [...] What she is feeling at that point, what she has that is clinical, pain or an open injury which needs to be dressed, nursing care. (N8)*

The professionals are concerned with reducing the possible consequences and preventing health problems resulting from the violence suffered, so that the women may feel safer. They hope, through actions such as listening and the provision of advice, to be able to contribute to relieve and calm the woman in the face of the situation of violence. The listening undertaken by the professional is shown as a time in which the woman can let off steam and feel relieved. Sometimes, they also hope to help the woman to understand that she is not to blame for the violence which she suffered; to protect, to support, to call somebody, such as a family member who can help.

> *[...] [to minimize] the stress, to send off the tests, to advise the person. [...] Even to help calm the person a little. (N1)*

> *We hope that she doesn't have health issues beyond what she has already suffered [...] such as an unwanted pregnancy, an STD, AIDS, or some other consequence [...]. this is the objective, but it is not my objective. This is a protocol which we follow. [...] I comply with what is determined. I am from a generation in which people do what has to be done [...] I hope that she will feel a little safer [...] That she will feel well, calmer in relation to everything. (N3)*

> *I went [...] to see if I could give any help, some support in that moment, if she's calling somebody, if she's asking for a family member, because I was thinking that she was very lonely [...] but she didn't give me any opening at all. (N5)*

They have an expectation of understanding the situation, that the women will develop an awreness regarding the violence, and seek help so as not to return with the same problem

The professionals show the need to investigate the history and understand the situation of violence experienced, exactly as this occurred; to know from the woman the origin of the injury, of the aggression, and who the aggressor was. The intentionality is to undertake the chemoprophylaxis for HIV, the serology tests, contraceptive use; and to guide and find out if she was awareness of the aggression; to help the rest of the team to understand the situation and not to judge the woman. Some indicate that it is

through curiosity, through instinct, or because of being shocked by the situation.

> *We always have a preconceived idea. [...] But why did she get hit? [...] I would like to know exactly what had happened. (N2)*
>
> *Here, we try to find out how these things occurred, perhaps because we have to see whether or not it will be necessary to undertake the HIV chemoprophylaxis, contraception, all the blood tests, the whole technical thing, which has to be done [...] One important thing is about the listening, as it helps the team around not to judge. (N4)*
>
> *We try to talk in order to find out the origin of the injury, of the aggression, because the vast majority of them deny that it was the partner who hurt them, or their son [...], because many of them say that they fell [...] In order to understand what has happened, who it was who hit them, and whether they are aware of that, because many of them think that it is natural, normal (N7.)*

They talk with the women and partners with the purpose that these may become aware, become aware of their rights, value themselves as human beings, and know that they have alternatives; that they can free themselves of the partner who hurts them and that they can get a job. They expect the strengthening of the woman so that these do not continue in that situation, such that they seek help, and do not return with the same problem. They indicate the possibility of looking for help in the support services, such as the Women's Special Police Station (*Delegacia da Mulher*) and other services and professionals. For them, the violence is recurrent and the woman does not always manage to leave the situation, and they recognize that the family members need to help the women and talk about this.

> *When we are available, I ask if she is going to report him to the police [...][the purpose] is to know whether for her, as I put it, "the penny has dropped", to know whether she has the intention of leaving the situation, of resolving her problem. [...] To call her attention to the fact that she can and should seek a support service. (N2)*
>
> *[...] that she should wise up a little, that they may see that other things in life exist. That you can have an independent life [...]. I seek to show her that she is a person, that she has the right to be happy [...]. we want them to wake up to this, but it doesn't always happen. (N3)*
>
> *We talked quite a lot with her, to convince her to seek help with some family member, with somebody. (N6)*
>
> *So I try to awaken this, so that they may in this way see of their rights [...] I talk with them, about the importance of them valuing themselves as human beings, as women, not to let this continue after, again, with that person, receiving aggression. [N7]*

The nurses indicate the need to undertake referrals to other professionals such as: psychologists, social workers and health agents, and also to other services such as the Specialized Center for Social Assistance (CREAS), Women's Shelter and Obstetric Center, for the cases of sexual violence. Some seek not to be involved with the situation, due to considering that this is a job for a specialist professional, a physician, psychologist or social worker. The intentionality of these actions is that the women should seek attendance, that the services should provide support, embrace these women, and in the cases of sexual violence, undertake semen collection.

> *She came with the police notification in her hand, so she came for an examination, because of sexual aggression [...] And then what do we do? We refer her to the psychologist. (N1)*
>
> *[Regarding referral] The first thing the service does is the embracement in relation to what they have to do. [...] Through the referrals, I intend to give support to her in the other bodies. (N4)*
>
> *[Regarding the conversation with the family members] That the family members can help her too, and that they can see [...]. (N7)*
>
> *I haven't got to the point of involving myself in the psychological part. I don't think that that treatment is my job. Like, what happened, to provide advice about reporting to the police [...] I leave that more to those who really have to do the work, the social work or psychologist, the person who is a specialist in this, a physician. (N9)*
>
> *[...] The strengthening of this patient [...] That this woman may open her eyes. (N10)*

DISCUSSION

The professionals, in undertaking the care, act knowingly, as prior to acting, they have a representation in mind of what they will do, in a preconceived project[14], through the physical care they hope to recover the health. The intentionality is inserted in the context of these professionals' routine world of life, the scenario in which the human being lives, a world which is organized and determined socioculturally. All interpretations regarding this world are based on a stock of previous experiences, our own experiences and those transmitted in the form of a knowledge made available, and these operate as a system of reference[13]. For these professionals, the attitudes are based in a conception of health-illness which aims particularly for the recovery of peoples' physical health, and in the relationships aimed for.

The reference of the actions of caring of this world is based in actions such as undertaking examinations, applying dressings, administering medications, changing the patient's position, care with catheters, with pain, trying to save the person's life, that is, care with the women's bodies and also guiding the family members. They declare that they "*attend what is clinical and*

nothing more", due to understanding that mental health may be the responsibility of another professional. They present an expected behavior, standardized in their course of action, within their typical social role[13] of being a nurse, therefore, they act in this world of clinical care, anchored in their natural attitude[13]. In this type of attitude, we oppose reflection, as we are totally oriented towards purpose, the object of the action, and are not aware of ourselves[17].

The nurses find themselves inserted in a world which existed before they did, and provide the care based on what is prescribed, on what is realized in the institution. They consider the care to be normal, established culturally. When protocols exist, they comply with what is defined, and do what they have to do. The things which are not questioned are considered as "givens, and givens appear to me in the way that I and others in whom I trust experienced them and interpreted them"[13:124]. They are the things held as evident. However, what is considered evident today may come to be questioned tomorrow, if we are induced to change the focus of our interest[13].

Hence, the care for the women in situations of violence is often permeated by the valorization of the technical knowledge. This finding converges with other studies from the Area of Health in which the professionals limit themselves to treating the physical injuries[7,9]. They rationalize this through not feeling able to provide comprehensive care for women in situations of violence[11]. Emphasis is placed on the need to understand the violence beyond the biological aspect, the aspect of the injuries. For this, the professionals must act as agents of health promotion, constituents of a network of services which seek to confront the sequellae and eradicate the culture of violence[14].

The context of the violence experienced by the women is nearly not addressed, unless they declare the situation, which often does not occur. This result is in conformity with other studies, as VAW is presented as a veiled and invisibilized situation in the health services[7-9].

At this point, there exists nearly no relationship of familiarity between the women and the nurses, in the form of us. We experience the world of life according to levels of familiarity and anonymity. The relationship of familiarity is experienced in the form of we-relationship, in which one is aware in relation to the other and particpates in the other's life, allowing the understanding of the other as unique in her individuality[13]. However, when we withdraw from the uniqueness and individuality of those similar to us, few aspects are considered relevant for the problem which it is desired to treat or resolve, being configured as an anonymous relationship.

The professionals also project in their actions the possibility of minimizing the harm from the violence, to comfort and to help the women; to prevent the appearance of an unwanted pregnancy or STDs. Sometimes this action is recorded in accordance with what is determined in the institution, thus, they mention complying with what is realized as routine. Inserted in the social group, they undertake the social role of being a nurse, based in what is standardized for the profession. They follow the system of knowledge acquired, in which the members of the social group accept the schema of the pre-existing cultural patterns transmitted by their predecessors. This attitude is referred to as thinking as usual. They act in accordance with the naturalized customs of the group, which constitute the social inheritance, and dispense explanations of questioning[13].

The action of caring was revealed to be typified, based in the knowledge accumulated by the professionals over their lives, founded on their experiences constructed historically and in their professional training. This tipification[13] integrates a typical model of the social role of being a nurse which is still constructed and transmitted socially as biological care, founded in the currently-dominant biomedical model, based on the curing of the disease and on the care in the situations of illness. The world is experienced and interpreted in terms of types which may be cultural objects, for example, a syringe or a stethoscope, or, furthermore, typical social roles and relationships. The tipifications emerge in the routine experience of the world as something evident[13:133].

They converse with and listen to the women, and sometimes place themselves in a situation of indignation (as this is an order which is different from their reality). Faced with the shock, they change their tension of consciousness, and through changing the focus seek to provide relief. At this point, they demonstrate breaking with their natural attitude, in the world of routine life so that based on these women's experiences, they may re-signify this attendance[13]. They express the need to become closer to the woman, if this shows herself to be open to talking about the violence. They want to offer protection and reveal help with the purpose of the woman understanding that she is not guilty for the violence. They have as an expectation the emotional and psychological well-being. When this interaction takes place, there is a face-to-face situation, which is a direct experience between people, a communicative social encounter in which time and space is shared[13,17]. This type of relationship is configured as a possibility of nursing care for these women as their experience comes to be seen by the professional in its subjective dimensions. As a result, the care is broadened beyond physical well-being.

The professionals, sometimes, try to understand the situation of violence based on their own experiences of being women, anchored in the traditional social roles of what being a woman and being a man is. They try to put themselves in the place of the women and believe that their preconceptions do not influence the work carried out. The entire understanding always returns to that which has meaning and only something understood is endowed with meaning[13]. They show that they want to understand the context in order to be able to direct the actions of individual care and also to share with the on-call team the understanding that the violence against women has its origin in the macho culture, in which the man imposes himself: and thus to reduce the possibility of judgment by the team.

With the objective of strengthening the women that the violence may not be repeated, that they may be able to leave the violent atmosphere and avoid the possible harms to their

health, such as death, the nurses converse about the possibilities that they have such as work, the search for judicial authorities, the Women's Special Police Station, the support of the family and regarding the right not to suffer violence, and to be happy. At this point, they understand the context of the world of life of these women, understand them as human beings with rights, in particular to live a life without violence. They guide their actions based on the understanding that for the women to leave the situation, they need to become conscious regarding the problem. This relation of synchrony between the professionals and the women is called a face-to-face situation and is you-orientation, as they are conscious of the other human being, the women, as people who have life and awareness[13]. However, at these times the nurses, based in the experiences of their world of life, show that they do not understand the motives of the women for remaining in the situation and returning to the health service with the same problem.

When they interact with questions regarding reporting the attack to the police and seeking help, they base themselves in their stock of knowledge, founded in cultural objects which may refer to conventional ways of doing things[13]. They believe that the best for the woman at that moment is to report the violence to the police or to seek help from a family member. Thus, they base their actions making inferences based in their prior experiences[13] regarding the women's family relationships, as well as the behavior which they should have, faced with the situation. However, they end up failing to contextualize each woman's world of life. At this point, there is no reciprocity of perspectives[13], as this would encompass the apprehension of objects and their aspects which are known and evident to both, professionals and women in situations of violence.

It is emphasized that the women do not always want to report the incident to the police. It needs to be taken into account that for some women, the partner's participation in supporting the family and bringing up children, as well as the fear of beginning a new life, among other factors, can cause them to think about the possibility of leaving the situation of violence without necessarily breaking up with the partner. As a result, overcoming the situation of violence will not necessarily occur through the separation of the couple. It is important that women should receive support through which they can understand the mechanisms involved in the violence, so as to build strategies for confronting it in their routine and acquiring greater control over their lives[18]. These anticipations are structured in the stock of knowledges which these women have available. As a result, they project their actions based in their previously undertaken actions which are typically similar, *tipicality*, to what is being projected. In protecting, it is necessary to visualize the state of things to be undertaken by the future action before it is possible for them to outline the step-by-step stages of this action[13].

The professionals demonstrate that they perceive that the interventions do not always bring positive results and also the need to refer the woman to other locales. However, for the women to direct themselves to other locales, is for them to have to tell and retell the stories, suffering unnecessary or duplicative procedures. This is a critical point of the journey traveled by the women in their attempts to free themselves from the violence, a situation which is significantly debated and criticized by women's movements[11].

The need to refer to other professionals and possible services which attend these women reflects that they expect the support, the continuity of the care, such that the women may construct a perspective of life without violence. In conformity with another study, the psychologization of the violence and the devalorization of the social character of the health-illness process is understood. As a result, the purpose of the health attendance continues to be the cure of the illness and when there are no physical injuries, the problem is related to mental health, avoiding the professional responsibilities[7].

Equally, they recognize the need for multi-professional and articulated care with other services and have expectations that a network should exist. In relation to the already existing services, they mentioned difficulty in monitoring and implementation of communication between the services. However, there is a need for greater mobilization such that this referral for transference of care may exist. This action is projected in thought, continuing as a reverie[13], that is, this supports the National Confrontation Policy[1] and the other public policies directed towards women's health and overcoming gender inequalities, as it breaks with the possibility of articulation in a network.

This result converges with a study undertaken regarding the critical routes of the women in their search for help; in this, women, professionals and service coordinators indicate the network to be fragmented and far from the reality which the women experience. These indicated, as limiting factors, the difficulty in understanding the guidance and processes, the fragmentation and absence of a center in which they could receive comprehensive care. However, some professionals report the wish to transform the forms of intervention, with a view to creating mechanisms for bringing actors closer and organization of flows[11]. The approximation of actors refers to a social relationship in which the meanings will determine the direction of the actions, in the study in question, the formation of the care network.

It was possible to grasp that the nurses, when they converse with and guide the women, project that these may migrate from the natural, non-reflexive attitude, to the reflexive attitude, so as to strengthen the women so that the violence may not be repeated. This is although, sometimes, immersed in their biographical situation and the baggage of their knowledge, these present difficulties in understanding that the violence against women integrates a complex and multidimensional cycle which is difficult to break.

FINAL CONSIDERATIONS

Grasping the meaning of the professional action of nurses in experiencing the care of women in situations of violence made it possible to broaden the view to the way in which the care is undertaken in urgent and emergency services as well as in relation to the organization of the process of caring for these female service users. The initial intentionality, *the recovery of*

physical health and the women's well-being, was revealed as the typical way of being a nurse in an urgent and emergency service. This points to the need to broaden the focus of care to the subject in her unique situation, to beyond her body. Reinforcing the urgency of encompassing the actions of care, other determinants which make up these women's world of life, such as, the social relationships, the intersubjective dimension, with the partner, with the children, family members, neighbors, even when these relationships are weak. These questions are permeated by traditional gender roles, relating to work and income, to housing and articulation with other services upon which the women may rely in an attempt to minimize the harm from the violence experienced or to break with the situation.

The nurses demonstrated the extent to which the work process in an Emergency Room department or obstetric center is focused on the manifestations of the disease. It is understood that these are challenges to be overcome in the organization of the service itself with a view to breaking with the fragmentation of the care, overcrowding, consequent overload of the professionals and weak or inexistent articulation with the other services in the care network.

In order to embrace these people it is essential that nurses put themselves in an attitude of being with, in intersubjective relationship with the women, sharing the same time and space, in which they understand their needs for care and commit themselves to them. This requires that the professionals share responsibilities with the women, family members and with other professionals so that they may reflect together regarding the possibilities for confronting violence in the different "we's" of the care network. Hence, in a relationship of reciprocity of perspectives, such that the nursing care may be contextualized in these women's world of life, and bearing in mind their care needs, there is a need to horizontalize this care so as to articulate it with other professionals and services. In order to contemplate the translation of the knowledge with clinical practice, it is essential that the nurses appropriate communication and their social role in the health team, which often consists of organizing work processes and embracing the unique demands for care of the women. The encouragement of actions which aim to deconstruct the natural, nonreflective attitudes of the professionals in relation to the women's situation is recommended, as is the implementation of an institutional culture so as to visibilize the situations of violence.

On the other hand, when the nurses listen, converse and guide, they share the same time and space with the women. They understand the context of these women's world of life, understand them as human beings with rights, in particular to live a life without violence. They guide their actions based on the understanding that for the women to leave the situation, they need to become aware of the problem.

The reasons which lead the nurses to act/care are configured as possibilities for reinventing the routine of care for women in situations of violence. These points require the nurses to have the recognition of their subjectivity in the care, that they may empower themselves as women so as to put themselves in an intersubjective relationship with these people, in which the dialogue may be a permanent construction. To know the world of life of these professionals and their action of caring, still anchored in the biomedical model, indicated the urgency that in training in the Health Area, skills should be developed such as listening, embracement, and communication for dealing with the subjectivity of the other; to involve oneself with situations of illness which go beyond the injuries.

This study presents some limitations which are characteristic of qualitative studies, such as being delimited in the hospital and Emergency Room scenario. However, its contribution is in deepening the issue studied and in the understanding of the meaning of the action of these professionals, which justifies the importance of the analysis used.

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