

Possibilities for addressing child abuse in systematized nursing consultations*

AS POSSIBILIDADES DE ENFRENTAMENTO DA VIOLÊNCIA INFANTIL NA CONSULTA DE ENFERMAGEM SISTEMATIZADA

POSIBILIDADES DE ENFRENTAMIENTO DE LA VIOLENCIA INFANTIL EN LA CONSULTA DE ENFERMERÍA SISTEMATIZADA

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ABSTRACT

Child abuse has been increasing, and addressing this phenomenon is within the responsibilities of health services. The International Classification of Nursing Practice in Public Health (Classificação Internacional das Práticas de Enfermagem em Saúde Coletiva – CIPESC®) is a tool that systematizes care and identifies child abuse during nursing consultations. The present study aimed to identify the limitations and potential of CIPESC® in nursing consultations with children that were victims of domestic violence. The present qualitative descriptive case study examined 15 web-based reports on violence completed by primary care nurses from the Curitiba City Council (Secretaria Municipal de Curitiba) in the state of Paraná. Although CIPESC® has shown potential, the diagnoses and interventions presented in the classifications were not fully utilized by the respondents. The reports showed worrisome limits regarding the recognition of needs and vulnerabilities involving the phenomenon of violence. In conclusion, it is necessary to contribute to the nomenclature the attributes concerning freedom and autonomy, which are essential for addressing violence, in addition to methods for evidence-based interventions.

DESCRIPTORS

Child
Domestic violence
Nursing diagnosis
Nursing care
Needs assessment

RESUMO

A violência infantil vem crescendo e aos serviços de saúde compete lidar com este fenômeno. A CIPESC® é uma ferramenta sistematizadora do cuidado e pode visibilizar a violência infantil nas consultas de enfermagem. Este estudo buscou identificar os limites e potencialidades da CIPESC® na consulta de enfermagem com crianças vítimas de violência doméstica. Estudo descritivo, qualitativo, tipo estudo de caso, analisou 15 relatos por web-questionário de enfermeiros da atenção básica, da Secretaria Municipal de Curitiba, Paraná, sobre a ocorrência de violência. Embora a CIPESC® tenha mostrado potencialidades, os diagnósticos e intervenções existentes na nomenclatura não foram plenamente acionados pelos pesquisados. Apresentou limites preocupantes no que tange ao reconhecimento das necessidades e vulnerabilidades que envolvem o fenômeno da violência. Conclui-se que é preciso agregar à nomenclatura os atributos referentes à liberdade e autonomia, essenciais para o enfrentamento da violência, além de maneiras de intervir baseadas em evidências.

DESCRITORES

Criança
Violência doméstica
Diagnóstico de enfermagem
Cuidados de enfermagem
Determinação de necessidades de cuidados de saúde

RESUMEN

La violencia infantil está en crecimiento, compete a los servicios de salud enfrentar el fenómeno. La CIPESC®, herramienta de sistematización del cuidado, puede visibilizar la violencia infantil en las consultas de enfermería. Se buscó identificar límites y posibilidades de la CIPESC® en consulta de enfermería con niños víctimas de violencia doméstica. Estudio descriptivo, cualitativo, tipo estudio de caso; analizando 15 testimonios por cuestionario-web de enfermeros de atención primaria de la Secretaría Municipal de Curitiba-PA, sobre ocurrencia de violencia. Aunque la CIPESC® haya expresado potencialidades, los diagnósticos e intervenciones existentes en la nomenclatura no fueron plenamente accionados por los entrevistados. Presentó límites preocupantes en lo atinente al reconocimiento de necesidades y vulnerabilidades que envuelven al fenómeno de la violencia. Se concluye en que es necesario agregar a la nomenclatura los atributos referentes a la libertad y autonomía, esenciales para enfrentar la violencia, además de modos de intervención basados en evidencias.

DESCRIPTORES

Niño
Violencia doméstica
Diagnóstico de enfermería
Atención de enfermería
Evaluación de necesidades

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INTRODUCTION

Violence, both as a term and a subject, is complex, polysemic and controversial. Social rules guide judgments, which makes violence assume different meanings according to different times, locations, circumstances and realities. For this reason, given the nature of this phenomenon, the study object should be multidisciplinary and should not be limited by strict and compartmentalized subjects⁽¹⁾. Violence is rooted in social relationships but is built on subjectivity and inner conscience. Thus, violence is a force that is external to individuals and groups and cannot be analyzed or treated outside the society that produces it. In addition, the internal specificity of violence and its historical particularity must be considered⁽¹⁾. Violence requires multi- and interdisciplinary actions, as it involves health, social, legal, psychological, anthropological, religious and other areas. In addition, the problem of violence, its prevention and the promotion of citizenship must be included in professional training⁽²⁾.

The occurrence of violence and accidents has transformed the profile of health problems in Brazil and the world. To address this problem, new approaches, which had not been addressed in the health sector until recently, are necessary. These approaches include lifestyle determinants and environmental and social conditions, thus increasing the longevity of the population and its effect on the quality of life. Even with the enactment of the National Health Policy for the Reduction of Accidents and Violence, the system has been slowly organized to address the needs that accompany problems while trying to fulfill the overall demand⁽³⁾.

Child abuse occurs mainly in the family environment, and it is a universal, endemic and complex event. It is one of the manifestations of domestic violence that occurs in the family environment, including other family relationships that extend beyond the home environment where the family resides⁽⁴⁾. Domestic violence is not a phenomenon restricted to certain social or economic classes⁽²⁾, and it generally affects more than one family member, although children have been shown to be primary victims because of their physical and character weaknesses⁽³⁾.

Consequently for the child, there are traits manifested during childhood, such as learning difficulties, and those that manifest during adult age, such as weak and insecure bonds, less frustration tolerance, aggression with peers and others, difficulty addressing their own emotions and the repetition of violence with other children. For example, these individuals can be violent with their own children, thus confirming that the phenomenon tends to be cyclical and affects subsequent generations. Considering that an individual acquires the notions of right, respect,

tolerance, self-esteem and the ability to resolve conflicts during childhood, children who have suffered some type of abuse or have not had relationship models that were beneficial for the formation of these notions may become abusive adults⁽⁴⁾.

Within the nursing context, vulnerabilities that involve children require systematic and routine care, which can be achieved by a nursing consultation because of its strong educational component and its potential to strengthen the bond between the users (children and their families) and professionals. The systematization of the nursing consultation assigns a scientific characteristic to the practice, thus allowing action not only in individual care but also promoting changes in the family environment and epidemiological profile of a community⁽⁵⁾.

Thus, the city of Curitiba (PR) was used as the setting for this study for two reasons. The first is the nursing care systematization using the International Classification of Nursing Practice in Public Health (Classificação Internacional das Práticas de Enfermagem em Saúde Coletiva – CIPESC[®]), which was available in the electronic medical records and could be accessed by all basic health units in the municipal system⁽⁶⁾. The CIPESC[®] is used to systematize nursing consultations, and its interventions follow municipal program activities, which are organized into technical protocols and manuals that are available to different health professionals within health teams⁽⁷⁾. Curitiba's Primary Care nursing is noted for its intensive health prevention and promotion, which goes from the identification of the population's needs to effective care⁽⁶⁾. However, the Basic Human Needs idealistic benchmark was used for the construction and organization of the CIPESC[®] nomenclature of nursing diagnoses and interventions, constituting the initial major conflict with public health benchmarks, which are based on dialectical and historical materialism.

The second reason is the existence of the Protection Network for Children and Adolescents at risk of violence, which aims to prevent and monitor violent cases that are identified by reporting facilities present in the city, such as health units, hospitals, day care centers and schools, among others. The flow of care planned by the Protection Network for confirmed or suspected cases includes evaluations from more than one provider, evaluations of historical occurrences, the presence of warning signs and the establishment of the severity level to outline the procedures to be adopted. According to the severity level (mild, moderate or severe), the actions might be specific and informative and inserted in normal or priority flow in care centers and social programs. The actions might also be a staff discussion regarding the case until the Child

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Protection Council or other child protection measures are involved⁽⁸⁾. The CIPESC[®] aggregates diagnoses and nursing interventions related to violent problems according to the Network Protocol.

Curitiba is noted for health policies designed to fulfill the health needs that arise from its epidemiological profile, aimed at ensuring the health of its population and promoting child development. In recent years, the city has managed to reduce the most important indicators of health, education, welfare, culture, recreation and development. For this purpose, Curitiba relies on the political organization and involvement of various professionals⁽⁹⁾.

A previous study⁽⁹⁾ showed that in nursing consultations using CIPESC[®], nurses did not use violence diagnoses at a similarly high rate as child abuse reported by the Protection Network. Therefore, we investigate how the nursing consultation systematized by CIPESC[®] recognizes and handles the phenomenon of child abuse. Thus, the present study aimed to identify the limitations and potential of using CIPESC[®] in nursing consultations with children who are victims of domestic violence.

METHOD

The present study is a descriptive case report study with a qualitative approach that emphasizes the results related to child abuse that emerged from a larger study regarding the potential and limitations of CIPESC[®] for recognizing and addressing children's health needs. The empirical data were collected from nurses in Curitiba's Primary Care facilities using a web-based instrument developed using the ASP.NET 3.5 framework. MySQL 5.1.30 was the database used.

For analysis, the results were organized and described according to the organization of the CIPESC[®] nomenclature, which groups the respective diagnoses and nursing interventions according to the affected need. These needs are divided into psychobiological and psychosocial categories⁽⁶⁾.

Neglect (Chart 1)

Chart 1 – The needs and nursing diagnoses selected in the neglect cases reported by nurses in Curitiba 2010

	Need affected	Nursing diagnoses
Psychobiological need	Growth and development	Inadequate child development Inadequate self-care Altered personal hygiene
	Skin and mucosal integrity	Compromised skin integrity in the child Contusion Burn
	Nutrition	Inadequate food intake in infants Risk of malnutrition
	Sleep and rest	Inadequate sleep
Psychosocial need	Self-image	Distorted body image
	Participation	Limited citizenship rights Inadequate coping
	Safety	Loneliness risk

Altogether, 412 nurses from Curitiba's municipal health system were invited via letter or e-mail to participate in the primary study from June to August 2010. Twenty-eight nurses responded to the invitation and 22 reported having experienced some violent situation against children or adolescents during nursing consultations; only 15 respondents described this situation. All reports were included in the analysis of the present study. The respondents were also asked to indicate the specific field in the nursing diagnoses and interventions of the CIPESC[®] nomenclature (available in the data collection instrument) that they considered appropriate. The respondents were also asked to indicate other needs that they considered important that were not included in the CIPESC[®] nomenclature. Web-based data collection was selected because the instrument could be easily accessed by the respondents and could provide diagnoses and nursing interventions in a tree format following the model adopted in the city's electronic medical records, thus making the instrument respondent friendly.

All ethical principles were preserved, and the project was approved by the Research Ethics Committees of the School of Nursing of the University of São Paulo (Escola de Enfermagem da Universidade de São Paulo – USP) and the Curitiba City Council under protocol numbers 829/09 and 69/09, respectively. The subjects were invited to participate in the study, and those who consented digitally signed the informed consent terms.

RESULTS

Use of CIPESC[®] in violent cases

The 15 cases of violence described by the respondents were grouped by the type of violence: neglect (5), physical (4) and sexual (6). None of the reports were specific for psychological violence, although this type of violence is believed to be present in the other violence types. Psychosocial and psychobiological needs were identified in all of the reports and for each type of violence.

The respondents did not select specific violence diagnoses, although they were present in the nomenclature. Some of the interventions focused care on the injuries caused by neglect, alternatives to solve family conflicts, monitoring and home visits. Only interventions, such as the investigation of possible neglect and its connection

with notifiable injuries, identified specific strategies for addressing violence; however, the cases were not notified and referred to the Protection Network. No other need was recognized other than those identified in the Curitiba CIPESC® nomenclature.

Physical Violence (Chart 2)

Chart 2 – The needs and nursing diagnoses selected in the cases of physical violence reported by nurses in Curitiba 2010

	Need affected	Nursing diagnoses
Psychobiological need	Environment	Risk for domestic accident - child Drug use
	Body care	Altered personal hygiene
	Skin and mucosal integrity	Skin abrasion Burn Compromised skin integrity in the child
Psychosocial need	Gregarious	Conflicted family relationship Conflicted bond
	Freedom	Impaired decision making

None of the selected diagnoses identified the violence situation that the child was exposed to or at risk of. The proposed interventions included specific care for injuries caused by aggression, recognition of family potential, identification of determinants of family conflict, incentive to change habits, identification of the support system, moni-

toring and home visits. Interventions for including the child or family in the Protection Network were not suggested, except for those that suggested investigating the possibility of neglect and connecting it to notifiable injuries. Based on these results, these children would remain unmonitored by the system, according to the respondents.

Sexual violence (Table 3)

Table 3 – The needs and nursing diagnoses selected in the cases of sexual violence reported by respondents in Curitiba 2010

	Need affected	Nursing diagnoses
Psychobiological need	Growth and development	Inadequate child development
	Skin and mucosal integrity	Compromised skin integrity in the child
	Environment	Drug use Risk for domestic violence Use of alcohol and other drugs Sexual abuse
	Perception	Pain
Psychosocial need	Gregarious	Conflicted family relationship Compromised mother-child bond
	Participation	Absent coping Inadequate coping Adequate coping
	Safety	Sadness Shame in women that were victims of violence

The sexual violence situations that were described prevailed quantitatively over the other situations. Specific violence diagnoses were observed, such as risk for domestic violence, sexual abuse and shame in women who were victims of violence. In two reports of explicit violence (a 15-year-old brother who sexually abused an 8-year-old brother and a situation of attempted abuse by another child), specific violence diagnoses were not selected, which suggested that the Protection Network was not notified, the Child Protection Council was not contacted and there were no referrals (as the municipal protocol suggests). In other reports, interventions attempted to overcome conflict by providing support, addressing the situation, home monitoring and an investigation of pos-

sible neglect, among other interventions, but without recording the notification. The diagnostics relative to other family members and the possible aggressor were also identified, such as in cases in which the report informed or suggested that alcohol or other drugs were used. Some diagnoses and interventions were specific of actions for women who were victims of violence. However, the diagnoses or interventions were selected for children, such as the diagnosis of shame in women that were victims of violence.

Among the other needs recognized by the respondents, the need for the proper investigation of sexual abuse, a technical report for evidence of abuse, immediate action of the Child Protection Council, legal protec-

tion support and psychosocial needs related to protection were also mentioned. The respondents suggested that other professionals, institutions, public agencies and parents may be the social subjects responsible for meeting the needs identified, which suggested intersectorality as a method of addressing violence. From another perspective, nursing professionals did not position themselves as social actors to address these needs.

DISCUSSION

The organization of the Protection Network for Children and Adolescents at risk of violence in the city of Curitiba has shown that violence visibility is the initial step to address this problem. The planned and implemented actions have not found sufficient space to reduce the indicators and modify the scenario identified. However, confronting violence is a sensitive issue because it involves different aspects of social life and requires interventions in many areas that extend beyond the health sector and its capacity for action⁽⁹⁾.

How health professionals approach situations of family violence against children and adolescents demonstrates their lack of preparedness, particularly in terms of identifying instances of violence, for example, if an omission is because of neglect or because the family has minimal economic resources. There is an attempt to medicalize this phenomenon because of the difficulty in addressing social aspects and health promotion. In addition, the professionals that are working with cases of violence must be cared for because of the intense emotional charge to which they are exposed and the absence of protection in cases of allegations of abuse⁽¹⁰⁾. The results of the present study show that a lack of preparedness also occurred in Curitiba because the perception of the interviewed nurses was limited to a few nursing diagnoses offered without a broad or deep approach to the topic. Of the 28 respondents to complete the study, 22 stated that they encountered cases of violence in professional practice, and only 15 described the situation. This participation also demonstrates that although violence is a topic that is common during nurses' routines, it is not treated with the appropriate seriousness or priority level based on the actions of the professionals interviewed.

Curitiba's CIPESC® nomenclature consists of diagnoses for recognizing violence and the interventions to address it. However, many interventions are diffused among diagnoses that suggest other processes and not specific violence diagnoses. This limitation prevents the identification of the problem and the continuity of care because the confrontation is not focused on specific diagnoses. Only half of the respondents who described violent situations acknowledged that there were other needs beyond those identified with Curitiba's CIPESC® nomenclature, and these involved other professionals from different areas but not the nursing staff explicitly.

Specific diagnoses that address the different aspects and needs of children, the aggressor and the family are necessary for violent situations.

The term neglect is difficult to define because it involves cultural, social and economic aspects of each family or social group. However, if treated as a form of violence, neglect allows the denaturalization of the power attitudes expressed in the absence of care and protection⁽³⁾. Although neglect is characterized by the omission of care for children by the family and society, it cannot be separated from the social problem represented by the parents' socioeconomic condition. Thus, intentionality is questioned⁽²⁾.

Neglect cases were the ones that most affected needs. Neglect is also the most common form of violence reported to the Protection Network. Thus, it is evident that neglect is the type of violence most recognized by professionals. An analysis of the reports from the Protection Network from 2004 to 2008 indicated an approximate 125% increase in the number of reported violent cases. Between 2004 and 2009, domestic or intra-family violence was the most frequent, and the most affected children were from 5 to 9 years old followed by children 10 to 14 years old. Neglect corresponds with the most commonly reported type of violence and accounted for 71.4% of the notifications from 2008 to 2011. In 2009, there were 338 (13.9%) reports of recurrent violence against children from birth to 9 years old among the 2,428 total notifications. Neglect appeared as the last notification in 65.3% of cases from a study sample that examined the evolution of recurrence⁽¹²⁾.

The needs affected in neglect cases were mostly psychobiological. The psychological exhaustion that interferes with the biological processes of child growth and development are more explicit. Psychological exhaustion directly affects the childcare practiced during consultations and health promotion actions and are more recognized by professionals. Nevertheless, the need relative to the environment, which includes violence diagnoses, was not triggered in neglect cases and did not produce diagnoses and interventions connected to notifications of the Protection Network.

Diagnoses related to physical violence report identified marks of physical aggression and family relationship conflicts as possible causes of violence. Similar to neglect cases, the proposed interventions did not suggest a notification of the Protection Network.

From the perspective of children and their families, domestic violence is a component of the family microsystem and is viewed as a common practice based on the belief in authoritarian values and the power of the parents over their children. The practice of punitive physical violence produces feelings of anger, hurt and humiliation in children⁽⁴⁾.

The use of force that causes physical violence may be associated with a cultural model that justifies and reinforces violence as a form of discipline, thus favoring the trivialization and chronicity of violence against children. Some observations may be associated with cases of physical violence, such as the precariousness of housing, personal hygiene, the absence of a feeding routine, rest and leisure. Disobedience is among the reasons for physical violence, and characteristics of the victim that displease the aggressor or the absence of acceptance of the victim within the domestic space are among the reasons for neglect⁽²⁾.

The consequences of child abuse can manifest themselves in different manners until adulthood, such as behaviors related to child abuse, psychiatric or behavioral disorders, transgressive behaviors and drug use. There is a higher incidence of physical violence against boys, sick children, and in families with numerous members or a concurrent history of violence between intimate partners⁽¹³⁾. Nationally, violence has previously been shown to affect children of both sexes, but different types of violence are observed for different sexes. For example, sexual violence is more frequent against girls and physical violence is more frequent against boys⁽¹⁴⁾.

The Protection Network considers any sexual violence as serious. In the reports, the respondents indicated specific diagnoses of violence in addition to diagnoses of bonding, coping and the use of alcohol and drugs⁽⁶⁾. Sexual abuse involves the practice of sexual games in homo- or heterosexual relationships intended to achieve sexual excitement and pornographic or sexually erotic practices. Studies show that girls are the most frequent victims and that the father is the primary aggressor followed by the stepfather and individuals who interact with the family. This form of violence negatively affects a child's life and may lead to important physical and emotional harm, such as delays in learning and development, behavioral disorders, social isolation, early sexualization and low self-esteem. Therefore, the consequences of abuse extend beyond the individual and become a form of impaired growth, development and integration of the child into healthy social relationships. Therefore, abuse compromises society itself⁽³⁾. Thus, understanding sexual abuse is not restricted to the victimizer and the victim because this would exclude the social contexts and groups where the abuse occurs, is hidden and occurs repeatedly.

The perception of health services users treated by the Family Health Strategy (FHS) regarding the Domiciliary Visit (DV) showed that this strategy facilitates access to the service and health actions because it mediates the relationship between the home and service. For users, the actions developed at home are a method of bringing the professional closer to the family dynamics so the most vulnerable families should receive greater support. Visits are expected to be more frequent and include actions of specialized doctors, whereas in practice, they have been performed by Community Health Agents (CHA) or, occasionally, another professional. However, compulsory and frequent visits are not desired because they are associated with the intrusion of the health sector into private life

when an imposing posture that devalues the knowledge and decisions of users is adopted in the educational practice of daily visits⁽¹⁵⁾.

The nursing consultation, when performed by well-trained professionals, is an important resource for detecting cases of violence because of the greater contact with the family and understanding the family dynamics, which is further enhanced by daily visits⁽¹¹⁾.

The CIPESC[®] showed potential in nursing consultations associated with cases of violence against children. However, the triggered diagnoses and interventions indicated an important gap in recognizing needs from the perspective of historical and dialectical materialism, which is the framework that anchors the principles of public health. CIPESC[®] organizes groups of needs following the theory of basic human needs, thus indicating the individuals and their needs and reducing them to isolated and markedly biological processes in practice. Even psychosocial needs are limited to isolated events that are not always articulated in the social context and reality of the subject or propose any change to this context. There is also a disarticulation between the triggered diagnoses and actions recommended by the Protection Network through the municipal protocol for recognition, reporting and monitoring of violent cases.

For public health, health needs are broad and embedded in a complex web of characteristics that comprise reality and directly affect the production and social reproduction time and satisfaction of needs. From this perspective, the phenomenon of violence extends beyond the physical marks and evidence of the various vulnerabilities and needs of the subject and his social group, which is larger than the phenomenon itself. Such vulnerabilities can be recognized during nursing care, particularly during the consultation if it is performed in a systematic manner and is theoretically informed by historical and dialectical materialistic references, which provides professionals a broad view of the reality in which they operate.

When studying the meaning assigned to the nursing consultations in childcare performed by the nurses of the FHS⁽⁵⁾, the authors suggest a search for comprehensive care, including physical examinations, anthropometric measurements and educational and preventive actions for children and caregivers. The nurses emphasize the importance of systematization as a manner of directing care, particularly for health promotion, favored by the moment of interaction and closer bonds with the users. However, there are moments of professional frustration when the professional encounters adverse family situations and feels powerless⁽⁵⁾.

Thus, the use of the CIPESC[®] alone does not ensure adequately systematized care. The tool requires prior knowledge of the nursing process, systematization of nursing care, theoretical frameworks of Public Health, technical scientific content specific for Primary Care nursing and institutional support for decision-making based on the needs identified in the consultation. The professional

training adjusted to the primary care model adopted is essential for quality care that transforms the reality in which it operates. It is not sufficient to use the tool as a mean of systematizing if the care does not fulfill the expectations and needs of the population.

CONCLUSION

Some authors argue that Curitiba is on the correct path: it uses intersectorality, prevention strategies and monitoring of confirmed cases of violence and reporting to identify the problem. However, as demonstrated by the present study, practice in the healthcare facilities might not be consistent with the perspective of the Protection Network. The diagnoses and nursing interventions that indicate the risk or occurrence of violence are not mentioned by all professionals, although reporting suspected and confirmed cases is compulsory. There is a weakness

in Curitiba's CIPESC® nomenclature identified in previous studies and confirmed in the present study: if professionals do not think that violence is a focus of their practice in a broad dialectic perspective based on objective reality (not only warning signs), vulnerabilities will not be recognized and the phenomenon will not be exposed in a manner that enables intervention.

It is important to contribute to the nomenclature attributes that are relative to freedom and autonomy, which are essential for addressing violence, in addition to evidence-based intervention methods.

It is important to promote debates and train health professionals about violence against children and adolescents so they can provide adequate care. It is also important to emphasize the importance of this problem with the initial training of health care staff so they are aware and can learn to address it in their daily care routines.

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