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Assistance provided by health professionals to women in situations of violence: a social representations study

Assistência de profissionais de saúde a mulheres em situação de violência: estudo de representações sociais

Asistencia brindada por profesionales de la salud a mujeres en situación de violencia: estudio de representaciones sociales

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ABSTRACT

Objective: to understand the contents included in the social representations of Urgency and Emergency health professionals about the assistance provided to women in situations of domestic violence and to discuss the health care practices for women in such situations. **Method:** a qualitative study, guided by the procedural approach proposed by the Theory of Social Representations and conducted between January and May 2023 with 40 professionals from the Urgency and Emergency sector of a public hospital, after due approval from an ethics committee. The data were collected by means of semi-structured interviews and processed in IRAMUTEQ. **Results:** health professionals' care practices are based on treating injuries, in referring patients and in notifying violence, and point to the need for guidance regarding the services that are available in the municipal care network. **Final considerations:** it is evidenced that the professionals ground their social representations about the assistance provided to women in situations of domestic violence on everyday elements and on normative and institutional practices.
Descriptors: Health Personnel; Hospital Care; Women; Domestic Violence.

RESUMO

Objetivo: compreender os conteúdos das representações sociais de profissionais de saúde da urgência e emergência sobre a assistência às mulheres em situação de violência doméstica e discutir a prática assistencial de saúde à mulher em situação de violência doméstica. **Método:** estudo qualitativo, orientado pela abordagem processual da Teoria das Representações Sociais, realizado com 40 profissionais do setor de urgência e emergência de um hospital público, entre janeiro e maio de 2023, após aprovação do comitê de ética. Dados coletados por entrevista semiestruturada e processados no *software* IRAMUTEQ. **Resultados:** as práticas assistenciais dos profissionais são pautadas no tratamento das lesões, nos encaminhamentos e na notificação da violência e apontam a necessidade de orientação sobre os serviços disponíveis na rede de assistência no município. **Considerações finais:** evidencia-se que os profissionais ancoram suas representações sociais sobre a assistência a mulher em situação de violência doméstica em elementos do cotidiano e em práticas normativas e institucionais.
Descritores: Pessoal de Saúde; Assistência Hospitalar; Mulheres; Violência Doméstica.

RESUMEN

Objetivo: comprender el contenido de las representaciones sociales de los profesionales sanitarios de urgencias sobre la asistencia a las mujeres en situación de violencia doméstica y discutir la práctica de atención a la salud de las mujeres en situación de violencia doméstica. **Método:** estudio cualitativo, guiado por el enfoque procedimental de la Teoría de las Representaciones Sociales, realizado con 40 profesionales del servicio de urgencias de un hospital público, entre enero y mayo de 2023, previa aprobación del comité de ética. La recolección de datos se realizó mediante entrevistas semiestructuradas y el procesamiento de datos por medio del *software IRAMUTEQ*. **Resultados:** las prácticas asistenciales de los profesionales se basan en el tratamiento de lesiones, derivaciones y denuncias de violencia e indican la necesidad de orientación sobre los servicios disponibles en la red de atención del municipio. **Consideraciones finales:** es evidente que los profesionales anclan sus representaciones sociales sobre la atención a las mujeres en situación de violencia doméstica en elementos cotidianos y en prácticas normativas e institucionales.
Descriptores: Personal de Salud; Atención Hospitalaria; Mujeres; Violencia Doméstica.

INTRODUCTION

Domestic violence includes various violent actions driven by gender inequalities, encompassing its physical, psychological, sexual, moral and patrimonial forms put into practice by a woman's relative or acquaintance, regardless of living together or not[1]. The repercussions of this violence can seriously endanger women's physical integrity, evidenced as injuries in the face, thorax and spinal cord, as well as traumatic brain injuries, which frequently require urgency in-hospital assistance[2].

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Gender-based violence stands out in the guidelines defining public policies; it is a problem that can affect both women's and their family members' health, with repercussion that can be reversible or irreversible and which is present in different societies and social classes, with the possibility of also including negligence[3].

Historically, men have been assigned family-related decision making. Consequently, socially-constructed roles influenced by culture and religion imply the conception that men hold power over women, with the right to subdue and oppress them, perpetrating violence against them in several ways[4].

With the objective of contributing to facing this problem, Law No. 11,340 (dated August 7th, 2006) was created in Brazil (known as the Maria da Penha Law) and is considered an important legal framework to prevent and cope with domestic violence. With that law as a starting point, a number of legal mechanisms were created to inhibit acts of domestic violence against women in Brazil[1].

When seeking care for the injuries arising from violence, women may not reveal to the professionals that the assaults are the reason for their health status[5], with the need for multiprofessional teams to be on the alert to identify situations of domestic violence, in addition to making the necessary referrals for women to be assisted in their needs. Especially in their Urgency and Emergency sector, hospitals are characterized by a busy routine with a large demand of patients and professionals working their while experiencing an exhausting work routine[6].

In addition to that, domestic violence against women is underpinned by symbolic and socio-cognitive processes that influence how this phenomenon is perceived in society. Cultural representations frequently associate women with frailty, submission and dependence; in turn, they attribute an authority and control stance to men. These processes can contribute to accepting violence, rendering it invisible or tolerable in various contexts, including institutions. In the health field, these social representations can affect the way in which professionals recognize, welcome and refer women, highlighting the need to review imageries that blame women and minimize severity of the assaults[2].

Beyond the work routine, the assistance provided by health professionals to women in situations of domestic violence is influenced by their social beliefs, values and traditions[7], associated with all the scientific knowledge they have acquired throughout their careers. In this context, the concern for this study was based on the following guiding question: "How do health professionals represent the assistance provided to women in situations of domestic violence?".

Thus, the objective was to understand the contents included in the social representations of Urgency and Emergency health professionals about the assistance provided to women in situations of domestic violence and to discuss the health care practices for women in such situations.

THEORETICAL FRAMEWORK

Serge Moscovici's Theory of Social Representations (TSR) was chosen as guiding framework in this study due to understanding that it enables appropriating the study object with the aim of understanding it better. For Moscovici, the complexity inherent to the notion of social representations is easy to understand, but not its concept. Moscovici was always reluctant to present a precise meaning of social representations for considering that any attempted definition might result in reducing their conceptual scope[8].

Based on the knowledge shared by health professionals and their care practices, it is possible to find out how common sense and experiences are associated with scientific knowledge and shape the social representations about the assistance provided to women in situations of domestic violence.

Among the TSR approaches, the procedural one was chosen to ground this study, as it allows understanding the dynamic processes through which social representations and constructed, transformed and shared by people in their social and professional contexts[9].

METHOD

This is a descriptive and exploratory study of a qualitative nature, grounded on the TSR and focused on its procedural approach, followed the *Criteria for Reporting Qualitative Research* (COREQ) guidelines. The approach allowed understanding how health professionals represent the assistance provided to women in situations of domestic violence, integrating subjective and normative elements. This approach considers social representations as the study of the processes through which people represent the world[8,9].

The study was conducted in a medium- and high-complexity regional public hospital located in southern Bahia, Brazil. The participants were 40 health professionals from the Urgency and Emergency sector, selected for convenience. The inclusion criteria considered professionals with permanent or contractual employment and previous

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experience in caring for women in situations of domestic violence. The professionals excluded were those that were away from work due to leaves or vacation during the data collection period.

Data collection was in charge of first author (MSc student in Health Sciences) and of the second author (MSc in Nursing), both with previous experience in qualitative research studies. The researcher in charge had no previous relationship with the participants and was introduced to them at the approach in the hospital. All explanations regarding the study objectives, relevance and methodology were provided beforehand, ensuring a relationship marked by trust. The rest of the research team (comprised by PhDs in the Nursing area) took part in planning, analysis and discussion of the results.

The data were collected in-person between January and May 2023 by means of semi-structured interviews conducted individually at a private room in the hospital. In addition to that, a sociodemographic questionnaire was applied to characterize the participants' profiles. The researcher introduced herself at the first contact with the professionals, explained the research objectives and that participation would be voluntary, ensuring secrecy and anonymity. All the participants signed a Free and Informed Consent Form.

The interviews followed a script that was structured with open questions exploring conceptions, knowledge and care practices related to domestic violence. All the interviews were recorded and lasted a mean of ten minutes. Data saturation was reached in interview number 35; however, another five interviews were conducted to confirm saturation of the findings.

The text data were processed in IRAMUTEQ® *(Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*), which is anchored in the R software and allows performing different statistical analyses on a given text *corpus*, tables, individuals and words[10].

The Descending Hierarchical Classification (DHC) or Reinert's method was used in this study to process the data, as it allows grouping the statistically significant words and performing a qualitative data analysis. This method allows obtaining Text Segments (TSs), which are grouped into different classes based on their similarity. The association between each TS and the classes is established by means of the Chi-square test: the lower the value, the lower the association[10].

From the processing phase, the software illustrates the data analysis in a DHC dendogram, which organizes the associations between the classes and makes their most characteristics TSs available[10]. The software processed the *corpus* in 58 seconds; the analysis of the results stage was carried out immediately after the processing phase, interpreting and discussing the findings based on the TSR.

The research protocol respected resolutions No. 466/2012 and No. 510/2016 from the National Health Council, with due approval by the Research Ethics Committee. The study participants were explained the research content and objectives, as well as about their voluntary participation and regarding secrecy and anonymity warranties by reading and signing the Free and Informed Consent Form. With the objective of ensuring anonymity, the professionals' testimonies were identified with the word “Participant”, followed by numbers from 1 to 40 representing the order of the interviews and of the professional categories.

RESULTS

In Social Representations studies, it is fundamental to know the belonging groups. Thus, the study participants were 40 health professionals: 29 females and 11 males; their age varied from 22 to 70 years old and 26 self-declared as brown-skinned. As for religion, 30 participants self-declared as Catholics, there were nine Protestants and one subject stated professing no religion. Regarding marital status, 24 were married or were in stable unions, 10 were single and six were divorced

In relation to professional categories, there were 15 nurses, 11 nursing technicians, nine physicians, three physical therapists and two social workers. Among the participants, 26 professionals reported having some specialization, 13 did not attend graduate programs and one subject reported being a PhD. As for time since training, it was from 5 to 10 years in the case of 27 professionals. Only one participant reported having attended a training course to assist women in situations of domestic violence.

A total of 279 TSs were obtained from the lexical analysis performed in the data treatment phase. Of them, 227 were analyzed, thus representing 81.36% leverage of the submitted material. Consequently, the *corpus* presented 1,556 forms, with 9,756 instances, and word lemmatization obtained a total of 1,026 with 934 active and seven supplementary forms. The DHC method was applied from matrices crossing TSs and words based on similarity of their contents, obtaining six classes divided into two thematic axes.

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At a first moment, the DHC generated presented a text *corpus* divided into two subgroups, called Axis A and Axis B. For this study, we focused on the analysis of Axis B comprised by classes 3 and 4 (Figure 1). The division of the respective classes is made by words based on their frequency, as well as on an indication of the significance degree of the words with highest affinity with the class.

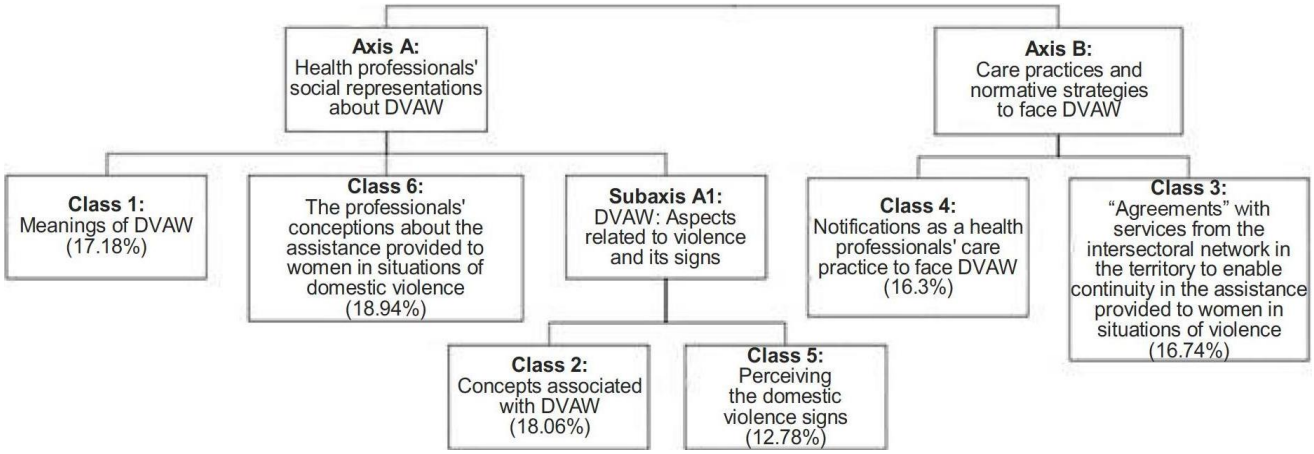

Figure 1: Distribution of the thematic classes into axes according to the Descending Hierarchical Classification. Itabuna, BA, Brazil, 2023.

Axis B enabled understanding the care practices and normative strategies devised to face domestic violence against women, based on the elements comprising Class 3 ("Agreements" with services from the intersectoral network in the territory to enable continuity in the assistance provided to women in situations of domestic violence) and Class 4 (Notifications as a health professionals' care practice to face DVAW). The words or terms that comprised classes 3 and 4 and which were analyzed presented Chi-square (x^2) values between 140.20 and 20.91.

Axis B: Care practices and normative strategies to face domestic violence against women.

The contents gathered in Axis B present how the thought related to the practical dimension of health professionals' social representations about the assistance provided to women in situations of domestic violence is elaborated, in a way that contributes elements from the professionals' practical thinking through their behaviors and attitudes, as well as through the norms established by health services.

The analysis of the axis evidenced that, during the assistance provided to women in situations of domestic violence in the urgency and Emergency sector, health professionals play an important role in facing and preventing DVAW, as they provide guidelines and make referrals for women to feel welcomed at this first moment and strengthened to seek help to cope with the repercussions of the violent situation experienced.

Class 3: "Agreements" with services from the intersectoral network in the territory to enable continuity in the assistance provided to women in situations of domestic violence

From the Class 3 analysis, the most significant words were as follows: agreement (x^2=140.2), service (x^2=120.5), refer (x^2=96.59), have (x^2=90.72), Women's Police Station (x^2=90.72), hospital (x^2=44.44), know (x^2=33.93), place (x^2=33.41) and CERPAT (x^2=30.65), among others.

These elements indicate that when faced with situations of violence, in addition to treating the injuries arising from violence, the professionals from the unit seek to refer women to other services from the intersectoral network, which can be corroborated in the following excerpts:

> *I refer the victim to the Women's Police Station in case she wants to file a report, there is the Women's Shelter and the Reference Center for Women's Care [Centro de Referência de Atendimento à Mulher, CRAM] in the city downtown, the hospital doesn't have an agreement but the social service refers the women who wish so to the protection services, we don't have much to do here, we're a hospital, we only treat injuries as they come. (Participant 10, Social worker; Score: 629.94)*

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> *Depending on the victim's requirement, I can refer her to the Women's Police Station in case she wants to file a report, to the Reference Center for Women's Care [Centro de Referência de Atendimento à Mulher, CRAM], there's also the Specialized Social Assistance Reference Center [Centro de Referência Especializado de Assistência Social, CREAS], I always refer to the Women's Shelter here in the city, for sexual violence cases we have the Prevention, Assistance and Treatment Reference Center [Centro de Referência em Prevenção, Assistência e Tratamento, CERPAT] for HIV/AIDS and Hepatitis. The Municipality offers other services such as the Women's Health Reference Center, in addition to agreements with social assistance services, all these services from the network are linked to welcome victims of violence, the professional that treated the injuries only has to refer the woman, we treat wounds here, we indicate surgery if necessary (Participant 13, Nurse, Score: 549.96)*

> *I apply dressings when necessary, I always advise the victim to resort to the Women's Police Station in case she wants to file a report, I know about the Maria da Penha Patrol from the Military Police and it works really well in monitoring the victims here in the city, when violence is more than evident, we call the Military Police, there's not much to do in the hospital. (Participant 16, Nursing technician; Score: 655.46)*

> *I always refer the victims to the Women's Police Station, to the Prevention, Assistance and Treatment Reference Center [Centro de Referência em Prevenção, Assistência e Tratamento, CERPAT] for HIV/AIDS and hepatitis, in sexual violence cases, our Municipality should ease access to psychological assistance for victims of violence, I usually refer them to the basic units in their neighborhoods so that nurses refer them to Psychology services, I think the hospital's only agreement is with the CERPAT to refer sexual violence victims. (Participant 18, Nurse, Score: 549.96)*

Some of the professionals' testimonies allow noticing the need for services to provide guidance about the network places that provide assistance to women in situations of domestic violence.

> *I believe that the hospital has agreements, I don't know with which services but I believe that there is an agreement and that the social service makes the referrals, coordinators should provide guidance about these services to the whole team (Participant 27, Nursing technician; Score: 637.15)*

> *I don't know any service to refer domestic violence victims, I also don't know if the hospital has any agreement with welcoming services for victims but, If it doesn't have it, it should start formalizing those agreements and guide us even for professionals to refer more confidently. (Participant 31, Physician, Score: 556.49)*

Class 4 - Notifications as a health professionals' care practice to face DVAW

Class 4 was comprised by the following expressions: notification form (x^2=84.33), know (x^2=71.66), notify (x^2=36.37), hospital (x^2=33.34), in-hospital surveillance center (x^2=26.25), fill-in (x^2=25.51) and nursing technicians (x^2=20.91), among others.

The study findings in this Class evidence that the health professionals' care practices played an important role to identify and fight against DVAW by filling-in notification forms as a first step, as can be verified in the reports below:

> *Notification forms are important to provide diverse information to put an end to violence against women, the first time I saw the form was during an internship and I always tell the nurse to fill it in when I know that a given woman is a victim of violence, it's one of the first things I do. (Participant 7, Nursing technician; Score: 421.92)*

> *Here we notify the domestic violence cases, I don't have much access to the forms here in the hospital; in general, it's the In-hospital Surveillance Center staff that notifies, I know that any professional can do it now, but I'm a nursing technician, when I learn about some case I tell my nurse to notify or let the hospital's Surveillance are know, I know that notifications are a way to help fight against violence. (Participant 12, Nursing technician; Score: 288.48)*

> *I'm familiar with mandatory notification forms to report domestic violence, I always fill it in when I know that a given woman has been a victim of violence, I know they're an important tool to fight against violence. Here in the hospital, filling the forms in is up to the multiprofessional team: nurses, physicians, social worker, nursing technicians or the In-hospital Surveillance Center staff can do it. (Participant 13, Nurse; Score: 370.31)*

> *We always notify here, it's one of the first things we do the minute we know it's about violence, it's a way to help victims in ensuring their rights. The hospital always surveys the investigations and we always notify. In the state-level meetings, our hospital is praised as one of the units that most reports domestic violence; most of the times it's the In-hospital Surveillance Center that notifies here, but any professional can do it, the Emergency sector identifies the case and it goes to In-hospital Surveillance from there. (Participant 29, Nurse; Score: 291.04)*

However, even if it health professionals' ethical and legal duty, some participants reported not being familiar with notification forms or having doubts related to which professional should fill them in at the hospital unit, as can be seen in the following testimonies:

> *I know there's a mandatory notification form for domestic violence cases, I never stopped to read it or took any with me but I know they have it here in the hospital because a nurse comes every day asking if any there's any case of*

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> *violence, I know the form is important but that part is more targeted at Nursing, I think nurses can fill it in. (Participant 6, Physical therapist; Score: 316.24)*
>
> *Here in the hospital, the only form I know is the one used in releasing post-exposure medications for HIV [Human Immunodeficiency Virus], nobody showed me the notification form, I don't know if we have this form in the hospital, if we do, it should be up to the In-hospital Surveillance Center. (Participant 12, Nursing technician; Score: 288.48)*
>
> *I'm not familiar with the notification form; if there is such a form here in the hospital, nobody ever showed it to me, I'm not aware of how important that form is. (Participant 27, Nursing technician; Score: 370.78)*
>
> *I'm not familiar with the notification form, nobody ever showed it to me since I work here, I've worked as a nursing technician in another hospital for more than 20 years and I also have never had that form. (Participant 30, Nurse; Score: 352.90)*
>
> *Notification forms are extremely important to fight against violence and prevent it, it helps protect the victims, I never saw one here but I know they're mandatory in the whole hospital, I don't know who fills them in, perhaps the screening nurses that welcome women as they arrive. (Participant 34; Social worker; Score: 299.68)*

Based on the participants' reports, it was noticed that the professionals need more knowledge about DVAW mandatory notification; in addition to that, they need to feel supported and sensitized to identify and report suspected or confirmed DVAW situations.

DISCUSSION

For the participants included in this study, the contents of the social representations about the assistance provided to women in situations of domestic violence are targeted at treating the physical injuries, at the referrals to network services and at notifying violence, which shows the practical dimension of the representations.

Health professionals' practice is important to identify possible domestic violence cases among the women that seek assistance in health services. Despite the magnitude of DVAW, there are no reports by the professionals taking part in this study about strategies to prevent violence, only care measures for women who have suffered some type of assault[11].

This fact can be attributed to the intense work routine imposed on the professionals working in the Urgency and Emergency sector, given overcrowding of patients in the units and deficits in the infrastructure, in addition to stressful situations and insufficient staffing[6].

In one of the reports it can be seen that only the physical injuries caused by domestic violence are treated during the assistance provided, corroborating the findings of another study that reports Emergency assistance to women victims of violence as care which should prioritize treating the injuries by implementing care measures restricted to healing the traumas[12].

In this sense and based on the work process, the participants guide and refer women in situations of domestic violence to the network protection services they know about. The professionals state that the interventions performed during urgency care are insufficient for women to overcome domestic violence and that it is necessary to refer them to other services to enable care continuity.

The professionals' conceptions about the care network for women in situations of domestic violence are related to the articulation of a broad set of services of an intersectoral nature. Some of these services are as follows: Health Secretariats, Basic Units, Social Assistance Secretariat, Police Station Specialized in Women's Care (*Delegacia Especializada de Atendimento à Mulher*, DEAM), Specialized Social Assistance Center (*Centro Especializado de Assistência Social*, CREAS) and Support Shelters[13].

Consequently, this articulation among the network services for the assistance to women in situations of violence needs to be mediated by collective communication and contact with the professionals, including the institutional definitions of the roles that each service can play during the care provided[13].

In this sense, a study conducted with community health agents revealed that these professionals build their representations about domestic violence based on the types of violence and on women's affective ties and social/family contexts, which strengthens their performance in preventing, identifying and referring cases. Such social representations guide practical behaviors and reflect the importance of the link between territory, welcoming and intersectoral performance[14].

This perspective evidences that the care provided to women in situations of violence should not be limited to immediately healing the physical injuries; it requires a comprehensive approach that takes into account the meanings attributed to violence, the social conditions involved and access to an effective protection network.

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In addition to that, in the professionals' testimonies it can be noticed that some referrals are made based on women's intention to file a report or seek help. A study conducted with Primary Health Care (PHC) professionals evidenced that the assistance they provide is guided by women's will and that, in those situations in which the victims do not want to file a Police report or choose to withdraw it, the professionals consider their performance as ended[11].

Even if linked to women's autonomy, this behavior can reflect social representations that move violence to the victims' private scope, weakening institutional accountability. Traditional conceptions of male power continue to legitimize aggressive behaviors, making domestic violence be treated as an intimate problem and not as a violation of women's rights[15].

It is verified that some professionals are not aware of the Municipal network services to refer women victims of violence, which gives rise to the need to train and sensitize the entire multidisciplinary team to provide adequate assistance to women in situations of violence, not limiting care to treating physical injuries and lacking the necessary referrals given the situation[12].

In view of this, health units are essential to identify DVAW because, in theory, they offer assistance and care to women, with the possibility of identifying and notifying these events before more severe consequences arise. Even with the busy routine in health services, the professionals involved in care need to be on the alert to notify suspected or confirmed violence cases[16].

However, when violence is only understood because of its physical signs (such as visible injuries), its detection becomes limited[17]. Social representations centered on physical violence hinder recognizing more subtle forms like psychological violence, neglecting important signs and delaying adequate care.

This limitation in recognizing the various forms of violence reinforces the importance of notifications as a visibility and coping instrument. In this context, since 2003 Law No. 10,778 makes notification of domestic violence mandatory and reasserts the relevance of records in the assistance provided by health professionals to the women arriving at public and private health services due to this complex problem[18]. In addition to that, health professionals should notify violence regardless of women's consent or their family members'[19].

By filling in a notification form, data are collected that contribute to understanding violence and to devising public policies targeted at preventing and facing this phenomenon. The current study showed that the participants acknowledge notifications as a resource to protect and ensure the right of women subjected to violence.

However, it is also noticed that some professionals are unaware of DVAW as a mandatory notification problem, have had contact with notification forms and have doubts as to how to fill them in or to which professionals should notify, which contributes to DVAW under-reporting. In addition to that, it is to be acknowledged that the professionals are afraid of been retaliated against by the aggressors, which can lead to not filling in notification forms[20].

In view of this, under-reporting seems to contribute to the relative invisibility of DVAW; therefore, it is necessary to implement training and qualification sessions during technical and undergraduate courses, in addition to permanent health education activities to improve health professionals' performance[21].

In this context, a study conducted in Turkey also discusses the need to train health professionals for them to assist women victims of domestic violence, evidencing that the professionals find difficulties notifying cases and making the necessary referrals[22].

In Brazil, this weakness also emerges even in women's social representations, associating institutional assistance (especially from the Police), fear-related experiences, insecurity and embarrassment. Such perceptions expose structural failures in the services, which not always welcome their life experiences or needs, indicating the urge to review care practices and relationships[23].

That reality is also reflected in the care practices witnessed in the current study. Based on the representational elements, it is verified that part of the professionals are unaware of the notification forms in the care practices and that, although they understand the need to refer women to some protection service, they also do not know the services available in the Municipal network.

Based on these practices, it is possible to understand how certain social representations work in care organization. In light of the TSR, the professionals' performance described in this study is grounded on representations that attribute meaning and legitimacy to the way in which domestic violence against women is recognized and faced in health services.

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In this context, the professionals' social representations do not merely shape their perceptions regarding domestic violence but also exert a direct influence on the intervention modalities adopted in health services. Valuing referrals as the main response, centering care on the physical manifestations of violence and scarce familiarity with mandatory notifications reveal ways of thinking that naturalize fragmented and disarticulated network actions. This collective imagery reinforces a performance logic that, although with good intentions, tends to minimize the complexity inherent to the phenomenon and to render other dimensions of violence invisible, such as psychological emotional and institutional.

Study limitations

The intense and unforeseeable routine in the Urgency and Emergency sector (marked by high demand and work overload) limited the professionals' availability to take part in the research, which can imply a potential selection bias.

FINAL CONSIDERATIONS

The professionals ground their social representations about the assistance provided to women in situations of domestic violence on everyday elements and on normative and institutional practices. In the study context presented, the professionals' representations are influences by their social values, personal experiences and professional knowledge acquired throughout their careers.

It is verified that the professionals understand that the care provided in the in-hospital unit is insufficient for women to overcome the situation of violence undergone and condition the assistance provided to women's willingness to prolong it or to be referred.

However, the team's lack of knowledge in relation to the service network and to filling in notification forms results in negative consequences such as DVAW under-reporting in the unit. Based on the representational content learned, there is a clear need for debates among multiprofessional team members and for training sessions on the assistance to be provided to women victims of violence to improve strategies targeted at identifying and facing domestic violence against women.

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Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Assistance provided by health professionals to women in situations of violence: a social representations study*".