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RESEARCH ARTICLE (ORIGINAL)

Perceptions, beliefs, and knowledge of family health nurses about domestic violence: An exploratory study

Perceção, crenças e conhecimentos dos enfermeiros família sobre violência conjugal: Um estudo exploratório

Percepción, creencias y conocimientos de los enfermeros de familia sobre la violencia conyugal: Un estudio exploratorio

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Abstract

Background: Domestic violence (DV) constitutes a public health concern, and nurses' beliefs and knowledge influence their intervention.
Objective: To analyze the perceptions, beliefs, and knowledge of family health nurses (FHN) about DV.
Methodology: Observational, descriptive, and correlational study applied an online questionnaire to a non-probabilistic sample of 98 FHNs, including scales on perception, beliefs, and knowledge about DV.
Results: In a DV situation, most FHNs (78%) refer the victims to other professionals, and only 16% report the crime. Only one third of FHNs had specific training in this area and identified as barriers to their intervention, the lack of theoretical and technical training and inadequate health unit organization. Globally, FHNs showed a low level of beliefs (1.44 ± 0.45) and acceptable knowledge (2.9 ± 0.41). There was a significant correlation between the male gender and the level of beliefs about DV.
Conclusion: FHNs deal with DV situations but training and favorable conditions in health units are necessary to intervene effectively.

Keywords: domestic violence; intimate partner violence; culture; family nursing; primary health care

Resumo

Enquadramento: A violência conjugal (VC) representa um problema de saúde pública, sendo a intervenção dos enfermeiros influenciada pelas suas crenças e conhecimentos.
Objetivo: Analisar as perceções, crenças e os conhecimentos dos enfermeiros de família (EF) sobre a VC.
Metodologia: Estudo observacional, descritivo e correlacional, partindo de uma amostra não probabilística de 98 EF, através de questionário *online*, utilizando escalas sobre perceção, crenças e conhecimentos sobre VC.
Resultados: Numa situação de VC, a maioria dos EF (78%) encaminha as vítimas para outros profissionais e apenas 16% faz a denúncia. Um terço dos EF fez formação nesta área. Como barreiras para a sua intervenção, identificaram a falta de preparação teórica e técnica e falhas ao nível da organização das unidades de saúde. Globalmente, apresentaram baixo nível de crenças (1,44 ± 0,45) e conhecimentos aceitáveis (2,90 ± 0,41). O sexo masculino influenciou significativamente o nível de crenças sobre VC.
Conclusão: Os EF percecionam situações de VC, contudo necessitam de formação e de condições favoráveis nas unidades de saúde para intervirem de forma efetiva.

Palavras-chave: violência doméstica; violência por parceiro íntimo; cultura; enfermagem familiar; atenção primária à saúde

Resumen

Marco contextual: La violencia conyugal (VC) representa un problema de salud pública, y la intervención de los enfermeros se ve influida por sus creencias y conocimientos.
Objetivo: Analizar las percepciones, las creencias y los conocimientos de los enfermeros de familia (EF) sobre la VC.
Metodología: Estudio observacional, descriptivo y correlacional, basado en una muestra no probabilística de 98 EF, en que se usó un cuestionario en línea, con escalas sobre percepción, creencias y conocimientos acerca de la VC.
Resultados: En una situación de VC, la mayoría de los EF (78%) derivan a las víctimas a otros profesionales y solo el 16% lo denuncia. Un tercio de los EF han recibido formación específica en este ámbito. Como obstáculos a su intervención, señalaron la falta de preparación teórica y técnica, y las deficiencias en la organización de las unidades sanitarias. En general, presentaban bajo nivel de creencias (1,44 ± 0,45) y conocimientos aceptables (2,90 ± 0,41). El sexo masculino influyó significativamente en el nivel de creencias sobre la VC.
Conclusión: Los EF detectan situaciones de VC, pero necesitan formación y condiciones favorables en las unidades sanitarias para intervenir eficazmente.

Palabras clave: violencia doméstica; violencia por la pareja; cultura; enfermería familiar; atención primaria de salud

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Introduction

Domestic violence (DV) is considered a matter of public health. According to data from the annual report of the Victim Support Association (APAV), DV is the most frequent criminal offence committed against individuals in Portugal, with 19,846 cases reported, accounting for 76.8%. A majority of victims were women, with a total of 10,308 cases, or 77.9%. Nonetheless, there has been a surge in the number of male victims, with 2601 cases, or 19.6%. The majority of victims and perpetrators in both cases fall within the 25-54 age range. Around 40% of cases involve an intimate relationship between the perpetrator and victim, according to APAV (2021).

Health services are a preferred location for identifying incidents of sexual violence, and for many victims, they provide a convenient place to receive support and information (Plataforma Portuguesa para os Direitos das Mulheres [PPDM] 2017). As such, and considering that it is a public crime, health professionals have a central role to play in detecting the risk of DV and, specifically in the context of primary health care (PHC), they must act in early detection, develop a systemic family intervention and be trained to act.

However, IGAS data reveals that health services' reporting of these situations is still inadequate, recommendations are ignored, and professionals are insufficiently sensitized to this systematic and effective assessment (IGAS, 2020). Limited recognition of violence is apparent from studies that only identify physical signs, both in hospital emergencies (Durham-Pressley et al., 2018) and in PHC (Oliveira et al., 2020; Sousa et al., 2021). Health professionals' personal perceptions and beliefs regarding violence (Mendes, 2016) and insufficient preparation also affect the interventions used for victims (Fisher et al., 2020; McLindon et al., 2019). In PHC, family health nurses (FHNs) are integral in identifying and referring cases of DV due to their expertise in family assessment and intervention. This places them in a favourable position to screen and monitor these cases due to their direct contact with victims and families, making them significant in preventing and detecting them early. Nevertheless, FHNs' approach to these patients and families may be influenced by their perceptions, beliefs, and knowledge. Therefore, this study sought to examine FHNs' perceptions, beliefs, and knowledge regarding DV and to investigate the potential influence of sociodemographic and professional factors on these perceptions and beliefs.

Background

DV is defined as violence perpetrated by a partner or spouse that causes physical, sexual or psychological harm and can take various forms, including physical, sexual, emotional, psychological, and economic (Direção-Geral da Saúde [DGS], 2016). It typically follows a cyclical pattern, known as the cycle of violence, which was identified by Lenore Walker (1979; DGS, 2016). The cycle includes: (i) a tension-building phase, (ii) an acute explosion phase, and (iii) a honeymoon phase. This pattern of behavior brings about numerous repercussions for both the victims and the entire family system. These consequences are related to health and socio-economic factors, including joblessness, higher healthcare expenses, and the encouragement of isolation within both the social and familial spheres (DGS, 2016).

Erroneous beliefs rooted in society and families often contribute to the excusability and increased prevalence of violence (Faria, 2019). Such beliefs tend to blame the victims, downplay the perpetrator's responsibility and culpability, and undermine the gravity of violent acts. These beliefs remain widespread in the general population, especially among men with lower education and socioeconomic status (Faria, 2019). The study by Mendes (2016) conducted with doctors and nurses reports that men exhibit more legitimation and trivialization of DV compared to women. The results demonstrate that male professionals have higher tolerance towards violent acts, tend more to blame the victim, and carry beliefs that attribute violence to external factors such as substance abuse, unemployment and stressful family life.

These beliefs about DV, which are also present among health professionals, hinder its signalling and reporting, preventing timely intervention (Durham-Pressley et al., 2018). These authors showed that health professionals in emergency departments had misconceptions about DV, with the majority of nurses (60.9%) failing to identify patients who were victims of DV and reporting inadequate knowledge about DV (36.1%). Fisher et al. (2020) also found a lack of knowledge among 76% of hospital health professionals, highlighting that 34% of them did not know how to respond. Regarding the approach and specific skills of health professionals, 72% reported having little or no training that would allow them to have confidence and knowledge of specific clinical skills on how to act in cases of violence (McLindon et al., 2019). In the specific context of PHC, a study with nurses showed that the recognition of cases of violence and the identification of signs and symptoms during care practice was favored by the relationship of bonding and closeness with patients and by qualified listening, and that in addition to the more clinical and curative approach (in the face of physical signs), nurses made referrals to other family support teams and/or to secondary health care (a more specialized level of care; Sousa et al., 2021).

The lack of knowledge about violence, and the lack of training during their academic career, is also pointed out by health professionals (Alshammari et al., 2018; Oliveira et al., 2020), reinforcing the need for theoretical and technical training for nurses to enable them to deal with, recognize and identify victims of violence. In addition, fear of offending and refraining from value judgements, intrusion and a lack of communication skills seem to be limiting factors for a more effective intervention (Alshammari et al., 2018; Oliveira et al., 2020).

Regarding the most common difficulties, constraints, and barriers faced by health professionals in the health services, the literature emphasises the following: insufficient privacy for victims during care and referrals (Durham-

-Pressley et al., 2018); inadequate knowledge and training regarding DV (Durham-Pressley et al., 2018; Oliveira et al., 2020); and absence of dedicated spaces to deal with such cases (Durham-Pressley et al., 2018; Oliveira et al., 2020). 2020); the absence of intervention protocols and regulations (Durham-Pressley et al., 2018); lack of specific spaces to address these cases (Durham-Pressley et al., 2018); absence of action protocols and regulation of intervention (Oliveira et al., 2020); and the occurrence of possible aggressors when approaching and contacting potential victims, along with their expressed fear, as well as time limitations (Fisher et al., 2020). Given the limited national studies in the context of PHC, coupled with the vital roles of family assessment tools and the close professional-family relationship, it is crucial to ascertain the perceptions, beliefs, and knowledge of professionals regarding DV to enable effective training and action strategies in such situations.

Hypotheses

H1- Sociodemographic characteristics (*e.g.* age, gender, marital status) significantly influence FHNs' perceptions, beliefs, and knowledge about DV;
H2- Professional variables (e.g. length of professional experience, academic qualifications and training in the field of violence) have a significant influence on FHNs' perceptions, beliefs, and knowledge about DV.

Methodology

An observational, cross-sectional descriptive-correlational study was carried out. The population of this study was 245 nurses working in Family Health Units (USF) or Personalized Health Care Units (UCSP) of the Baixo Mondego Health Center Group (ACeS BM). A non-probabilistic purposive sample was used, with the inclusion criterion being nurses working in USFs and UCSPs in the ACeS BM, while nurses working in other units (*e.g.* Community Care Units and Public Health Units) were excluded. The sample consisted of 98 FHNs, with a response rate of 40%, given that for a sample of less than 500 participants, response rates of 20-25% provide reliable statistical data (Wu et al., 2022). The study was approved by the Health Ethics Committee of the Regional Health Administration of Central Portugal (ARSC; process no. 79/2020).
Data collection included a questionnaire to characterize the sample and three instruments validated for the Portuguese population: 1) Sociodemographic questionnaire, consisting of six questions (two open, two multiple, and two dichotomous), to characterize the sample and the sociodemographic variables (gender, age, marital status), and professional variables (years of professional practice in PHC, academic qualifications) and training in the field of violence; 2) A questionnaire on the characterization and perception of violence against women, consisting of three multiple questions; and the initial part of the questionnaire entitled "Representations of Domestic Violence and the Response of the Legal System" (Cabral & Quintas, 2011, cited by Cabral, 2011), consisting of four seven-point Likert questions (1 - *disagree* to 7 - *agree*), which assess the scale of the phenomenon of violence against women, its visibility, the opinion on its criminalization, and the perception of its main players. This part also included three multiple questions about the intervention of FHNs in situations of DV within the context of their professional practice, two multiple questions about the way they act and refer situations of DV, and a dichotomous question about the importance attributed to FHNs in situations of DV;
3) The Domestic Violence Belief Scale (E.C.V.C.; Machado et al., 2015) evaluates opinions regarding psychological and physical violence in relation to marital relationships. The assessment comprises 25 items, and respondents rate their views on a five-point Likert scale (1 - *totally disagree* to 5 - *totally agree*). Each item is associated with one of four factors that relate to differing beliefs: factor 1 (16 items) concerns the legitimisation and trivialisation of minor violence; factor 2 (10 items) relates to the legitimisation of violence in response to the woman's actions; factor 3 (8 items) pertains to the legitimisation of violence due to its attribution to external causes; and factor 4 (6 items) addresses the legitimisation of violence based on the preservation of family privacy, which precludes third-party intervention. The overall score is determined by averaging the sum of responses to items rated from 1 to 5. The score measures an individual's level of acceptance and/or tolerance of DV, with a higher score indicating greater tolerance and acceptance of VA for both the overall scale and its factors (Machado et al., 2015). The E.C.V.C. has an internal consistency of 0.93, calculated using the Cronbach's alpha coefficient (α) (Machado et al., 2015). In this study, an overall α of 0.97 was obtained, similar to that found for factors 1 (α = 0.97), 2 (α = 0.96), 3 (α = 0.97) and 4 (α = 0.96) of the scale; 4) Domestic Violence Questionnaire - Causes, Maintenance, and Resolution (QVC-CMR; Alarcão et al., 2007, cited by Aguilar, 2010) assesses knowledge about factors related to the onset, maintenance, and resolution of DV. It consists of three sets of statements relating to factors that contribute to the onset of violence, its maintenance, and its resolution. Each group of factors is made up of 14 statements, evaluated on a four-point Likert scale (1 - *completely disagree* to 4 - *completely agree*), where the total score corresponds to the average of the factors, and can be from 1 to 4, where a higher score corresponds to a higher level of knowledge. In Aguilar's (2010) study, the scale had an internal consistency of α = 0.84. In this study, the internal consistency was α = 0.88, and the scores for factors 1, 2 and 3 were 0.90, 0.84 and 0.80, respectively.
Data was collected between January and May 2021 through online questionnaires, which were sent to the institutional email address of FHNs by the Nursing Department of ACeS BM. The participants received prior information about the study objectives through their institutional email addresses and the online question-

naire. Informed consent was obtained, which ensured safeguarding compliance with the General Data Protection Regulation and guaranteed the security, protection and confidentiality of the data provided.

Descriptive and inferential statistics were utilized to analyze the data, including frequency, percentage, mean, standard deviation, maximum, and minimum values. The sample's normality was evaluated with the Kolmogorov-Smirnov test, indicating non-normal distributions with a significance level of less than or equal to 0.05. Non-parametric statistical tests were employed, with a *p*-value threshold of < .05 deemed to be statistically significant. The following tests were conducted: the Spearman test (examining variables of age and professional experience in relation to levels of beliefs and understanding about DV), the Mann-Whitney U-test (exploring variables of gender, marital status, and previous DV training in connection to levels of beliefs and understanding about DV), and the Kruskall-Wallis test (investigating the variable of academic qualifications in connection to levels of beliefs and understanding about DV). The IBM SPSS Statistics software, version 26.0, was used for the analysis.

Results

Sociodemographic and professional characterization of the sample

Most of the participants were women (85.7%), married (83.7%), with an average age of 48.2 ± 6.9 years (ranging from 33 to 62 years; Table 1). Half of the participants were graduates (54%), with an average time in professional experience of 24.6 ± 6.2 years (minimum 11, maximum 38). Around a third (30%) had had specific training in DV (Table 1).

Table 1

Sociodemographic and professional characterization of the sample (n = 98)

Sociodemograhic/professional/educational variables	*N*(%)	M ± *SD*
Gender		
Female	84 (85.7)	
Male	14 (14.3)	
Age (years)		48.2 ± 6,9
Marital status		
Married	82 (83.7)	
Single*	16 (16.3)	
Academic qualifications		
Bachelor's degree	53 (54.1)	
Master's degree	13 (13.3)	
Posgraduate specialization degree	32 (32.7)	
Professional experience (years)		24.6 ± 6.2
Previous training in DV		
Yes	29 (29.6)	
No	69 (70.4)	
Importance attributed to training in DV		4.62 ± 0.6

Note. * Includes single and widowed people; *M* = Mean; *SD* = Standard-deviation; *DV* = Domestic violence.

Perception of DV

The data obtained showed that the majority of FHNs (*n* = 76; 78%) had come into contact with situations of DV, identifying on average two signs, namely "emotional problems" (*n* = 62; 82%), "relationship problems" (*n* = 38; 50%) and "physical signs" (*n* = 30; 40%). The most common intervention was referral to other professionals (*n* = 60; 79%), followed by advice to report (*n* = 52; 68%), with only (*n* = 12; 16%) choosing to report.

The problem of DV is perceived as increasing (5.47 ± 1.36), with greater sensitivity (5.60 ± 1.34) and less tolerance (2.71 ± 1.66) towards it. Participants perceive that DV exists in the experience of many families (4.98 ± 1.55), affects different social classes (6.27 ± 0.96) and not only families from low social classes (2.3 ± 1.66). They consider DV to be a crime (6.7 ± 0.87) in which the majority of perpetrators are men (5.77 ± 1.51) and identify women as victims (5.91 ± 1.65).

With regard to barriers, the majority of FHNs identified: "Lack of knowledge and specific training" (*n* = 66; 67%), "Lack of protocols for detecting and referring victims" (*n* = 63; 64%), "Time constraints" (*n* = 51; 52%), "Lack of private spaces" (*n* = 26; 27%), "Fear of reprisals" (*n* = 24; 25%) and "Discomfort" (*n* = 14; 14%).

With regard to the role of the FHNs, the interventions suggested were: Improving coordination with local victim support teams (*n* = 83; 85%), PHNs' specific training in DV (*n* = 81; 83%) and Knowledge of protocols for detecting and referring victims in PHC units (*n* = 80; 82%). There was almost unanimity (96%) among the FHNs

about being a reference point for the early detection of situations of DV in their intervention with families.

Beliefs and knowledge about DV

The FHNs displayed low global scores (1.44 ± 0.45) with a median (quartile-Q1;Q3) of 1.36 (1.16;1.56), indicating minimal beliefs about DV, attributing it primarily to external factors (median (Q1;Q3) of 1.58 (1.33;2)), and the desire to protect family privacy (median (Q1;Q3) of 1.5 (1.17;1.67; see Table 2)).

The average knowledge score was 2.9 ± 0.29, with a median (Q1;Q3) of 2.87 (2.69; 3.08). Understanding the causes contributing to the onset of DV exhibited the lowest average (2.34 ± 0.55), whereas a higher average was observed for the comprehension of resolution factors (3.27 ± 0.35; Table 2).

Table 2

Characterization of the level of beliefs and knowledge about DV (n = 98)

Level of beliefs about DV	***M* ± *SD***	***Med (Q1;Q3)***
E.C.V.C. Factor 1: Legitimation and trivialization of minor violence.	1.26 ± 0.47	1.13 (1;1.25)
E.C.V.C. Factor 2: Legitimation of violence due to woman's conduct	1.36 ± 0.50	1.2 (1;1.5)
E.C.V.C. Factor 3: Legitimation of violence due to external factors	1.68 ± 0.58	1.58 (1.33;2)
E.C.V.C. Factor 4: Legitimation of violence due to desire to protect family privacy	1.54 ± 0.53	1.5 (1,17;1,67)
E.C.V.C. mean global score	1.44 ± 0.45	1.36 (1.16;1.56)
Level of knowledge about DV		
Factors for Onset of DV	2.34 ± 0.55	2.43 (2;2.73)
Factors for Maintenance of DV	3.10 ± 0.34	3.07 (2.93;3.23)
Factors for Resolution of DV	3.27 ± 0.35	3.25 (3;3.57)
QVC-CMR Score médio global	2.90 ± 0.29	2.87 (2.69;3.08)

Note. *M* = Mean; *SD* = Standard-deviation; *Med* = Median, *Q* = Quartile; DV = Domestic violence; E.C.V.C = Domestic Violence Belief Scale; Q.V.C. – CMR = Domestic Violence Questionnaire – causes, maintenance, and resolution.

Relationship between FHNs' sociodemographic and professional variables and their beliefs and knowledge about DV

There were only statistically significant differences in the variable gender and level of beliefs about DV ($U = 384$; $p = 0.015$), in which men always presented higher median responses, compared to women (66.6 versus 46.6). There were no statistically significant differences ($p > 0.05$) in the remaining variables: age, marital status, academic qualifications, time of professional experience, and previous training in and level of beliefs and knowledge about DV. Therefore, overall, the hypotheses were not verified, only in H1, the gender (male) of the participants was significant in relation to beliefs about DV.

Discussion

This study analyzed FHNs' perceptions, beliefs, and knowledge about DV.

Regarding FHNs' perception of DV, the data showed that they came into contact with DV situations in their professional context and, overall, they seem to have a comprehensive perception of the phenomenon, namely about detection signs, such as victims/aggressors, presenting greater sensitivity and lower tolerance to DV. This perception may be partly due to greater visibility of the topic on social media, as well as the change in legislation, which considers DV as a public crime. Furthermore, the existence of documents issued in awareness campaigns in this area may contribute to this greater perception and low tolerance towards DV.

Regarding the approach to victims, the data showed that FHNs did not feel competent to deal with the problem, citing gaps in theoretical training and organization of services in response to DV situations, which is in line with other studies carried out, either in hospital contexts (Alshammari et al., 2018; Fisher et al., 2020), or in PHC (Oliveira et al., 2020; Sousa et al., 2021) and which may explain the low rate of reporting among FHNs that served as a sample in this study. Also mentioned by IGAS (2020) is the low reporting by health services; which should serve as a reflection for more effective and efficient training of these professionals, particularly in assessment and guidance, including notification in information systems, as recommended in current guidelines.

Regarding beliefs, the results obtained revealed average scores indicative of low levels of beliefs among FHNs and a greater agreement with the legitimization of violence by attributing it to external causes and the desire to protect family privacy, believing that it is a matter of private life (Matos & Cláudio, 2010). A possible explanation for this result may be due to gender issues. In this study, there were differences between men and women and PHN beliefs, with higher belief scores (tolerance and acceptance) in men, in line with other studies carried out with health

professionals in the context of PHC (Mendes, 2016; Mendes & Cláudio, 2010). According to Faria (2019), men may be less likely to consider those who most resemble themselves as guilty or responsible. Although there is a relationship between gender and sex, these are distinct concepts. Therefore, future studies should delve deeper into gender issues by including other instruments (*e.g.*, Peters' Domestic Violence Myth Acceptance Scale, adapted by Giger et al., 2017) in order to relate beliefs with other variables (e.g., attitudes towards women, attributions of gender roles).

The results revealed acceptable levels of knowledge of FHNs (average score of 2.90 ± 0.29), with 50% of participants presenting values ≥ 2.87, of which 75% with values ≥ 3.08 (scale of 1- 4). These results were similar to those reported in the study by Silva (2015), in which higher levels of knowledge were found in the factor measures necessary to resolve DV and lower levels in the causes underlying its onset. These results suggest that FHNs are less aware and clear about the causes underlying the onset of DV, and on the other hand, they seem to be more clear about the measures necessary to resolve these situations. Therefore, and as a preventive strategy, training in this area can be relevant for early detection of a potential DV situation. These results, as well as the absence of statistically significant correlations regarding the time of professional experience and the academic qualifications of the FHNs with their beliefs and knowledge about DV, could be due to the fact that the higher education level of the respondents could determine less agreement with beliefs that legitimize violence, when compared to participants with less qualifications (Faria, 2019; Mendes & Cláudio, 2010).

The study developed had limitations such as: small sample, consisting of FHNs from a single ACeS, limiting the generalization of results and the non-representativeness of the sample for Portuguese FHNs. As a suggestion for future studies, quota sampling could be an option, in order to obtain a significant number per group (*e.g.*, age). Also opting for the online questionnaire probably limited obtaining a higher response rate, despite sending a reinforcement email to increase the response rate during the data collection period. However, as the study was developed during the COVID-19 pandemic, we encountered some barriers in disseminating the data collection instrument and in the participation of nurses. Since studies carried out with FHNs, within the scope of PHC, were also scarce, a gap that this study sought to address, more studies should include other professionals from family health teams for a better understanding of the phenomenon.

Conclusion

FHNs perceive DV situations as part of their intervention with patients/families, but due to the lack of specific training in this area, and difficulties in approaching and intervening with DV victims, they act mainly in referrals to other professionals, opting less for reporting.

This study evidenced that FHNs have a low level of beliefs and acceptable knowledge about DV. Gender significantly influenced their beliefs, with men seeming to tolerate and accept DV the most.

Based on the results, the following are suggested as facilitating measures for a better approach to DV by FHNs, in the context of family health teams: improving continuous and structured training in this area for all nurses, initiated during the academic career, and reinforced by units, increasing knowledge and focusing on beliefs, in order to unequivocally clarify their role in risk assessment and action in the face of a suspected DV, making notifications in information systems, improving the effective training of these professionals and the organizational and interinstitutional articulation, through the creation of good practice manuals and coordination protocols, as is already the case in other areas. In this sense, since this study was completed, a FHN training project has been developed in some USF in ACeS BM, which aims at the systematic and effective assessment of risk situations for patients/families. Thus, the training of FHNs in this topic can reinforce skills that allow them to plan and develop interventions with families, promote healthy intimate and conjugal relationships, raise awareness of the perception of situations of violence, signal and identify victims, playing an important role in interruption of the cycle of violence and prevention in this context.

Author contributions

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