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Original article

Health professionals' perceptions of strategies in prevention and caring of intrafamily violence in a southern Brazilian context

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Abstract. *Background and aim:* To identify health professionals' perceptions of interdisciplinary practices and care technologies in the prevention of intrafamily violence in a southern Brazilian context. *Methods:* qualitative study, with twelve professionals who work in the Municipal Health Network, in Florianópolis, accessed through the snowball method. Data collection took place from March 2022 to July 2023, through semi-structured interviews and qualitative thematic analysis. *Results:* emerged results for assistance strategies in approaching families in situations of intrafamily violence and care technologies for vulnerabilities. The first category identified is called: 1) Meaning of violence and training needs. This category includes two subcategories: a) Definition of domestic violence Participants conceptualise domestic violence; b) Training of professionals; The second category identified concerns: 2) How to report abuse. Two subcategories are described: a) reporting, b) assessment by the professional, c) difficulties; The third 3) Intervention strategies, and the subcategories: a) Empathy, b) continuity of care, c) The problem of disconnected services; The fourth category: 4) Network intervention strategies. And its subcategories: a) Working with the multidisciplinary team, b) Intersectoral work, c) Liaison with external services; The fifth category 5) Strategies to prevent individual and collective violence: a) Individual strategies, b) Collective strategies, c) Macrosocial interventions and, finally, the sixth category 6) Care strategies for vulnerabilities in domestic violence. *Conclusions:* caring for families in situations of violence is complex and demands interdisciplinary work, which, for different reasons, may not occur in an ideal way. Still, it is possible to identify the development of care plans and prevention strategies that target the issue of violence, as well as the use of light technologies. Among the technologies of care, the primary health care protocols at municipal level were mentioned as guidelines for interdisciplinary practices in situations of care for violence. (www.actabiomedica.it)

Key words: domestic violence, violence, interdisciplinary placement, technologies, nursing

Introduction

In global public health, domestic violence is a 'silent pandemic' (1) with significant psychosocial risks. In the area of health, studies into violence have only recently begun, compared to other areas of knowledge, given the evidence of the impacts it has on people's well-being (2). Intrafamily violence is a public health issue, which is defined by any type of abuse, including physical, emotional, financial, psychological and other forms towards people of any age, and children are among the most affected group, with more than three million referrals to child protective authorities per year (3). However, family violence is a critical public health problem in Latin America (4). Globally, violence against women, especially intimate

partner violence, is recognized as a public health problem, and with priority urgency because it affects individuals, their families and the entire global health community (5). According to the World Health Organization, in the year of 2019, at least 36% of young people aged 10-29 years old referred to be in a physical fight, approximately 3 in 4 children between 2 and 4 years suffer physical and psychological punishment regularly, by parents and caregivers, and the numbers certainly underestimate the dimension of the problem, since child abuse deaths may be incorrectly attributed to falls, burns and other accidents (6). Adolescence is a privileged time to interrupt intergenerational violence. Prevention aimed at and parents is an effective approach which is especially important for adolescents exposed to violence at home (7). Children's exposure to domestic violence and sexual abuse should be considered a research priority, the extent of which requires cross-cultural efforts to develop and implement interventions that prevent or reduce the level of exposure (8). In Brazil, there are experiences of creating social technologies (with digital support) as good practices in primary health care that help to tackle everyday violence (9). The pandemic and social isolation have dramatically affected domestic life for many families, where the pattern of violence has become present in its different manifestations. Studies show that the impacts have greatly affected childhood and adolescence from a mental and social health perspective (5-12). Families experiencing parental child abuse showed high levels of intrafamilial violence and affected neurodevelopmental conditions (13). In this respect, nursing professionals and others can care for families at different levels of prevention, although training in providing health care and screening victims of violence, but is still incipient (14).

Method

Aims

The study aimed to identify the perceptions of health professionals about prevention and in the care of families in situations of violence interdisciplinary practices and assistive technologies in the health network in the capital city of Santa Catarina, Brazil, with a focus on the tools and assistive strategies used by professionals and teams interdisciplinary practices and assistive technologies in the care of families in situations of violence.

Design and method

This is a qualitative study that used a semi-structured interview instrument with thematic analysis (15). The study report followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (16).

Participants

Twelve (12) health workers from Florianópolis municipal health network, in Santa Catarina, Brazil.

Setting

The locations chosen for the interviews were the Family Health Strategy units and the Child and Youth Psychosocial Care Centre in Florianópolis/SC.

Data collection

Participants were recruited through contacts with health services. Data collection ran from March to May 2022, with a pause due to difficulties in accessing the survey caused by the high demand for local services following the COVID-19 pandemic, and was resumed from October 2022 to June 2023. Participants were then selected using the avalanche data collection technique. The semi-structured interviews were conducted virtually via the Google Meet® platform, respecting the availability of the participants, and were audio-recorded after the participants signed a written consent form. The conclusion of the data collection phase respected the saturation of the information collected.

Tools

The interview was developed by the research team, based on their own experience and with consultation

of the relevant literature. The questions selected for the interview were linked to the research objective. Table 1 shows the interview areas and examples of questions.

Data analysis

The transcribed interviews were then analysed by two researchers. The anonymity of the interviewees was guaranteed by using codes with letters and numbers. The stages of the Minayo thematic qualitative analysis are Pre-Analysis, Exploration of the Material, Treatment of the Results Obtained and Interpretation (15).

Ethics

The research was approved by the School of Public Health of the Municipal Health Department of the city where it was carried out, in compliance with resolutions 466/2012 and 510/2016, which guide the ethical principles of research with human beings. The study was submitted to *Plataforma Brasil* and approved by the Ethics Committee for Research with Human Beings of the Federal University of Santa Catarina (CEPSH/UFSC), registered under Certificate of Presentation of Ethical Assessment (CAAE) 53333221.9.0000.0121.

Results

Limitations of the teams approach12 professionals participated in the study. Eight interviews were conducted online and four face-to-face at the workplaces of the professionals interviewed. The average duration of the interviews was 1 hour. A characterised presentation of the study participants' perceptions and experiences of working with families in the health care setting can be seen in the table below (Table 2).

The analysis of the qualitative data resulted in two central thematic categories (Table 3):

Assistance strategies in the approach of families in situations of intrafamily violence

1. The first category identified is called: Meaning of violence and training needs. This category includes two sub-categories:
   a. Definition of Intra-family violence Participants conceptualise intra-family violence:

   Some respondents define intra-family violence as follows:

   "I consider violence between people who live together like this or who have relationships and family ties, with all types of violence." (P3)

   "Intra-family violence it is violence that occurs within families. And that can be in various forms, from physical, psychological, social, deprivation, right… it's… access to certain situations." (P6)

Table 1. Areas of the interview and examples of questions.

Thematic Area	Question
Knowledge of the in-team approach to intra-family violence	1. What do you understand by intrafamily violence? 2. How do you perceive the team's approach to caring for and preventing intrafamily violence?
Strengths of the approach to intra-family violence	3. What resources in the community support the team in providing care and prevention to families in situations of violence? 4. What technologies and tools does the team use to deal with families in situations of violence? How are they used? 5. What opportunities do healthcare staff have for training and continuing education to deal with this type of demand in the health service?
Limitations of the teams approach	6. What other difficulties does the team encounter in this approach?

Table 2. Amount of participants duration in network, by profession and work setting, Florianópolis, SC, Brazil, 2023.

Profession	Participants	Work Setting	Duration in Network
Nurses	3	Family Health Strategy	12-20 years
	1	Resident in Family Health	2 years
	1	Municipal contract	4 years
	1	CAPS	18 years
Nursing technicians	2	Primary Health Care	8 years each
Social Workers	1	Resident in Family Health	8 months
	1	CAPS	7 years
Psychologists	1	ESF	19 years
	1	CAPS	7 years

Source: The authors (2023).

Table 3. Synthesis of the categories and sub-categories, Florianópolis, SC, Brazil, 2023.

Categories	Sub-Categories
Meaning of violence and training needs	Definition of intra-family violence
	Training of professionals
How the complaint is made	The reports
	Direct assessment of professionals
	The difficulties
Individual intervention strategies	Use of empathy
	Continuity of care
	The problem of disjointed services
Networked intervention strategies	Working with the multidisciplinary team
	Intersectoral work
	Liaison with external services
Individual and collective violence prevention strategies	Individual strategies
	Collective strategies
	Macrosocial interventions
Assistance strategies for dealing with families in situations of intrafamily violence	Support for families
	The work with the multidisciplinary, intersectoral team and municipal network services
	Violence prevention strategies
Care technologies for vulnerabilities in intrafamily violence	

b. The training of professionals

Participants point out in their perceptions that management is complex and unique for each family situation. There is little experience and difficulty in caring for cases that professionals lack preparation and training in the health area, despite the experience of approaching the subject in the multidisciplinary family health residency course. The interviewees state:

"But I didn't know anything about communication skills during my entire degree and then

during my residency I saw how important this is… service is different when you know how to approach it, you know?" (P2)

"I don't remember that we had an offer on the Telehealth courses […] I keep my own courses." (P12)

Participants affirm the importance of training professionals to identify signs that lead to suspected violence. When asked about the continuing education actions provided by the network, the technical level participants reported that the few actions provided are especially aimed at higher education professionals. They said in fact:

"Not everyone has this [...] training to work with people who are victims of violence, or even to understand when there is someone who may be suffering some type of domestic violence." (P12)

"There is, but generally it's like I said, it's just more doctors or nurses. As a coach and as a team in general, we don't have this training." (P10)

2. The second category identified concerns: How reporting takes place.

Two sub-categories are described: reporting, assessment by the professional, difficulties

a. reporting

Some professionals who have been working longer in primary health care mentioned experiences in handling cases of intrafamilial violence against children and adolescents. Most of the support took place when reports of cases of violence were received during follow-ups, with the Board of Guardianship or at the request of the community health officer (CAH) and observations from the community.

"So, I don't remember much about user searches for the service, it's not very common, okay? [...] So, we found out for some reason, either from the health agent, or a neighbor, or some suspicion of us paying a visit... [...] I already received, but like, a complaint from the Council Guardian and not that they arrived at the post, searching. Some neighbor who reports it." (P3)

Spontaneous complaints made by direct victims of intra-family violence do not occur commonly. In the context of the PHC services of the nurses interviewed, the community itself reveals signs or indirect information about cases in families.

"Here where I work today there are a lot of cases, I think they don't always reach us through the family. Arrives through a neighbor, arrives through an ACS, okay? There were few cases, knowing the general context, in which it was the victim who was looking for help or the person inside the house who was looking for help." (P4)

b. evaluation by the professional

Furthermore, other indirect situations or secondary complaints lead professionals to suspect about violence, whether in reception services due to spontaneous demand or scheduled consultations, nurses perceive in the physical examination evaluation and in the anamnesis approach any sign of physical violence or not, and in narratives about family relationships, between parents and children or intimate partners, and child care, which lead to the need for investigation.

"Then, in the history, during the consultation, you end up discovering that there is, sometimes, psychological violence towards partners, women, right? Or teenagers in relation to their parents or some parents... [...] over this time, it always appears, right? Or a health worker, a neighbor who says: "oh, this child cries a lot"… there was a yellow light!" (P3)

"In the reports of very young children, because they really talk and express themselves through drawings, through games, right? [...] And sometimes the situation will appear, when it is more veiled, in a family service" (P9)

One of the participants also shows hesitation when forwarding complaints for further investigation of suspected cases of violence. There are difficulties in approaching the potential victim, especially in cases where complaints are made by third parties, such as friends, neighbors or family members.

"How to approach it? How can we tell that person that we know something is happening,

that someone else told them? That it wasn't… through her, that we found out? That we heard from other people? Huh? So this subject, until you get to the health center, and you can sit down and talk to the person, is a completely difficult subject to approach. Because at that moment the person can become aggressive towards you." (P9)

c. difficulties

However, some participants cite the difficulty of identifying violence and acting to prevent its occurrence, making it possible to act only on the consequences.

"[...] we always seem to be running in circles, right? Because ... one of the problems is that we are not able to act on the cause. We are always acting on the consequences of the violence." (P12)

"Although the teams have planning meetings, [...] they are usually to act on situations that have already happened or are happening, right? And prevent situations that don't happen again. But the preventive aspect [...] that this violence does not happen, this intervention, this possibility, is much rarer." (P12)

3. Intervention strategies

a. Empathy

A humanised approach to care is essential, as they emphasise empathy and non-judgement, and are concerned about the effects that care can have on the well-being of individuals, reinforcing ethical principles. They also work to resolve family conflicts in order to maintain the bond with the family.

"For example, if she has already undergone one of our services, I try to review her medical records so that she does not repeat the same things again and does not repeat the suffering process. [...]And I also raise the issue of non-judgment. Talk about the ethical issue too, everything that is said within the office remains within the office, but if there is a situation there where I see that the patient is still in a risky situation, I need to say: look, this situation, even for your protection and my professional protection, I need to share with another colleague, but this way, he is a trusted colleague [...]." (P1)

b. continuity of care

The continuity of care in some cases follows flows established in the network, through instruments such as the RAIVS protocol, which provides care to victims of sexual violence in the City of Florianópolis, and PACK, Practical Approach to Care Kit, a tool for evaluating and managing patients in PHC, which involve other services in the intersectoral network. Compulsory notification, in case of suspicion and/or identified situation of violence, is a mandatory intervention for all health professionals.

"Look, I use the RAIVS protocol more like this, for referrals to networks, to support victims of violence in the municipality. It's the instrument I use." (P1)

"[...] we have a flowchart of what to do in a service like this. The network brings us this, for example, domestic violence, who does it have to look for? Sexual violence against children, who should I contact? So there we have a flowchart of if it is a child who has suffered sexual violence, they have to go to the Children's Department, which means I have to contact the Child Protection Council, I have to contact social services... So he brings me a range so that I can Don't forget what to do [...]." (P4)

"The notification, even if the person doesn't want to, we do, that's our obligation as professionals." (P2)

c. The problem of disjointed services

When services are disconnected, it becomes difficult to provide longitudinal assistance to families in situations of violence, even from the individual perspective of the victim. And the lack of resolution of violence situations in the public system delays preventive actions that break the cycle of violence.

"I don't see the counter-reference. It seems that the patient gets lost along the way, in the sense that we lose sight of him. We just forward it and we don't get a response. [...] Most of the time we know the outcome because the patient returns at some point. Sometimes even when you go to the

territory, you see the patient and you end up approaching them." (P1)

"When they notify the hospital, then we find out. I also think that this notification system is sometimes flawed." (P3)

"[...] The institutions are playing their role, but they don't sit down to be able to organize themselves and establish a joint line of action. Everyone does their part in a somewhat isolated way." (P12)

4. Network intervention strategies
   a. Working with the multidisciplinary team

The work of the multidisciplinary team was mentioned by the participants at several points during the interview, linking it to the importance of having a variety of care resources. They also highlighted the significant collaborative action between professionals from social services and psychology, supporting the PHC team.

"[...] when we respond to situations of violence, we never need to respond alone, we need other professional categories and then multidisciplinary work comes into play, psychology, social work, from psychological support to bringing resources so that family member can get out of the situation they are in, the nursing care, the medical approach too [...]." (P2)

"Yes, we try to resolve it within the team, with the support we have, which is why it really depends on the case [...] So we end up doing a home visit, then we ask for support from the social worker, I end up trying to articulate it, make some plan of action and depending on the case [...]." (P3)

   b. Intersectoral work

The articulation between the services of the SUS network and the public safety and social assistance network must also integrate the treatment of violent situations, offering all available resources so that health care is comprehensive for people, victims of violence and those raped in their rights as citizens.

"In some sectors there are referrals, and we see a lot of intersectoral work." (P2)

"[...] some situations of violence are also being monitored in the area, by the Family Health Teams, by PHC psychologists... we have an outpatient clinic especially for... children and adolescents [...] sometimes I refer them to the police station. I've sent them to the women's shelter..." (P8)

   c. Liaison with external services

Liaison with services outside the network is also necessary and the main constitutional body mentioned by the participants when dealing with violence against children and adolescents was the Protection Council.

"And even the family is suspicious of some anonymous complaint made by the doctor or nurse. But it is a child who is already being monitored by the Guardianship Council, by the Protection Service, but there was this threat." (P5)

"We have the Guardian Council, which we are still a little afraid of, we have to be a little careful, because the counselor is someone from the community." (P4)

Schools and kindergartens were also mentioned as allies in the identification of violence, as well as the inclusion of children and adolescents and their families in the health service to address intra-family problems and prevention.

"So, there was a case of a child… [...] The boy was about five years old and started to behave aggressively at school. [...] when we called this mother to talk about the child, we could already see that the relationship was abusive towards the partner and the child sometimes ended up reproducing what he saw, including the violence that the mother suffered [...] In this part of the children, the school and daycare centers are very close partners." (P3)

Individual and collective violence prevention strategies

   a. Individual strategies

The prevention strategies mentioned by the participants were varied and cover aspects of thematic interest that integrate health, human rights and citizenship, which broadens the view of the problem of violence to an interdisciplinary approach. Health education

was regarded as an important tool in the prevention of violence through individual or group activities.

"[...] health education, this is very important, related to sexual education, the issue of rights too, which belongs to the citizen, making a police report [...] Knowledge of protective laws, [...] I think reinforcing this... of statutes, of adolescent children, which also ends up coming to us in the area of health." (P1)

The direct approach to problems of violence and the possibility of safe communication during consultations are strategies that offer opportunities for preventive actions, seeking to exchange information that enables individuals/families to identify risk factors and protection against violence in the different ways in which it occurs.

"The direct approach in consultations too, asking if you have suffered any form of violence, if there are any signs of violence in your relationships [...]." (P2)

b. collective strategies

"I think that collective activities thinking about schools, for example, talking about this with teenagers, with children, from an early age because we often end up identifying these issues when we are going to do some educational activity [...] I think the use of posters, these types of things within health units, because I also encourage patients to talk." (P2)

According to one respondent, the availability of activities and services after school hours for children and adolescents is also a way to prevent violence, support vulnerable families or minimise risks through health promotion, such as the creation of supportive environments and healthy public policies.

"I think the issue is not just social, but also the type of resources. If the child has access to education and other activities. [...] So these timetables, these activities, these are policies that I think would be preventative, because then it could work in these community spaces where the person also has access. Being able to connect, being able to talk to someone, having a network of contacts. So these activities, these options, could minimise the child not being exposed for so long, it would permeate other spaces, the chance for them to connect and be able to report it, to cut this cycle of violence." (P3)

Discussing violence prevention practices, it was identified that some of the strategies used focus on health promotion, particularly those developed in group and community activities.

"The promotion belongs to the collective. These are extramural activities. It's at school, it's in the elderly group, it's in the women's groups in the neighborhood, in the territory, you know?" (P1)

"I think the issue of family therapy, so maybe it's not just us, right? There is psychology present... But the family approach... I saw this a lot happening at CAPS when I did the residency internship, there was the family group, where the family members would go and then some issues would be addressed, right?" (P2)

c. Macrosocial interventions

There is also the conviction that promotion and prevention actions must take place at a macrossocial and macro-political level in order to achieve better results, with public policies targeting these situations, organisation of campaigns and média outreach.

"Advertising too, I think, in this case, campaigns, talking about…" (P2)

"[...] But thinking in a more macro way, I think it really involves public policies. In relation to children and teenagers, right? [...] It is obvious that, for example, an educational activity, a relaxation activity, leisure activity, access to culture, I think that everything contributes to improving the human being as a whole or accessing emotions and things that can be worked on to minimize what generates this violent behavior, right? I think so. But I think that to achieve something broader, not thinking about individual action, in a specific case, I would have to think, I believe, about broader public policies of promotion, right? From media, from access, right? From reporting issues, access to services, various issues like that [...]." (P3)

Care strategies for vulnerabilities in intra-family violence

The soft technologies identified in the participants' reports are highlighted by statements on communication, active and sensitive listening.

"It's respectful and empathetic, it starts with active listening [the approach to families] [...] And I think that's where communication skills come in because that's when it's time for you to create a bond or you break the bond altogether, and non-violent communication." (P1)

Communication, as a soft technology in the care of adolescents and their families, protects them from approaches that invade privacy or disrespect intimacy.

"When the mother comes to seek psychological care, the girl has changed her behavior, so we try to take a more general approach first so that she doesn't feel invaded, right? About menstruation, about dating, sexuality, and then start going into other points, right?" (P4)

Soft-hard technologies were also mentioned, such as, for example, the use of visual resources, such as informative posters. The display of posters is also related to prevention strategies, as it draws attention and could be a stimulus for recognizing a situation of violence, in addition to demonstrating to families that the unit is a place to welcome this type of violence. demand.

"[...] We have some posters that the patient is looking at when they are in the waiting room. The other day I passed by, I saw the patient taking a photo of the poster. He knows? So we work on this in the waiting room, right? For visual reasons." (P4)

Furthermore, in P2's statements, the use of soft-hard technologies associated with hard technologies is identified, through the use of images, prostheses and care instruments, with educational purposes in care. Furthermore, the RAIVS protocol and PACK were mentioned previously, which also configure technologies.

"I think the use of images too… I will want to explain to them how I am going to do the physical examination and sometimes I use images or vaginas prosthesis or a speculum to show what the physical exam will be like… That kind of thing. I think these devices with photos on the internet help to calm down a little." (P2)

The use of the Genogram and Ecomap are briefly commented by two participants, as instruments used in some family services:

"[...] I use the ecomap and the genogram that help a lot to try to see these relationships; It's a interdisciplinary support to work [...] The part of permanent education that we have on this topic is daily, it is routine, because every team meeting this topic is discussed again and again, and then I can know where to direct it." (P6)

Furthermore, the interdisciplinary support of social assistance and psychology professionals are cited as tools used for this work.

Discussion

Assistance provided to families in situations of violence is complex, requiring healthcare professionals who deal with these situations to have complex skills and to work as part of a network. The actions of health professionals in relation to domestic violence reveal empathetic and humanised care, although there are gaps in knowledge and fragile training for this type of health demand. The need for "advanced and complex" skills is highlighted not only by our study, but also by other studies that recognise nurses' lack of knowledge or training on domestic violence (16,17). Professionals consider it important to care for families in situations of violence, but they have little contact with the topic in their professional lives due to their lack of theoretical and practical experience. The lack of integration between theory and practice during training results in professionals who are unprepared to deal with these situations, and in the few approaches they receive on the topic, they receive them in a fragmented way and disconnected from reality (18). In addition to training, meeting the demands of domestic violence requires the work of a multidisciplinary team, from identifying cases and their initial approach to monitoring in the care network. Health professionals in the

multidisciplinary residency, realize the importance of teamwork when they report that it makes the service more effective and enables comprehensive care (19). It seems that social service and psychology professionals have greater guidance and knowledge when dealing with this type of case, although they are not the only professionals who approach families in situations of violence in the PHC team. Interdisciplinary and multidisciplinary practices are recognised and present, but the idea of fragmented care still prevails due to the difficulty of counter-referrals within the care network and weaknesses in the longitudinality of care for families in the area. Although this may be linked to a flawed referral system, difficulties in using competent public services, or lack of time due to precarious employment, it also demonstrates a lack of coordination among the family health team professionals themselves. Municipal management of primary healthcare services and the employment relationship of professionals influence team turnover and staffing levels (19). This study, conducted in Brazil, highlights the importance of the role of Community Health Agents (CHA), members of Family Health Strategy teams. Community health agents play a fundamental role in identifying situations of violence in the community through home visits and in connecting families with the teams. In most cases, they are the first to receive information through comments from people close to the victim or through on-site observations (20). It is noteworthy that the work of health professionals on the issue of domestic violence is facilitated when a bond of trust is created with families and their individuals, in the daily work in the territory, using community resources for intervention, prevention and health promotion strategies (21). The care plan for families in situations of violence includes home visits as an intervention strategy and reiterates the importance of the role of the CHA in approaching women in situations of domestic violence, involving therapeutic projects that include children and adolescents in this monitoring (22). Our results show how the strategies mentioned and activated by participants relate to the Singular Therapeutic Project (PTS) and various protocols and strategies that are abundant in South American literature. In particular, the Singular Therapeutic Project (PTS), mentioned as a treatment strategy, sets out an action plan involving various professionals, seeking to restore individual, group and family well-being (23), which is particularly relevant in the work of the teams at the Psychosocial Assistance Centre for Adults (CAPS) and Children and Adolescents (CAPSi), as it involves the family, school and other care providers (24). In care plans, referrals within the network follow the Comprehensive Care Protocol for People in Situations of Sexual Violence, identified as the "RAIVS protocol", and the Practical Care Approach Kit (PACK), which uses flowcharts to indicate referral services in different areas, from police stations to health centres, CAPS and hospitals, as well as their areas of expertise (25). The PACK 'is a comprehensive tool to support clinical decision-making in primary care, aimed at managing adult patients aged 18 years and older' and covers various health conditions, including sexual violence (25). Other technological tools also used by our participants are the Genogram and Ecomap. The Genogram and Ecomap tools are some of the most consolidated technologies in PHC. While the Genogram displays the family composition and traces the relationships within this cycle, the Ecomap outlines the family's relationships with the community, enabling an assessment of the available support network (26). Through these tools, it is possible to identify family members who are victims and aggressors, based on relationships and interactions (27). The use of these instruments helps the health team to develop team care strategies shared with the family to face the situation. In addition to sophisticated technological tools and protocols, participants emphasise that communication and empathy play a fundamental role in relationships with victims of violence. Communication skills can be highlighted as soft technologies, together with non-violent communication. Considering communication as a way of transmitting and receiving a message, non-violent communication emphasises the way in which this communication is done, highlighting the importance of it being done empathically, seeking a compassionate connection through verbal and body language (28). Relational technologies are fundamental elements for creating bonds in situations of violence (29). Another social technology application, aimed at men and the prevention of domestic violence through a group, also identified that in order to operationalise work using social technology, intersectoral,

interdisciplinary and multiprofessional coordination is necessary, as well as institutional consent, bioethics and public funding to access the institutions involved and the participating men (30).

Conclusion

The research addressed the issue of intra-family violence, which, although known by health professionals, expresses the complexity of its management in daily practices in the community, causes discomfort and apprehension in the work of health services, especially when there is a lack of training, during the period of professional training and, later, continuing education. Interdisciplinary practices in meeting the demands of intra-family violence are fragmented due to the difficulties encountered in forwarding these demands, whether of a political and social nature or related to the actions of the professionals themselves. Social actions to prevent violence, for example those of an educational nature, follow the materials provided by the Ministry of Health, through posters and informative images displayed in health centers. The use of health technologies, represents various levels of prevention. As for the instruments, some protocols that guide the professional's actions in relation to the referral of demands for violence within the network and the use of digital technologies.

Ethic Approval: the Ethics Committee for Research with Human Beings of the Federal University of Santa Catarina (CEPSH/UFSC), registered under Certificate of Presentation of Ethical Assessment (CAAE) 53333221.9.0000.0121.

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Authors Contribution: GC Manfrini and LVG Andrade - Have made a substantial contribution to the concept or design of the article; or the acquisition, analysis, or interpretation of data for the article, and drafted the article or revised it critically for important intellectual content; G Artiolli - Approved the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved., MA Santos - Have made a substantial contribution to the concept or design of the article; or the acquisition, analysis, or interpretation of data for the article.

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