

# Domestic violence against children and adolescents: social support network perspectives

*Violência doméstica contra crianças e adolescentes: olhares sobre a rede de apoio*

*La violencia doméstica contra los niños y los adolescentes: perspectivas de la red de apoyo*



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## ABSTRACT

**Objective:** To identify and analyze the social support network of families involved in violence against children and adolescents, from the perspective of health professionals and families in a municipality of the state of São Paulo, Brazil.

**Methods:** This was a qualitative strategic social study, anchored in the paradigm of complexity. Data were collected from 41 health professionals and 15 families using institutional or personal network maps, and semi-structured interviews. Analysis was conducted by organizing the data, constructing theoretical frameworks, and categorizing resulting information.

**Results:** The category “weaving the network” was unveiled, with family experiences and professionals focused on a logic of fragmentation of care.

**Final considerations:** The creation and implementation of public policy are urgently needed to address the needs of this population, by empowering families and communities and developing research that respects the multidimensional nature of the phenomenon.

**Keywords:** Adolescent. Child. Family. Domestic violence. Social support. Nursing.

## RESUMO

**Objetivo:** Conhecer e analisar as redes de apoio a famílias envolvidas na violência contra crianças e adolescentes pela perspectiva de profissionais da atenção básica à saúde e de familiares em um município do interior do Estado de São Paulo, Brasil.

**Métodos:** Pesquisa qualitativa, do tipo social estratégica, delineada pelo Paradigma da Complexidade. A coleta de dados foi realizada com 41 profissionais e 15 familiares por meio de Mapas da Rede Institucional ou Pessoal e entrevistas semiestruturadas. A análise se deu por meio da organização das informações, formação de quadros referenciais e categorização.

**Resultados:** Desvelou-se a categoria “Tecendo a rede” com vivências familiares e dos profissionais centradas numa lógica de fragmentação do cuidado.

**Considerações finais:** Desvela-se a urgente necessidade da construção e/ou efetivação de políticas públicas direcionadas às famílias com o empoderamento do núcleo familiar e comunitário, bem como da realização de estudos com abordagens que respeitem a multidimensionalidade do fenômeno.

**Palavras-chave:** Adolescente. Criança. Violência doméstica. Família. Apoio social. Enfermagem.

## RESUMEN

**Objetivo:** Analizar las redes de apoyo a los familiares involucrados en la violencia contra los niños y los adolescentes en el municipio del interior del Estado de São Paulo.

**Métodos:** Investigación cualitativa, del tipo social estratégico, delineada por el Paradigma de la Complejidad. La recolección de datos fue realizada con 41 profesionales y 15 familiares a través de Mapas de la Red Institucional o Personal y entrevistas semiestruturadas. El análisis se dio por medio de la organización de las informaciones; Formación de cuadros referenciales y categorización.

**Resultados:** Se desveló la categoría “Tejiendo la red”, con vivencias familiares y de los profesionales centradas en una lógica de fragmentación del cuidado.

**Consideraciones finales:** Se desvela la urgente necesidad de la construcción y/o efectividad de políticas públicas dirigidas a las familias, con el empoderamiento del núcleo familiar y comunitario, así como por la realización de estudios con la multidimensionalidad del fenómeno.

**Palabras clave:** Adolescente. Niño. Familia. Violencia doméstica. Apoyo social. Enfermería.

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## ■ INTRODUCTION

Violence represents a serious public health problem, accounting for over one million deaths per year worldwide. Among the world population aged 15 to 44 years, violence is the fourth leading cause of death. These figures represent only fatal cases, being that every day, thousands of people are victims of nonfatal violence<sup>(1)</sup>.

Violence is defined as the intentional use of power or physical strength, whether actual or threatened, against individuals, groups, or communities, which results or has a great chance of resulting in injury, death, psychological harm, deprivation or maldevelopment<sup>(2)</sup>. Children and adolescents are among the main victims of violence; defined by the WHO as individuals between 0 and 19 years old, every day, as many as 227 children die because of interpersonal violence worldwide. Such violence often occurs within relationships with people of trust, responsibility, or power – the domestic space<sup>(1-2)</sup>.

The WHO uses the ecological framework to understand and approach violence, considering a multifactorial problem that stems from interaction at four levels – the individual, the relational, the community, and the societal<sup>(2)</sup>. This framework considers the context in which individuals are inserted, and not individuals in isolation.

Legal provisions and the literature have shown that organizing networked care approaches to such phenomena enables more effective actions given the challenges to health promotion and the prevention of health problems among children and adolescents<sup>(3-4)</sup>. These networks, whether personal or institutional, consist of a specific social ensemble of actors, groups, or institutions, both formal or informal, within a given territory, that share power and human and material resources<sup>(5-6)</sup>. Additionally, networks can provide emotional, instrumental, and informational support. Emotional support consists of conversation and establishing affective relationships among people. Instrumental support includes actions or materials provided to aid in daily tasks, while informational support consists of the orientation and information available about community resources<sup>(7)</sup>.

This concept dialogues with Edgar Morin's paradigm of complexity, which is used to underpin the understanding of the object of the present study. Morin proposed complex thinking to address what is "interwoven" from a dialogical point of view, which implies considering the separate and sometimes contradictory parts that interact to compose the phenomenon, which is inserted in a specific context<sup>(8)</sup>.

Understanding a complex phenomenon such as support networks in their social, emotional, instrumental, and informational dimensions requires methodological procedures that can contextualize the issue of violence against children and adolescents and capture the meaning of actions developed by health professionals. These aspects require new methodological strategies to understand the studied reality. This, in turn, demands exchanges between disciplinary and interdisciplinary knowledge, pointing to coordinated actions and proposals among the different sectors that work with the theme of violence.

Given the paucity in the literature involving a multidimensional approach to such a complex phenomenon as domestic violence against children and adolescents, the aim of this study was to identify and analyze care networks of families involved in violence against children and adolescents, from the point of view of primary health care (PHC) professionals and family members.

## ■ METHODOLOGY

This was a qualitative strategic social study, anchored in the paradigm of complexity. In this type of research, perceptions, beliefs, values, and feelings are usually considered within a specific context, centering on concrete and focal social problems. Instead of problem resolution, strategic social studies seek to understand the phenomenon<sup>(9)</sup>. In the paradigm of complexity, notions such as comprehension and contextualization guide the theoretical and methodological process, like in strategic social research. Comprehension implies grasping the meaning of objects or happenings and their relationship with other objects or happenings, forming "a band of relationships, which in turn are interwoven and coordinated into socially and individually constructed webs, or networks, which are constantly updated. Contextualization consists of strategies that seek to understand given phenomenon not in isolation, but as part of a given context, from which they acquire meaning<sup>(8-10)</sup>. From this perspective, different dimensions of the object can be apprehended, especially the similarities and differences that exist between the dimensions the compose the studied phenomenon.

The field of the present study was a municipality in the state of São Paulo, Brazil, which occupies an area of 796 km<sup>2</sup> and has a population of 1,144,862 inhabitants. Forty-one health professionals from PHC units and 15 families involved in cases of violence against children

and adolescents participated in the study. PHC units were chosen because of their role in coordinating communication in health care networks and mediating population health actions, representing a complex and multidimensional system<sup>(6)</sup>.

The data were constructed by employing the minimum map of the external institutional social network (Figure 1) with healthcare professionals and the minimum map of the social personal network (Figure 2) with families. The first map was developed by Ude<sup>(5)</sup>, which was based on the second map constructed by Sluzki<sup>(11)</sup>. These tools helped to identify the relationships of participating institutions or individuals with formal or informal organized community groups, including different government and nongovernment institutions and sectors. The goal of the map is to define existing resources and gaps, so that existing social networks can then be integrated, strengthened, and optimized.

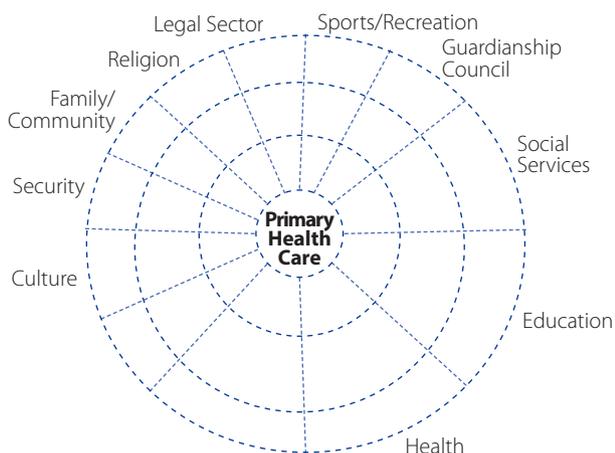
Both maps are represented by circles divided into quadrants; in the institutional map, these quadrants represent education, health, the legal sector, security, religion, environment, work, recreation, culture, social services, and families, among other sectors suggested by health professionals. In the personal map, the quadrants refer to the fields of friendships, school/work, and community relationships (religion, sports, movies, theater, clubs, squares, among others). One of these quadrants addresses the family's relationship with health and social services. These maps (Figures 1 and 2) help understand how such relationships are established. They are drawn using different types of lines, graphically representing the nature of the relationships between the

participating families and people/institutions. Dark gray lines represent significant relationships, light gray lines indicate weak relationships, and black lines refer to broken or inexistent relationships<sup>(11)</sup>.

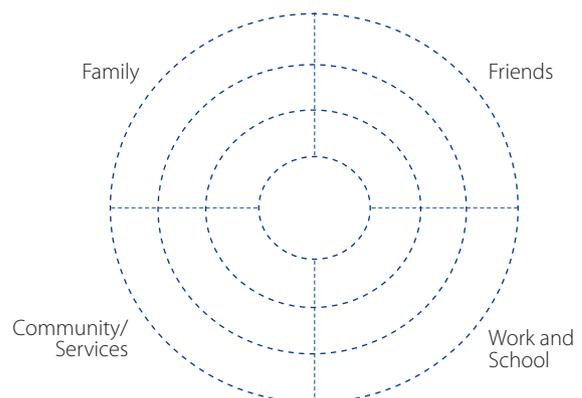
To construct the maps, the participants were first introduced to the researchers and the objective of the study. Next, they received an explanation of the maps and the meaning of each type of line. Participants were free to include institutions and/or sectors, and the networks were supposed to represent their actual experience and not an ideal situation<sup>(5,11)</sup>.

The drawn maps were analyzed using the following criteria: size (number of institutional or personal ties, in which networks could be classified as reduced, median or expanded); density (quality of ties according to type of line – significant, weak, and broken and/or inexistent); distribution/composition (number of people or institutions located in each quadrant, which enables the identification of the networks' weaknesses and strengths); dispersion (geographical distance between participating individual or institution and the other elements placed on the map); and homogenous or heterogeneous (differences and similarities between people and or institutions composing the network)<sup>(5,11)</sup>.

Semi-structured interviews were used as a strategy to complement the mapping technique. The process of selecting participating PHC units began on January 14, 2013, through meetings with the heads of the municipality's health districts. The municipality is geographically split into five health districts (North, East, Northwest, Southwest, and South). In these meetings, it was decided that data would be collected from one PHC unit in each



**Figure 1** – Model of the Minimum Map of the External Institutional Social Network (adapted from Ude, 2008)



**Figure 2** – Model of the Minimum Map of the Social Personal Network (adapted from Sluzki, 1997)

district. Based on the availability and organization of local teams, data collection was conducted between April 24, 2013, and December 17, 2013, with 41 professionals. The maps and interviews were previously scheduled with health professionals, who were selected considering the heterogeneity of professional centers. The maps were built before the interviews, as the professionals were invited to collaborate in the interviews. All the meetings took place at the professionals' work units. Interview scripts consisted of two open-ended questions, which enabled access to the participants' singular view on the issue, namely: 1) What does the health team do when faced with a suspected or confirmed case of domestic violence against children and adolescents? 2) What actions are carried out in these situations? The interviews lasted an average of 20 minutes, and participants were identified with the letter P and a number according to the order of the interview: P1, P2, P3, and so forth. The participants' professional category was not indicated, except when such information proved relevant to data analysis. Through procedural data analysis, the researchers perceived data saturation after the tenth interview, and thus no more participants were interviewed.

Data was collected from the families by contacting a nongovernment organization (NGO), co-funded by the municipal government, which conducts interventions with families involved in violence against children and adolescents, referred from family services or the Special Court for Children and Adolescents of the referred municipality. The maps and interviews were conducted sequentially with 15 families assisted by the service, who were selected based on a discussion with the local team, according to greater availability to participate in data collection. Data was collected with family members between July 10, 2015, and November 20, 2015. The maps and interviews were developed at the NGO; at the families' residence during home visits, and at family members' workplace, before work hours. The interviews consisted of two open-ended questions: Have you ever received help to face life challenges? What is your view of this?

The interviews lasted approximately 15 minutes. Data saturation was confirmed after the 15<sup>th</sup> family. The family maps and interviews were identified with the letter F and numbered according to the sequence in which they were conducted (F1, F2 and so on).

The professionals and family members consented to being recorded and were ensured anonymity. The interviews were recorded using EasyVoicer software on an MP5 device and later transferred to a microcomputer and fully

transcribed. Data collection with the professionals was conducted before that with family members, during the development of one of the author's doctoral thesis. At a later moment, given the need to complement data, family members were interviewed. The time elapsed between one data collection period and the other (approximately two years) was not considered a collection bias, as the objective of the study was not to compare but to reach a multidimensional understanding of the phenomenon. Additionally, the time between data collections did not see significant changes in the municipal context.

The study was submitted to analysis by the Research Ethics Committee of the Ribeirão Preto College of Nursing, University of São Paulo, and approved on November 14, 2012, under protocol CAAE 01726512.0.00005393, notification letter 217/2012. Furthermore, participants signed free and informed consent forms. In addition to municipal approval, district and local authorization was requested from participating services.

For data analysis, the following steps were conducted<sup>(10)</sup>: organizing the collected information, including the map drawings and the transcribed interviews, and identifying and categorizing the most relevant and pertinent aspects to the object of study; organizing theoretical frameworks according with the main points presented by the professionals and family members, to establish an overall picture of the information that enabled their categorization; and constructing a framework that enabled establishing relationships among the data, organized into categories, which encompassed aspects related to the studied phenomenon through expressions, conceptions and/or elements. The maps were submitted to specific analysis, but always in connection with the interviews. Next, the empirical data was analyzed from the perspective of the paradigm of complexity, the scientific literature, and existing legal provisions. Through this work, the category "weaving the network" emerged.

## ■ RESULTS AND DISCUSSION

### Participant characteristics

The professionals consisted of 17 community health agents; 4 nursing aides; 4 nurses; 1 occupational therapist; 4 pediatricians; 2 psychologists; 1 psychiatrist; two clinicians; 1 dental assistant; and 5 multiprofessional health residents. Six participants were male and the rest, women. Most of the professionals were between 31 and 40 years old, had completed technical or higher education 1 to 5

years prior to the study, and worked at the studied PHC unit also for the same amount of time.

The family members who participated consisted of one father, one grandmother, and thirteen mothers of children and adolescents assisted by the service in question.

### Weaving the network

Next, both maps are presented, the first related to institutional social networks and the second, personal social networks (Figures 3 and 4, respectively) to enable better visualization.

To improve the analysis, this study will present a brief description of the maps presented above, even though it is not feasible to analyze each one of the maps developed in the study. The first map relative to Unit 5 presents a median network in which there is a predominance of weak ties, presenting only four significant relationships, one of them with families. Thus, the network's density is low. Relationship dispersion presented close or regional ties to the unit, which refers to a municipal policy. Geographic proximity, in this case, was not directly related to the significance of the relationships. A homogenous network was unveiled, with a predominance of ties in three sectors (health, education, and social services).

The map of Family 1 showed a small network, with only two significant relationships and low density. The network

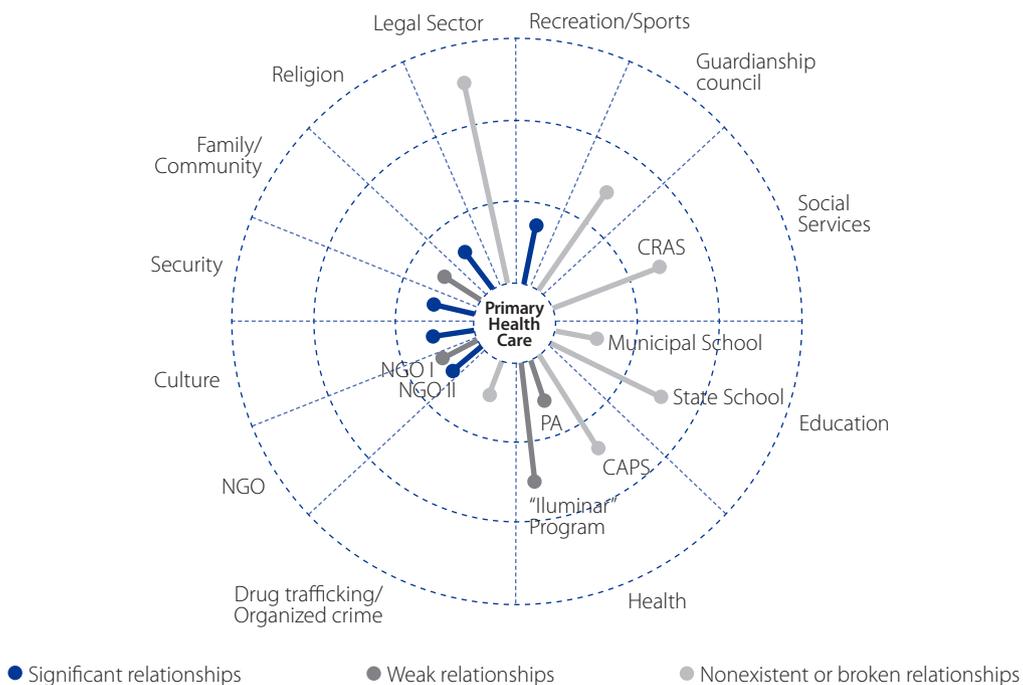
included few people and institutions, demonstrating significant gaps and weaknesses. The relationships observed were geographically close to the families, however this did not impact the quality of such ties. Extended family contradicts this fact, for according to the discussion below, geographic distance between members was a factor that influenced broken relationships. The network was homogenous due to the low level of diversity between relationships in the quadrants.

The units were located in different territories, thus they presented specificities. Two units presented a median-sized network, while the others presented reduced networks, with few networks depicted in the quadrants. The density of the networks in the five units was low, with many weak or broken relationship and few significant ties. Regarding distribution and composition, there were more institutions connected to the social service and education sectors; and important gaps shown in the absence of institutional ties in the other sectors.

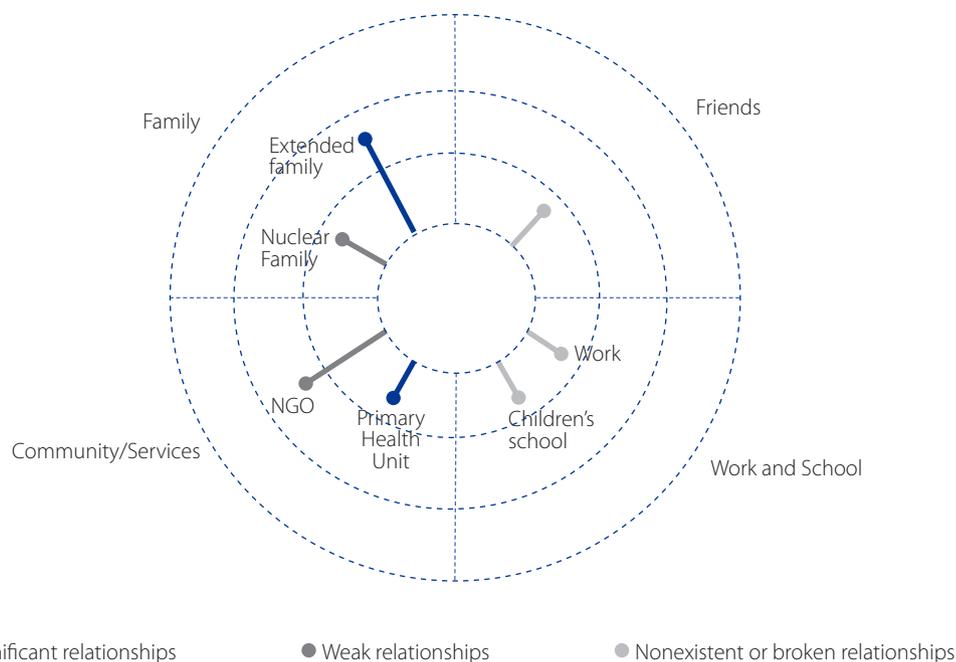
Regarding the family maps, the networks were also reduced, with approximately seven personal and institutional relationships. These were predominately weak or inexistent, depicting a low-density network with limits social support in various aspects:

*No, I don't have anyone I can count on like that... (F 2)*

*What happened in my life [situation of violence], many believe that... many discriminate me... (F 3)*



**Figure 3** – Minimum Map of External Institutional Social Network of Unit 5. Campinas, 2014



**Figure 4** – Minimum Map of the Social Personal Network of Family 1. Campinas, 2015

Despite the observations made in current scientific literature and guidelines set forth by the official child and adolescent protection entities, care networks still represent a great challenge especially as they seek to overcome the dominant paradigm, which is based on division. In the present study, the professionals and families reported experiences – at the management, health care, and personal level – centered on this logic of fragmentation.

Regarding to the social services, the professionals were not familiar with the organization, including some services in sectors different from their own:

*But since I am not familiar with it, I do not think the work is effective... (P 5). So, this care policy is very confusing, isn't it? (P 1).*

The number of private entities in the social service sector was significantly higher than that of government entities. Their work processes are different than those of government entities, and suffer frequent changes. Thus, the actual constitution of social services ends up generating weaknesses and gaps in understanding of the sector's organization.

For family members, the relationship with the NGO, which is within the social service sector, was always significant, representing an important source of informational, material and, on occasion, affective support.

*[...] So there's no one to talk to, except for the girls at the NGO... (F 7)*

Families demonstrated the need for a “reference” service and professional, who coordinates care and that assist them over time. The education sector should represent one of the main pillars to protect children and adolescents, playing an essential role in the socialization of this population. However, according to the professionals, the coordination between health and education is not yet effective:

*Schools don't take responsibility for the problem of violence, they transfer the whole situation, they come in, tell you the most horrible ever and then say, “I've got a problem,” you see? (P 1)*

For families, the relationship with schools was perceived as weak, especially due to lack of reciprocity. The family members referred to an income distribution social program as the main source of instrumental support; for families to benefit from the program, the child or adolescent must be assisted by the PHC unit and attend school regularly.

The health professionals mentioned families and the community, especially local health councils (social control organizations formed by users, management, and workers), as significant relationships with the unit. In contrast, family members defined their tie with PHC units as weak:

*It's always hard to schedule appointments, we have to go there several times (F 3). They never have an opening for us, it's difficult... (F 11)*

Despite the legitimate place of social services, education, and health in protecting children and adolescents, they cannot be the only services to this end. Violence is a complex phenomenon, and families must be considered. Cultural, transportation, security, and legal actions, among other sectors and devices, must be activated to reach comprehensive protection of this population. A recent study about a protection network against sexual violence that investigated the point of view of child protection workers demonstrated that networked care at the local, municipal, national, and international levels is still far from being a reality<sup>(12)</sup>.

In this context, public policies must also be analyzed. Networked actions and forms of addressing contemporary problems is a new process that counterpoints traditional public policy approaches, usually based on fragmented, one-off, and compensatory actions. These generate simplistic and segmented actions that do not effectively work with such complex phenomena<sup>(5)</sup>. The present study found that despite some advances, public policy provided fragmented solutions for the vulnerabilities of families.

This issue has led to ruptured or duplicated actions and does not reveal the full institutional potential for care; furthermore, it does not provide families with comprehensive care, as it is assumed that comprehensiveness can be reached through interinstitutional and intersectorial coordination and integration. Thus, families are submitted to various atomized actions, which do not usually interrupt the cycle of violence. Most public policies disregard the family and community universe, or the territories in which these families reside, including specific contingencies, such as drug trafficking and organized crime, which hold great legitimized power<sup>(13-14)</sup>.

In the studied families, affective exchanges occurred with other family members, and material support was associated with friends. However, intense migratory activity among families made it difficult to maintain relationships with extended family:

*We have no family here, you see, my family is all from Natal, Rio Grande do Norte, and when I'm in trouble I always call S. [NGO professional] directly because she can help from a distance, and when they can't help, they tell me how to solve the problem, if it weren't for them by my side to guide me, they guide me, I'd be lost. (F 10)*

Regarding dispersion, which refers to the geographical distance between institutions and/or people, significant relationships were not directly associated with proximity in the case of healthcare professionals. They emphasized other forms of establishing communication, especially those related to technology, which was considered an important factor to the effective operation of networks. In turn, family members reported geographical distance as being directly related to weak or broken ties; they reported difficulties in accessing some services due to physical distance.

For both families and professionals, the networks were homogenous, with the presence of institutions from the same sector, mainly health, social services, and education; and the absence of all others. Families presented a low level of community participation, not identifying significant support from services or groups to which they belonged.

These weaknesses and gaps both cause and are an effect of fragmented care provided to families. Comprehensive, longitudinal, and coordinated care is still a challenge; it is difficult for families to effectively access services, which in turn do not carry out networked actions:

*No intervention was conducted with the family while the child was there. The mother was assisted by child protection services, "she's doing okay, so let's give her back." But there wasn't a true change in family dynamics... (P 2) Doing the work together, instead of referring cases to one another, the idea of partnership. I think partnership is still very weak within the network... (P 3)*

The paradigm of complexity dialogues directly with the concept of networks. In fact, on considering contextualization as the focus of the hologram principle, Morin emphasized the coordination between whole/parts, simple/complex, and unity/diversity, which allow for the object to be considered within its context. However, it is worth noting that Morin's idea of contextualization does not imply "juxtaposition", in terms of "accumulation" or "compiling" of information, but the unveiling of the numerous relationships that constitute and enable networks and grasping the "mutual relations and reciprocal influences between parts and the whole in a complex world"<sup>(8-15)</sup>. In this direction, the present research demonstrated the importance of providing broad context of the multiple dimensions the involve the issue of violence, in addition to the need to strengthen relationships between the different dimensions of the phenomenon – especially those between education, social services, and health sec-

tors – as a real possibility to organize more comprehensive, or networked, actions.

The adoption of network-based public policy in Brazil has been growing since 1990, in the search to overcome or replace a bureaucratic and hierarchical model of care for a model based on flexible the interweaving, sharing, and interdependence in commitments and outcomes<sup>(6)</sup>. It can be inferred that networked actions bring forth the notion of the relationship between different contexts: family, institutional, and community. Care provided to families, defined by social policies, has been considered a conservative and little effective practice, as it is rooted in a culture of tutelage and stigmatization, which does not invest in the autonomy of family groups<sup>(14)</sup>. A study analyzed the possibility of women survivors of violence reporting the abuse, defining their social networks. The results pointed to fragile and one-off actions, especially among health services, in addition to the absence of strategies to emancipate these women<sup>(16)</sup>.

Recent studies have emphasized the importance of coordinating programs and sectors to reduce the vulnerability of population groups, especially children and adolescents, and recognize their skills, talents, and creative capacity to (re)create various realities<sup>(17-18)</sup>. Actions that aim to address violence must be associated with the right of the population and community to participate in public health care decisions, with deliberative inclusive approaches, such as citizen juries<sup>(19-20)</sup>.

## ■ FINAL CONSIDERATIONS

The results of the present study point to weak support networks and significant gaps, both from the point of view of PHC professionals and families involved in violence against children and adolescents. The maps showed homogenous, low-density, and reduced networks, with few significant relationships. The findings point to the need to construct and/or implement public policy for this population, which help empower families and communities. From the methodological-theoretical perspective, this study also indicates: 1) the need to promote the development of knowledge capable of understanding multidimensional phenomena, issues that are both global and local, universal, and singular, i.e., complex; 2) the effectiveness of minimum map of external institutional social networks and family networks in contextualizing and understanding such a complex phenomenon as violence against children and adolescents.

Health and nursing must emerge as agents that contribute to debates about the theme, pointing out interdis-

ciplinary and intersectorial paths, seeking transdisciplinarity in care for families involved in violent dynamics. Further studies, especially within the scope of participative and intervention research, can indicate new possibilities to cope with the theme, as well as within the scope of primary and secondary prevention.

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