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ORIGINAL ARTICLE

Violence against women: knowledge, attitudes and beliefs of nurses and midwives

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Aims and objectives. To describe the knowledge, attitudes and beliefs of nurses and midwives who have attended to women who suffered violence. This study further analyses the possible changes of attitude that have occurred over the past five years.

Background. *Gender violence or violence against women* is the largest problem with regard to public health and violated human rights all over the world. In Italy, it is estimated that 31·5% of women suffer physical or sexual violence during their life. Healthcare operators play a crucial role in recognising the signs of the violence suffered when taking care of victims.

Design. A cross-sectional study was conducted.

Methods. A questionnaire was administered; this was used in a previous survey of a convenience sample of 51 nurses and midwives who work in an emergency room or in an obstetrics emergency room and gynaecological ward.

Results. Of the respondents, 51 (80·4%) have taken care of women who suffered violence, and 25 (49%) believe they can detect violence. The relational/communicative approach presents the most difficulty, and all the operators believe they need more knowledge. The number of operators who suggest women be observed in an emergency room and file a complaint or who primarily consider listening to women has decreased. A tendency to 'blame' women, although decreasing, persists; it is higher among male nurses and, in general, among male operators.

Conclusion. Knowledge of this issue has not been completely recognised among operators despite training and the emergence of the phenomenon in the mass media. Difficulties in receiving and in relational procedures continue to exist, in addition to 'blaming' the woman.

Relevance to clinical practice. Awareness paths and cultural changes regarding the phenomenon of violence need to be developed, as does a specific training programme on the approach to and assessment of the abused woman.

What does this paper contribute to the wider global clinical community?

- Contributes to an understanding of the knowledge, attitudes and beliefs of healthcare operators towards a female victim of violence.
- Contributes to an understanding of critical issues in the approach of healthcare operators to the abused woman.

Key words: abused women, beliefs, gender violence, knowledge, midwife, nurse

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Introduction

Gender-based violence (GBV), or *violence against women* (GAW), is the largest problem of public health and of violated human rights all over the world (World Health Organization WHO 2013a).

Violence against women is defined as: 'Any act of gender-based that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. . .the unequal condition of women contributes to generate their vulnerability' (United Nation Office of High Commissioner 2014, p. 73).

The European Council (2011) defines domestic violence as 'any act of physical, sexual, psychological or economical violence occurring in the family or domestic unit, or between regular or occasional partners or cohabitants, regardless of the fact that the authors of these acts shared or still share the residence with his victim'. According the Italian National Institute of Statistics (ISTAT) domestic violence is the most common cause of violent death among women aged between 16–44 years (Council of Europe 2006, ISTAT 2007, ISTAT 2015).

In Italy, it is estimated that 31·5% of women aged between 16–70 years have been victims of some forms of violence during their life (Italian National Institute of Statistics ISTAT 2015). Moreover, the data of Italian National Institute of Statistics ISTAT (2015 p.1) underline that '20·2% of women has been victim of physical violence; 21% of sexual violence of which 5·4% suffered the most serious forms of sexual violence such as rape and attempted rape'.

However, over the past five years, the occurrence of sexual or physical violence among partners has decreased from 13·3–11·3%, compared with the previous five years (Italian National Institute of Statistics ISTAT 2015).

Sexual violence is associated with several consequences on women's health including unwanted pregnancies, gynaecological conditions, such as vaginal bleedings, chronic pelvic pain, infections of the urinary tract, sexually transmitted diseases, including HIV/AIDS, hepatitis B or C, depression, post-traumatic stress disorder (PTSD) and suicidal thoughts and feelings (Latthe *et al.* 2006, Wenzel *et al.* 2006, Taft & Watson 2008).

Background

In Italy, 12·3% of women report suffering violence (Italian National Institute of Statistics ISTAT 2015). In the world, 35% of women have experienced either physical and/or sexual intimate partner violence or nonpartner sexual violence (WHO 2013c). The violence is an underestimated phenomenon because the women hide reporting it unless they are directly asked they do not tell anything (Taket *et al.* 2003, Feder *et al.* 2011).

The recommendations of World Health Organization (WHO 2013b) indicate the role of healthcare providers as primary source to improve the management of emergencies as well as to take care of and to heal violence victims, by recognising the related signs and by recommending the victims to reception and support centres.

Midwives, doctors and nurses are not particularly acquainted with considering the presence of this problem, and they are minimally prepared to do so (Lazenbatt *et al.* 2009, Taylor *et al.* 2013). The frequency of male violence and the seriousness of its consequences tend to be invisible to the eyes of healthcare operators (HCO) (Kahan *et al.* 2000, Rabin *et al.* 2000), although women who suffer violence visit health services, on average, three times more than others (Taket *et al.* 2003). Several studies have highlighted the reluctance of midwives (Lazenbatt & Thompson-Cree 2009), doctors and nurses (Gutmanis *et al.* 2007, Beynon *et al.* 2012) to talk of abuse. Several healthcare operators declare feeling discomfort when talking of abuse with women who have suffered violence (Baraldi *et al.* 2013). In certain cases, the abuse is not considered, and when it is suspected, there are no interventions to detect it, as if 'the reason' was missing (Bradbury-Jones *et al.* 2014).

Furthermore, many HCO are not able to properly assess or respond to domestic violence (Edin & Hogberg 2002, McCloskey & Grigsby 2005, Taylor *et al.* 2013), or they have difficulties detecting the signs and symptoms of abuse (Vieira *et al.* 2009).

Several factors have been identified by HCO as barriers to the recognition of domestic violence, such as a lack of training to identify women who suffered violence (Knapp *et al.* 2006), ignorance regarding the management of cases, feelings of insecurity when addressing the problem, minimal support for the victims (Monteiro *et al.* 2006), lack of time to devote to the problem and an inability both to use information and to recommend institutional paths (Knapp *et al.* 2006). These barriers have been attributed to the inappropriate attitudes of primary healthcare operators towards the victims of violence and abuse, with a general lack of information and training regarding gender violence (Peckover 2003). The persistence of prejudices, in which victims are masochistic or accomplices to the violence, is no less negative (Paci & Romito 2000).

The HCO play a key role to take care of women, if they are able to listen to their 'stories' and they are competent

for identifying the problem (Ahmad *et al.* 2009, Feder *et al.* 2009, Montalvo-Liendo 2009). They represent a crucial factor for allowing women to exit their situation of violence and for developing strategies and resources to fight it (Feder *et al.* 2006).

Furthermore, in recent years, healthcare operators and services have considered the problem of violence against women by developing 'good practices' to resolve the related issues (Romito 2000, Registered Nurses' Association of Ontario (RNAO) 2012, Moyer 2013).

Considering the long debates regarding the phenomenon of violence against women, which involve both health systems and institutions, and considering the importance accorded to it by the mass media, this study's objective was to describe the knowledge, attitudes and perceptions on gender violence of those nurses and midwives who are personally involved in the reception of the battered woman and to compare the collected data with those of a previous survey, conducted in 2008 (Di Giacomo & Palumbo 2008). In the last years, the Health Company of Rimini has proposed to the operators, who encounter abused women in their daily work (at ER, gynaecology and obstetric wards and Department of Gynaecology and Family Counselling), training on gender violence. This study will detect whether perceptions and opinions have changed over the past five years.

The main purpose of the survey was to describe knowledge, attitudes and beliefs of nurses and midwives towards a female victim of violence, and we hope to take the true picture of the situation.

The secondary goals are to identify the possible differences of approaches that exist among them and between the professions and to identify possible changes in their perceptions over the 5 past years and we want to describe the feeling of the healthcare operators.

Method

Design

A cross-sectional study was conducted between August and September 2013.

Setting

This study was conducted in the departments of the Health Company of Rimini, which is in charge of receiving women who suffered violence: emergency room, (two department), obstetrics emergency room, gynaecology and Department of Gynaecology and Family Counselling (four wards).

Sample

The survey used a convenience sample of 81 of 101 nurses and midwives who they are currently employed and eligible staff within the study setting and they have successfully completed the survey, between August–October 2013. We have excluded the nurses and midwives that they did not give the consensus and they failed to complete more than 75% of the survey items.

Data collection

We administered a questionnaire used in a previous survey in the same setting (Di Giacomo & Palumbo 2008). In 2008, we structured as *ad hoc* and we administered the questionnaire to a small group of health operators currently employed in the wards of the Health Company of Rimini involved in the study for checking whether the questions were clear and easy to understand; we did not modified anything and we used it to all involved sample of the study (Di Giacomo & Palumbo 2008).

The questionnaire consisted of two parts: the first part requested demographic and work-related characteristics of the sample. The second part consisted of 15 closed questions with one possible answer related to knowledge, attitudes and beliefs of those healthcare operators involved in the reception of abused women.

Specifically, the participants could answer using 'yes' or 'no' in three questions: 'yes' or 'no' or 'I don't know' in five items, and in the seven items, they could check among different descriptive answers. The items and the answers are outlined in the Table 1.

Data analysis

Data analysis was performed with STATAtm 9.2/SE (Stata Corp, College Station, TX, USA).

We used the descriptive statistical analysis to depict demographic characteristics of the sample and to analyse the individual responses of the questionnaire. For determining the differences between midwives and nurses and between the data of this study and the data of the previous survey, we used 'The Pearson Test'. The statistical significance was fixed at $p < 0{\cdot}05$.

Ethical considerations

We asked and we obtained the authorisation by the Hospital Health Direction; we did not required the Ethics

Table 1 Questionnaire items

N.	Items	Answers
1.	Have you taken care of women who had suffered sexual violence and/or family abuse?	☐ Yes ☐ No
2.	If you have taken care of women who suffered violence at work, have you found difficulties?	☐ Always ☐ Occasionally ☐ Never ☐ I don't know
3.	Are there a plan care or a protocol or a procedures for the women who suffered violence in your Department?	☐ Yes ☐ No ☐ I don't know
4.	Are you able to indicate the different steps of caring for women who suffered abuse and to describe the necessary procedures for legal action?	☐ Yes ☐ No ☐ I don't know
5.	Do you know 'Dafne Project'?	☐ Yes ☐ No ☐ I don't know
6.	Have you attended specific training courses on the proper behaviour to follow and on the management of violence cases (rape, mistreatment, and other forms of violence, not only physical, in the last 3 years?	☐ Yes ☐ No
7.	You intervene in the care of the abused woman:	☐ By myself ☐ With other professions
8.	What is the first recommendation to provide an abused woman?	☐ Visit the closest 'Violence Against Women Desk' or a similar service ☐ Visit an ER ☐ Visit an ER and fill in a felony complaint ☐ I don't know
9.	What color of triage evaluation system would you assign to an abused woman?	☐ Red (emergency or to treat immediately) ☐ Yellow ☐ Green ☐ White ☐ I don't know
10.	What is the most difficulty have you encountered in receiving battered women?	☐ The relational and communication approach ☐ Applying the procedure for the care of women who suffered violence ☐ I don't have the adequate knowledge
11.	What do you consider it is important to provide to a woman who suffered violence?	☐ Listening and support ☐ Medical/legal consultancy ☐ Information ☐ Activation of the health network
12.	Do you consider important that health documents contain the all information provided by each woman, because?	☐ Yes, they are crucial for a possible trial ☐ No, because the involved woman could be afraid of the possible exposure of the information provided ☐ No, I don't consider this information crucial ☐ I don't know
13.	Do you need training for additional knowledge? (it is possible more answers)	☐ The juridical aspects ☐ The relational aspects ☐ The application of procedure ☐ The juridical, the relational aspects and the application of procedure ☐ No, I don't need knowledge
14.	Do you believe that the woman's behaviour could have facilitated the violence itself?	☐ Yes ☐ No ☐ I don't know
15.	Do you think to detect whether a woman suffered violence?	☐ Yes ☐ No ☐ I don't know

approval for this study as no changes to clinical practice were undertaken (Health Ministry 2008).

Eligible participants were given information regarding the survey by one of the investigators (AC). Anonymity was explained and that the data would be coded to ensure responses could not be match to participants. Consent was implied with the return of the questionnaire. The data were recorded in the database for analysis by a researcher who had not participated in the data collection.

Results

Demographic and work-related characteristics

Fifty-six (70%) healthcare operators completed the questionnaire. Five questionnaires were excluded, of which three presented less than 75% of the answers to the items and two did not designate the position.

Fifty-one (63·7%) questionnaires were analysed and were compared to 44 of the survey of 2008.

Forty-one (80·4%) participants were female, 35 (68·7%) were aged 40 and under, 31 (60·8%) were nurses, and 20 (39·2%) were midwives. Twenty-four (47·1%) nurses were

working in the emergency room. The demographic and work-related characteristics of respondents are described in Table 2.

Forty-one (80·4%) of the participants declare who they have taken care of women who had suffered sexual violence and/or family abuse. Twenty-five (61%) of these are nurses and 20 (48·8%) work in the ER.

Knowledge

Forty-five (88·2%) HCO state there is a plan or protocol or procedures care for the abused women in their department; all the participants (7) of the gynaecology and obstetrics ER agree with this statement.

Twenty-two (43·1%) of the respondents say they attended specific training courses on the proper behaviour to follow and on the management of violence cases (rape, mistreatment and other forms of violence (including not only physical): 9 (29%) of nurses vs. 13 (65%) of midwives, with a meaningful difference between the two professions ($p = 0{\cdot}011$).

All agree with the necessity of additional knowledge. In particular, 30 (58·9%) would require specific and more thorough knowledge of the juridical and relational aspects and of the application of procedure; 10 (19·6%) would solely require knowledge of relational aspects. In addition, six (11·7%) would only require juridical aspects, and five (9·8%) would only require the application of procedure.

Fifteen (75%) midwives believe they need training for all the above mentioned aspects vs. 15 (48·3%) of nurses; however, two (10%) vs. eight (25·8%) need training only for the relational aspects; there were no meaningful differences between the professions.

Table 2 Demographic and work-related characteristics of health operators ($N = 51$)

Characteristic		n° (51)	%	IC	
Age	<30 years	14	27·5	15·9%	41·7%
	31–40	21	41·2	27·6%	55·8%
	41–50	11	21·6	11·3%	35·3%
	51–60	5	9·8	3·3%	21·4%
Gender	Female	41	80·4	66·9%	90·2%
	Male	9	17·6	8·4%	30·9%
	No response	1	2	0%	10·4%
Education	High School Jr	2	3·9	0·5%	13·5%
	High School	7	13·7	5·7%	26·3%
	College	15	29·4	17·5%	43·8%
	Bachelor's Degree	27	52·9	38·5%	67·1%
Occupation	Nurse	31	60·8	46·1%	74·2%
	Midwife	20	39·2	25·8%	53·9%
Ward/health service	Family counselling	15	29·4	17·5%	43·8%
	Gynaecology	5	9·8	3·3%	21·4%
	ER	24	47·1	32·9%	61·50%
	Obstetric ER	7	13·7	5·7%	26·3%

Attitudes

Forty-one (80·3%) of the respondents say they have taken care of women who suffered violence at work, and among these, 29 (70·8%), of which 18 are nurse and 11 are midwives, have always/occasionally found difficulties in receiving battered women. In addition, 56·8% (n. 29 of 51) of participants affirm they would probably have difficulties to take care of the women subjected to violence, whereas 17 (33·3%) say they would not and 25 (49%) of HCO declare their ability to detect whether a battered woman [16 (64%) of nurses vs. nine (36%) of midwives]. In addition, 25 (49%) do not know to answer, and one (2%) cannot detect.

Twenty-eight (54·9%) healthcare operators would assign yellow as triage assessment, and only one (1·6%) would assign green; also 15 (75%) midwives would assign red (emergency to treat immediately) vs. 5 (16·1%) of nurses. There is statistical significance between the two professions ($p = 0{\cdot}000$).

According to 26 (50·9%) of the participants, the first recommendation to provide an abused woman is to visit an ER and to file a felony complaint, 12 (23·5%) recommend visiting the closest 'Violence Against Women Desk' or a similar service, and 12 advice being observed in an ER, without no statistical significance between nurses and midwives (Fig. 1).

Beliefs

Twenty-seven (52·9%) participants reflect that listening and support approaches are the primary 'offers' to a woman who suffered violence, 14 (27·4%) the activation of the health network, seven (13·7%) the medical/legal consultancy and two (3·9%) information.

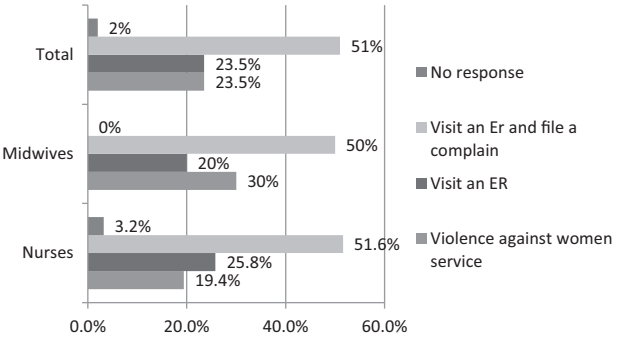

Figure 1 Recommendations for the abused woman. What would you recommend to a woman who suffered violence?

The differences in the answers between nurse and midwives are listed in Table 3.

According to 35 (68·6%), the relational/communication approach represents the largest difficulty they encounter when taking care of abused women; 10 (19·6%) affirm they do not have adequate knowledge; and 6 (11·7%) state that the most difficult part is properly applying the procedure. Difficulties in the relational approach are the most indicated by both nurses and midwives (Table 4).

Forty people (78·4%) [23 (57·5%) nurses vs. 17 (42·5%) midwives] consider important that health documents are thorough and contain all the information provided by each woman because they are crucial for a possible trial, four (7·8%) of all nurses do not consider these one essential because the involved woman could be afraid of the possible exposure of the information provided, and six (11·7%) do not consider this information crucial at all.

Twenty-tree (45·1%) of the respondents do not believe that the woman's behaviour could have facilitated the violence itself, whereas 10 (19·6%) believe it did (Fig. 2); there was not a statistical significance between nurses and midwives ($p = 0·069$).

The perception of any behaviour that facilitates violence primarily exists among nurse (nine vs. one midwife) and primarily among male nurses: for five male nurses (55·5% of their total) and only for four (9·7%) of female nurses ($p = 0·008$).

Training appears to have an influence on the behaviour of 'woman blaming' ($p = 0·037$); however, it does not appear to influence the difficulties in receiving battered women ($p = 0·091$).

Table 3 What service is important to offer to a woman: differences between professions?

	Total n. 51		Nurses n. 31		Midwives n. 20	
Offered service	*n*	%	*n*	%	*n*	%
Listening and support	27	52·9	17	62·9	10	37
Health network activation	14	27·4	9	64·2	5	35·7
Medical/legal consultancy	7	13·7	4	57·1	3	42·8
Information	2	3·9	1	50	1	50
No response	1	1·9	0	0	1	100

Table 4 Differences of approach between nurses and midwives

	Nurses n. 31		Midwives n. 20	
Different approaches	*n*	%	*n*	%
Relational approach	23	65·7	12	34·2
Knowledge	6	60	4	40
Procedure application	2	33·3	4	66·6

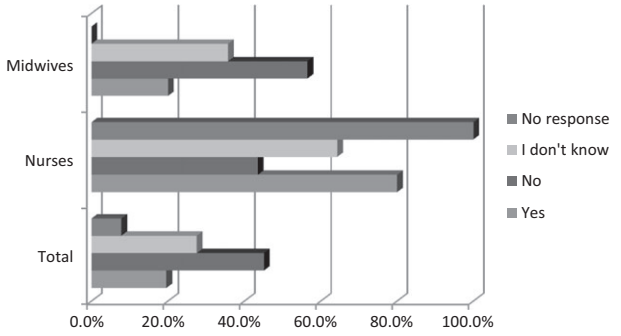

Figure 2 Do you think that any behaviour of the woman could have facilitated the violence itself?

Discussion

Comparing staff participants, in 2008, interested healthcare operators were 44: eight midwives and 36 nurses, mainly female, 35 (79·5%); in addition, 32 (72·8%) were aged 40 or under. The increase in the number of obstetrical personnel is probably a consequence of the increased staff, following the reorganisation of the obstetrics unit in 2008 and the formalisation of the obstetrics ER, while the personnel in the gynaecology were not involved in the previous survey.

The most represented unit was the general ER. There is a meaningful difference between the professions ($p = 0·025$).

A higher percentage of participants (80·4%) declare that they have taken care of women who suffered sexual or family violence and it has increased compared to 2008, when it was 72·7% of the total.

Also the presence of procedures or protocols in each one's department is increased (88·2% vs. 75% in 2008).

The use of protocols can improve the identification of abuse and the management of women who suffered violence abuse (O'Campo *et al.* 2011), but it must be supplemented by formal training.

The difficulties in the reception of women who suffered violence are shared by all healthcare operators, and there is a minimal difference in necessity of additional knowledge that is considered inadequate, 19·6% vs. 13·6% of 2008.

Fifty-eight per cent of the respondent vs. the previous 38·6% state that they need training regarding juridical and relational aspects and in the application of procedures, while has decreased the percentage of those who detect violence, 49% vs. 68·2% in 2008. In addition, the number of those who do not know to answer has increased, 49% vs. 20·5%. Probably, they have an increased awareness of training necessity.

Also the study of AbuTaleb *et al.* (2012) showed that nurses felt they have benefits from additional training in management of battered woman.

It has decreased the percentage of those who affirm having difficulties in the reception of abused women: from the previous 78·1% to the current 70·7%. The rates are similar to the results of Ramsay *et al.* (2012). However, the 4·9% of the operators do not know to answer (this percentage did not exist in 2008) and have increased the percentage of those who do not answer, (7·3% vs. 3·1%). Other studies showed that education has a crucial role in order to strengthen and improve attitudes of the healthcare operators who attended to battered woman and their response to the needs of victims (Hegarty *et al.* 2010, Djikanovic *et al.* 2015).

It has increased the assignment of red code as triage assessment; probably, the operators have more awareness that the women abuse is an health emergency. The recommendations to provide an abused women to visit an ER and to file a felony complaint have decreased from the previous 59·1% to the current 51%; however, it remains the most important indicator in percentage.

The percentage of those healthcare operators who believe they are able to detect that a woman suffered violence has decreased from the previous 68·1% to the current 49%; (64% of nurses vs. 36% of midwives), with a meaningful difference ($p = 0{\cdot}006$). These rates are higher than the rates reported in the study of Lazenbatt *et al.* (2009), where only the 22·5% of the midwifes were sure about identifying violence in practice. So many women would remain at risk of consequences of abuse if the operators are not able to identify them.

The percentage of the operators who consider the activation of the health network the primary 'offer' to an abused woman has increased (27·5% vs. the previous 22·7%). These results are in contrast with Ramsay *et al.* (2012), who reported the 49% of nurses tended to contact a violence service provider. The percentage of respondents who consider important to provide detailed and thorough information to women has decreased to 78·4% vs. the previous 84·1%, and the percentage (11·8% vs. 8%) of those who does not answer has increased.

Providing information is essential: so the battered women could make informed decisions about which services can meet their specific needs.

This study show a higher percentage of operators (43·1%) has attended specific training courses on the management of violence cases of the study of Androulaki *et al.* (2008), but a lower percentage of healthcare operators who provide information and psychological support. A possible explanation for these findings is that previous education did not sufficiently focus on changing attitudes. It is necessary providing an ongoing support in the practice (Feder *et al.* 2011).

The operators do not always provide proper information, for example to visit an ER and to file a felony complaint, which would allow women to confront with their violence experienced, to begin its processing, as recommended in the literature, and to collect proof for possible legal action. Only the study by Androulaki and colleagues (2008) shares the importance of providing information to file a complaint, while the ability of healthcare operators to offer psychological support and to provide information regarding rights and services is emphasised by other studies; however, the results are not comparable (Androulaki *et al.* 2008, Ramsay *et al.* 2012).

The percentage of those who believe the victim's behaviours have facilitated the violence itself has decreased, although the data remain important and have no meaningful difference ($p = 0{\cdot}241$) (Fig. 3).

A discomfort feeling in receiving and listening to the abused women persists, as, ultimately highlighted by other studies (Lazenbatt & Thompson-Cree 2009, Ramsay *et al.* 2012, Baraldi *et al.* 2013).

Among some healthcare operators, there is a cultural attitude of prejudice and stigmatisation towards women who, although victims, are blamed. Myths and negative stereotypes relative to abused women remain justified by societies. Several studies indicated the presence, among operators, of the frequent stereotype of the battered woman. She is considered partially responsible for her situation of abuse (Lazenbatt *et al.* 2005, Baraldi *et al.* 2013, Taylor *et al.* 2013), she has facilitated in any manner the violent episode, and she has voluntarily chosen violent partners or to live in situations of abuse (Shadigian & Bauer 2004, Marinheiro *et al.* 2006, Baraldi *et al.* 2013).

Limitations

The limited and convenient sample, the use of a self-report questionnaire and the analysis provided by the personnel of a single company do not allow us to generalise conclusions. Furthermore, this study does not allow the verification of possible associations; probably, it is due to small numbers.

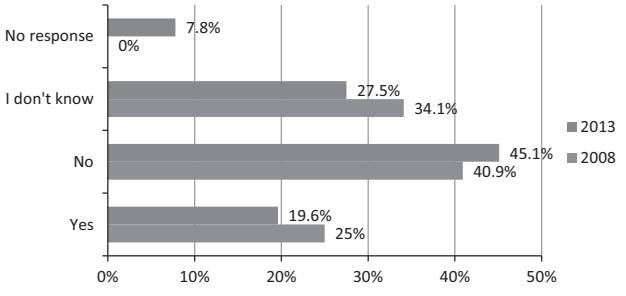

Figure 3 'Woman Blaming'. Compared to the previous survey in which the data were assembled (yes, always and sometimes).

Conclusions

Further studies are required to identify and understand why the phenomenon of violence against women still creates a feeling of discomfort among operators, despite the huge evidence provided by institutions and despite the training paths that have been developed in recent years (Regione Emilia Romagna 2013).

The training of qualified personnel with a higher awareness and knowledge of the phenomenon and of the adequate instruments to discover and manage abuse cases in an efficient manner (WHO 2013b, ISTAT 2015) is definitely one of the answers to the problem. However, it is necessary that all the involved healthcare professionals are sensitised towards the problem and that they are properly trained to approach and assess the abused woman and not solely regarding medical care. Operators need to be trained in the management of each case, by means of specific training courses that are not simply limited to knowledge but that targets an in-depth examination of the related and complex problems, which question stereotypes and prejudices and enhance the understanding of the psychosocial consequences of violence against women. Training needs to be multidisciplinary and must concern the different aspects of the answer to violence: identification; safety assessment and protection planning; communication and clinical skills; recordation of the referenced episodes; and an offer of caring pathways (WHO 2013b).

Moreover, the healthcare operator needs to cooperate with other services to offer women overall help, which is able to consider all the aspects of the problem of violence, from the health aspect to the social and caring aspects.

It is probably necessary to develop and debate the theme of gender violence first within society because it is a phenomenon that continues to be based on a perspective of gender differences and of the lower power of women in culture and in society (Jewkes 2002).

Relevance to clinical practice

Nurses and midwives are often the first operators who receive women who have suffered violence. These healthcare providers' behaviours and interventions need to be properly balanced and oriented in a manner that is respectful of their psychical and emotional conditions to alleviate the sense of helplessness, shame and despair the victimised women can feel and to avoid altering the long process of readjustment they begin to confront.

The literature also focuses on the gender typology involved in the care of the abused woman. Nursing and midwifery are generally female jobs; those nurses and midwives who are professionally involved in episodes of gender violence are in the best position to address these issues (Walton-Moss & Campbell 2002). From this perspective, nursing and midwifery probably are not using their huge potential fully; thus, both regarding the identification of violent episodes and regarding the original help, they can provide support and understanding to women in relation to the emotional aspects of distress and vulnerability (Goldblatt 2009).

Nurses and midwives, most of whom are women, are in a unique position to screen, during every visit, every woman who has suffered abuse; they can intervene properly and conduct further research by using the referenced experiences of abused women to reduce domestic violence.

Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published.

Conflict of interest

No conflict of interest has been declared by the authors.

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Contribution

Study design: PD, AMB, LS; Data collection and analysis: PD, AC, MS; Manuscript preparation: PD, AB, AC.

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