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Original Article

PSYCHO-EMOTIONAL REPERCUSSIONS OF DOMESTIC VIOLENCE: THE PROFILE OF WOMEN ON BASIC HEALTHCARE*

REPERCUSSÕES PSICOEMOCIONAIS DA VIOLÊNCIA DOMÉSTICA: PERFIL DE MULHERES NA ATENÇÃO BÁSICA

REPERCUSIONES PSICOEMOCIONALES DE LA VIOLENCIA DOMÉSTICA: PERFIL DE MUJERES EN LA ATENCIÓN PRIMARIA

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This research proposes to investigate the socio-demographic profile of the women assisted in a health service and the psycho emotional repercussions of domestic violence on them. This is an exploratory, descriptive study with a quantitative approach, developed at the Cidade Verde Integrated Family Health Unit, in João Pessoa, PB, Brazil. 400 women were interviewed in January and February 2010 and semi-structured interviews were used. From this amount, 211 women (52.75%) were identified with history of domestic violence and composed the study sample. As a profile of the victims of violence, the study showed a high incidence of adults (78.67 %), married (45.04%), earning up to two minimum salaries (72.03%), complete high school level (33.17%), dark skinned victims (46.44%), catholic (50.13%) and housewives (56.87%). The main psycho-emotional impacts included were: sadness, anger and depression. Services of health should serve as places of orientation in the detection of violent events, promoting actions which identify the problem and its coping.
Descriptors: Violence Against Women; Health Services; Women's Health; Nursing.

Objetivou-se com esta pesquisa investigar o perfil sociodemográfico e as repercussões psicoemocionais da violência no âmbito doméstico de mulheres atendidas em um serviço de saúde. Pesquisa de caráter exploratório-descritivo com abordagem quantitativa, desenvolvida na Unidade de Saúde da Família Cidade Verde Integrada, João Pessoa-PB. Foram entrevistadas 400 mulheres em janeiro e fevereiro de 2010, através de entrevista semiestruturada. Dessas, 211 mulheres (52,75%) foram identificadas com história de violência doméstica que compuseram a amostra do estudo. Como perfil das vítimas de violência, tivemos prevalência da faixa etária adulta (78,67%), casadas (45,04%), com renda de até dois salários (72,03%), ensino médio completo (33,17%), cor morena/parda (46,44%), religião católica (50,13%) e 56,87% não trabalhavam. As principais repercussões psicoemocionais foram tristeza, raiva e depressão. Os serviços de saúde devem servir como locais de alerta na detecção de eventos violentos, promovendo ações que facilitem a identificação do problema e seu enfrentamento.
Descritores: Violência Contra a Mulher; Serviços de Saúde; Saúde da Mulher; Enfermagem.

El objetivo fue investigar el perfil sociodemográfico y las repercusiones psicoemocionales de la violencia en el ámbito doméstico de mujeres atendidas en servicio de salud. Investigación exploratoria, descriptiva con enfoque cuantitativo, desarrollada en Unidad de Salud Familiar de la ciudad Verde Integrada, João Pessoa-PB, Brasil. Fueron entrevistadas 400 mujeres en enero y febrero de 2010, a través de entrevistas semiestructuradas. De estas, 211 mujeres (52,75%) con historia de violencia doméstica compusieron la muestra del estudio. Como perfil de las víctimas de violencia, hubo alta prevalencia de víctimas adultas (78,67%), casadas (45,04%), renta hasta dos sueldos (72,03%), enseñanza media completa (33,17%); afro descendientes (46,44%); religión católica (50,13%) y 56,87% solo trabajaban en el hogar, tuvo como principal impacto psicoemocional tristeza, rabia y depresión. Los servicios de salud deben servir como sitios para detección de la violencia, promoción de acciones que faciliten la identificación del problema y su enfrentamiento.
Descriptores: Violencia contra la Mujer; Servicios de Salud; Salud de la Mujer; Enfermería.

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INTRODUCTION

The violence against women is not a current phenomenon, but something which was brought culturally in the relations of gender, which define the differences between the man and woman. These differences between the two sexes are delimited both in the field of professional acting as well as in the laws elaborated by the human beings which makes clear the inequalities between them. The acts of violence practiced by the aggressors against the victims not only involve personal matters but they also represent political, cultural and social order matters[1].

In the current context, the violence of gender shows a face which is still the face of silence, but it is part of the alarming statistics which starts to surpass the private areas and they start to reach society as a whole, thus demanding competent public policies and a study made by WHO (World Health Organization, 2005) in several countries of the world, it was observed that between 13% (Japan) and 61% (Peru) of the women already suffered some kind of physical violence sometimes along their lives while from 4% to 46% of them have already been forced to have sexual relations against their will[2].

In Brazil, the violence against the woman assumes the dimension of a problem of public health, reaching ¼ of the population. Despite the high frequency, it points to the possibility that these figures can be even higher once the psychological aggression (verbal and behavioral manipulation, insults, blackmail and isolation) are rarely perceived as violence once they are not immoderate and/or cruel acts which leave severe physical damages[3]. What happens is that the psychological violence against the woman has becoming so ordinary that it is no longer perceived as aggression.

According to a world report on violence and health, elaborated by the World Health Organization, the most prevailing form of violence against the women is the one practiced by her close partner (conjugal violence) within private areas, and this is not restricted to their homes, with rates of prevalence ranging from 15% to 52% of women who experienced some kind of violence perpetrated by their partners[2].

The multiplicity of impacts of the conjugal violence has a stronger repercussion in the life of the woman more than just the sum of those impacts and does not necessarily result in action which could decrease or eliminate the aggression by her partner. The impacts in health, at work and in the family life tend to restrain the autonomy of the victimized woman and to affect her capacity to effectively search for help[4].

In this sense, it becomes necessary to discuss the public policies turned to the health of the Woman, once the violence of gender is an aggravating factor for involving the physical and psychological aspects and many times it happens for long periods of time and this can have severe consequences to health and even death.

Studies show that the attention to women in a situation of violence occurs in a fragmented and punctual manner. Regarding the services, they are not prepared to attend them in a full time manner. In a general way, the victims of violence follow several paths, due to a disarticulate process of the services. Regarding the assistance, it is noticed that the health professional creates a fragmentation of the action and the object of work. In this case the subject induces the approach of health/disease to the biomedical knowledge which are disarticulated in the socio-economic contexts[5].

Another big impasse shown regarding the acting of the health professionals is that in general, the women who are attacked by their partners look for the services of health showing several symptoms not specifically related to aggression. And the health professionals, in most of the cases, only take care of the physical symptoms not considering the psychosocial aspects. The victims of violence are having several complaints, but they avoid communicating to the health professionals the real situation of the violence they are experiencing,

because they are ashamed and these health professionals do not question anything once they have limited time available for the attendance[6].

The situation becomes worse when the woman is pregnant or during the puerperal period, once it brings significant consequences to the health both of the mother as well as of the baby, such as, abortions, delivery and premature birth, low weight at birth, interruption of breastfeeding and even maternal and/or fetal death, once it is a period in which the woman is more fragile.

We considered that the problem of the violence of gender has an interface with health, where a greater number of women in a situation of violence look for the health services in order to have the attendance of other demands of health unconcerned to violence and even in these cases, in general, they are not identified. Once the need of an intervention of an effective manner in the resolution of the problem is recognized, we question: How many and who are the women registered in the Family Health Strategy (FHS) exposed to the situations of violence? Which psycho-emotional repercussions affect these women facing episodes of violence?

So, this work had the objective to know the social demographic profile and investigate the psycho-emotional repercussions facing episodes of domestic violence in women registered in the Integrated Family Health Unit of Cidade Verde, in the county of João Pessoa, PB, Brazil.

METHOD

It is an exploratory-descriptive study with quantitative approach, performed at the Cidade Verde Integrated Unit, which has four teams of family health, located in the III Distrito de Saúde do Município de João Pessoa, PB, Brazil. As to the outlining of the study 400 hundred women registered in the service made part of that universe, whose access was made through the services of family planning, cervical-vaginal cytology and prenatal assistance. 211 made part of the sample, and they were selected by the following criteria of inclusion: being older than 18 years, being identified with a previous history of domestic violence and wanting to participate in the study.

The data collection was made in January and February 2010, through interviews technique, from previously tested and elaborated script, composed of sociodemographic data (schooling, family income, social status, ethnic group/color of the skin, time of marital status, citizenship, religious belief, marital status, time of conjugal situation, profession, and occupation/position) and other specific questions referring to psycho-emotional repercussion of domestic violence.

The participation of the women were negotiated, through the application of ethical principles of respect to their will, transparence of the purpose of the research and agreement in participating in the study through the signature of the Informed Consent Form (Resolution 196/96). The research was approved by Committee of Ethics and Research of the Hospital Universitário Lauro Wanderley, of the Universidade Federal da Paraíba (UFPB), registered under no. 007/10.

The statistical and descriptive analyses of the data were made with the help of the Statistical Package for the Social Sciences (SPSS) application, version 11.5 and presented through graphic and table representation. The analysis of the results had as theoretical contribution, recent publishing and other bibliographic sources pertinent to the theme being questioned.

RESULTS

Of the 400 interviewed women, we could detect 211 (52.75%) in a situation of violence of gender, whether it was physical, psychological, sexual or patrimonial.

Table 1 represents the social demographic data of the women victims of violence. The current situation of the participants, conjugal situation, family income, degree of schooling, ethnic group, religion and whether they work out of their homes, was considered.

Table 1– Sociodemographic data of the women victims of violence (211 women). João Pessoa, PB, Brazil, 2010

Variables	Women in a situation of violence (211)	
	n	%
Age Range		
Adult	184	87,2
Third age	11	5,2
Adolescent	16	7,6
Pregnant/Puerpera		
Pregnant	23	11,0
Puerpera	1	0,5
Marital Status		
Married	95	45,0
Consensual Union	57	27,0
Single	40	19,0
Divorced	17	8,0
Widow	2	1,0
Income		
E – Up to 2 minimum wages	152	72,0
D – From 2 to 6 minimum wages	59	28,0
Schooling		
Complete High School	70	33,0
Incomplete Grade School	58	27,5
Complete Grade School	62	29,5
Iliterate	6	3,0
University Degree	15	7,0
Ethnic group/color of skin		
Dark-skinned	98	46,5
White	88	42,0
Black	22	10,0
Indian	3	1,5
Religion		
Catholic	110	52,0
Evangelic	61	29,0
Without religion	30	14,0
Others	10	5,0
Working outside:		
No	120	57,0
Yes	91	43,0

Chart 1 presents the psycho-emotional repercussions of the violence on women, which were: sadness (21.31 %), anger (13.11 %), depression (4.92 %), insult (3.27 %), fear (2.46 %), humiliation (2.46%), anxiety (2.46 %), other feelings (2.46%) in which are inserted: embarrassment (0.82 %) threat (0.82 %) and isolation (0.82 %). With the higher frequency more than one repercussion appeared (44.55%).

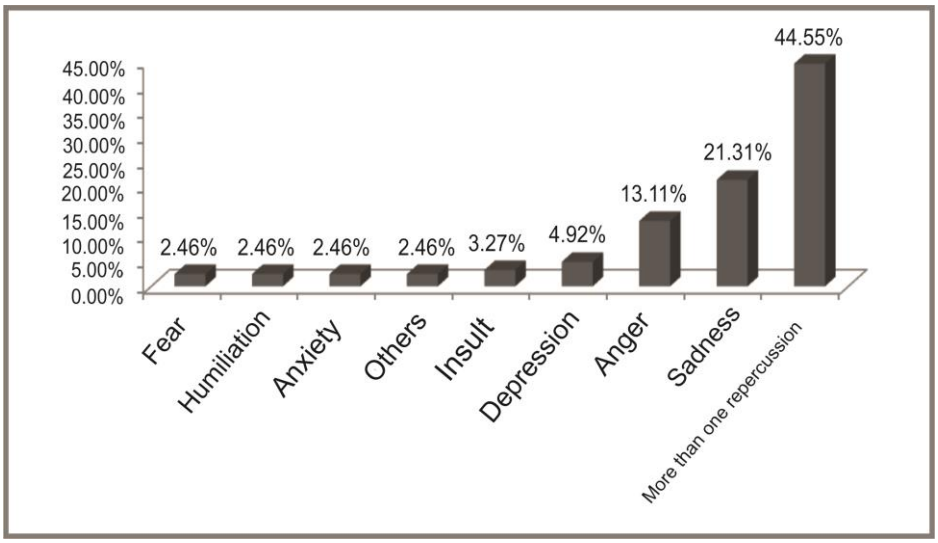

Chart 1 – Psycho emotional repercussions practiced at home(211 women). João Pessoa, PB, Brazil, 2010.

DISCUSSION

The present study revealed that 52.75% of the interviewed women already suffered some kind of violence, thus confirming a study made in Ribeirão Preto with a sampling of 265 women, which revealed a percentage of 45.3% of women suffering violence sometime in their lives[7].

A research made in Greater São Paulo showed that among 3,193 users of 19 health services, 76% of the women suffered some case of violence. This shows that the violence of gender is a common reality in our society, especially in the Health Units when the demand is predominantly female and the woman in a situation of violence tend to look for the services with higher frequency[8].

These results reveal the high levels of violence experienced by women in the domestic and family context, until recently ignored, vulgarized and considerer natural. These data show the possibility of the health services to be the proper places for the identification of the cases of violence, above all in the case of the kind of violence being questioned, once the women are users who look for the health service more often.

In these cases, the presence of the nursing professional becomes an important element in the detection of such episodes, once the nurse is one of the health professionals with a closer contact with the users of the service and the community and knows the demands of their area with the help of the communitarian agents of health and the home visits. The nurses, because they manage care, and in a general way, they provide the articulation between the other health professionals and services, are key-health professionals in the assistance to the user who suffers violence[6].

The approach offered to the woman in the health services, especially within the basic health care will make possible important unfolding in the construction of the strategies of coping with the situation of the violence experienced. These strategies will help in the transformation of the reality, reducing or eliminating the vulnerability to violence and promoting health and the rights of citizenship[9].

As to the socio-demographic aspects represented in Table 1, within the age range variable, there was a predominance of adult women which was also found in previous studies. Some authors confirmed in a research made in a Centro Especializado de Referência (Specialized Center of Reference) attending women who had been victims of violence in the city of Fortaleza, CE, Brazil that 70.3% of them were in the range of

development from 20 to 39 years old, 25% older than 40 and 4.7% adolescents (15-19 years)[10].

Three studies made in the health services located in: Ribeirão Preto; São Paulo, Santo André, Diadema, Mogi das Cruzes and Varjão (a region located in the metropolitan area of Brasília, DF, Brazil), also showed, in their sociodemographic distributions of the victims of violence, a larger number of women in the adult age range, with average age of 34.6, 31 and 30 years respectively[7-8,11]. The users of the health services are adult women, probably because they are the ones who attend the services more often to take care of their own health and also due to the incumbency which is attributed to them to take care of the members the family. Considering that the health policies turned to women are predominantly to the adult women, we point out the fragility in the actions towards the adolescents and elderly women, which can contribute to the low insertion of these groups in the health services[10-12].

Results obtained in a study with pregnant women showed even higher figures with a prevalence of 0.9% to 20.1% in a situation of violence[13]. The current research showed a high figure of domestic violence, although inferior to specific studies with pregnant women, once the population of the present work was not selective for the gestational condition. Once all the women who accepted the conditions of the research participated in the study.

A research made with 278 women ranging from 15 to 49 years old resident in the metropolitan area of Brasilia confirms the present study, showing that 83% of the interviewed women were married or lived in a stable union[11]. Another study made in a Center of Reference in the county of Fortaleza, CE, Brazil showed that 48.4% of the women under a situation of violence kept a consensual union or were married[10].

Most the women in a situation of violence are married or keep stable relationships, which makes evident a greater incidence of violence against the woman happening at home[12,14]. Therefore, it is within their houses that there are more chances for the aggressions to happen without interruption and under the shelter of the home privacy[1]. The results of the present study confirm such statement.

Thus, the Family Health Strategy is an indispensable complement in detecting episodes of domestic violence, once the program is based on the family, their relations and psychosocial context in which these users are inserted. So, nursing can develop important acting once it has the possibility of acting with the family and not only with the subject.

When questioned about the family income the women reported in most of the cases earning between one and two minimum wages monthly, thus showing the context of need/scarcity in which they lived. In a previous study made with women who registered complaints by domestic physical aggression at the Delegacia Especializada da Mulher (Precinct Specialized for the Woman) in the county of João Pessoa, PB, Brazil, it was noticed that most part of the women are in this socio-economical range, with 73.1% in classes D and E[12]. A previous research made in a Specialized Center of Reference in Fortaleza, CE, Brazil, with women in a situation of violence reviewed a similar result showing that 45.7% of the women earn up to two minimum wages[10].

In this context, we notice that the domestic violence mainly happens within those social levels of low income, due to a greater financial difficulty and eliminating the structure of the family, thus favoring an aggressive behavior. However, we must prudently analyze this statement, once the higher prevalence of violence in the less favorable social classes can be related to the fact that the poor people tend to denounce more, providing visibility to the problem usually hidden among the wealthier people[15]. This fact occurs because the people of lower classes use the services of SUS (Unified Health System) differently from the ones with the higher economical level who choose private health plans.

Still in Table 1, under the item schooling, it was evident that 70 (33.17%) women had complete high school, followed by 62 (29.38%) with complete grade school and 58 (27.48%) with incomplete grade school. But, in other researches made before this study, there was predominance of women having incomplete or complete grade school or with less then eight years of schooling[10-12]. Such situation is pointed by some authors as one of the factors which favors violence, once the women with more schooling tend to have a lower degree of tolerance to this situation[13].

The lower the social and financial support is, the higher is the risk of violence. It is supposed that there is a tendency of the women to be submitted to the victimizer for lack of opportunity to fight and face violence. Besides that, subjects with lower schooling are more frequently found in the population ranges in the condition of poverty, which favors the social exclusion and low self esteem, thus reducing the perspectives that they might have better paid activities in the work market.

It is the duty of the health professional and the society to find ways of inclusion of the population who suffers these unfavorable conditions of life. Health involves a whole psychological, social and economical context, therefore there is the need to developed intersectoral work through a partnership with the organized civil society, churches, community associations, police stations, tutelary councils, public and management prosecution; so that the social iniquities can be diminished and so, the subject can find coping strategies with the violence through nets of support[6].

Regarding skin color, the result of this study confirmed the research performed in the county of São Paulo and in 15 counties which were part of Zona da Mata in the state of Pernambuco with 2.128 women between 15 to 49 years of age, where there was a predominance of dark-skinned and white women(35 e 34.1%)[15]. However, a study made in emergency units with a sample of 1,500 attendances due to external causes (accidents and violence) revealed that 59.9% attended were black (dark-skinned and black) with low schooling[16].

Regarding the religion variable, a previous research showed that this data were different, 19.1% were Catholics, 26.3% evangelic, 12.1% followed no religion and 28% were spiritualists. The author of that study affirms that the violence of gender reaches women of all religions and such data has not influenced in keeping their homes less violent[17]. However, it is indispensible to search the help of religious entities, which had a strong influence in the population and can develop important work in the fight to the violence of gender.

When the variable occupation was analyzed, it was noticed that 120(56.87%) women were housewives. A research before this study, in a district health center of Ribeirão Preto, São Paulo, Brazil, showed that of the 265 interviewed woman, 41.9% were unemployed or reported to be housewives[7]. The same confirmed by study made of 7,750 police investigations and circumstanced terms made in a Delegacia de Defesa da Mulher (Precinct Specialized of the Woman) in the county of Araçatuba, São Paulo, Brazil, in which the number of the ones who stated to be housewives was predominant[14].

In evaluating the repercussions of the violence in the woman´s health under the present study we noticed the prevalence of several feelings. It was evident that the woman victims of violence tend to present more frailty, so they can suffer permanent effects in their self esteem and self image, becoming less secure of their values and more prone to pressure[18].

A study make in a county of the countryside of São Paulo, with a sample constituted by twelve women who registered complaint at Delegacia Policial da Defesa da Mulher (DDM)(Precinct Specialized of Woman) between 2003 or 2004 showed that all the women reported humiliation and fear[19]. In the attendance to women who are victims of violence, fear, in its most

diverse expressions, is what paralyzes them: the fear to be killed by her partner, the fear to take care of the children alone and prevent them of their basic needs, fear of exposition and scandal[20].

During the appointment, the nurse, above all, listens to the women who wish to expose their fears and anguishes. The building up of a link between the health professional and the patient allows the women victims of violence a vision of their problem, many times so hidden that it becomes invisible to the eyes of the health professionals. At this point it is important to count upon the support of the other health professionals, specially psychologists and social assistants, once the coping of the situation requires a differentiated look and listening, with the development of collective and individual actions, in different scopes[6].

One of the most important findings in this study was the evidence of a high prevalence of violence against woman among the users of the family health units emphasizing that theses situations were not recognized by the nurses and other health professionals who attend these women. In a similar survey among the users of services of primary health care made in the county of São Paulo, we found similar prevalence to the ones under this study[8]. Another finding was the invisibility of the violent occurrences by the same women, who see them as natural, vulgar and relativize the violence they suffer, and what is worse, they to do not perceive them as such.

In the assistance to the health of the women who are victims of domestic violence, the nursing team is present from the beginning, responding to their asking for help. The nurses, showing availability and acceptance to listen to them and stimulating their expressions on what they experienced, allowing them to be protagonists of their own care[19]. So, the nurse, when taking care of the patient, must have the sensibility to perceive signs of violence, even in a subtle manner, especially the psychological violence which although not physically apparent, is capable of leaving long and severe sequels on the woman.

The search of a health service results from the need of care provoked by the physical violence, by the psychological sequels, besides the vague symptoms and inexplicable pains. Many times the woman does not allow herself to report the episodes of violence she suffers, keeping the problem hidden, thus making its diagnosis difficult. The relative invisibility is strengthened by the complexity of the violence, turning it into an aggravation of difficult intervention. So, many women do not report and many nurses do not ask about that, due to the limited available time of assistance. There is also the conception that home violence is a private problem and it can only be solved within this domain.

Moreover, the lack of instruments of welcoming and the resolutive arsenal towards the problem, makes the health professionals agree with that invisibility[13]. Besides theses factors, there is still the lack of capacitation of the health professional to detect a situation of violence in the complaints presented by the women. In most of the cases, the health professionals are only worried in the physical symptoms, not considering the psychosocial aspects, with a strong tendency to prescribe medicine.

The health professionals still believe that they should not be involved, due to the lack of existent mechanisms in the services to interfere, facing the complexity of the phenomenon. They also point out that this fact is linked to the lack of formation during the graduation to deal with this theme, thus provoking embarrassing situations and, for not knowing what to say, they feel impotent facing the problem under question[6].

Besides that, from the strategic point of view, the health services do not developed actions articulated with the services of psychosocial assistance of the net of assistance to women, thus resulting in independent and inefficient actions. Knowing these services and doing the

necessary forwarding are important steps for the identification of the problem and its coping[6].

Although the problem of violence is a complex one, as well as its solution, we believe that it is indispensible to approach it and make it visible. Some strategies have been proposed in order to decrease its invisibility in the health services, such as: recognize the violence of gender as a public health problem and enable the health professionals to identify it and to approach it through welcoming; recognize the integrity of the women as subjects with human rights; to inform them on the resources of the society such as precincts for women and shelters and identify the situation of risk of life to protect the patient working in articulation with the other sectors of the society[21].

Primary health deserves to be highlighted when we are dealing with actions regarding the violence against women for several reasons. In the first place, this level of attention has a great emphasis in the actions of promotion and prevention of health, besides that, it has an increase of the coverage and recent strategy, valuing the home visit through the growing implantation of the Family Health Strategy. This level of attention requires a frequent, constant and legitimate access to the women along all their lives, a relationship which is closer to the community and is directed to common problems of health very much associated to domestic and sexual violence against the woman.

In order to prevent the cases and the promotion of non-violence, the researches suggest several actions, from a population perspective which does not necessarily pass through the action of services of health: the campaigns using the means of mass communication; the education for the equality of gender; the control of weapons in society; the control of urban violence; the control of publicity and abuse of alcohol; the quality of salaries between man and women; the quality of political participation[15].

The prevention, however, goes through actions which can be taken by the health services. In the first place, the combat to the institutional violence and the stimulus to the integrality of the attention are promoters of a good communication and interpersonal relations at work, thus showing in an exemplary manner by contrast pointing to its refusal and the non reproduction of that practice inside the services. So, the purpose to make violence visible as a question acting against its vulgarization is a practice which starts 'at home' in the health service itself. The work oriented by the principles of PAISM (Program of Complete Attention to the Health of the Woman), with the promotion of the reproductive and sexual rights and the work with conflict of gender in the perspective of the strengthening of the women and the emancipation of all users and workers, is fundamental in this sense[15].

Besides that, it is necessary to understand the role of all the professionals of the service, especially the Health Communitarian Agents (HCA), in the preventive dimension of the service. If all the health professionals can be the promoters of human rights and the intersectoral net which renders support to the non-violence and also provide work, housing, nursery and school which are all fundamental fundaments in emancipation for a life free of violence, the HCA find themselves in the specific situation of access and differentiated relation facing the questions of the housing and of the communitarian life of the user of the service[22].

Violence against women is a complex and multi-dimensional problem which has been gradually approached as a matter of public health. The sector of health has as important role in the combat to this kind of violence through the means of developing researches, notification of cases, organization of services of reference to the victims and other proposals of intervention. However, no strategy for the combat against violence can avoid approaching the cultural backgrounds of these abuses besides evidently attending the immediate needs of the victims. This means to challenge attitudes and social beliefs which provide the

foundation for the violence of men against women and create a manner of negotiation of the power between the genders in all levels of society[13].

CONCLUSIONS

The study showed the prevalence of violence in the adult age range, married, and with income up to two minimum wages, complete high school, dark-skinned, catholic and housewives, thus showing that the violence against the woman is a social problem of public health. Besides that, it brings serious consequences for the personal development and for the health of the victimized woman. This problem is reflected in the increase of the rates of suicide, abuse of drugs and alcohol, besides all the psychic suffering caused by the incapacity of the woman to cope with the situation experienced, resulting in negative feelings such as sadness, anger, depression, fear, embarrassment and others.

We must call attention to the silence and the invisibility surrounding the question of the violence against the woman highlighting the nature of the problem situated within the scope of private life and the family relations. There is a difficulty in talking about the subject and dealing with it, both in the women who suffered aggression as well the health professionals. Behind this silence there are two important questions: the non recognition that the violence against the woman is a problem of attention to health and the trend to use the language of the disease, which makes difficult the communication between the health professional and the users of the service.

So, the health services must be like places of warning in the detection of violent events, promoting actions which can make the identification of the problem and its coping easier. At the same time, it is essential to establish a relation of trust in which there is respect and the woman can feel welcome and not judged. The quality of the assistance is related to sympathetic, respectful and welcoming relation, which the health professionals must establish with the women in a difficult moment of their lives.

Nevertheless, the proliferation of studies have shown the dimension, the complexity and the seriousness of the violence against the women regarding the impact on their health, it is still necessary a wider recognition considering it is a public health problem. The training of the health professionals becomes indispensible, as well as the sensitization of the managers of the public health, the de-stigmatization of the problem and the mobilization and empowerment of the civil society. Together, such actions will guarantee improvement in the assistance and in the quality of life of these women especially within the less privileged groups, once they have fewer resources and therefore are more exposed to violence.

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