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Visible and invisible marks: facial injuries suffered by women as the result of acts of domestic violence

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Abstract *This article focuses on female facial injuries caused by domestic partners in the light of the cultural assumption that the face is the most valued area of the human body. Through a quantitative/qualitative approach, the study aimed to estimate the prevalence of lesions on the face, head and neck of women abused by their partners. The intention is to comprehend the significance, from the victim's standpoint, of the marks originated in the violent episode and investigate issues concerning healthcare in the treatment of injuries. Statistical data were obtained from reports of the Special Police Department for Women in Salvador, Bahia, and the qualitative phase of research consisted of interviews with women who filed such reports. The results showed that, in 63.2% of studied cases, there were injuries to the face and/or head and/or neck of battered women. Speech analysis revealed that facial injuries, especially permanent ones, tend to result in feelings of low self-esteem, shame and humiliation in the victim, causing severe psychological distress. It was revealed that healthcare was limited to the physical aspects of victimization, without the perception of domestic violence as a health problem and the consequent lack of referral of patients to the centers for women in situations of violence.*

Key words *Domestic violence, Facial injuries, Spousal abuse*

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Introduction

This article presents research data from a study about women who have been victimized by their partners, and focuses on cases where physical violence caused injury to the face of the woman who was attacked. This study seeks to approach this issue from the standpoint of contemporary Western culture, which considers the face as one of the most valued areas of the human body[1]. Also examined was the high incidence, referred to in national and international studies, of lesions to the face, head and neck of women who were victims of intentional violence[2-4]. In view of the fact that the face is a special part of the body which has enormous symbolic value, this study concentrates on the following issues: how often has this region been the object of domestic violence against women, according to records in the city of Salvador in the State of Bahia? What is the profile of women who have registered this type of physical abuse? What does this mean to women when they talk about this type of facial injury? How have the local health services dealt with the demand created by female victims of this type of facial injury committed by their partners?

Domestic violence or violence caused by a close partner can be understood to mean that which occurs between people who are or have been involved in an affectionate-sexual relationship, either on a formal or informal basis[5]. Even though men are also subject to such violence, most of the victims in this type of relationship are women[5-7].

Recognized as a violation of human rights, since the 1990s[8], violence against women is also seen as a serious public health problem and global epidemic. Even though not all aggressors are intimate partners or ex-partners, it is within a conjugal relationship that these occur, and mainly against women. Prolific scientific output exists on this subject, as regards trying to understand the roots of these incidents and how to propose effective strategies to prevent and confront this issue.

According to Grossi[9], to have a better understanding of the dynamics and violence of an intimate-partner relationship, certain factors should be considered that are related to both partners regarding what produces violent co-existence, as well as the cultural context in which the couple is situated. According to the author, men and women both take part in constructing violent interaction, even though in different ways. Izumino[10] also shares this view, adding that domestic violence occurs in a power relationship between genders, where power circulates between partners, albeit in an asymmetric form. This approach enables more beneficial outcomes when elucidating violent relationships and equating the dualism of male-tormentor versus female-victim[7,9,10].

It is recognized that this confrontational form of co-existence is the result of a hierarchical social environment of gender inequality, where the male has historically been given the "natural" attributes of strength and dominance, while females are viewed as frail and submissive[9-11]. That is to say, men are seen as being superior to women, thereby making it seem natural and legitimate that, in certain circumstances, a male partner can use violence against his female companion[9,11]. In Brazil, from the twentieth century, these rigid models of masculinity and femininity began to be questioned by feminist movements that denounced violence based on gender and demanded convictions for so-called "honor crimes," which had, until then, been legally justified[9,11].

It is undeniable that great advances have been made and that the slow historical process of deconstruction of "natural" gender standards has occurred in modern Western society. Even so, violence in the domestic sphere has manifested itself in new ways and, in some regions, the epidemiological indexes have shown a significant increase in such incidents in many different countries, especially regarding the number of female victims of domestic violence[5,6,12].

Reichenheim et al.[13] consider that Brazil shows a "shocking pattern" of domestic violence, where statistics suggest that one woman is killed every two hours somewhere in its territory, which places the country in twelfth place on the international scale for female homicides. Even though feminist movements have managed to maintain their activities to fight against violence against women, and more rigorous laws in this sense have been enacted since 2006[14], new information indicates an even more unfavorable situation. According to the updated Map of Violence[6], Brazil has risen to seventh place in the world ranking of female victims of homicide. Another, even more recent publication, that produces statistics based only on national data, registered the State of Bahia as being in second place among Brazilian States for the number of cases of female homicides, placing it only behind the State of Espirito Santo[15].

In addition to causing deaths, as has been widely documented, violence between couples aggravates immediate and long-term consequences for the non-fatal victims of such aggressions, involving serious and chronic injuries that, for their part, will affect the family network, so-

Ciência & Saúde Coletiva, 20(9):2911-2920, 2015

cial and work relationships, as well as the health-care system[5,7,8].

Domestic violence and the female face

In the review of the available literature, few reports were found that specifically focused on the female face in cases of domestic violence. However, there is wide agreement that the region of the head, neck and, especially, the face, are parts of a woman's body most liable to violent attacks. There are several studies written in English which show that "*injuries to the HNF - head, neck and face*" can indicate violence by a partner, due to their frequency[16,17]. In Brazil, Deslandes et al.[18], when analyzing cases of domestic violence in Rio de Janeiro, calculated that 37.5% of women receiving treatment in two hospital emergency departments, were injured in the head or the face by their aggressors. In a research study conducted in a basic health unit in the municipality of São Paulo, Schraiber et al.[19], found that similar attacks accounted for 54.6% of such injuries, while Rabello and Caldas Júnior[3] found that, when examining cases of bodily injuries reported to the Police Precinct for Women Victims of Violence, in a capital in northeastern Brazil, found that, in 56.2% of these cases, the victims were injured in the cranium and facial area. In another study, based on field research conducted in a town in the interior, Lamoglia and Minayo[20] concluded that, in this same context, a woman's face was the *locus o*f the body that was usually targeted by the violent blows of their aggressive partners.

This trend also appears to be confirmed in the international scenario, since all findings point in the same direction. In a hospital in the state of Oregon in the USA, the proportion of women with oral and maxillofacial injuries caused by domestic violence represented 81% of the cases researched[4]. Data collected in four hospitals in Greece (two in urban and two in rural areas) showed a incidence equal to 62% of traumas to the head or face of female victims of domestic violence[21]. In Malaysia, Saddki et al.[2] reviewed 242 recorded cases of women who had been attacked by their partners who were treated in a special hospital for victims of violence, and found that 74.8% of these had maxillofacial injuries (50.4%) or injuries to the head (24.4%). Thus, the same pattern appears to repeat itself in research conducted in Brazil, North America, in Europe and in Asia, involving populations representing different social, economic and cultural profiles, which illustrates the global dimension of the close relationship that exists between violent acts that occur in a domestic environment and attacks made on a woman's face.

We need to question the simplistic common belief, referred to in several scientific works, that attributes the high rates of facial injuries in female victims of domestic violence, as being solely due to the fact that the face is the least-protected and most exposed area of the body. We also need to consider the subjective nuances involved in this phenomenon. Based on this viewpoint, a more thorough investigation is justified, in view of the assumption that a temporary or permanent physical injury associated with this region, can take on a singular meaning, when suggesting an overlap between physical or psychological violence, which is provoked by this type of humiliation; the threat to the preeminent *locus* of personal identity and violence to human dignity that an act of aggression to the face can represent[1,3,20,22-24].

Methods

A quantitative-qualitative approach was chosen due to the aims of this study, namely, to understand the dimension of the object of study by linking statistical data to subjective issues. This complementarity between quantitative and qualitative methods is referred to by Minayo[25] as a step towards achieving a better understanding of these phenomena based on a dialogic interaction between the inputs. The methodological strategy is based on the following outline:

Quantitative stage

A descriptive, transversal study, based on: a) calculating the incidence of injuries to the face and/or head and/or neck (HNF injuries) of women, aged between 18 and 59, who went to the Special Police Department for Women (DEAM), at the unit in Brotas, in Salvador, Bahia., to report physical violence committed against them by their partners; b) to characterize the profile of those reporting such acts of violence and obtain information related to the victim's case.

Initially, this study was designed as a means to investigate only facial injuries, however, it was noted that in many Police Occurrence Reports (PORs), the term "head injuries" was used to describe injuries to the area of the forehead, the eyes and neck of the victim (the latter usually included in cases of trauma to the jaw or below the chin). It was therefore decided to include data related to the head and neck as well. This decision

also made it easier to compare our own with international research findings[16,17].

An intimate partner was defined as: a husband (in either a formal or informal union); companion, boyfriend or occasional sexual partner, provided that, at the time that the act of violence was committed, the aggressor was maintaining or had previously maintained a close relationship with the victim. The DEAM was selected because it was necessary to work only with registered cases of domestic violence. In other areas that could be used as a field of research, such as hospital emergency departments and healthcare units, this type of violence is often not mentioned by the victims, which would result in a bias in the selection of the case studies[2,19,21,26].

Included in this survey were the PORs that came under the heading of "body injuries," during the period between January 1, 2004 and December 31, 2008. This selection was based on the year 2006 (when Law 11.340/2006 – the Maria da Penha Law[14] was introduced) for the purpose of investigating possible differences in the number of registered complaints, during the two-year period before and two years after the afore-mentioned Law was enacted. This investigation will be the object of another research study.

Calculations for this sampling were guided by a pilot study, where a random selection of 164 PORs was made of the total number of entries at the same DEAM, between 2002 and 2008. The PORs used in this pilot study were excluded from the main survey. The aim of this preliminary work was to estimate the incidence of HNF injuries and test the suitability of the proposed information collection instrument. The frequency of HNF injuries found was 70.1%. A confidence level of 95% was established with a 5% error probability, to include a total number of 323 PORs as a minimum sampling required. To obtain a representative sampling for the 11,741 PORs typified as "body injuries," for the selected period, a two-stage cluster probability sampling technique was used[12].

The sixty months for the research period of interest were included in the random selection. Two days in each month were randomly selected and then three PORs per day for each month, making a total sampling of 360 PORs. Each POR was read carefully and the socio-demographic information about the victim and the incident involved was transcribed on the data collection instruments. Thirty-two cases of acts of violence were excluded, since the aggressors did not qualify as intimate partners, and a further two cases did not meet the inclusion criteria, which meant that 326 PORs were validated for the purpose of the analysis. A data bank was created using IBM SPSS version 20 software for the information collected, to produce the proposed statistical descriptions.

Qualitative Stage

The second part of the study, which was conducted during the period following the first phase, included narrative interviews with women who had a history of facial injuries caused by their partners and which were characterized as body injuries in police records. The aim was to discover more how the women felt, based on their own words, about the facial injuries they had received, as well as to investigate issues related to the healthcare treatment they had received for the injuries they had suffered.

The narratives of ten women who had filed a complaint at the DEAM were analyzed. Four interviews were conducted at the Police Station itself and six took place in special centers for women in situations of violence located in town. All these meetings were held between July and November 2012, in private rooms, with enough privacy to guarantee the confidentiality of the information provided. Access to these women was organized through the intermediary of the psychosocial services at both locations. Only one of the eleven women (within the parameters of inclusion) invited to take part, refused to do so. Since the statements that were given met the data saturation criteria, it was decided not to include other informants.

The participants were guaranteed anonymity, as well as the freedom to refuse our invitation to participate in this survey. Their narratives were only recorded and transcribed once they had signed informed consent agreements. Furthermore, we offered to request psychotherapeutic support and dental treatment for all those who needed help in these areas and who were not receiving the necessary assistance.

An analysis of their statements was essential from the point of view of body sociology, for which the content was reorganized according to categories of meanings, so as to establish a nexus between their statements and these theoretical framework guidelines[25].

The informants were aged between twenty-seven and forty-seven and had different socio-economic backgrounds, educational levels and skin colors. Seven of these women had separated from the partners who had attacked them and described violent events during the time they were living together and after they had separated.

Ciência & Saúde Coletiva, 20(9):2911-2920, 2015

The other three were still living with their partners at the time they registered their complaints and gave interviews.

All ethical aspects as foreseen by current legislation were respected by obtaining approval for this project from the Research Ethics Committee at the Institute of Collective Health at the Federal University of Bahia.

Findings and discussion

Of the 326 PORs researched, 206 recorded the presence of HNF injuries committed by a close partner, resulting in a prevalence of 63.2% ($IC_{95\%}$ = 57.0; 67.6). In 101 police bulletins (31%), no reference was made to injuries in these regions. In nineteen cases (5.8%) the information recorded was not clear (Table 1).

In Salvador, the high prevalence of 63.2% shows similar results to other research based on the same subject. In order to provide a comparison, Table 2, as follows, shows the findings of studies conducted since the 1980s. As can be seen, in the almost thirty years that have elapsed between the first and present investigations, the prevalence variation has oscillated, but has always maintained high rates, the minimum frequency being 37.5% and the maximum 81%. These differences may be attributed to the different methods and field studies employed.

Collating the prevalence of 63.2% estimated in this study, with an average annual rate of occurrences classified as "bodily injuries" during the period studied (11,741 in five years, with an annual average of 2,348 registered cases), it may be inferred that every year nearly 1,484 women presented some form of HNF injury, caused by domestic violence. Since these findings can only be applied to those women who actually went to the DEAM in question, it is reasonable to assume that this is a far wider problem, bearing in mind that many cases are never reported by the victims.

An analysis of the records included in this sampling indicates that the age of the women filing complaints varied between eighteen and fifty-six, giving an average age of 30.2 (DP = 8.2). With regards to data collated by age group, it may be noted that 77.9% were aged between twenty and thirty-nine years. Most of the women were dark-skinned (67.2%), lived in poorer neighborhoods (67.8%) and had completed between five and nine years of schooling (39.6%). As regards their occupation, 193 women (59.1%) said they had some sort of paid job, 70 (21.5%) said they were "housewives," fifteen (4.6%) were unemployed and twenty-two (6.8%) were students. This information is shown in Table 3.

Findings in respect of the age of the victims, their level of schooling, district where they live and occupation reiterate other studies[2,3,7,18]. With regards to the high level of dark-skinned and

Table 1. Absolute frequency (*f*) & relative frequency (%) of HNF injuries in women beaten by their intimate partners. DEAM-Brotas, Salvador, 2004-2008.

HNF Lesion	*f*	%
No	101	31.0
Yes	206	**63.2**
No information	19	5.8
Total	326	100

Table 2. Prevalence of HNFinjuries in female victims of domestic violence.

Author/ Date	Place where study was conducted	Source of data	Prevalence of HNF injuries (%)
Dourado; Noronha	**Brazil (Salvador/BA)**	PU*	**63,2**
Saddki et al.[2], 2010	Malaysia (State of Kelantan)	HS**	74,8
Bhandari et al.[27], 2006	USA (State of Minnesota)	Minnesota DAP***	40,0
Rabello e Caldas Jr[3], 2006	Brazil (João Pessoa/PB)	PU	56,2
Schraiber et al.[19], 2002	Brazil (São Paulo/SP)	HS	54,6
Petridou et al.[21], 2002	Greece (Athens)	HS	62,0
Le et al.[4], 2001	USA (Portland/OR)	HS	81,0
Deslandes et al.[18], 2000	Brazil (Rio de Janeiro/RJ)	HS	37,5
Berrios e Grady[28], 1991	USA (San Francisco/CA)	HS	68,0
Azevedo[29], 1985	Brazil (São Paulo/SP)	PU	61,1

* Police Unit. ** Healthcare Services. *** Minnesota Domestic Abuse Program.

black women who reported such aggressions, this may be due, among other factors, to the socio-demographic characteristics of the capital city of Bahia where, according to the Municipal Information System for Salvador[27], more than seventy percent of the population consists of non-white persons, especially those resident in poorer neighborhoods. In this respect, D'Oliveira et al.[12] note that the association between variable of race/skin color and violence by an intimate partner, when controlled by other socio-demographic variables, tends to disappear.

Table 4 shows information related to the act of aggression that led to the lodging of an official complaint. It can be seen that the act of aggression usually occurred at the home of the victim (67.2%) and that 229 of those accused (70.3%) were the close companions of the woman assaulted, while 92 of them (28.2%) committed a violent act after the conjugal ties had already ended. As already mentioned in the methodology section, others who committed such assaults have been excluded from this survey.

Data related to the place where the violent act took place and where the woman's partner was the main aggressor, are also corroborated by many other published works[2,3,7,18,21]

It's worth observing that approximately 25% of all aggression took place in external environments (in a public place or street), which shows that, in many cases, possible social sanctions against those committing acts of violence in the presence of third parties does not act as a deterrent. Another question that is worth considering relates to the fact that nearly thirty percent of the aggressors were no longer living with their victims, which could indicate that, for a woman, severing the ties they have with a violent partner does not always mean ending the risk of suffering physical violence or moral degradation. In certain situations, severing a relationship merely leads to even greater aggression which, if effective measures are not adopted to protect her, could end with the woman being assassinated[28].

Table 3. Absolute frequency (*f*) & relative frequency (%) as regard age group, skin color, education, residence and occupation of women who have been beaten. DEAM-Brotas, Salvador, 2004-2008. (N = 326)

Characteristics	*f*	%
Age group (years)		
18 a 19	25	7,7
20 a 29	155	47,5
30 a 39	99	30,4
40 a 49	38	11,7
50 a 59	8	2,5
No information available	1	0,3
Skin color		
White	33	10,1
Black	66	20,2
Dark-skinned	219	67,2
No information available	8	2,5
Education (years of study)		
0 to 4	26	8,0
5 to 9	129	39,6
10 to 12	124	38,0
13 or more	19	5,8
No information available	28	8,6
Residence		
Poor neighbourhood	221	67,8
Middle-class neighbourhood	78	23,9
No information available	27	8,3
Occupation		
Paid employment	193	59,2
Housewife	70	21,5
Student	22	6,8
Unemployed	15	4,6
No information available	26	8,0

Visible and invisible signs of aggression

The analytical process of the narratives revealed singular experiences of victimization, together with similarities in perceptions regarding aggressions to the face. Those most frequently mentioned are highlighted here: the repercussion caused by marks resulting from violence and the sense of humiliation and shame caused in particular by being attacked in the face.

As a rule, being exposed to a traumatic event tends to result in those affected suffering physical

Table 4. Absolute frequency (*f*) & relative frequency (%) as regards the location of the violent incident and link between the aggressor and the victim. DEAM-Brotas, Salvador, 2004-2008. (N = 326)

Information about the incident	*f*	%
Location of violent incident		
Victim's home	219	67,2
Public place or street	81	24,8
Home of third parties	12	3,7
Aggressor's home	10	3,1
Other location	1	0,3
No information available	3	0,9
Aggressor (relationship with victim)		
Partner	229	70,3
Ex-partner	92	28,2
No information available	5	1,5

Ciência & Saúde Coletiva, 20(9):2911-2920, 2015

and psychological reactions, in different degrees and according to individual and social factors, as well as those related to the type of trauma experienced[29]. Even though all those interviewed had suffered aggressions to the face, some described more serious effects related to the subjectivity of these acts of violence, irrespective of whether these left physical or emotional marks:

I can no longer look at myself in the mirror. I looked once and never could do so again, because I didn't want to see how I look. Even now, when I see myself like this [...] *How can I show myself with this mark on my face and a broken tooth?* [...] *my tooth is going to be restored, but the mark on my face remains* [...] *and even if there are no marks, here inside of me it is even worse* (E – 7, aged thirty-three).

Based on this narrative, it can be seen that injuries to the face caused by domestic violence, tends to aggravate the after-effects of what happened, given the symbolic relevance given to this area of the body[1]. This is what Le Breton[24], means when he says:

The face is, of all the parts of the human body, the one where the highest values are concentrated [...] An *alteration to the face, showing the mark of an injury, is a dramatic experience* [...] *an injury, even a serious one, on the arm, the leg or on the stomach doesn't make a person feel ugly, these do not change their sense of identity.*

Another informant, when questioned about the trauma she had suffered, translated her experience into the author's theoretical postulate:

To have a scar on your face is really ugly. You can wear a coat to hide one on your arm. You can wear trousers to hide one on your leg, but that thing you have, marking your face, it's really ugly. (E – 9, aged thirty-one).

Visible physical scars, involve invisible, emotional scars, which together reverberate on the subjectivity as well as the social relationships of the person who has been victimized. Furthermore, marks that were intentionally inflicted on the face of a woman seem to establish a further element of masculine power, exercised in the form of physical violence on an area of the body that is high visible and, according to Le Breton[1], is culturally symbolic *of a subtle revelation the loss of which (disfiguration) frequently results in a person losing the will to live, profoundly affecting their sense of identity.*

Humiliation and Shame

Feeling a sense of humiliation and shame associated with aggressions to the face were frequently mentioned in these statements. Humiliation in particular was mentioned, irrespective of whether or not the act of violence was committed in front of third parties. A feeling of shame, on the other hand, was related far more to a fear of outsiders seeing the marks of violence and the projection of their moral judgment as a result[30].

A feeling of humiliation is usually associated with asymmetric relationships of power, when one of the parties involved in such an interaction is arbitrarily placed in a position of inferiority in relation to the other[31]. This situation is described by the Maria da Penha Law[14] as one of the psychological forms of violence used against a woman, since this causes emotional damage and poses a threat to self-image. The feeling of humiliation is not only linked to judgments made by outsiders, but also to an inner feeling of degradation caused by aggression. One of the informants revealed the emotional impact caused by two slaps that she received to the face during one of many acts of violence that occurred during the nine years she lived with her partner:

Researcher: Do you think the fact that he hit you in the face was different to any other part of the body?

– The two slaps to my face were very different [...] *It was humiliating. It was worse than the punches.*

R: Do you think the slaps were more humiliating than the blows he gave you?

– Much more humiliating. Two slaps in the face, Nobody knows about this, I never told anyone. [...] *I'm telling you now. I never had the courage to tell anyone about the two slaps he gave me in the face. It felt so humiliating, I couldn't tell anyone* (E – 8, aged thirty-three)

However, according to the concept of the informant, the slaps to her face, although less brutal than a blow, produced intense moral suffering, since humiliation was part of the act itself. According to Brazilian legislation, a slap in the face is viewed as a crime against a person's honor, classified under the heading of an "Insult" and, according to Silva[32]: "A slap is identified as a "True Insult," since it is demeaning, and humiliates the person who was slapped."

An inability to share the experience seems to be related to the negative social value given to aggressions to the face, and the possibility of being exposed to third parties implies embarrassment or shame on the part of the person offended.

According to La Taille[30] shame: "can be triggered by the simple fact that others have seen this act, even when no negative judgment is involved on the part of those witnessing the event." In

this sense, another participant describes how she modified her behavior, so as to attract less attention to the marks on her face:

I stopped using lipstick after this (the scar resulting from the aggression). *I stopped using lipstick. I stopped because I feel that if I use this here it will show (the scar) even more* [...], *just draw attention to it. So, I now feel ashamed* (E – 6, aged forty-three).

The subtraction of the esthetic resource of lipstick, one of the cultural symbols of femininity, illustrates her attempt to avoid others looking at the marks left by her partner's act of aggression and the possibility of being judged according to these scars, hence her sense of shame. This shows, in a certain way, the revictimization of a woman who, deprived of her usual beauty aids, endures further suffering as a result of the violence she has experienced.

Invisibility in the healthcare sector

Since all the informants suffered facial injuries during acts of domestic violence, most needed medical care to treat their injuries. The main injuries were abrasions, bruises, bruising and swelling, resulting from pysical attacks (without the use of a weapon), such as slaps, punches and being shoved. Also mentioned were dental fractures and injuries involving cuts-contusion caused by the use of a blunt object.

In the most serious case, the victim showed scars from severe lacerations to the face and neck, caused by an attack by her ex-companion who was armed with a broken bottle.

When describing their experiences when they sought healthcare service treatment, none of those interviewed reported that the professionals had made the obligatory notification, as stipulated by Law 10.778, and in force since 2003[33], for cases of domestic violence against women, nor were they referred to other services that are part of the network providing assistance to women in situations of violence.

This omission was not noticed as such by most of the participants, which indicates that the biomedical model usually tends towards dividing individuals into *soma* and *psyche,* using a dividing line between the needs of the body and their non-tangible needs, relegating the former to other non-health departments. However, one of the interviewees revealed that she had questioned the assistant doctor about clarifying the cause of her injury:

After he (the doctor) *had stitched it up, I said: "aren't you going to ask me why I had these stitches, no, what caused this injury? And he said: 'Ah, yes, I have to make a medical report here.' I said: 'Yes." So he made the report there, and wrote "aggression," but did not mention the reason for the aggression.* (E – 7, aged thirty-three).

This case seems to reflect a broader reality. The study conducted by Schraiber et al.[26], in nineteen public healthcare centers, in the city of São Paulo, registered 2,321 cases (76% of the total number investigated) of domestic violence among its users. However, acts of violence were only registered in eighty-nine (3.8%) of the medical charts. These authors concluded that the high prevalence of violence against women contrasted with the invisibility that this phenomenon has within the health sector, at least in official terms.

The literature review carried out by Bernz[34] indicated that violence against women remains a huge challenge for healthcare professionals. Some of the limitations they list include: lack of qualification or lack of capacity training, cultural resistance to discussing this issue with patients and prioritizing a biologistic approach, in detriment to precepts of integrality. Thus, the treatment given to those participating in this survey shows the replication of a pattern that is still hegemonic, characterized by reductionism, whose therapeutic competencies are limited to merely prescribing medication and using material technologies alone. Thus, this attitude tends to distance healthcare professionals from recognizing domestic violence as a health issue, as well as block the efforts made by some sectors of society to give greater visibility to domestic violence which, historically, has always been linked to the private domain[10,18,25,34].

Final Considerations

The findings of this study, associated with several other academic publications on the subject, show the importance that an attack on the female face has in violent domestic relationships, not only because of the high incidence of such cases, but also because of the serious repercussions that these have on the lives of the victims.

With regards to the frequency of such cases, it should also be added that recent data, supplied by the DEAM involved in this research, show that between 2009 and 2013, the average number of registered cases of "bodily lesions," continued to be very similar to the figures established in this study, that is, around 2,500 cases every year[35]. Based on the estimate provided here, it is very probable that nearly one thousand five hundred

Ciência & Saúde Coletiva, 20(9):2911-2920, 2015

complaints involving HNF injuries caused by a partner will be registered annually at this police department, which shows the substantive requirements that need to be addressed by the different areas of assistance as regards this phenomenon.

In addition to these issues, it is worth noting the proportion of ex-partners who are responsible for reported acts of aggression, which demonstrate the risk that some women are vulnerable to when they try to end a confrontational relationship. Davies et al.[28] argue that this situation may be due to individual and, particularly, socio-cultural factors which shape asymmetric power relationships between genders, where the male partner continues to nurture feelings of control and rights over a woman, even after the relationship has ended. These authors also state that stalking (a more visible form of harassment), as well as the risk of femicide is greater when the aggressor is an ex-partner rather than during the time they cohabited.

As regards the subjective implications of violence as emphasized in this study and revealed during the statements given by informants, it is evident that emotional suffering is associated with the visible and invisible marks left by the abuse they have suffered. Based on this same perspective, Dourado and Noronha[22] cite violence to facial beauty (a highly-valued attribute in modern Western society), the degradation of self-image and the threat to personal identity as some of the aggravating factors in this type of victimization. Following this same line of thought, Halpern[16] suggests that the marks left can be felt as visible reminders of suffering, which can heighten post-traumatic sequels. That is to say, the experiences being studied indicate that physical and emotional needs are interwoven, which need to be followed-up through joint efforts by different healthcare sectors. In cases similar to those emphasized in this survey, health needs often require multidisciplinary actions by doctors (emergency physicians, plastic surgeons, orthopedists, and others), dentists, physiotherapists and psychologists who have been sensitized and trained to deal with victims of domestic violence.

In addition to articulating the need for integrality-based health care, the demands of the victims of this particular form of violence, because they go beyond the limitations of healthcare, require a network of actions that include areas of public security and the judiciary. In this respect, it is essential that the intersectional flow of care for women in situations of violence can be achieved in a concatenated form between different points of the network, thereby avoiding the fragmentation of assistance and contributing to the resolution and effectiveness of these actions.

Finally, it is imperative that visibility is given to the objective and subjective dimensions of female victimization in a domestic environment, and that, in the health sector, in particular in emergency and basic units, women who present non-accidental injuries to the face that indicate violence by their partners, be questioned about the cause of the aggression and, in confirmed case, that these are referred to other sectors within the network that deals with violence against women. Preventing renewed incidents and minimizing the negative repercussions that are evident through this research, should be issues that are re-considered in the everyday performance of these services.

Collaborations

SM Dourado worked in the conception and execution of research, in the analysis and interpretation of data and writing article. CV Noronha oriented the master's thesis that originated the article, collaborated in the analysis and interpretation of data and writing article.

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