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Intrafamily violence and speech therapy: a content analysis

Violência intrafamiliar e fonoaudiologia: uma análise do conteúdo

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ABSTRACT

Purpose: to analyze the difficulties and facilities reported by Speech and Language Pathology and Audiology in cases of domestic violence against children and/or adolescents. **Methods:** cross-sectional research, carried out through the application of questionnaires with speech therapists from Paraná and Santa Catarina. Professionals from the clinical field who assisted children and adolescents were included, and speech therapists who only assisted adults and the elderly were excluded. The data were explored through the Content Analysis methodology. **Results:** 75 Speech and Language Pathology and Audiology were included, 70.7% from Paraná and 29.3% from Santa Catarina. Of the participants, 52% assisted children and/or adolescents with suspected or confirmed cases of violence. In the content analysis, the results were allocated on a single axis subdivided into three thematic sub-axes: 1.1 professionals who did not report difficulties or facilities, sub-axis 1.2 the facilities and sub-axis 1.3 the difficulties. **Conclusion:** The facilities of the Speech and Language Pathology and Audiology in caring for victims of child and youth intrafamily violence are related to a good therapeutic bond between the patient and/or family members and adequate multidisciplinary/interdisciplinary and network work. The difficulties in Speech and Language Pathology and Audiology care for children and adolescents victims of violence are related to the dialogue with the family, the support bodies, the frequency of the patient, the elaboration of therapeutic strategies, and the lack of professional and psychological preparation of the speech therapist.

Keywords: Speech and language pathology and audiology; Violence; Exposure to violence; Child; Adolescent

RESUMO

Objetivo: analisar as dificuldades e facilidades relatadas por fonoaudiólogos em casos de violência intrafamiliar contra crianças e/ou adolescentes. **Métodos:** pesquisa transversal, realizada por meio da aplicação de questionários com fonoaudiólogos do Paraná e Santa Catarina. Foram incluídos profissionais que prestavam atendimentos clínicos voltados a crianças e adolescentes, sendo excluídos fonoaudiólogos que atendiam apenas adultos e idosos. Os dados foram explorados por meio da metodologia de Análise do Conteúdo. **Resultados:** foram incluídos 75 fonoaudiólogos, sendo 70,7% do Paraná e 29,3% de Santa Catarina. Dos participantes, 52% atenderam crianças e/ou, adolescentes com casos suspeitos ou confirmados de violência. Na análise de conteúdo, os resultados foram alocados em um único eixo, subdividido em três subeixos temáticos: 1.1 profissionais que não relataram dificuldades ou facilidades, subeixo 1.2 as facilidades e subeixo 1.3 as dificuldades. **Conclusão:** as facilidades do fonoaudiólogo no atendimento às vítimas de violência intrafamiliar infantil e juvenil estão relacionadas ao bom vínculo terapêutico com paciente e/ou familiares, ao adequado trabalho multidisciplinar/interdisciplinar e em rede. Já as dificuldades no atendimento fonoaudiológico voltado a crianças e adolescentes vítimas de violência são relativas ao diálogo com a família, aos órgãos de apoio, à frequência do paciente, à elaboração de estratégias terapêuticas e à falta de preparo profissional e psicológico do fonoaudiólogo.

Palavras-chave: Fonoaudiologia; Violência; Exposição à violência; Criança; Adolescente

Study carried out at the Regional Speech Therapy Council - 3rd region – CREFONO-3, covering the states of Paraná (PR) and Santa Catarina (SC), Brazil.
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INTRODUCTION

Intra-family violence is defined as any action or omission that harms the freedom and development of those involved, whether they are members of the same family or sporadic family members and visitors[1]. This form of violence can be interpreted as an asymmetrical and hierarchical relationship of power to subjugate others, placing them in a position of inequality due to their age or gender[2]. When it comes to intra-family violence against children and adolescents, it can occur in any family configuration. Even though it happens more frequently in the domestic environment, it is not restricted to this space. It also occurs in public places[2].

Violence does not have a single cause. On the contrary, it is multi-causal, related to social, economic, cultural determinants, and behavioral aspects. Thus, it is necessary to involve professionals from different areas, such as health, education, justice, civil society, media, and public and private initiatives to take effective actions in the face of violence[3]. However, as the negative impact of family violence on the victim's well-being is recognized, the work of professionals and health services to fight it becomes even more essential[3].

Violence suffered by children and adolescents in its many manifestations - physical, psychological, sexual, neglect, or abandonment - increases the demand for care in health services. Therefore, the health sector is considered the main gateway to care for victims of violence, enabling their recognition, especially when the family is responsible for perpetrating violence against their children[4]. Thus, it means that health professionals are in a position to identify likely situations of violence, given that victims seek health services due to physical or emotional harm[3].

However, there are impasses among health professionals regarding fighting violence[5]. These obstacles include: the lack of information regarding signs and symptoms of violence against children and young people; the physical, social, economic, and emotional lack of structure for dealing with violent situations since many professionals feel helpless and are unable to guide the family; lack of knowledge of legal aspects to be considered when referring victims of violence, and support bodies; and the lack of training courses on intra-family violence[5,6]. Research also points to professional difficulties involving aspects such as denial, prejudice, and fear related to the legal obligations that must be assumed in cases of notifications to specific bodies, such as Guardianship Councils[7,8].

Given the above, health professionals must reflect and acquire knowledge that provides support to act and intervene effectively in situations of family violence. When presenting conditions to ensure help to the victim and their whole family, the professional tends to abandon actions that incriminate and marginalize the people involved, including the perpetrators. Therefore, it is not enough for the professional to identify cases. They must also be prepared to handle each situation, mitigating the guilt and shame of the people involved in the family network and, more broadly, in the community's dynamics[9].

Speech therapists are among health professionals who face child and juvenile rape. The proximity this professional can establish with the child or adolescent, combined with the fact that they remain in a private environment without guardians, makes monitoring more favorable for identifying possible victims. Furthermore, frequent contact with the family can help identify situations, being an important moment for prevention and intervention, as it can break the cycle of violence repeated within different families[9].

Therefore, this study aimed to analyze the ease and difficulties reported by speech therapists in clinical care for children and adolescents victims of intra-family violence.

METHODS

This study was approved by the Ethics Committee of the Tuiuti University of Paraná under no. 34894720.6.0000.8040. It is a transversal, descriptive, and analytical study. It comprised sending questionnaires in March 2021 to 4,297 speech therapists working in Paraná and Santa Catarina, registered with the Regional Speech Therapy Council – 3rd region (CREFONO-3).

The questionnaire was structured on the Google Forms platform, with 29 questions based on an instrument developed in previous research[9]. However, it was adapted to cover questions capable of responding to this study's objectives. The initial part of the questionnaire, which had eight questions, addressed the participants' sociodemographic and educational data, such as place of residence, training time, areas of expertise, and academic level. The second part focused on the role of the speech therapist in situations of violence, including the number of cases treated, the victim's gender and age group, and the ease and difficulties faced by professionals. Finally, the last question had an open space for statements or comments.

The CREFONO-3 sent the questionnaire by email to professionals on March 12, 2021, which remained open for responses for two months. This method was chosen to reach the largest number of professionals working in both states quickly and simultaneously. Initially, 60 completed questionnaires were received in one month. Due to the low engagement, the instrument was sent a second time to speech therapists the following month, with another 25 answered questionnaires. Thus, 85 questionnaires were collected in total. The participants had their identities preserved, coded, and recognized using Arabic numbers from 1 to 85.

Professionals who worked in a clinical setting with children and adolescents were included. Speech therapists who only treated adults and older people were excluded. A convenience sample was used. It included participants who responded to the questionnaire and met the eligibility criteria. All included individuals signed the Informed Consent Form.

The responses collected were explored through Content Analysis (CA) because this methodology allows for exploring the linguistic content collected based on quantitative and qualitative criteria[10]. The qualitative analysis was developed based on the recognition of themes present in the participants' speeches and organized into categories, allowing interpretation and discussion[10]. This analysis was organized into three phases.

The first stage, called pre-analysis, aimed to organize the research material. It included the selection of documents, the formulation of hypotheses, and the development of indicators that supported the final interpretation. At this stage, the exhaustiveness rule was considered in which all elements of the researched corpus were considered[10].

The second phase explored the material through coding, seeking to systematically transform the raw data into common units[10]. Coding occurred through the textual cut of the recording units, which presented variable nature and dimensions, focusing on the themes[10]. Then, the enumeration rules were applied to evaluate the frequencies of the registration units[10].

The third phase dealt with classifying and aggregating registration units into categories. This procedure comprised grouping the units according to their common characteristics organized into thematic categories[10].

The responses were grouped for descriptive statistical analysis with the percentage calculation in the quantitative analysis. The analyses were carried out using the Jasp statistical software, version 0.14.1.

RESULTS

Even though 85 questionnaires were collected, two professionals decided not to participate in the study after reading the ICF, and eight were excluded because they only treated adults and older people. Therefore, 75 speech therapists were included.

Of the 75 participants, 70.7% were from Paraná and 29.3% from Santa Catarina. Regarding the time since graduation, five (6.7%) graduated less than a year before this study, 30 (40%) graduated between 1 and 5 years, 15 (20%) between 6 and 10 years, 13 (17.3%) between 10 and 20 years, and 12 (16%) for more than 20 years. Regarding the academic level, 37 (49.3%) of the speech therapists had specialization or advanced training, 27 (36%) only had an undergraduate degree, six (8%) had a master's degree, and five (6.7%) had a doctorate.

Regarding the areas of activity, 53 (70.7%) worked as generalists, 11 (14.7%) worked with language, seven (9.3%) with audiology, one (1.3%) with voice, one worked with (1.3%) orofacial motricity, one (1.3%) in educational speech therapy, and one (1.3%) worked in the service specializing in violence.

Of the 75 surveyed professionals, 39 (52%) treated children and/or adolescents with suspected or confirmed cases of violence. The public most affected by violence included children between 2 and 12 years old (48%), followed by teenagers (32%) and babies (13.3%). The types of violence found included psychological violence (41.3%), physical violence (38.7%), sexual violence (36%), and neglect and abandonment (26.7%). Table 1 describes the difficulties or ease reported by speech therapists who dealt with cases of family violence against children and/or adolescents.

Chart 1 presents the composition categories of the axes and their sub-axes, along with examples of the recording units that represented the analyzed material. The components of the categories are described in the column between the categories and examples of the recording units, summarizing the content of each category constituted based on the answers prepared by the participants to the questionnaire items. Each recording unit was followed by the indication of the Arabic numeral of the participant who uttered it.

Axis 1 refers to the difficulties or ease presented by speech therapists in cases of intra-family violence against children and/or adolescents. It comprised three sub-axes: 1.1, whose professionals reported no difficulties or ease; 1.2, the ease listed by speech therapists; and 1.3, the difficulties faced.

DISCUSSION

The discussion regarding the difficulties and ease presented by speech therapists in cases of intra-family violence against children and/or adolescents was organized around three sub-axes.

Sub-axis 1.1: No difficulties or ease

In this sub-axis, 5.3% of speech therapists reported no difficulties or ease in cases of intra-family violence against children and/or adolescents. In order to understand these participants' reports, it is important to clarify the specificities that allowed the cases to be conducted: a speech therapist worked in the specialized violence service; a speech therapist had been a researcher in the field for over 20 years; another professional completed all the training offered by the municipal department of his location; and the other improved on the subject through training promoted by the Ministry of Health/Fiocruz.

Table 1. Difficulties and ease reported by speech therapists who dealt with cases of intra-family violence against children and/or adolescents

	N	%
There were no difficulties or ease	4	5.3
Ease due to the therapeutic bond	2	2.7
Ease due to networking	1	1.3
Difficulties in communicating with the family	7	9.3
Difficulties regarding support bodies	7	9.3
Difficulties regarding patient attendance	1	1.3
Difficulties regarding the patient making the complaint	1	1.3
They believe it is not the role of the speech therapist	2	2.7
Difficulty in managing the patient	3	4
Lack of professional preparation	10	13.3
Lack of psychological preparation	3	4

Source: The authors
Subtitle: n = Number of professionals; % = Percentage

Chart 1. Difficulties or advantages faced by speech therapists in cases of intra-family violence against children and/or adolescents

AXIS 1 – Difficulties or advantages for speech therapists in cases of intra-family violence against children and/or adolescents		
Subaxis 1.1: No difficulties or ease		
Categories	**Category components**	**Examples of recording units corresponding to the answers given by participants/participant identification number**
There were no difficulties or facilities	No reports of difficulties or ease.	*No (19, 48, 57). Quiet (67).*
They believe it is not the role of the speech therapist	Because they did not believe it was their role, they did not report any difficulties or ease.	*I believe it is not my role to intervene in this (38). I believe it is not my role to act in these cases (41).*
Sub-axis 1.2: Ease		
Ease due to the therapeutic bond	Transfer Listening Trust	*This case was easy, as the mother established transference and had a place of listening in therapy (63). I noticed greater trust in the therapist (73).*
Ease due to networking	Networking Team work	*The ease I see is the fact that we work in a network, enabling access to different social facilities and areas of service (81). The ease is working with an interdisciplinary team (20).*
Sub-axis 1.3: Difficulties		
Difficulties in communicating with the family	Difficulty talking to family. Difficulties talking to parents.	*Difficulty talking to family; some do not attend, others do not talk (23). Difficulty talking to parents (58).*
Difficulties in relation to support bodies	Support network Guardianship Council What services to look for	*Sometimes I had difficulty with the support network (20). Difficulties, as the Guardianship Council did not want to make the complaint, as it was a known person; We went to the Public Prosecutor's Office psychologist to take the complaint (26). Difficulty in knowing how to behave in the situation and difficulty in finding ways to report it anonymously, as the patient trusted me with this situation (29). The difficulty lies in not knowing which services to seek or trust, fearing that the child may suffer even more violence or be prevented from continuing with care (74). The Guardianship Council, when called, showed a lot of ambiguity in its direction, leaving me with doubts about my conduct in calling the Council (1).*
Difficulties regarding patient attendance	Low frequency	*Difficulty in patients attending therapy! (6).*
Difficulties in relation to the patient making the complaint	Patient report	*Yes, the patient reports the aggressor (18).*
Difficulty in managing the patient	Difficulty for professionals to develop engaging therapy.	*Has difficulty carrying out the proposed therapy. Difficulty understanding simple games, such as memory games (65).*
Lack of professional preparation	unpreparedness, Misinformation, Unfamiliarity, Lack of involvement.	*Yes. I didn't know how to deal with it, we're not prepared for it (37). Difficulty in obtaining information about violence (38). Yes. My lack of knowledge probably led to giving up on therapy and the possibility of some intervention in the violent situation. The parents disappeared from the map after I discovered the violent situation and talked to them to put them on the wall and confess (39). Difficulty in what to do, as depending on the behavior, it could make the situation worse (55).*
Lack of psychological preparation	Psychological unpreparedness.	*Difficulties with my individual (psychological) issues. Because it is a topic that involves suffering and guilt (20). Many difficulties. I didn't know how to deal, I didn't know what to do. Despair took over. Fear of notifying and suffering retaliation from parents (40). I had a lot of difficulties in handling the cases, messing with my psychology a lot, so I decided to seek psychoanalytic support for myself, I went back to analysis in order to deal with this listening (61).*

Source: The authors

It was observed that the professionals mentioned would, in theory, be more prepared to deal with situations of violence due to their professional experience and the search for specific training. Therefore, they did not report difficulties or ease in conducting the cases. In line with this, a study shows that training and qualifications increase the opportunities for properly

managing intra-family violence situations [11]. In other words, the more training or experience in a given subject, the greater your preparation to deal with it in your clinical practice.

Two (2.7%) participants reported that it was not the role of the speech therapist to act in cases of violence, which leads to the need to reflect on the myth of non-violence portrayed in the speeches of the two speech therapists and rooted in Brazilian society. The myth of non-violence operates as a foundation in the mythical construction of society as good, one, undivided, peaceful, and orderly, creating the image of generous, happy, supportive people who are unaware of situations of violence and spite toward human beings[12]. This image encourages individuals to ignore human rights violations, outsourcing the role of acting in these cases[13].

The corrective-normative tradition that supports the speech therapy practice of many professionals is also considered limited to treating language complaints. It does not consider the suffering of the subject, their family members, and the violence established in this relationship[13]. It is also worth highlighting the fact that few works address violence and speech therapy, which is a form of denial of this reality that consolidates the myth of non-violence[13].

Sub-axis 1.2: Ease

Two (2.7%) speech therapists reported ease in the ease sub-axis due to the therapeutic bond. Their speeches highlighted the importance of the bonding relationship between the professional and the patient and between the professional and family members. The bond consists of building relationships of affection and trust resulting from closeness and acceptance, responsibility, and resoluteness that enhance comprehensive care for the subject and expand the gateway to care, especially for victims of violence[14].

By conceiving listening as producing effects on the subject, the speech therapy clinic constitutes itself as a generator of care and transformation[15]. Regarding family members, listening emerges as a potential bond between them and the therapist. Parents modify the quality of dialogue and relationship with their children based on the therapeutic experience with the speech therapist, becoming figures with more linguistic-discursive resources[15]. Therefore, it is essential to recognize the family as an integral part of the therapeutic process and not just as auxiliaries or passive recipients of the work. Based on the relationship of trust established between the speech therapist and family members, paths will emerge to reframe situations of violence[15].

Speech therapy will help in cases of violence by giving a voice to silenced victims[9]. The therapeutic relationship produces clinical interactions that provide security to the patient, allowing them to dialogue freely[16]. Thus, the therapeutic bond established between the victim and the speech therapist will help break the silence, seek help, interrupt the situation of violence, and give new meaning to the family context of those involved[17].

Still, a professional (1.3%) cited ease thanks to networking. Regarding intra-family violence, the dynamics of network work stand out through articulation between different sectors and areas, seeking a dialogue that makes it possible to achieve integration between social assistance, education, health, social defense, and culture. This work strengthens social protection for children and adolescents[18]. Interdisciplinary action promotes the exchange of experiences in an integrated and coordinated way between professionals and provides security when activating support bodies[19].

Teamwork appears as a potential way to confront situations of violence, as it comprises a suitable space for discussing violent cases and events and for formalizing care flows. Confronting violence requires a systematic dialogue between professionals, a factor that contributes to the notification and overcoming of isolated, disconnected acts that fall within the individual competence of each professional[20].

Sub-axis 1.3: Difficulties

The difficulties faced by speech therapists in situations of violence against children and adolescents included the impasses in talking to the family, which stood out. Seven (9.3%) professionals reported these impasses. Therefore, it is worth noting that a child's first learning occurs within the family. Thus, it is indisputable that the family plays a primary role in the development of children and adolescents. Characterized as the main educational agent and the central nucleus of the child's integral development, the family is the primordial member of the therapeutic process and not just a supporting element[16,21]. The relationship between therapist and family includes the acceptance of family demands and is not merely restricted to guidelines[16].

Seven (9.3%) speech therapists mentioned difficulties regarding support bodies. Even though it is not the most appropriate conduct, speech therapists often face violence alone because they do not have institutional support, which results in difficulties regarding support bodies[13]. There are intersectoral gaps between the activities of the Guardianship Council and the health sector, seen by the community as a gateway to treating injuries, which often result from violence. Therefore, there is a need for a partnership between the Guardianship Council and health services, aiming to facilitate and make communication and coordination of actions effective, providing spaces for dialogue and finding mechanisms to standardize care and the monitoring of victims[13].

Three professionals (4%) reported difficulties in therapeutic management with the victim of violence. Regarding this factor, in many cases, speech therapists ignore the subjective life of their patients and face them as if they were just a biological body, ignoring the real suffering and restricting their work to speech therapy complaints[13]. Another explanation for this difficulty lies in the lack of contact with this subject in the training of health professionals, which creates obstacles in addressing the subjective issues of victims[22].

Furthermore, it is worth noting that a child who has been abused may have their playful ability blunted due to feelings of guilt, fear, anger, apathy, and negative feelings[22]. Considering this perspective, the persistence of proposing recreational activities can be a way of coping with this situation. Therapeutic play enables balance and reorganization, reducing the negative feelings caused by violence[23]. Through games, children and adolescents begin to express what they experience. When playing, they can separate themselves from traumatic situations while situating themselves in the present, past, and future, symbolizing, speaking, and representing disturbing

content. Therefore, infants feel free to discover new meanings in response to their experiences[23].

One professional (1.3%) mentioned difficulties regarding the patient's frequency of therapy. In speech therapy, research shows that the discontinuity of therapeutic monitoring is a recurring factor in clinical care[13, 17, 24]. The possible causes for this occurrence were related to the speech therapists' inappropriate management of the case and the lack of knowledge to act in these situations[13, 17].

A speech therapist (1.3%) reported difficulties regarding the patient reporting it to the responsible body. It is important to clarify that notification is the responsibility of any citizen who witnesses, becomes aware of, or suspects violations of the rights of children and adolescents[19]. Ultimately, notification is an institutional and not merely an individual responsibility. Professionals, especially those who work directly in serving the population, must carry it out[25].

The health professional must talk to family members, explaining the need to notify them so that they can benefit from adequate assistance. The person accompanying the victim needs support, whether in the case of being the aggressor himself or in dealing with the aggressor. Therefore, the professional's relationship with the child or adolescent's companion must be firm, sincere, and, at the same time, demonstrate the sensitivity this moment requires[25]. It is necessary to clarify that notification is neither a favor nor an act of charity that professionals may or may not provide. It is their duty[19].

Among the difficulties reported by speech therapists in cases of violence against children and adolescents, the lack of professional preparation was the most cited, with ten (13.3%) mentions. It is common for professionals to complain about the lack of knowledge on violence, the lack of structure to deal with cases, the lack of knowledge regarding the notification flow, and the difficulties of an integrated and intersectoral approach[18]. There is also the fear of affecting the professional's safety and the refusal to get involved with judicial bureaucracy[26]. It should be noted that health professionals must deal with different events and concerns for which they often do not feel capable or have not been properly prepared. If, on the one hand, there is the desire to move away, on the other, there is a moral obligation to help the victims and their families[18].

The lack of psychological preparation reported by three (4%) speech therapists was considered a difficulty in situations of violence. It is important to point out that the fear of retaliation afflicts health professionals and often makes them provide reductionist assistance, omitting the role they should play. Thus, it is necessary to consider the care demands directed at these professionals, identify their feelings, and contribute to implementing actions to reestablish and promote their general health[25]. When they do not feel welcomed and protected or even do not understand their role in protecting the victim, professionals tend to provide fragmented, inhumane, and negligent assistance based on the biomedical model of health, reduced only to identifying and treating diseases, disregarding the situation of violence[26].

This study's limitation referred to the restricted number of participants, assuming that the topic addressed would justify the low return of questionnaires. Other studies on violence presented similar data[27,28]. It is worth noting that the taboo behavior surrounding violence is present in the social environment, generating the silencing of what is seen and experienced, conceiving itself as a rule of coexistence learned in social groups. However, it indicates a "sacralized" field that prevents discussion, speaking, and reflecting on violence[29].

CONCLUSION

Ease in speech therapy care for victims of child and youth intra-family violence relates to the good therapeutic bond between patient, family, and speech therapist. Furthermore, it relates to adequate multidisciplinary, interdisciplinary, and network work. Difficulties in speech therapy care for children and adolescents who are victims of violence are related to dialogue with the family and support bodies, the patient's lack of attendance at clinical work, the development of appropriate therapeutic strategies to assist the patient/victim, and the speech therapist's lack of professional and psychological preparation.

Regarding speech therapists who did not report difficulties or ease in dealing with cases of violence, it is worth noting that training and qualifications contribute to this situation. Therefore, the need for ongoing training and training regarding the addressed topic is confirmed.

REFERENCES

1. Vieira LTQ, Almeida JP, Santos LR, Leite PM, Falone VE, Do Amaral WN. A ética no atendimento da vítima de violência doméstica: uma dificuldade do profissional da saúde. Revista Bioética Cremego. [Internet]. 2021 [citado em 2023 Maio 11];3(1):8-12. Disponível em: https://rbc.emnuvens.com.br/cremego/article/view/46.
2. Unicef: Fundo das Nações Unidas para a Infância. Panorama da violência letal e sexual contra crianças e adolescentes no Brasil [Internet]. 2021. Disponível em: https://www.unicef.org/brazil/media/16421/file/panorama-violencia-letal-sexual-contra-criancas-adolescentes-no-brasil.pdf
3. Costa D, Tacsiy RC. Percepções dos profissionais de saúde sobre a criança vítima de violência, em um município do sudoeste goiano. RSM [Internet]. 2020 [citado em 2023 Maio 11];7(1):1-10. Disponível em: http://revistas.famp.edu.br/revistasaudemultidisciplinar/article/view/106.
4. Dias EP. (Des)articulação da rede de assistência às crianças e adolescentes vítimas de violência intrafamiliar. Braz J of Develop. 2020;6(12):101703-17. http://dx.doi.org/10.34117/bjdv6n12-603.
5. Rodrigues PS, Menegucci MEV, Perceguini MEE, Gimenez FVM. As potencialidades e fragilidades da atenção básica na prevenção à violência infantil: revisão integrativa. Rev Foco. 2023;16(3):1-16. http://dx.doi.org/10.54751/revistafoco.v16n3-023.
6. Silveira NO, Trindade CS, Bonamigo AW, Silva HTH. O profissional da Estratégia Saúde da Família na Atenção Básica e o enfrentamento à violência doméstica: uma revisão. Saúde em Redes. 2022;8(1):57-73. http://dx.doi.org/10.18310/2446-4813.2022v8nsup1p75-88.
7. Muniz BAA, Dantas LM, Santana MM. Notificação de violência infantojuvenil: percepção dos profissionais da Atenção Primária à Saúde. Trab Educ Saúde. 2022;20(1):1-19. http://dx.doi.org/10.1590/1981-7746-ojs620.
8. Cruz NPS, Silva MC, Santos HL, Oliveira CM. Preenchimento da ficha de notificação compulsória de violência interpessoal e autoprovocada: desafios enfrentados pelo profissional de saúde. HumanÆ [Internet]. 2019 [citado em 2023 Maio 11];13(2):1-16. Disponível em: https://revistas.esuda.edu.br/index.php/humanae/article/view/687.

9. Noguchi MS. O dito, o não dito e o mal-dito: o fonoaudiólogo diante da violência familiar contra crianças e adolescentes [tese]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2005.

10. Sampaio RC, Lycarião D, Codato AN, Marioto DJF, Bittencourt M, Nichols BW, et al. Mapping and reflections on the use of content analysis in SciELO-Brazil (2002-2019). NTQR [Internet]. 2022 [citado em 2023 Maio 11];15(1):1-15. Disponível em: https://publi.ludomedia.org/index.php/ntqr/article/view/747.

11. Costa VS, Aguiar RS. Perception of the multidisciplinary team about care for children and adolescents who are victims of violence. RSD. 2020;9(4):1-19. http://dx.doi.org/10.33448/rsd-v9i4.3038.

12. Chaui M. Sobre a violência. Belo Horizonte: Autêntica Editora; 2017.

13. Noguchi MS, Assis SG, Santos NC. Entre quatro paredes: atendimento fonoaudiológico a crianças e adolescentes vítimas de violência. Ciênc saúde coletiva. 2004;9(4):963-73. https://doi.org/10.1590/S1413-81232004000400017.

14. Ribeiro RUP, Silva AL. Notificação compulsória de violência na atenção básica à saúde: o que dizem os profissionais? Revista LEVS/UNESP- Marília. 2018;21(1):115-30. http://dx.doi.org/10.36311/1983-2192.2018.v21n21.p164.

15. Barbosa CL, Alencar IBG, Mendes VLF, Souza LAP. Fonoaudiologia e escuta clínica em equipe de saúde mental: percepção de pais de crianças com transtorno do espectro do autismo. Rev CEFAC. 2020;22(1):1-13. http://dx.doi.org/10.1590/1982-0216/202022110819.

16. Plexico LW, Manning WH, Dilollo A. Client perceptions of effective and ineffective therapeutic alliances during treatment for stuttering. J Fluency Disord. 2010;35(4):333-54. http://dx.doi.org/10.1016/j.jfludis.2010.07.001. PMid:21130268.

17. Jampersa L. Quebrando o silêncio: violência familiar e o trabalho clínico de profissionais da saúde [dissertação]. Curitiba: Faculdade de Ciências Biológicas e da Saúde, Universidade Tuiuti do Paraná; 2022.

18. Milani ML, Ossig VD. As políticas públicas e o enfoque no agressor para o desmonte da violência intrafamiliar contra crianças e adolescentes. Rev Húmus [Internet]. 2019 [citado em 2023 Maio 11];9(27):2-17. Disponível em: https://periodicoseletronicos.ufma.br/index.php/revistahumus/article/view/12831

19. Lira SVG, Moreira DP, Carneiro GMA, Noronha CV, Vieira LJES. Articulação entre o conselho tutelar e o setor saúde no enfrentamento à violência intrafamiliar. Trab Educ Saúde. 2018;16(2):821-35. http://dx.doi.org/10.1590/1981-7746-sol00131.

20. Marinho RAQC, Aguiar RS. A atenção primária como eixo estruturante da redução dos indicadores de violência contra crianças e adolescentes. REVISA. 2019;8(2):228-41. http://dx.doi.org/10.36239/revisa.v8.n2.p228a241.

21. Mochon AAA, Moura OS, Lima RA, Almeida JE. Um estudo sobre a participação da família como elemento potencializador do processo de aprendizagem dos filhos. Rev Humanid Inov [Internet]. 2022 [citado em 2023 Maio 11];9(10):361-78. Disponível em: https://revista.unitins.br/index.php/humanidadeseinovacao/article/view/7024.

22. Oliveira VG, Felice EM. A relação mãe-filho no enfrentamento do abuso sexual infantil: a visão do psicólogo. Aletheia. 2022;55(2):7-29. http://dx.doi.org/10.29327/226091.55.2-1.

23. Vieira GMO, Soares JM, Pereira LCC, Gomes SAVP, Andrade LAS. O uso de recursos lúdicos no atendimento a crianças e adolescentes vítimas de violência sexual. CGHS UNIT-AL [Internet]. 2022 [citado em 2023 Maio 11];7(2):78-88. Disponível em: https://periodicos.set.edu.br/fitshumanas/article/view/10296.

24. Acioli RML, Lima MLC, Braga MC, Pimentel FC, Castro AG. Violência intrafamiliar contra crianças e adolescentes: identificação, manejo e conhecimento da rede de referência por fonoaudiólogo em serviços públicos de saúde. Rev Bras Saúde Matern Infant. 2011;11(1):21-8. https://doi.org/10.1590/S1519-38292011000100003.

25. Reis AM, Labuto MM. Violência infantojuvenil e o papel do cirurgião-dentista na identificação e notificação de maus-tratos. Cad Odonto UNIFESO. 2022;4(2):62-8.

26. Berthold O, Hoffmann U, Clemens V, Witt A, Fegert JM. Kinderschutz im Gesundheitswesen verbessern: Fachberatung, Weiterbildung und Forschung am Beispiel des misshandlungsbedingten Kopftraumas. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2019;62(8):960-9. http://dx.doi.org/10.1007/s00103-019-02982-2. PMid:31263914.

27. Pereira PC, Williams LCA. A concepção de educadores sobre violência doméstica e desempenho escolar. Psicol Esc Educ. 2008;12(1):139-52. http://dx.doi.org/10.1590/S1413-85572008000100010.

28. Fornari LF, Fonseca RMGS. Prevenção e enfrentamento da violência de gênero por meio de jogos educativos: uma revisão de escopo. RISTI. 2019;(33):78-93. http://dx.doi.org/10.17013/risti.33.78-93.

29. Lima JBQ, Souza FF, Nascimento KC, Oliveira TD. Arquitetura Silenciosa da Violência: reflexões sobre os processos de naturalização que retroalimentam violências. REBEH. 2020;3(12):186-207. http://dx.doi.org/10.31560/2595-3206.2020.12.10605.