Rev. Latino-Am. Enfermagem
2013 July-Aug;21(4):920-7
www.eerp.usp.br/rlae

Original Article

Factors associated to the imposition of types of violence against women informed in sentry services

Luiza Jane Eyre de Souza Vieira[1]
Renata Carneiro Ferreira[2]
Gracyelle Alves Remigio Moreira[3]
Ana Paula Soares Gondim[4]
Maria Alix Leite Araujo[5]
Raimunda Magalhães da Silva[5]

Objective: to identify the prevalence and the factors associated to the imposition of the different types of violence against women informed in sentry services. Method: transversal study accomplished through 939 notification forms of cases of violence against women, referring to the three years from 2006 to 2008 in Fortaleza, Ceará. Univariate and multiple analyses by logistic regression were realized. Result: the results showed a positive association between the imposition of types of violence against women with a schooling varying from illiterate to basic education and the aggression which had occurred other times. Conclusion: this knowledge contributes to the delineation of specific actions that aim at facing this problem, as well as generates subsidies for adequate attendance proposals and guidance for the victims who call on health services.

Descriptors: Violence Against Women; Risk Factors; Health Services; Health Services Statistics.

[1] PhD, Full Professor, Universidade de Fortaleza, Fortaleza, CE, Brazil.
[2] MSc, Professor, Faculdade de Ensino Superior do Ceará, Fortaleza, CE, Brazil.
[3] Doctoral student, Universidade Estadual do Ceará, Fortaleza, CE, Brazil.
[4] PhD, Adjunct Professor, Centro de Ciências da Saúde, Universidade Federal do Ceará, Fortaleza, CE, Brazil.
[5] PhD, Full Professor, Universidade de Fortaleza, Fortaleza, CE, Brazil.

Corresponding Author:
Luiza Jane Eyre de Souza Vieira
Universidade de Fortaleza
Av. Washington Soares, 1321
Bairro: Edson Queiroz
CEP: 60811-905, Fortaleza, CE, Brasil
E-mail: janeeyre@unifor.br

Introduction

The violence against women is a phenomenon that reflects the inequalities of the genders in society[1], establishing itself as public health problem for the magnitude of its prevalence[2], seriousness and recurrence, as well as for the negative consequences in the life quality of the victims.

World-wide studies disclose high prevalence and variability (15% to 71%) of the problem[3-4]. In Brazil, the mortality statistics show that every two hours there is a homicide of a woman[5], representing the last degree of an aggression scale that many times begins with the psychological violence. The literature even presents the close partners or former partners as the main perpetrators of this violence[6-7].

Among the definitions what violence against women is, the study is guided by the definition from the Belém de Pará Convention, adopted by the American States Organization in 1994, which defines it as any action or conduct based on gender, which causes death, damage or physical, sexual or psychological suffering to the woman, both in the public and in the private scope[8].

According to Law nº 11,340/2006, the types of violence against women appear in physical, psychological, sexual, patrimonial and moral forms[9]. However, studies warn about the interrelation of the different types of violence, configuring those cases into complex events where these forms interlace, reverberating in the gravity of the situations[6-7].

Understanding the phenomenon, the authors defend the influence of social factors in the occurrence of those violence cases[10]. Low schooling, poverty, lower income of the women or unemployment, as well as the use of alcohol and illicit drugs between the partners seems to exacerbate the magnitude of the problem.

The violence against women has been a frequent issue in the routine of the health services, which play a basic role in diagnosis, registration, notification and treatment of the cases[11], beyond presenting themselves as propitious places for the effectuation of necessary strategies in the light of this problem.

The reference services for sentry violence were instituted with the intention to contribute to the visibility of the phenomenon through the potential that those present in order to generate qualitatively high information. This produced knowledge is essential for the implementation of prevention strategies and control of the problem, for the evaluation of the implemented actions and for the planning of the resources and services[11].

The sentry services are responsible for the notification of cases of violence against specific groups according to Law Nº 10,778 that makes the notification of violence against women in the public and private health services obligatory[12]. It is important to add that Decree nº 104 of 25 January 2011 orders the domestic violence, sexual and/or other types of violence as 45º event of obligatory notification throughout the national territory[13].

The increasing publication on the subject is recognized, however the prevalence, the typological diversity that enters the health services reflects the complexity of the problem and demands further investigation. While the international organizations alert the governments about the value of the human rights and the reduction of the social inequalities, the integral health of women still remains threatened by the force, power and disrespect of the condition as citizen[8-9].

Considering that the professional nurse passes the hierarchic levels of attention regarding the health of women, the study contributes to the social practice of this category, as the understanding of the phenomenon favors the delineation of strategies and specific actions, aiming at the prevention and the confrontation of the violence against this group, as well as fomenting the health promotion.

The study adopts as constructive analytical theories the legal requirements that rule the subject, considering the specifications of the violence against women[8-9,12-13].

In this meaning, to understand the factors that can contribute to the imposition of the types of violence against women, as well as sociodemographic and behavioral characteristics of women in violent situations, characteristics of the aggressions and the aggressors, may well contribute to qualify the assistance, beyond providing a contextual care on the part of the nurses. Furthermore, facing violence is complex and is associated to the lack of visibility of the problem for different entities, especially for the health services.

In this context, the study has as objective to identify the prevalence and the related factors to the imposition of the different types of violence against the woman informed in sentry services.

Methods

Transversal study that used as data source the notification forms of women who were violence victims in Fortaleza, Ceará, referring to the period 2006 to 2008. Fortaleza, capital of the state Ceará, similar to other Brazilian metropolises[2], concentrates a significant number of registrations of violence against women[14].

Putting the reader in the picture, at the time of the study, the administration of violence against women in Fortaleza was offered by four sentry services. The study reached three of these services, enclosing 75% of the notifications in the selected three years, which means, 960 cases.

For the accomplishment of the analysis, the study took as base the notifications regarding women of equal or superior age to 12 years who were residents in Fortaleza. From the 960 present cases, 21 were excluded: 16 for aggression against women younger than 12 years and five for not identifying the type of violence, resulting in 939 analyzed forms. For the accomplishment of the data collection, one of the authors entered previously in contact with the managers of these services, presented the objectives of the research and scheduled appointment dates and times to carry it out.

This stage was accomplished manually, form by form, in the period from July to October 2009. Important is to state that the collection of these data was made in a reserved room, under surveillance of employees of the respective services, considering the secrecy that involves attendances of this nature.

The typologies of violence adopted in the study followed the ones mentioned in the notification form[15]. In this form, the occurrence data was considered that are related to physical and psychological/moral violence, recklessness/abandonment, sexual violence, torture and patrimonial violence. It is worth to point out that the form as well includes the human trafficking and the child labor, that for demanding other epistemological concepts were not targets of this investigation.

The dependent 0 variable was the registration of two or more types of violence against women and as independent variables, sociodemographic data (conjugal situation, age group, schooling, skin color, occupation, sexual orientation, pregnancy, any kind of deficiency); aggression data (place of occurrence, if it occurred other times, number of involved people); aggressor data (gender, type of relation with the victim, suspicion of alcohol use). The variables were described in accordance with the nomenclature referred to in the notification form[15].

The chi-squared (χ^2) test was used to analyze the fact of women suffering two or more types of violence in relation to the independent variables. $P<0.05$ was established for statistic significance. The choice of the variables for the construction of the multivariate logistic regression model was based on the method of automatic selection (*Stepwise*). The relation strength between the independent and the dependent variables was expressed in esteemed values of *Odds ratio* (OR) gross and adjusted, with Reliability Interval (IC) of 95%. The data were organized in the SPSS program (SPSS Incorporation, Chicago, United States), version 16.0; and analyzed through the STATA *software* (Stata Corp LP, College Station, TX 77845, USA), version 11.0.

The research obeyed the norms of Resolution nº 196/96, of the National Health Authority that regulates research with human beings and was approved by the Committee for Ethics in Research of the University of Fortaleza under concurring opinion nº 123/2009.

Results

Among the 939 analyzed forms, the frequency of violence imposition against women was 73.9% (694). Only one single type of violence was experienced by 245 women (26.1%), subdivided into psychological/moral violence (85.7%), physical violence (74.9%), recklessness/abandonment (18.2%), sexual violence (13.3%), patrimonial violence (4.0%) and torture (2.7%).

The average age of the analyzed women who were violence victims was 33.26 years (DP=11.05). The average age among the women who were victims of two or more types of violence was 33.32 years (DP=10.57) and in the group of one single type of violence it was 33.08 years (DP=12.30).

Married women of 30 or more years of age; who have a schooling from illiterate to basic education; dark skin; unemployed; having sexual relations only with men; not pregnant and with no deficiency were the most frequent victims (Table 1).

In Table 1 is to observe that the variable schooling presented statistic significance (p=0.029) with the fact of these women being victims of two or more types of violence, whereas conjugal situation, age group, skin color, occupation, sexual relations, pregnancy and any type of deficiency did not present any significance (p>0.05).

In the group of women who suffered two or more types of violence, the frequency of the place of the aggression was highest in the residence (89.9%); the violence was recurrent (91.4%); with the involvement of one aggressor (88.2%); of masculine gender (97.5%); close partner of the victim (73.8%); with suspicion of alcohol consumption (66.5%). Among the women who suffered a single type of violence, also the residence predominated (81.6%); the aggression occurred several times (80.5%); with one involved aggressor (89.5%); of masculine gender (96.6%); close partner of the victim (65.8%); with suspicion of alcohol use (57.7%) (Table 2).

Table 1 - Sociodemographic characteristics in relation to the imposition of types of violence against women. Fortaleza, CE, Brazil, 2006 to 2008

Variable	Violence				Total (%)	p
	One type (N=245)		Two or more types (N=694)			
	n	%	n	%		
Conjugal situation						0.112
Married	145	63.9	453	69.6	598 (68.1)	
Unmarried	82	36.1	198	30.4	280 (31.9)	
Age group (in years)						0.174
12-29	104	42.6	257	37.7	361 (39.0)	
≥30	140	57.4	425	62.3	565 (61.0)	
Schooling						0.029*
Illiterate/basic education	142	58.9	451	66.7	593 (64.7)	
Secondary/higher education	99	41.1	225	33.3	324 (35.3)	
Skin color						0.394
Dark	137	58.0	373	54.8	510 (55.7)	
Not dark	99	41.9	307	45.1	406 (44.3)	
Occupation						0.942
Employed	104	43.7	294	43.4	398 (43.5)	
Unemployed	134	56.3	383	56.6	517 (56.5)	
Sexual relations						0.141
Only with women	10	7.2	20	4.2	30 (4.9)	
Only with men	128	92.8	458	95.8	586 (95.1)	
Pregnancy						0.484
Yes	16	6.5	37	5.3	53 (5.6)	
No	229	93.5	657	94.7	886 (94.4)	
Any type of deficiency						0.283
Yes	14	5.7	54	7.8	68 (7.2)	
No	231	94.3	640	92.2	871 (92.8)	

* Pearson chi-squared test; significant when p<0.05

In table 2, the majority of the variables showed statistical significance (p<0,05) in the Univariate analysis, with exception of the number of involved people and the gender of the aggressor.

Table 2 - Characteristics of the aggression and the aggressor in relation to the imposition of different types of violence against women. Fortaleza, CE, Brazil, 2006 to 2008

Variable	Violence				Total (%)	p
	One type (N=245)		Two or more types (N=694)			
	n	%	n	%		
Place of the occurrence						<0.001*
Residence	191	81.6	605	89.9	796 (87.8)	
Other place	43	18.4	68	10.1	111 (12.2)	
Recurrent occurrence						<0.001*
Yes	186	80.5	613	91.4	799 (88.6)	
No	45	19.5	58	8.6	103 (11.4)	
Number of involved people						0.573
One	214	89.5	605	88.2	819 (88.5)	
Two or more	25	10.5	81	11.8	106 (11.5)	
Gender of the aggressor						0.480
Female	08	3.4	17	2.5	25 (2.8)	
Male	227	96.6	655	97.5	882 (97.2)	

(continue...)

Table 2 - (continuation)

Variable	Violence				Total (%)	p
	One type (N=245)		Two or more types (N=694)			
	n	%	n	%		
Relation with the victim						0.019*
Close partner	154	65.8	501	73.8	655 (71.7)	
Other relation	80	34.2	178	26.2	258 (28.3)	
Suspicion of alcohol use						0.024*
Yes	116	57.7	401	66.5	517 (64.3)	
No	85	42.3	202	33.5	287 (35.7)	

* Pearson chi-squared test; significant when p<0.05

The non-adjusted analysis showed a positive association between women who suffer two or more types of violence with the schooling (OR=1.39; IC95%=1.01-1.91); occurrence place (OR=2.00; IC95%=1.28-3.08); recurrent aggression (OR=2.55; IC95%=1.63-3.97); relation of the aggressor with the victim (OR=1.46; IC95%=1.04-2.03) and suspicion of alcohol use by the aggressor (OR=1.45; IC95%=1.03-2.04) (Table 3).

In the multiple logistic regression model is to observe that there were positive associations of women who suffer two or more types of violence, the schooling varying from illiterate to basic education (OR=1.43; IC95%=1.05-1.96) and recurrent aggression (OR=2.41; IC95%=1.57-3.71) (Table 3).

Table 3 - Factors associated to women who suffer two or more types of violence. Fortaleza, CE, Brazil, 2006 to 2008

Variable	n	%	Suffering two or more types of violence			
			Not adjusted		Adjusted	
			OR (IC95%)	p	OR (IC95%)	p
Conjugal situation						
Married	598	75.7	1.29 (0.92-1.79)	0.112		
Unmarried	280	70.7				
Age group (in years)						
12-29	361	71.1				
≥30	565	75.2	1.22 (0.90-1.67)	0.174		
Schooling						
Illiterate/basic education	593	76.0	1.39 (1.01-1.91)	0.029*	1.43 (1.05-1.96)	0.022*
Secondary/high education	324	69.4				
Skin color						
Dark	510	73.1				
Not dark	406	75.6	0.87 (0.64-1.19)	0.394		
Occupation						
Employed	398	73.8				
Unemployed	517	74.0	1.01 (0.74-1.37)	0.942		
Sexual relations						
Only with women	30	66.6				
Only with men	586	78.1	1.78 (0.72-4.12)	0.141		
Pregnancy						
Yes	53	69.8				
No	886	74.1	1.24 (0.63-2.33)	0.484		
Any type of deficiency						
Yes	68	79.4	1.39 (0.74-2.76)	0.283		
No	871	73.4				
Place of occurrence						
Residence	796	76.0	2.00 (1.28-3,08)	<0.001*		
Other place	111	61.2				

(continue...)

Table 3 - (continuation)

Variable	n	%	Suffering two or more types of violence			
			Not adjusted		Adjusted	
			OR (IC95%)	p	OR (IC95%)	p
Recurrent occorrence						
Yes	799	76.7	2.55 (1.63-3.97)	<0.001*	2.41 (1.57-3.71)	<0.001*
No	103	56.3				
Number of involved people						
One	819	73.8				
Two or more	106	76.4	1.14 (0.70-1.92)	0.573		
Gender of the aggressor						
Female	25	68.0				
Male	882	74.2	1.35 (0.49-3.37)	0.480		
Relation with the victim						
Close partner	655	76.4	1.46 (1.04-2.03)	0.019*		
Other relation	258	68.9				
Suspicion of alcohol use						
Yes	517	77.5	1.45 (1.03-2.04)	0.024*		
No	287	70.3				

* Pearson chi-squared test; significant when p<0.05

Discussion

This study presents as differentiation the identification of the factors associated to the imposition of types of violence against women, investigations that had chosen this specific topic as research object being scarce in Brazilian literature.

The findings showed a greater prevalence of women being victims of two or more types of violence, indicating that these overlap and hardly occur isolated. Other inquiries had found similar results, emphasizing the interlacement of the physical, sexual and psychological aggressions, stating that the imposition of several types of violence seems to be associated to the higher seriousness of the cases and the demand for specialized services[6-7,16].

The residence constitutes a privileged place for the occurrence of these cases, reaffirming what is disclosed in literature[17-18] – that more than 90% of the aggressions against women happen in the domestic environment. The home is the most frequently chosen place due to the fact that the aggressions are facilitated through occurring in privacy, protected from the interference of other people[18]. In this form, the private ambit that circumscribes the phenomenon restrains the disruption and the visibility of the casuistry.

The biggest occurrence of the violence perpetrated by the close partner of the victim, as found in this research, expresses subordination and domination, in which exist unequal distribution of privileges, rights and duties, establishing asymmetries of power based on the gender differences[19]. The aggressions perpetrated by the partner or former partner are recognized as one of the most frequent forms of violence against women[7,17,20]. A study accomplished in the eastern region of India with 1,718 women certified a higher risk of violence on the part of the husband than any another person[3].

Another relevant finding of this research that reiterates literature[4,7] shows the association of the alcohol use by the aggressor with the situations of violence against women. Inquiries recognize the ingestion of alcohol as an important factor of domestic violence, which may be explained by the disinhibiting effect on the behavior of the aggressors, as a way of minimizing the responsibility for the violent behavior, or even, the combination of the alcohol use with the practice of violence may act as a denouncing factor of the impulsive personality[21].

The authors[22] also demonstrated, in a research of qualitative approach, the deriving upheavals of the alcohol consumption in the families, emphasizing the high levels of interpersonal conflicts which emerge in several forms of domestic violence. However, the alcohol is not mainly responsible for the aggressions, acting as facilitator of previously determined situations[17].

The unadjusted bivariate analysis showed an association between women being victim of two or more types of violence with the variables: schooling, place of occurrence, recurrent aggression, relation of the aggressor with the victim and suspicion of alcohol use by the aggressor. After the adjustment of the variables

only the low schooling, varying from illiterate to basic education, and the fact of the recurrent aggression remain positively associated to the outcome.

The low educational level of the women who are violence victims is shown in studies in other countries[3,23] and in Brazil[16-17,24]. In countries of Southern Asia, the higher schooling levels have become a factor of protection against violence forms[3]. A Brazilian research, accomplished through forms of medical attendance and reports of legal medical institutions, showed that most of the victims had not concluded the basic education[17].

However, women of all educational levels face situations of violence[7]. What differentiates the behavior of these women is, that the smartest ones had greater personal autonomy, diminishing the tolerance towards aggressions[4]. And when becoming victims, almost always call on medical doctors' offices and particular law firms. In this manner, an underrepresentation in the registrations can occur, associating the situations of violence against women to poverty[7], since the majority of the inquiries is accomplished in public services.

The manifestations of violence against women present themselves in this study as directly associated to the fact of the aggressions being recurrent, indicating that the problem reveals itself in an intense and repetitive form in the lives of the victims. The authors[19,25] show that the women, many times, waive the formal denunciation for being financially or emotionally dependent on the aggressor, just as well from fear or embarrassment of the exposition of the case. This episode contributes to violence acquiring a routine character.

Inquiries demonstrate that most of the aggressions against women do not constitute a single event, but in several episodes can last for decades[10,19]. This context collaborates with the level of gravity of the situations of violence, reverberating negatively in the physical, mental and social health of the victimized women. And the consequences of this problem are clearly perceived in the ambit of the health services, either for the costs that they represent or for the complexity of the attendance that they demand.

Conclusion

The results of this research showed as factors associated to the imposition of different types of violence against women the low schooling and the recurrence of the aggression.

It is important to point out that the study in question is one on demand of sentry services, and the achieved findings cannot be generalized for the population of female victims in general, considering that a part of these victims at least calls on attendance.

However, this knowledge contributes to delineate specific actions that aim at the confrontation of this casuistry, as well as it generates subsidies for adequate proposal of attendance, guiding the victims that call on the health services, contributing to the visibility of the violence against women.

References

1. Ilha MM, Leal SMC, Soares JSF. Mulheres internadas por agressão em um hospital de pronto socorro: (in)visibilidade da violência. Rev Gaúcha Enferm. 2010;31(2):328-34.

2. Silva MA, Falbo GH Neto, Figueiroa JN, Cabral JE Filho. [Violência contra a mulher: prevalência e fatores associados em pacientes de um serviço público de saúde no Nordeste brasileiro]. Cad Saúde Pública. 2010;26(2):264-72. Inglês.

3. Babu BV, Kar SK. Domestic violence against women in eastern India: a population-based study on prevalence and related issues. BMC Public Health. 2009;9:129. doi:10.1186/1471-2458-9-129

4. Vieira EM, Perdona GSC, Santos MA. Fatores associados à violência física por parceiro íntimo em usuárias de serviços de saúde. Rev Saúde Pública. 2011;45(4):730-7.

5. Reichenheim ME, Souza ER, Moraes CL, Jorge MHPM, Silva CMFP, Minayo MCS. Violence and injuries in Brazil: the effect, progress made, and challenges ahead. Lancet. 2011;377(9781):1962-75.

6. Schraiber LB, D'Oliveira AFPL, Couto MT, Hanada H, Kiss LB, Durand JG, et al. Violência contra mulheres entre usuárias de serviços públicos de saúde da Grande São Paulo. Rev Saúde Pública. 2007;41(3):359-67.

7. Gadoni-Costa LM, Zucatti APN, Dell'Aglio DD. Violência contra a mulher: levantamento dos casos atendidos no setor de psicologia de uma delegacia para a mulher. Estudos Psicologia. 2011;28(2):219-27.

8. Decreto nº 1.973, de 1 de agosto de 1996 (BR). Promulga a convenção interamericana para prevenir, punir e erradicar a violência contra a mulher, concluída em Belém do Pará, em 9 de junho de 1994. 1996. [acesso 9 abr 2012]. Disponível em: http://www.jusbrasil.com.br/legislacao/112212/decreto-1973-96

9. Lei nº 11.340, de 07 de agosto de 2006 (BR). Cria mecanismos para coibir a violência doméstica e familiar contra a mulher. 2006. [acesso 21 jun 2012]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11340.htm

10. Moura LBA, Gandolfi L, Vasconcelos AMN, Pratesi R. Violências contra mulheres por parceiro íntimo em área urbana economicamente vulnerável, Brasília, DF. Rev Saúde Pública. 2009;43(6):944-53.
11. Gawryszewski VP, Silva MMA, Malta DC, Mascarenhas MDM, Costa VC, Matos SG, et al. A proposta da rede de serviços sentinela como estratégia da vigilância de violências e acidentes. Ciência Saúde Coletiva. 2007;11(Sup):1269-78.
12. Lei nº 10.778, de 24 de novembro de 2003 (BR). Estabelece a notificação compulsória, no território nacional, do caso de violência contra a mulher que for atendida em serviços de saúde públicos ou privados. 2003. [acesso 14 mai 2012]. Disponível em: http://www.abenfomg.com.br/site/arquivos/outros/09_LEI_DE_NOTIFICACAO_VIOLENCIA.PDF
13. Portaria nº 104, de 25 de janeiro de 2011 (BR). Define as terminologias adotadas em legislação nacional, a relação de doenças, agravos e eventos em saúde pública de notificação compulsória em todo território nacional e estabelece fluxos, critérios, responsabilidades e atribuições aos profissionais de saúde. 2011. [acesso 20 jun 2012]. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/portaria_104_26_2011_dnc.pdf
14. Diniz K. Em Fortaleza, violência contra a mulher é epidemia crônica. Grupo UN 15 dez 2011. [acesso 20 junho de 2012]. Disponível em: http://www.grupoun.net/em-fortaleza-violencia-contra-a-mulher-e-epidemia-cronica/
15. Ministério da Saúde (MS). Sistema de informação de agravos de notificação (SINAN), ficha de notificação/investigação individual, violência doméstica, sexual e/ou outras violências. Brasília – 2008. 2008. [acesso 13 mar 2012]. Disponível em: http://saude.gov.br/svs
16. Kronbauer JFD, Meneghel SN. Perfil da violência de gênero perpetrada por companheiro. Rev Saúde Pública 2005;39(5):695-701.
17. Garcia MV, Ribeiro LA, Jorge MT, Pereira GR, Resende AP. Caracterização dos casos de violência contra a mulher atendidos em três serviços na cidade de Uberlândia, Minas Gerais, Brasil. Cad Saúde Pública. 2008;24(11):2551-63.
18. Leôncio KL, Baldo PL, João VM, Biffi RG. O perfil de mulheres vitimizadas e de seus agressores. Rev Enferm UERJ. 2008;16(3):307-12.
19. Deeke LP, Boing AF, Oliveira WF, Coelho EBS. A Dinâmica da Violência Doméstica: uma análise a partir dos discursos da mulher agredida e de seu parceiro. Saúde Soc. 2009;18(2):248-58.
20. Lettiere A, Nakano AMS. Violência doméstica: as possibilidades e os limites de enfrentamento. Rev. Latino-Am. Enfermagem. 2011;19(6):1421-8.
21. Rovinski SLR. Dano psíquico em mulheres vítimas de violência. Rio de Janeiro: Lumen; 2004. 271 p.
22. Reinaldo AMS, Pillon SC. Repercussões do alcoolismo nas relações familiares: estudo de caso. Rev. Latino-Am. Enfermagem. 2008;16(esp):529-34.
23. Oyunbileg S, Sumberzul N, Udval N, Wang JD, Janes CR. Prevalence and Risk Factors of Domestic Violence among Mongolian Women. J Women's Health. 2009;18(11):1873-80.
24. D'Oliveira AFPL, Schraiber LB, França-Junior I, Ludermir AB, Portella AP, Diniz CS, et al. Fatores associados à violência por parceiro íntimo em mulheres brasileiras. Rev Saúde Pública. 2009;43(2):299-310.
25. Lima VLA, Souza ML, Monticelli M, Oliveira MFV, Souza CBM, Costa CAL, et al. Violência contra mulheres amazônicas. Rev. Latino-Am. Enfermagem. 2009;17(6):968-73.

Received: June 25th 2012
Accepted: Apr. 22nd 2013

Erratum

Issue v21n4, page 920

For

Maria Alix Leite Araujo[4]
Raimunda Magalhães da Silva[5]

Read

Maria Alix Leite Araujo[5]
Raimunda Magalhães da Silva[5]

For

[4] PhD, Adjunct Professor, Centro de Ciências da Saúde, Universidade Federal do Ceará, Fortaleza, CE, Brazil.
[5] PhD, Full Professor, Centro de Ciências da Saúde, Universidade Federal do Ceará, Fortaleza, CE, Brazil.

Read

[4] PhD, Adjunct Professor, Centro de Ciências da Saúde, Universidade Federal do Ceará, Fortaleza, CE, Brazil.
[5] PhD, Full Professor, Universidade de Fortaleza, Fortaleza, CE, Brazil.