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ORIGINAL ARTICLE

(In)visibility of violence against women in mental health[1]

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ABSTRACT - The aim of this study was to analyze the perception, beliefs and knowledge of mental health professionals about violence against women and public policies related to this issue. To accomplish this objective, 12 interviews were carried out. Based on data analysis, five themes were proposed: "perception of demands presented by women and men", "experience in providing care to women victims of violence", "link between violence and mental health", "knowledge about the Maria da Penha Law and women-centered public policies", "(Lack of) knowledge about the compulsory notification of violence against women". Professionals had difficulties dealing with these themes, especially related to addressing and notifying violence. Their practices are based on their intuition rather than on theoretical and practical knowledge.

Keywords: violence against women, mental health, health professionals

(In)visibilidade da violência contra as mulheres na saúde mental

RESUMO - O objetivo deste estudo foi realizar um levantamento acerca da percepção, crenças e conhecimentos sobre violência contra as mulheres e políticas públicas em profissionais de saúde mental. Foram realizadas 12 entrevistas e, a partir da análise de seus conteúdos, foram criadas cinco categorias: "percepção das demandas apresentadas por homens e mulheres", "experiência no atendimento a mulheres que sofreram violência", "relação entre violência e saúde mental", "conhecimento sobre a Lei Maria da Penha e políticas públicas para as mulheres" e "(des)conhecimento da notificação compulsória da violência contra as mulheres". Os profissionais apresentaram dificuldade para lidar com o tema, principalmente relacionada à notificação da violência e ao encaminhamento do caso. A atuação é baseada na intuição e não em conhecimentos teórico práticos.

Palavras-chave: violência contra mulher, saúde mental, profissionais da saúde

Violence against women, as defined in the Belém do Pará Convention (1994) "shall be understood as any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere" (Article 1). This subject has frightening dimensions, with important impacts on the society. It gained visibility from the 1990s onwards, and is considered a public health issue by the World Health Organization (WHO) (WHO, 2005).

According to a review of global data on violence against women performed by the WHO in 2013, 35% of the women in the world have been victims of physical and/or sexual violence. In some countries this figure can be as high as 70%. According to these statistics three in every group of five women were or will be victims of violence. Therefore, we should bear in mind that it is an epidemic that must be fought (WHO, 2005; WHO, 2013). Despite the alarming data, most of the cases are not yet identified. According to a study by the European Union, only 14% of the women have reported to the police the most serious incident of violence committed by an intimate partner (European Union Agency for Fundamental Rights, 2014).

Reality is not different in Brazil. According to the *Mapa da Violência* (2015) - a survey carried out by Flacso/BR - Brazil moved from the 7th (2012) position in femicide rates, in a sample comprising 84 countries, to the 5th position in a sample of 83 countries. Still according to the *Mapa da Violência,* of the 4,762 cases of femicide in 2013, 50.3% were perpetrated by family members, and mostly (33.2%) by partners or ex-partners.

The exposure to risk situations, such as violence against women, has been strongly associated with several psychiatric conditions. Dillon, Hussain, Loxton & Rahman (2012) analyzed 75 articles that link violence against women and mental disorders. The survey was done on three online databases (SAGE Premier, ProQuest and Scopus) selecting articles published from January 2006 to June 2012. Combinations between the expressions "domestic violence" and "intimate partner violence" and "physical health" and "mental health" were made. The articles analyzed the association of the experience of violence with depression (in 42 studies), post-trauma disorders (in 14 studies), anxiety (in 16 studies), suicide and self-extermination (in six studies) and psychological problems (in 19 studies). This study demonstrates the high correlation between violence and mental disorders described by researchers. Trevillion *et al.* (2014), Nyame, Howard, Feder & Trevillion (2013), Schraiber, D'Oliveira & Couto (2009) and Barreto, Dimenstein & Leite (2013) showed the expressive number of domestic violence victims using mental health services in Brazil and abroad. Therefore, these services play an important role in the identification, prevention and referral of domestic violence to specialized services (WHO, 2010).

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To provide effective care to women, health professionals working with health care should have knowledge and feel skilled to meet this demand. However, studies demonstrate that health professionals are not duly trained to handle violence against women (Schraiber & D'Oliveira, 1999; Nyame et al., 2013; Rose et al., 2011).

Considering the relevance of recognizing violence against women as an epidemic, as well as its impact on their mental health and the insipid presence of this topic in the health professionals' undergraduate courses (Souza, Penna, Ferreira, Tavares & Santos, 2008), this article aimed to investigate the perception, beliefs and knowledge about violence against women and related public policies among health professionals in a Psychosocial Care Center - *Centro de Atenção Psicossocial II*[3] (CAPS II) of a Brazilian capital city. It tried to check to which extent health professionals understand this topic and are aware of the network and services available for referral and joint work with these women.

Method

To reach the research objectives, 12 health professions of a *Centro de Atenção Psicossocial II* in a Brazilian capital were interviewed. Professionals were from different specialties: One psychiatrist; five psychologists; two nurses; one practical nurse; one occupational therapist; one social assistant; and, one health manager. Considering the small size of the team (12 professionals) and aiming to preserve confidentiality and the professionals' identities, they were presented as: "*ps* area professionals" which included psychologists and the psychiatrist; and "health professionals" which included the remainder health professionals. This division considered that *psi* area professionals were thoroughly trained in topics related to mental health and suffering, while general health professionals were not necessarily very trained in these topics.

Of the 12 professionals, eight worked 20 hours/week, and only four worked 40 hours/week. Regarding professional training, three held only undergraduate degrees, two held Master's Degrees, one held a Doctor's Degree and four professionals took specialization courses. Length of service ranged from one to nine years, where length for most participants ranged from four to six years.

Semi-structured interviews were made, with triggering questions that firstly aimed to get acquainted with the health professionals' routine and how they handled the demands of men and women served by the CAPS. In a second moment, more specific questions were asked to analyze the extent of these professionals' knowledge about violence against women, its relation (or not) with mental health, and the systems available in the network to cope with such demand.

Most of the times the interviews were made at the workplace, in a separate room to preserve the respondent's confidentiality. Only two interviews were made outside of the workplace, upon the respondents' request, but in confined sites where confidentiality could also be preserved. Interviews lasted 49 minutes, on average. Participants authorized the recording of the interviews (totaling 588 hours) that were further fully transcribed for data analysis.

The project was approved by the Committee of Ethics and Research of the *Instituto de Ciências Humanas* of the *Universidde de Brasília* (CAAE: 47775515.3.0000.5540) and by the Committee of Ethics and Research of the *Faculdade de Saúde do Distrito Federal* (CAAE: 53102116.6.3001.5553). Before being interviewed, participants signed the Free and Informed Consent Term - FICT.

The analysis of content was performed for data processing (Bardin, 1977; Minayo, 2014). Firstly, the texts of all interviews were skimmed to know the recurrent topics. Then, a critical reading was performed to find the most relevant topics brought up by the participants. The two researchers performed this process in separate. Then, the topics found by both researchers were compared and the five categories of the interviews were listed, following criteria of homogeneity, exhaustion, exclusivity, objectivity and pertinence, as proposed by Bardin (1977).

The five categories built from the content analysis were as follows: "perception of demands presented by women and men", "experience in providing care to women victims of violence", "link between violence and mental health", "knowledge about the Maria da Penha Law and women-centered public policies", "(Lack of) knowledge about the compulsory notification of violence against women". The professionals' responses were divided according to the categories.

Results and discussion

Perception of demands presented by men and women Of the 12 professionals interviewed, seven (58.3%) perceive differences between men's and women's demands. According to them, women ask for more help, cry more, bring more contents, more relationship problems and reports of violence, as said the *psi* area professional 4: *"related to family problems, most of them. Social problems and family problems, right? Separation, difficulties with the children, right? Also violence, right? Against her, right? Permeating families, these issues are clearly present".*

In the professionals' perception, men, in turn, askless for help, are more focused and tougher, and suffering is typically related to sexual and labor activities, as shown in the speech of the *psi* area professional 2: *"usually men regret stop working, for example, and lose their masculinity".*

A difference quoted by many professionals is that men seekless to health services than women. Moreover, even the male users have more difficulties in talking about their suffering. This way, professionals understand that when men explicitly expose their suffering, it is a sign of a serious situation, and the team should be more worried:

> *then it is the same history: women let it all out, either by crying, dancing or shouting. Men become tougher, and that's where danger lays, right? That's why there are more suicides among men than women, right? Because men, they turn to themselves and say nothing* (health professional 3).

For women, because they seek more health services and talk more openly about themselves and their problems, professionals use to disqualify or overlook their suffe-

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ring labeling them "whiners" and using the diagnosis of "multi-complainant". The health professional 4's speech exemplifies this disqualification: *"women always are more multi-complainant, right? They always bring much more complaints in this loving sense, the need of relations with the husband, the children, right?"* The use of this kind of "diagnosis" is a problem because it bears a negative idea about women's speech and disqualifies their suffering. Content loses importance and is perceived as yet another "complaint".

Two professionals deny the existence of differences between men's and women's demands. Denial consisted in ignoring this difference, but pointing it out in their speeches. In these cases there was a tendency towards rationalizing the responses. Professionals' speeches were of universal character, based on the argument that:

> *everybody talks about suffering, right? Everybody is talking about love, rejection, whatever, of lost dreams. (...) I don't see a woman's demand and a man's demand, but what I see, because after all everybody is talking about disaffection, abandonment, very serious social problems* (*psi* area professional 3).

Behind such universal speech lays the idea that there is no gender differentiation and everyone receives the same care. This idea must be challenged because if we do not point out and take on differences, we lose the possibility of providing gender-fair care. Schraiber, d'Oliveira, Portella & Menicucci (2009) corroborate the discussion and state the need for deconstructing the notion of equality found in health. This view changes any diversified care into the adoption of privileges rather than as the fulfillment of rights. Therefore, the equality ideology is a barrier to the pursuit of equity.

Despite their denial, the professionals disclosed differences in men's and women's demands. For men, and according to the professionals' perception, demand had to do with work. For women, in turn, it would be related to the fact that they are more victims of sexual abuse in childhood and relational difficulties with their mothers and husbands.

Three professionals stated never having thought about the difference between men's and women's demands. During the interview, two of them (*psi* area professional 5 and health professional 1) identified the difference between demands. Women's suffering was related to relational problems and the family's needs, while men's suffering was about being providers and their difficulties in seeking assistance. The third professional (mental health professional 2) effectively could not observe differences between the demands, only stating that everyone seeking CAPS do that to have access to medication.

The interviews showed that, although some professionals affirmed never having thought about the problem and others denied the difference, 11 professionals (91.7%) perceived differences in men's and women's demands. Moreover, there is a consensus about the major demands of each gender.

In general, men's suffering was related to their duty as providers and women's complaints were about issues of relational nature. In a study carried out in a psychiatric inpatient wing, Zanello & Bukowitz (2011) observed that 77% of women's complaints were of relational nature, while 71% of men's complaints were marked by sexual virility and labor activities. This study corroborates the statement of health professionals and reinforces the idea that mental suffering cannot be separated from gender studies considering that the psychical suffering is socially built (Zanello & Silva, 2012).

Experience in providing care to women who suffered violence. All professionals had provided care to women victims of violence in the CAPS II. During the interview the professionals commented on how they managed these women. Based on the professionals' responses, the behaviors quoted were divided into three groups: passive and welcoming attitudes; interventionist attitudes; and indifferent attitudes.

Passive and welcoming attitudes comprised behaviors such as listening, supporting, observing the emotional load, and observing silence. Of these, the most quoted behavior was that of listening (mentioned by seven professionals). The behaviors of these groups are important because they could ground more active behaviors. Eight professionals who admitted having passive and welcoming attitudes also performed interventions with women, as can be observed in the *psi* area professional 1 speech: "*so, it's that kind of stuff, listen a lot, collect a lot and, then, punctuate some things*".

The interventionist attitudes pooled behaviors like empowering, punctuating, guiding, asking, increasing frequency of care, discussing with the team, treating, notifying, rendering accountable, and paying home visits. It is worth highlighting that interventionist behaviors are not necessarily responsive to violence's demands.

An example of this unsuitability is the medicalization of women's suffering. The *psi* area professional 6, for example, affirms he does not take violence into consideration when he medicalizes female patients: *"regarding the medical conduct, drug therapy, existing violence or not, I will prescribe drugs for the depression picture. If [depression] has a reason or not, if the reason is violence or not, my conduct will not change*". When what is behind symptoms is disregarded, the history experienced by the woman is then reduced to her psychiatric condition.

According to Maluf (2010) what happens is a process of life medicalization and control over women's experiences. Through the massive use of psychiatric medications, psychiatry becomes a disciplinary device to control or monitor women. The intention is to suppress symptoms and let women keep on playing the social roles assigned to them (Zanello, 2010; Zanello, 2014).

Another interventionist action referred by the professionals, and that deserves special attention, is that women are rendered accountable, as can be observed in the following excerpt:

> *I guess that, in all ways, violence has something like I am not responsible for what happens. And I guess the clinical work follows the opposite way, saying: "Yes, you are responsible for yourself". And we'll have to start bringing about this autonomy and you'll have to take on the responsibility* (*psi* area professional 5).

In the social imagery, generally there are two options in situations of violence: render women accountable or victimize them. However, we should clarify the difference between rendering the woman accountable and work on her leading role in her own life. When professionals show the idea of accountability, we can find a psychological speech based on the idea of "what have you done to cause violence?" There is a search for how the "unconscious" worked on these cases.

However, when working on women's leading role, the professional empowers them to move away from that situation. This way, in the professionals' speech accountability can be read as an attempt of *psychologizing* (De Vos, 2013) violence; a practice that can be violent itself.

In indifferent attitudes the following behaviors were mentioned: not naming violence and not "bringing up" the topic. The lack of attitude and the indifference in relation to violence can be perceived as signs of the professionals' unpreparedness to handle the topic, lack of interest on the woman's report, disqualification and naturalization of violence.

Regarding the "not bringing the topic up" the health professional 1 stated as follows: "*sometimes I don't bring it up; in fact, we let things go this way, moreover because it is not much my duty (...) bring up this question"*. This speech clearly shows the respondent's lack of knowledge that violence is a topic also related to public health and to the clinical picture of mental disorder presented. Schraiber & D'Oliveira (1999), Rose *et al,* (2011), Nyame *et al,* (2013) worked on health professionals' practice in cases of violence, and also observed the same difficulty. For being in a biomedical light, many times professionals do not know how to manage these cases, and do not perceive these as a demand of the service. Therefore, the lack of services or care to manage the situation naturalizes the violence suffered by women.

An outstanding behavior in indifferent attitudes is that of not naming violence which, *per se*, could be considered to be a symbolic violence. The following speech makes it clear:

> *Yes... first, what does violence mean to the person, right? I'm not the one to tell her she is suffering violence because, well, she suffered that all her life; so, sometimes she is not feeling abused, this is not the case. So, when she felt it as violence, I'm a reserved person in this matter. Firstly because I'm not experienced enough to talk about this concept, because I believe that violence is a concept, right? And also because this is not the focus of the work, right? I don't assume it. It [violence] is part* (*psi* area professional 5).

In the excerpt above, the professional shows lack of social criticism and both theoretical and practice knowledge about how to deal with a demand of violence in service. One of the roles expected from health professionals in these situations is that of denaturing the violence suffered. Because of the escalating violence many times women do not perceive what they suffer as violence, and do not understand what lies behind her suffering. Health professionals are tasked with the duty of naming violence to women. By identifying that she suffers violence, the professional legitimates her suffering, validates her pain and can empower her to move away from this situation.

Link between violence and mental health. Professionals have also referred to the link between violence and mental health. Professionals' responses were pooled in four groups: The first group comprises those stating that violence plays a role in the configuration of mental disorders; the second states it is a recursive relation, i.e., mental disorders make people vulnerable to experience situations of violence, and violence assists configuring the mental disorder; in the third group were the professionals that stated that mental disorder brings vulnerability to situations of violence; and, the fourth group comprised professionals who had never thought about the matter.

In the first group, five (41.6%) professionals stated that they believe that violence plays an important role in the configuration of mental disorders. This violence may be current or could have been suffered in childhood, as stated in the following speech:

> *Gosh, a relation... strong. In screening is where I hear it more. Because there you see lots of people with histories of really huge suffering, well, since childhood, right? (...) And, sometimes, the person comes, sometimes, seeks for service and says that suddenly they are that way. And then, the person starts telling all histories, and you perceive that the great majority has histories of violence since childhood* (health professional 4).

In group 2, the four professionals (33.3%) considered the relationship between violence and mental health as a recursive one. The following speech expresses the thinking of professionals in this group:

> *it is a really strong relation. What I see is that many people disease because of the violence processes they have experienced, right? There is no, well, there is no doubt. And suffering also makes people become violent too* (*psi* area professional 3).

The relation perceived by most health professionals that violence damages the individuals' mental health and assists the configuration of mental disorders has been approached in several studies. According to Schraiber & D'Oliveira (1999), women victims of violence are more likely to develop diagnoses of depression, anxiety, insomnia and social phobia, among others. This finding was confirmed in a study by Rose et al. (2011) according to which women suffering violence come 11 more times to mental health services than women that have not experienced this situation.

In the third group, only one professional affirmed that the focus was on the disorder and this placed the subject in a situation more vulnerable to suffering violence, as in the speech of mental health professional 2: *"patients with mental disorders are both victims and... well.. how could I say it? They cause victims"*.

In the fourth group two professionals could not answer. This non-response to the question can be perceived as lack of criticism about the practice itself. This brings about the need for fostering professionals to think over social issues (such as violence, gender, race, social class) that assist the configuration of psychological suffering. If culture has important participation in mental diseasing and in how symptoms are manifested (Zanello, 2014), therapy should talk to it rather than being thought in an independent way.

Knowledge about Maria da Penha Law and women-centered public policies. The Maria da Penha Law (Law 11340/2006) is considered to be one of the most progressive laws in the world to fight violence against women. It served as grounds to many public policies proposed in Brazil. However, there is a gap between the law and the practice in services. This disparity can be observed in the speech of health professionals interviewed.

This law was mentioned by 50% of the professionals as one of the public policies to cope with violence against women. However, they had no further knowledge about that Law: six professionals said that they knew only what is common sense; three said they knew nothing about it; two said they knew it in practical terms; one knew the history of the creation of this law. These evidence a clear lack of

knowledge about the Maria da Penha Law among health professionals in the CAPS.

The professionals who stated that they knew the law in practical terms were psychologists. They said that in their undergraduate courses they had done internships in court or with professors working on this topic. Therefore, in university they had the opportunity of dealing with this topic not theoretically but in a practical level. The lack of approach of this topic in undergraduate courses has also been discussed by other surveys in Brazil, such as by Souza et al. (2008).

Although they claim to have little knowledge about the law, the professionals expressed their opinions on it. Many times these opinions were based on the common sense. For example, the idea that the Maria da Penha Law is not effective and has been misused by women, as follows:

> *I know it... the fact that a woman can denounce a man and... it basically criminalizes a man. [Laugh] (,,,) and I'm quite critical, I guess the criminalization process is bigger than, than, than, the remainder, right? That's it, the woman has the man arrested, shortly after she engages him again and arrested him. Most typical, right? In this sense* (*psi* area professional 2).
>
> *It's because sometimes women use the Maria da Penha, I say there should also be a João da Penha, because women use it [the law] in a distorted way, to have this power, this way: she is caught in the violence game, but go there and uses the Maria da Penha [laugh]. It is hard but it is also sensitive. I guess there is no assurance that a woman there, in Maria da Penha, is really suffering violence and is not abusing anybody, or that there is a real work to take her out of that. Hum... this is basically what I know* (*psi* area professional 5).

These speeches show that the professionals' unawareness about the law and the legal devices of protection and assistance to women can lead to mistaken thoughts and practices among professionals. These speeches bear an idea that women would be the "villains" and the creation of a protective mechanism gave them the opportunity to use public policies to "jeopardize" men. This idea is disseminated in the common sense, being an argument used by many to disqualify the Maria da Penha Law.

It is important to question the social myths that professionals have and the influence they exert in their professional practices. Thoughts like the aforementioned are a serious form not only of making violence invisible, since professionals do not try to learn about the law to ground their practices, but of the institutional violence that professionals themselves could commit when treating women in this situation. These stereotypes should be broken in the society, above all among public health providers.

In addition to the Maria da Penha Law professionals have referred to other public policies to cope with violence against women. In general, these were related to the places where to professionals referred their female patients when they identified situations of violence. Seven professionals (58.3%) quoted the *Programa de Assistência à Violência* (PAV). This program has the objective of "proving care to individuals in situation of violence, adopting a bio-psycho-social and interdisciplinary approach, in coordination with the care network, institutional and cross-sector referrals, promotion of culture of peace and monitoring of cases of violence" (Ministry of Health Decree # 141/2012). The program serves all individuals victims of violence, with no special focus on women in this situation. It is worth mentioning that the hospital where the CAPS is located also houses a PAV. Many speeches made clear the idea that professionals refer the female patients to this program to "remedy" a responsibility and "pass the problem on". Therefore, they would be complying with their duty of referring and solving the situation. When asked, most professionals said they did not accompany the women or their treatment in those places.

Other public policies to cope with violence also mentioned were the police stations specialized in assisting women (DEAMs), ordinary police stations, the Public Defender's Office, the *Pró-Vítima* Program, compulsory notification, and the hospital's social assistance. Despite referring to these public policies, professionals clearly showed they are more familiar to the name of such policies than with the role and duty of these policies in the network to cope with violence.

The professionals' knowledge about the Maria da Penha Law and public policies were actually based on common sense. Only three professionals stated the need for in-depth knowledge of the law and the topic. Therefore, one can observe the lack of interest on the subject and on seeking more efficient working practices. This lack of knowledge is largely highlighted in literature (Trevillion et al., 2014; Rose et al., 2011; Schraiber & D'Oliveira, 1999) as one of the barriers to the more effective practice to meet the demand of violence against women in Brazil and in the world. Therefore, investments should be made in the field of education to these professionals.

(Lack of) knowledge about compulsory notification of violence against women. Professionals mentioned compulsory notification. This should be highlighted because it is considered to be an important source for a database to formulate public policies. Nonetheless, health professionals have once again showed unawareness about the role of this mechanism, and do not enforce it properly.

Of the interviewed professionals, nine reported they do not comply with the compulsory notification. Those who do not comply with it claimed the following: fear of losing the link; high demand of the service; idea that it does not work; size and complexity of the notification form; lack of knowledge on the difference between reporting and notification; issues related to professional secrecy; and, unawareness of the mechanism. The following *psi* area professional 2's speech depicts some of the difficulties found by the professionals:

> *Look, it happened recently. We know a little more about how to do it, but we do very little. (...) Because recently they mandated us to do not only that on gender, only the gender-related issues of physical violence, but on several forms of violence. Our obligation was as follows: this is quite crazy, in fact. Any patient coming to the office or in any place, which has been abused in the past, present and future - future I'm joking. You have to fill out a giant form, surreal form. The notification form is very complex, you have to have lots of data, it takes about 20 minutes to complete it, I did it once.*

In addition, it also showed the belief that the notification is not intended to protect, being a way to denounce and criminalize:

Well, sincerely, the [forms] we completed were nowhere, because none of them had a decisive process of protecting someone, so… there you have these two sides that make you wanna give up, because it takes a lot of work, we don't have time to do it every time, and the other thing is that it comes to nothing. (...) because I think that notifications serve to protect, but I think that, well, we have to... it's as I say: denouncement, criminalization is important, but it is a very limited role, I guess, what we can do in this case. (...) I reported. And it was useless. It is as I said on that day, I had said it before: "... it may be useful to say that I protected myself as a psychologist, that I notified it, that I know it's true, then thinking on, on covering my backside, notifying is great, if the woman dies I say: I notified". So, thinking about myself it is great, but having in mind the therapeutic link, negotiation of all I said before, man... the case is screwed up. That's all, damned. But we know the form, but we almost never fill it out. We even have the forms in the cabinet. I think they are very complex... they super…

The arguments in this speech can be understood as the professional's unawareness about what compulsory notification really means. According to Law 10778/2003, all health professionals are mandated to notify the cases of violence against women assisted in public ad private health care services. Notification is an instrument of epidemiological surveillance aimed to map the forms of violence, its agents and proportions to then think over actions and policies focused on the most responsive prevention and care. No professional identified the notification as an epidemiologic surveillance tool.

The professionals also showed difficulties in understanding the difference between notification and denouncement or report. Notification is the referral to the epidemiological surveillance service, and serves as a source of data to formulate policies. In other words, based on data obtained from the notifications, the Federal Government maps violence and envisages more efficacious ways of working. Notification does not entail results specific to the notified case. It comprises a larger dimension of violence, i.e., the construction of the profile of women suffering violence and attending the service. Denouncement or report, in turn, is carried out in a police station before the police authority and generates a police report and inquiry (Maria da Penha Law, Art. 12) because, when concluded, it is the tool that subsidizes the Public Prosecutor's Office to file the accusation and start the criminal proceedings (Criminal Proceeding Code, Art. 24).

The professionals must know the difference between these instruments so they do not raise expectations of solving the specific problem upon notification, because this is not the role of notification. Likewise, managers and law and policy-makers should dialogue with one another and with professionals engaged in the related services. This way, problems only perceived in practice could be remedied, such as the criticisms to the notification form. Professionals reported the form complexity and extension as difficulties that should be considered to make the compliance with the law more efficacious.

Conclusions

Health professionals reported violence against women as recurring among the CAPS users, as evidenced in the following speech: *"our clients at the CAPS are mostly women, right? It is basically, I'm not sure, I'd say 90%, well... have… have recurrent situation of violence*" (*psi* area professional 1). Although there's a perception of the recurrence of these situations of violence, it usually is not notified neither are the women referred to the services available on the network. Notification and referral are made only in serious cases. All that, despite the fact that many professionals referred to violence as an important factor to understand the psychic diseasing process.

The (in) visibility of this topic among professionals is thus related, on one hand, to its clear perception and, on the other hand, to a failure that ends up making invisible the violence suffered by the female users, subsuming it in psychiatric diagnoses. This is due to the fact that professionals are unskilled in this topic, and do not seek legal instruments that could ground their practices. The interviews showed that practice is based on intuition and common sense, rather than on theoretical and practical knowledge. This way, we highlight the importance of training professionals to work with this content. The effort to enforce public policies should be a duty of both parties: those who propose and inspect the laws, and those participating in the daily life of the service itself.

It is worth highlighting that professionals responded differently about perception, beliefs, knowledge, practices and way of acting in face of the demand of violence against women, regardless their area. Further studies should then comprise other CAPS to expand the number of professionals and learn about specificities and differences between the categories. Such survey could point out paths to better qualify professionals in this topic, making public policies get off the ground to the different levels of public agents, including health professionals, notably the mental health professionals.

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