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RESEARCH

THE EFFECTS OF INTIMATE PARTNER VIOLENCE ON WOMEN'S AND CHILDREN'S HEALTH: THE COLLECTIVE IMAGINARY

EFEITOS DA VIOLÊNCIA POR PARCEIRO ÍNTIMO NA SAÚDE DA MULHER E FILHOS: O IMAGINÁRIO COLETIVO

EFECTOS DE LA VIOLENCIA POR PARTE DE LA PAREJA ÍNTIMA EN LA SALUD DE LA MUJER Y LOS HIJOS: EL IMAGINARIO COLECTIVO

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ABSTRACT

Objective: to understand the imagery constructed by women regarding the effects of intimate partner violence on their health and that of their children. **Method**: this was a qualitative, descriptive study conducted at a Women's Care Reference Center in Petrolina, Pernambuco, Brazil, with 12 participants who had experienced intimate partner violence. Data were collected between July 2019 and February 2020 through semi-structured interviews, systematized using the collective subject discourse (CSD), and interpreted in light of Michel Maffesoli's Comprehensive and Everyday Sociology. **Results**: the collective subject was between 32 and 56 years old, Black and Brown, evangelical, with a college degree, low income, and financially dependent. The following central ideas emerged from the CSD: "I became very ill" and "Living with my ex-husband disrupted my children's lives in every way." The discourses highlighted physical and mental illness, as well as intergenerational impacts, such as anxiety, withdrawal, and violent behavior in children. **Final Conclusions**: the collective Imaginary revealed intimate partner violence as a totalizing phenomenon that spans generations, structuring suffering as a symbolic and social experience. The findings point to the need for health care based on interdisciplinarity, articulation of knowledge, and intersectoral public policies to break cycles of violence.

Keywords: Battered Women; Family; Intimate Partner Violence; Activities of Daily Living; Women´s Health; Child Health.

RESUMO

Objetivo*: apreender o imaginário construído por mulheres sobre os efeitos da violência por parceiro íntimo em sua saúde e na de seus filhos.* ***Método****: estudo qualitativo e descritivo realizado em um Centro de Referência de Atendimento à Mulher em Petrolina, Pernambuco, Brasil, com 12 participantes que vivenciaram a violência por parceiro íntimo. Os dados foram coletados entre julho de 2019 e fevereiro de 2020 por meio de entrevistas semiestruturadas, sistematizados pelo Discurso do Sujeito Coletivo (DSC) e interpretados à luz da Sociologia Compreensiva e do Cotidiano de Michel Maffesoli.* ***Resultados****: o sujeito coletivo apresentou idade entre 32 e 56 anos, cor preta e parda, religião evangélica, nível superior completo, baixa renda e dependência financeira. Do DSC emergiram as ideias centrais: "fiquei muito doente" e "a convivência com meu ex-marido atrapalhou a vida dos meus filhos em tudo". Os discursos evidenciaram o adoecimento físico e mental, além de impactos intergeracionais, como ansiedade, retraimento e comportamentos violentos nos filhos.* ***Conclusões Finais****: o imaginário coletivo revelou a violência por parceiro íntimo como fenômeno totalizante que atravessa gerações, estruturando o sofrimento como experiência simbólica e social. Os achados apontam a necessidade de atenção em saúde pautada na interdisciplinaridade, na articulação de saberes e em políticas públicas intersetoriais para romper ciclos de violência*

Palavras-chave*: Mulheres Maltratadas; Família; Violência por Parceiro Íntimo; Atividades Cotidianas; Saúde da Mulher; Saúde da Criança.*

RESUMEN

Objetivo*: comprender el imaginario construido por mujeres sobre los efectos de la violencia por parte de la pareja íntima en su salud y la de sus hijos.* ***Método****: estudio cualitativo y descriptivo realizado en un Centro de Referencia de Atención a la Mujer en Petrolina, Pernambuco, Brasil, con 12 participantes que experimentaron la violencia por parte de la pareja íntima. Los datos fueron recopilados entre julio de 2019 y febrero de 2020 mediante entrevistas semiestructuradas, sistematizados por el Discurso del Sujeto Colectivo (DSC) e interpretados a la luz de la Sociología Comprensiva y del Cotidiano de Michel Maffesoli.* ***Resultados****: el sujeto colectivo presentó edades entre 32 y 56 años, de color de piel negra y mulata, religión evangélica, nivel superior completo, bajos ingresos y dependencia financiera. Del DSC emergieron las ideas centrales: "me enfermé mucho" y "la convivencia con mi exmarido arruinó la vida de mis hijos en todo". Los discursos evidenciaron el deterioro físico y mental, además de impactos intergeneracionales como ansiedad, retraimiento y comportamientos violentos en los hijos.* ***Consideraciones Finales****: el imaginario colectivo reveló la violencia por parte de la pareja íntima como un fenómeno totalizador que trasciende generaciones, estructurando el sufrimiento como una experiencia simbólica y social. Los hallazgos apuntan a la necesidad de una atención en salud basada en la interdisciplinariedad, en la articulación de saberes y en políticas públicas intersectoriales para romper con los ciclos de violencia.*

Palabras clave: *Mujeres Maltratadas; Familia; Violencia de Pareja; Actividades Cotidianas; Salud de la Mujer; Salud Infantil.*

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INTRODUCTION

Intimate partner violence (IPV) is a pervasive and challenging issue present across all cultures and recognized as a serious public health and human rights problem. It is the most prevalent form of violence against women, encompassing physical, sexual, and psychological abuse, as well as controlling behavior by partners. It is estimated that 641 million women worldwide have suffered from this type of violence, accounting for approximately 30% of women over the age of 15[1].

In Brazil, the data reveal an equally concerning scenario. According to the Pan American Health Organization[2], 16.7% of Brazilian women aged 15–49 have experienced physical or sexual violence by an intimate partner at some point in their lives, with 3.1% reporting incidents in the past year. More recent data indicate the persistence and severity of the phenomenon: a report based on the Notifiable Diseases Information System shows an increase in the number of reports of violence against women, rising from 113,476 in 2013 to 302,856 in 2023, with a recurrence rate of 44.7% in the latter year. Regional variations highlight inequalities: the Southeast led the number of reports, with 152,011 records, followed by the Northeast with 56,829, and the Midwest with 21,787[3]. These regional differences underscore the need for investigations that broaden our understanding of how IPV manifests in different sociocultural contexts.

Local studies further illustrate this situation by highlighting a high number of reports of violence against women in Pernambuco recently, with a concentration of cases in urban areas and among young, brown-skinned, single women[4]. These findings point to the intersectionality of gender, race, social class, and age as determining factors of vulnerability to violence.

Assaults are repeated daily, constituting tragic experiences that profoundly impact family life, affecting women's physical and mental health, as well as the development of their children. The physical repercussions range from immediate injuries to long-term outcomes, such as sexually transmitted infections, unplanned pregnancies, and obstetric complications[1]. Psychologically, common mental disorders such as anxiety, depression, insomnia, fatigue, and somatic symptoms are prominent. For children, living in violent environments is associated with internalizing symptoms (anxiety, withdrawal, sadness) and externalizing symptoms (aggression, attention problems, delinquent behavior), confirming the intergenerational nature of violence[5].

Given this context, we sought to answer the following guiding questions: How do women perceive the effects of IPV on their health and that of their children? What meanings are attributed to the repercussions of IPV on the mother-child family unit?

From Michel Maffesoli's perspective, violence can be understood as an ambivalent, multidimensional, and everyday phenomenon expressed in different forms (totalitarian, anomic, and banal), with the latter being representative of domestic violence, as it is part of the routine of family life[6]. Thus, understanding the effects of IPV from the social imaginary of women involves interpreting how experiences of suffering, fear, and illness are symbolically elaborated and shared in the social fabric.

Given the above, we aimed to understand the imaginary constructed by women about the effects of IPV on their health and that of their children. Multiple factors justify this study; first, by the magnitude of IPV in Brazil and worldwide, recognized as a serious public health problem and a social determinant of health, with physical, psychological, and intergenerational repercussions[1,7]. Second, there is a need to amplify women's voices, as their perception of the impacts of violence directly influences their help-seeking, adherence to support services, and decision to break the cycle of violence. Furthermore, understanding the effects of IPV from the female perspective allows for the interpretation of how experiences of suffering and illness are symbolically elaborated and shared, providing insights for more sensitive and integrated care practices. In this sense, the relevance of an interdisciplinary approach that combines health, psychology, social work, and the humanities is emphasized, an indispensable condition for understanding the complexity of IPV and for building more effective intersectoral responses[8].

Lastly, this study is grounded in an interdisciplinary understanding, which involves integrating knowledge from public health, psychology, sociology, and social work to grasp the complexity of IPV. This perspective recognizes that the phenomenon extends beyond the boundaries of the biomedical field and requires the integration of diverse professional knowledge and practices, promoting a more sensitive, comprehensive, and transformative approach to addressing violence against women.

METHOD

This research is an excerpt from the master's dissertation entitled *Cotidiano de mulheres em vivência de violência por parceiro íntimo: contribuições para o cuidar interdisciplinary* [Daily lives of women experiencing violence

from intimate partners: contributions to interdisciplinary care], which is part of the anchor project *Violência contra a mulher: implicações e necessidades humanas básicas afetadas* [Daily life of women experiencing IPV: contributions to interdisciplinary care]. The study was approved by the UNIVASF Research Ethics Committee under opinion no. 2,615,442 and amendment no. 3,350,005, dated May 27, 2019.

This is a descriptive, qualitative research study situated in the field of interdisciplinarity and based on the theoretical-methodological assumptions of Comprehensive and Everyday Sociology. The development and methodological description adhere to the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Data were collected from July 2019 to February 2020 at the *Reference Center for Women's Care* (CEAM) *Valdete Cezar*, in Petrolina (Pernambuco State, northeastern Brazil). A convenience sample of participants was selected based on the inclusion criteria: women undergoing psychological counseling with scheduled appointments at the service, over eighteen years of age, and experiencing domestic violence perpetrated by an intimate partner or ex-partner.

The psychologist provided the researcher, a nurse pursuing a master's degree in health sciences and the first author of this article, with the dates and times of the appointments of eligible women. Participants excluded from the study included those not receiving regular psychological counseling at CEAM during the data collection period, those whose situations of violence did not involve an intimate partner or ex-partner, and those in a state of emotional or clinical fragility who, in the opinion of the service psychologist, might have their well-being compromised by participation. No participants refused or withdrew from the study.

Interviews were conducted individually during a single meeting with each participant, guided by a semi-structured script prepared according to the study objectives. The script contained objective questions about sociodemographic characteristics and guiding questions that encouraged spontaneous narratives about experiences of violence by an intimate partner. The interviews explored the participants' daily lives before and after the experience of violence, the impact on their lives and that of their children, coping strategies, and future projections. Notable guiding questions included: "Tell me what your daily life was like before you lived with your partner"; "What activities did you do before and stop doing because of the violence you suffered?"; "After that, how did your life change?"; "What do you do to move forward with your life?"; "How did your children's lives change after the violence?"; and "How do you imagine a life without violence? What would it be like? What are your plans?"

The women were personally invited to participate after their psychological consultations, following a brief presentation of the researcher's credentials, motivations for conducting the study, and explanations about its purpose and relevance. After accepting the invitation, they were taken to a private room at CEAM, free from interference, where the free and informed consent form was read, questions were addressed, signatures were collected, and a copy of the form was given to the participant.

Twelve interviews were conducted, each averaging 60 minutes, and audio-recorded with a voice recorder with the participants' permission. The researcher transcribed the interviews in full, maintaining the secrecy and confidentiality of the information by identifying the participants with female names referring to flowers: Hortênsia, Gardênia, Dália, Rosa, Acácia, Angélica, Íris, Magnólia, Margarida, Yasmim, Melissa, and Açucena. Throughout the interview period, the researcher maintained a field diary in which impressions were recorded, which later supported the analysis of the content.

The audio-recorded interviews were meticulously transcribed, preserving the content and originality of the statements. The initial reading verified the study's objectives. Data collection and analysis concluded not by saturation criteria but by the quality of the data, aligning with the research objective.

Following the initial reading, narratives were systematized by constructing summary discourses using the Collective Subject Discourse (CSD) method. This method involves extracting meanings or significances from individual statements and organizing them into a single discourse, in the first-person, representing the collective opinions, positions, and beliefs[9]. All transcribed content underwent a new reading, informed by the theoretical--conceptual framework, alongside field diary impressions, to identify key expressions, anchors, and central ideas, which are key components of the CSD method.

The key expressions are literal excerpts from statements that convey the essence of individual opinions, representing the core meaning. The anchors are statements reflecting values, beliefs, ideologies, or theories underpinning the subject's worldview. The key expressions and anchors were grouped and synthesized according to semantic similarities to create the CSD. From the synthesis of the narratives in a single discourse, maintaining original meaning, the central ideas were extracted,

representing the central message guiding the CSD. The first two authors manually systematized the statements without using software.

The CSDs were interpreted using theoretical and methodological resources from Comprehensive and Everyday Sociology, as per the thoughts of French sociologist Michel Maffesoli, whose theory is receptive to the imaginary at the intersection of power, potency, sensitivity, and reason. For the author, the imaginary is "the state of mind of a group, a country, a nation-state, a community"[10]. Thus, as it involves affections, the notion of the imaginary is apt for understanding the emotions of the collective subject in the experience of IPV.

RESULTS

Characterization of the collective subject

The collective subject presented the following characteristics: age ranging from 32 to 56 years, self-identified as having black or brown skin color (n = 9), affiliated with the evangelical religion (n = 7), and marital status distributed as married (n = 3), single (n = 3), and divorced (n = 3). The highest level of education was the completion of higher education (n = 4), with a predominance of low income and either total or partial economic dependence on a partner or family (n = 8), in addition to being beneficiaries of the Auxílio Brasil Program (n = 4). Regarding family composition, there were female single-parent families (n = 4), characterized by the mother's sole responsibility for supporting and caring for the children; nuclear families (n = 4), comprising a couple and children; and extended families (n = 4), consisting of a couple and children alongside other close relatives, such as grandparents or aunts and uncles, who share daily life and family support.

The duration of cohabitation with a partner ranged from 5 to 36 years, with concurrent experiences of 2–4 types of violence: physical (n = 11), sexual (n = 2), moral (n = 9), psychological (n = 11), and patrimonial (n = 5).

Collective subject discourses

The systematization of narratives gave rise to two CSDs with two central ideas: *"I fell very ill"* and *"Living with my ex-husband disrupted my children's lives in every way."* These discourses reflect a collective consciousness marked by the physical and mental illness of women, as well as the intergenerational effects of violence on the lives of their children.

The first discourse underscores how the experience of IPV disrupts women's daily lives, affecting multiple dimensions of their health. The reported illness encompasses not only the physical body (e.g., anorexia, hypertension, nervous gastritis, insomnia) but also the emotional and psychological domains, manifesting as anxiety, depression, panic syndrome, loss of self-esteem, and loss of identity. This accumulation of suffering translates violence into an all-encompassing experience that corrodes not only the body but also the social and emotional roles of women, impacting their ability to work, care for themselves, dream, and plan for the future.

The underground centrality of the collective subject, interpreted in light of Maffesoli's concept as the "central element" of life that occurs "beneath" institutionalized structures and ensures social cohesion even without being endorsed (through affections, values, imagination, cultural practices), is revealed here in the perception of a life "ruined" by violence, in which suffering becomes a shared paradigm of meaning among the participants.

> *"Nowadays, if someone asks me, 'Are you the same person?' No, I'm not, because your life changes... My health changed completely. I became very ill, with anorexia, because I stopped eating; I didn't take care of myself. I developed panic syndrome; I became afraid of even taking a shower. I would stand in front of the shower and couldn't bring myself to get in; I would just put my hand in the water. My mind was profoundly affected by depression. I only thought about dying and taking my own life, and I set my house on fire. I developed diabetes and hypertension, started taking medication to prevent a heart attack, felt immense pain, and also have symptoms of nervous gastritis. I am anxious, I want to eat non-stop, but then can't eat properly and feel very nauseous. I don't sleep well; I have insomnia and horrible dreams. Additionally, I always liked sex, but I was repulsed after he raped me. I can say that I don't like sex anymore. I used to enjoy dressing up and was content, but with him, I stopped taking care of myself to avoid jealousy. I couldn't stand combing my hair because of all the violence. My mother asked me why it was so tangled, but I didn't tell her because I was afraid of being beaten again. After he entered my life, my self-esteem plummeted. I began to think I was worthless. I developed an inferiority complex. I think no one likes me. I feel ugly, fat, and different from others. This made me a very sensitive person. If I think about myself even a little, I cry. I didn't want to work anymore. I felt persecuted by him, and I still think I won't be able to do anything. This marriage destroyed me and my life plans. I was shaken; I cried easily and lived thinking about the future. I didn't use to live like this."*

(Hortênsia, Gardênia, Dália, Rosa, Acácia, Angélica, Íris, Margarida, Yasmim, Melissa, and Açucena)

The second discourse elucidates the impacts of violence on children's lives, revealing a collective imaginary characterized by the transmission of suffering and the rupture of family ties. The statements indicate that children not only witness violence but also internalize it into their bodies and life paths: they become ill, lose weight, and develop symptoms of anxiety and depression, and in some cases, exhibit aggressive behaviors, reiterating the sexist patterns experienced in the family environment. This collective discourse underscores the social dimension of violence by demonstrating how women's individual experiences reverberate within the family unit, compromising children's psychosocial development and perpetuating intergenerational cycles of violence. Shame, fear, trauma, and paternal rejection manifest an imaginary of family breakdown, where violence becomes a symbolic and emotional inheritance, complicating efforts to break definitively from the aggressor.

> *"This affected my children; they were frequently ill, witnessed the violence, and were afraid. Sometimes they would run to their room when the argument started. They became very disturbed and sad, fell ill, and lost weight because since I didn't eat, they ended up not eating either. Their father forbade them from going anywhere. My daughter suffered the most. When she played with a boy, she was severely beaten, and I was beaten too, so she withdrew, started crying, became stressed, aggressive, and behaved strangely. I think she has some psychological problems; she's a little depressed, has anxiety attacks, and is in a foster home because of him. I blame myself for this, for not leaving sooner. The boy witnessed the last assault and was very traumatized, scratching his knees and covering his ears because there was shouting and things being broken. He saw it, cried, and asked, 'Daddy, don't hit Mommy.' I believe all of this greatly damaged their relationship with their father, leading them to feel anger and shame regarding his behavior when he came home drunk. The first time they went to his house, they were afraid, cried significantly, and returned different, disobedient, even hitting me due to their father. For me, living with my ex-husband disrupted my son's life in every way, affecting his studies and relationships. He has had a few girlfriends, but ends up behaving like his father: macho, domineering, abusive, and then it doesn't work out. Today, he has practically abandoned me, treating me as his father did, but even so, I remain attached to him."* (Hortênsia, Gardênia, Dália, Rosa, Angélica, Íris, Magnólia, and Margarida)

Thus, the results reveal that IPV is not confined to the marital sphere but has broader repercussions, constituting a collective phenomenon that crosses bodies, subjectivities, and generations. This requires responses that extend beyond the individual sphere to encompass the social, community, and institutional support networks.

DISCUSSION

The elements of the individual narratives composed CSDs that reveal subjectivities captured in an imaginary world of memories and deep-rooted hurts, resulting in physical and mental illness among women experiencing IPV and extending also to their children, with visible and invisible outcomes.

The sociodemographic profile identified in this study (i.e., mostly Black or Brown women with low income, economic dependence on their partner or family, and living in single-parent or extended family arrangements) highlights the persistent gender and social inequality that permeates the experience of IPV. These findings corroborate recent research showing how socioeconomic vulnerability, race/color, and low education are risk factors for exposure to domestic violence[11,12]. The literature also shows that these conditions not only increase the likelihood of violence occurring but also make it more difficult to break the cycle of abuse, reinforcing the intersectionality among gender, race, and social class[7,13].

The collective imaginary allowed feelings of helplessness, hopelessness, and fear to emerge in the face of oppression by the partner. Fear, in addition to being an emotional response to the risk of aggression, can be understood as a strategy of domination used by the aggressor to maintain control over the woman, prolonging her vulnerability[13]. When interpreted in the light of comprehensive sociology, fear reveals itself as the recognition of the tragic in everyday life, that is, of the limit represented by the risk of death, the destruction of expectations, and the "symbolic death" of the future.

The tragedy of everyday life has given rise to symptoms of anxiety, depression, eating disorders, sexual disinterest, sleep disturbances, chronic pain, absenteeism from work, suicidal thoughts, and compulsive behaviors in the collective subject. These findings are consistent with recent studies that point to a strong association between IPV and common mental disorders, including major depression, post-traumatic stress disorder, low self-esteem, and self-destructive behaviors[13-15]. The somatization of suffering reported by the participants, such as hypertension, diabetes, and nervous gastritis, illustrates

how violence is inscribed in the body, an aspect also highlighted in studies that analyze the interface between gender-based violence and chronic health conditions[1].

In this context, the experience of violence not only compromised physical and mental health but also weakened what Maffesoli calls "underground power": the silent vital energy that sustains the ability to resist, dream, and plan for the future, even in the midst of suffering. The weakening of this power shows how IPV acts in a totalizing way, corroding not only the body and mind, but also the collective and symbolic force that gives cohesion to everyday life, transforming women's imaginary into a space of hopelessness and rupture[6].

In the collective discourse, the "underground centrality" of Maffesoli can be understood as the vital energy that persists despite suffering. However, the tragic experience of violence has compromised this power, affecting self-esteem and the perception of personal value. Recent research indicates a negative correlation between self--esteem and the legitimization of violence, revealing that women in situations of IPV tend to internalize feelings of inferiority, which makes them more susceptible to remaining in abusive relationships[5].

A study conducted during the COVID-19 pandemic explored the relationships among psychological abuse, self-esteem, and emotional dependence in women from the perspective of traumatic bonding theory. With a sample of 222 women, the research showed that the greater the psychological abuse, the lower the self-esteem and the greater the emotional dependence on the partner. This dynamic contributes to the cyclical maintenance of abusive relationships[16].

Complementarily, a study with young adults in France found that individuals with higher self-esteem and rational conflict resolution skills presented lower severity in severe forms of IPV (i.e., repetitive physical and sexual aggression and intense psychological violence), whereas avoidant or impulsive styles were strongly associated with the intensification of psychological violence[17]. These findings reinforce the idea that low self-esteem not only legitimizes subtle forms of violence, including the trivialization of psychological aggression and submission to norms of obedience, but also increases tolerance for abusive behavior, making it difficult to break the cycle of violence.

The duration of cohabitation with a partner, as presented by the collective subject, revealed that many women, even in the face of physical and mental illness, remained in abusive relationships for long periods. This finding is corroborated by studies showing how the perception of violence influences help-seeking behavior. A multicenter study conducted in 54 countries showed that only about half of women sought some type of support, mostly informal. Factors such as education, employment, economic status, and access to information were decisive both in the decision to seek help and in adherence to formal protection services[18]. Similarly, research conducted in Nigeria identified that sociocultural elements such as religion, marital status, and place of residence modulate the likelihood that victimized women will resort to formal services. The study shows that when the perception of the impacts of violence is minimized or naturalized, there is a greater tendency to maintain the abusive relationship[19]. These recent studies address both the sociodemographic characteristics of the collective subject and the CSD, in which participants expressed feelings of fear, helplessness, and hopelessness that not only cause physical and mental illness but also act as subjective barriers to seeking support.

The effects of violence also extended to the children, who were not just spectators, but individuals directly impacted by the experience. The narratives indicate physical illness, anxiety, depressive symptoms, eating disorders, as well as aggressive behaviors and the reproduction of violence experienced at home. These findings reinforce recent evidence that childhood exposure to IPV is associated with a higher likelihood of developing behavioral and emotional disorders, school difficulties, and the risk of perpetuating violent patterns[5,13,15]. The transgenerational nature of violence was evident, especially when sons began to reproduce sexist and abusive practices against their mothers, as also described in a longitudinal study on the intergenerational transmission of violence[15].

Therefore, the results showed that IPV negatively affects the daily lives of women and their families, changing lifestyles, causing physical and mental illness, and leaving invisible marks that span generations. Even when narrated as past experiences, such memories remain alive and active in the present, causing suffering. Given this, public policies to combat violence against women must consider not only immediate care, but also long-term care strategies focused on mental health, social support, and the prevention of the reproduction of cycles of violence.

Thus, in the face of tragic life events, Maffesoli[6,10] emphasized that the path to reconstruction lies in changing the imaginary, understood as the collective capacity to reframe lived experience. It is not a matter of denying pain or remaining trapped in the past, nor of projecting oneself into an uncertain future, but of rediscovering in the present the power to create new meanings for

existence. Within this horizon, the "underground power" emerges as the silent vital energy that, even when weakened by violence, persists as a possibility for rebuilding everyday life. This power can only flourish when sustained by networks of solidarity, recognition, and care, capable of welcoming silenced suffering and transforming it into bonds of hope. Therefore, women experiencing tragic situations of IPV need not only immediate interventions, but also a sensitive gaze that recognizes, in their silences and resistance, their appeals for dignity, belonging, and life.

Our findings demonstrated that IPV cannot be understood in a manner restricted to the biomedical field. On the contrary, it requires an interdisciplinary approach that integrates health knowledge with that of the social and human sciences, considering both the clinical and epidemiological aspects and the cultural, relational, and symbolic dimensions that sustain violence. Interdisciplinarity, in this sense, is a necessary path for interpreting the phenomenon in its complexity and for designing coping strategies that are aligned with the concrete reality of women and their families, bringing together different perspectives and bodies of knowledge to address a phenomenon that is at once health-related, social, and human.

In practice, the data presented here have direct implications for health professionals. By highlighting the physical and psychological symptoms associated with IPV, the results underscore the importance of physicians, nurses, psychologists, and other professionals recognizing violence as a social determinant of health. Such recognition requires relational skills, ethical sensitivity, and the ability to work in a network, promoting comprehensive care that goes beyond isolated encounters and is connected to an intersectoral support network.

Therefore, health practices should be oriented toward skilled listening, early identification of violence, and the construction of supportive bonds that enable women to access protection resources and rebuild their life projects. Thus, the consolidation of interdisciplinary practices that are sensitive to individual circumstances and sociocultural contexts is essential to mitigate the effects of IPV, break intergenerational cycles of violence, and promote health and dignity for women and families in vulnerable situations.

This study had some limitations, including the short data collection period due to the social isolation imposed by the COVID-19 pandemic, which interrupted face-to-face interviews. The data may be subject to recall bias, as they refer to past feelings and experiences. In addition, as this was a cross-sectional study, there was no longitudinal follow-up of health effects during and after experiencing IPV, and the repercussions on daily life from the perspective of children or other family members were not investigated, which could be considered in future research.

CONCLUSIONS

Based on the collective discourses, understood from the perspective of the social imaginary, it was possible to comprehend the multiple effects of IPV on the daily lives of women and their families. The results show that IPV has physical, psychological, social, and intergenerational repercussions, producing visible and invisible marks that permeate women's subjectivity and reverberate in their children, compromising their development and perpetuating cycles of violence. From the perspective of Comprehensive and Everyday Sociology, these findings made it possible to understand how the collective imaginary organizes meanings of pain, resistance, and reconstruction in the face of the tragic experience of violence.

Thus, the conclusions of this study reaffirm the importance of understanding IPV as a complex issue that goes beyond individual and clinical dimensions, requiring interpretations that are sensitive to subjectivity and the symbolic frameworks that structure women's daily lives. The imaginary, as an analytical category, proved to be a powerful tool for uncovering the ways of feeling, thinking, and resisting that emerge even in the midst of pain, revealing possibilities for recomposition and reexistence.

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