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ORIGINAL ARTICLE

INTERPERSONAL AND SELF-DIRECTED VIOLENCE: CHARACTERIZATION OF CASES REPORTED IN A REGIONAL HEALTH DEPARTMENT OF PARANÁ

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ABSTRACT

Objective: to characterize cases of interpersonal and self-directed violence through reports from a Regional Health Department in the interior of Paraná.

Method: retrospective documentary research, with a quantitative approach, carried out between May and June 2018. The study analyzed the reports of interpersonal and self-harm that took place between 2013 and 2016. The data were submitted to descriptive statistical analysis, presented by absolute and relative frequency distribution.

Results: There was an increase in violence. A total of 766 cases were reported, with a predominance of female victims in 565 (73.8%) reports. Of these, 322 (42%) were adults and 277 (47.9%) had a partner. Regarding the aggressors, 548 (75.5%) were men and 393 (51.3%) adults.

Conclusion: The research reinforces the importance of reporting and health care based on the responsibility of professionals. The increase in violence makes it essential to implement public policies and train professionals focused on reporting.

DESCRIPTORS: Violence; Public Health; Indicators of Morbidity and Mortality; Aggression; Public Policy.

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VIOLÊNCIA INTERPESSOAL E AUTOPROVOCADA: CARACTERIZAÇÃO DOS CASOS NOTIFICADOS EM UMA REGIONAL DE SAÚDE DO PARANÁ

RESUMO
Objetivo: caracterizar os casos de violência interpessoal e autoprovocada por meio de notificações de uma Regional de Saúde do interior do Paraná.
Método: pesquisa documental, retrospectiva, de abordagem quantitativa, realizada entre maio e junho de 2018. O estudo analisou as notificações de violência interpessoal e autoprovocada ocorridas entre 2013 e 2016. Os dados foram submetidos à análise estatística descritiva, apresentados por distribuição de frequências absolutas e relativas.
Resultados: Evidenciou-se aumento da violência. Foram registrados 766 casos, com predomínio de vítimas do sexo feminino em 565 (73,8%) notificações. Destas, 322 (42%) eram adultas e 277 (47,9%) possuíam companheiro. Em relação aos agressores, 548 (75,5%) eram homens e 393 (51,3%) adultos.
Conclusão: A pesquisa confirma a importância das notificações e de uma assistência à saúde pautada na responsabilidade dos profissionais. O crescente aumento da violência torna essencial a implementação de políticas públicas e treinamento dos profissionais responsáveis pelas notificações.

DESCRITORES: Violência; Saúde Pública; Indicadores de Morbimortalidade; Agressão; Política pública.

VIOLENCIA INTERPERSONAL Y AUTOINFLIGIDA: CARACTERIZACIÓN DE LOS CASOS NOTIFICADOS EN UNA REGIONAL DE SALUD DE PARANÁ

RESUMEN:
Objetivo: caracterizar los casos de violencia interpersonal y autoinfligida por medio de notificaciones de una Regional de Salud de interior de Paraná.
Método: investigación documental, retrospectiva, de abordaje cuantitativo, que se realizó entre mayo y junio de 2018. El estudio ha analizado las notificaciones de violencia interpersonal y autoinfligida que ocurrieron entre 2013 y 2016. Se sometieron los datos al análisis estadístico descriptivo, y se los presentaron por distribución de frecuencias absolutas y relativas.
Resultados: Se constató aumento de violencia. Se registraron 766 casos, con mayoría de víctimas del sexo femenino en 565 (73,8%) notificaciones. De estas, 322 (42%) eran adultas y 277 (47,9%) tenían pareja. Acerca de los agresores, 548 (75,5%) eran hombres y 393 (51,3%) adultos.
Conclusión: La investigación confirma la importancia de las notificaciones y de una asistencia a la salud pautada en la responsabilidad de los profesionales. El creciente aumento de la violencia hace esencial la implementación de políticas públicas y entrenamiento de los profesionales responsables por las notificaciones.

DESCRIPTORES: Violencia; Salud Pública; Indicadores de Morbimortalidad; Agresión; Política pública.

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INTRODUCTION

For the World Health Organization (WHO), the term violence is defined as the intentional use of physical force threatened or actual, against oneself, another person, or against a group or community, that might result in injury, psychological harm and death[1]. Currently, it is considered a public health problem because it is one of the main causes of morbidity and mortality worldwide, resulting in several impacts that affect both the individual and the population[2].

According to the International Classification of Diseases (ICD), in addition to accidents and other injuries, self-directed violence in voluntary ways are also considered external causes. In 2014, through a reflection study in the Brazilian scenario, it was observed that of the 1,222,381 deaths, 155,610 were associated with external causes. Violence reaches different levels of citizenship, as it affects different races, age groups, and sex[3].

It is worth noting that aggressions represent 37.4% of deaths, while external causes characterize the third cause of death in the general population and the first in the age group of up to 49 years. Thus, when considering the representativeness of this problem, the Ministry of Health (MS) created the Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence, regulated by Ordinance MS/GM n. 737, May 16th, 2001, approved by the Tripartite Commission (CIT) through Resolution n. 309, March 8th, 2001[4].

Besides, the MS has created a reporting system, making them mandatory in cases of violence or suspicion, enabling the development of public policies for the protection of victims, as well as the epidemiological knowledge of the reported cases, allowing the identification of the most vulnerable groups and assisting in the creation of prevention and protection actions for victims[5].

This study becomes relevant by emphasizing the epidemiological profile of violence, and by identifying the main age group affected, the sex of the probable perpetrator and the victim of this aggression. Therefore, the present research aimed to characterize the cases of interpersonal and self- directed violence caused by notifications in a Regional Health Department in the interior of Paraná.

METHOD

This is documentary and retrospective research, with a quantitative approach, aimed at characterizing the cases of violence reported in the National Notifiable Diseases Information System (SINAN) of the 8th Regional Health Department. This regional covers 27 municipalities, according to the last census of the Brazilian Institute of Geography and Statistics (IBGE) comprising a population of approximately 324,178 inhabitants[6].

The research sample corresponds to reports of interpersonal and self-directed violence, which were recorded during the historical survey carried out between January 2013 and December 2016.

All reports of interpersonal and self-directed violence recorded during the historical survey were included in the survey. As exclusion criteria, we point out the incomplete report forms, totaling 25 reports.

Data collection took place between May and June 2018, electing the variables: sex, age group, race/color, education, marital status, sexual orientation, site of the episode, year of the report, reporting unit, classification, typology and number of violence, sex and the aggressor's life cycle, number of people involved, type of violence, means of aggression, suspicion of alcohol use by the aggressor, the relationship between victim and perpetrator if it happened at other times, and prophylaxis in case of sexual violence.

As a methodological theoretical framework, manuals, protocols, legislation and scientific publications that addressed the research theme between the years 2013 and 2018 were used.

The data were arranged in Excel and had treatment in the Statistical Package for the Social Sciences (SPSS) version 25.0. Descriptive statistics were used to characterize the sample and distribution of frequencies.

This study was approved by the Research Ethics Committee Involving Human Beings of a University in the state of Paraná, under opinion 2,613,730.

RESULTS

Between 2013 and 2016, 766 cases of violence were reported. Considering the sociodemographic characteristics, it was possible to observe a higher incidence of cases in the female population of 565 (73.8%). As for the age group, there was an emphasis on adults 322 (42%) and adolescents 180 (23.5%). The predominant race was white 583 (76.1%), and regarding the victim's education, 327 (42.7%) had less than eight years of schooling.

As for the marital status variable, there was an emphasis on victims with a partner 277 (47.9%) and in the variable sexual orientation, heterosexuals 492 (64.2%), and concerning the site of the violent act, it is worth mentioning that the residence had an index of 546 (71.3%), followed by public places 79 (10.3%) (Table 1).

Table 1 - Sociodemographic data of victims of interpersonal and self-directed violence, reported in a Regional Health Department. Francisco Beltrão, PR, Brazil, 2016 (continues)

Variable	Frequency	
	Absolute (n)	Relative (%)
Sex		
Female	565	73.8
Male	201	26.2
Age		
Children (<12 years)	99	12.9
Adolescent (12 - 18 years)	180	23.5
Youth (19 - 24 years)	106	13.8
Adult (25 - 59 years)	322	42
Elderly (equal to or > 60 years)	59	7.8
Race/color		
White	583	76.1
Black	15	2
Yellow	3	0.4
Brown	157	20.5
Indigenous	1	0.1

Ignored	7	0.9
Schooling		
Less than 8 years of school	327	42.7
More than 8 years of school	302	39.4
Not applicable	40	5.2
Ignored	97	12.7
Marital status		
With a partner	277	47.9
Without a partner	367	36.2
Not applicable	90	11.7
Ignored	32	4.2
Sexual orientation		
Heterosexual	492	64.2
Homosexual	10	1.3
Bisexual	3	0.4
Not applicable	133	17.4
Ignored	128	16.7
Site of the violent act		
Residence	546	71.3
Public place	79	10.3
Collective housing	5	0.7
School	20	2.6
Place of sports practice	2	0.3
Bar or alike	41	5.4
Business/Services	5	0.6
Industries/Construction	4	0.5
Other	55	7.1
Ignored	9	1.2

Among the characteristics of the occurrences, the increasing attitude of reports was found. Regarding the reporting unit, the health unit was the one that most reported, with 763 (99.7%). As for the classification of violence, 628 (82%) of the cases were of interpersonal violence and 138 (18%) of self-directed violence.

Regarding the type of violence, 313 (40.9%) of the reported cases were against women and 279 (36.4%) against children and adolescents. Regarding the number of violence, 425 (55.5%) of the victims were subjected to one type, while 240 (31.3%) were subjected to two, simultaneously. Regarding the aggressor's life cycle, there was a predominance of 393 adults (51.3%), and as for sex, 578 (75.5%) predominated males. Considering the number of people involved in the violent act, 555 (72.5%) involved only one person (Table 2).

Table 2 - Report cases of interpersonal and self-directed violence in a Regional Health Department. Francisco Beltrão, PR, Brazil, 2016 (continues)

Variable	Frequency	
	Absolute (n)	Relative (%)
Year of report		
2013	75	9.8
2014	135	17.6
2015	179	23.4
2016	377	49.2
Reporting unit		
Health unit	763	99.7
Social worker unit	1	0.1
Center for women's help	1	0.1
Ignored	1	0.1
Violence classification		
Interpersonal	628	82
Self-directed	138	18
Type of violence		
Children and adolescents	279	36.4
Women	313	40.9
Men	115	15
Elderly	59	7.7
Number of violence		
One	425	55.5
Two	240	31.3
Three	67	8.7
Four	28	3.7
Five	6	0.8
Sex of the aggressor		
Female	137	17.8
Male	578	75.5
Both os sexes	26	3.4
Ignored	25	3.3
Aggressor's life cycle		
Child (0 - 9 years)	6	0.8
Adolescent (10 - 19 years)	68	8.9
Youth (20 - 24 years)	90	11.6
Adult (35 - 59 years)	393	51.3
Elderly (60 ou mais)	15	2.0
Ignored	194	25.4

Number of people involved		
One	555	72.5
Two or more	180	23.5
Ignored	31	4

As for the type, there was a predominance of physical, followed by psychological violence, 573 (74.8%) and 304 (39.7%), respectively. Concerning types of aggression, it was shown that physical force stood out, 429 (56%), followed by threat 146 (19.1%). It was observed that, in 585 (50.3%) cases, the aggressors were not suspected of using alcohol, and about the victim's bond with the perpetrator of the violence, the spouse 152 (19.8 %) and acquaintances 132 (17.2%). Of the reported cases, 343 (44.8%), took place more than once (Table 3).

Table 3 - Characteristics of the violent act and relationship between the aggressor and the victim of reports of interpersonal and self-directed harm in a Regional Health Department. Francisco Beltrão, PR, Brazil, 2016 (continues)

Variable	**Yes n (%)**	**No n (%)**	**Ignored n (%)**
Types of violence			
Physical	573 (74.8)	198 (25.2)	-
Psychological	304 (39.7)	462 (60.3)	-
Torture	67 (8.7)	699 (91.3)	-
Sexual	183 (23.9)	583 (76.1)	-
Financial	15 (2)	751 (98)	-
Negligence	30 (3.9)	736 (96.1)	-
Child labor	6 (0.8)	760 (99.2)	-
Legal intervention	5 (0.7)	761 (99.3)	-
Other	65 (8.5)	701 (91.5)	-
Means of aggression			
Physical force	429 (56)	330 (43.1)	7 (0.9)
Hanging	54 (7.1)	704 (91.9)	8 (1)
Blunt object	49 (6.4)	709 (92.6)	8 (1)
Cut	103 (13.5)	656 (85.6)	7 (0.9)
Hot substance/object	5 (0.7)	754 (98.4)	7 (0.9)
Poisoning	54 (7.1)	704 (91.9)	8 (1)
Fire gun	30 (3.9)	729 (95.2)	7 (0.9)
Threat	146 (19.1)	610 (79.6)	10 (1.3)
Other aggressions	106 (13.8)	648 (84.6)	12 (1.6)
Suspected use of alcohol by the aggressor	302 (39.4)	385 (50.3)	79 (10.3)

Relationship with the likely perpetrator of the violence			
Father	35 (4.6)	721 (94.1)	10 (1.3)
Mother	23 (3)	734 (95.8)	9 (1.2)
Brother	27 (3.5)	730 (95.3)	9 (1.2)
Stepfather	21 (2.7)	736 (96.1)	9 (1.2)
Stepmother	3 (0.4)	705 (92.0)	58 (7.6)
Spouse	152 (19.8)	605 (79)	9 (1.2)
Ex-spouse	27 (3.5)	730 (95.3)	9 (1.2)
Partner	37 (4.8)	720 (94.0)	9 (1.2)
Ex-partner	13 (1.7)	744 (97.1)	9 (1.2)
Children	26 (3.4)	730 (95.3)	10 (1.3)
Stranger	92 (12)	665 (86.8)	9 (1.2)
Acquaintances	132 (17.2)	626 (81.8)	8 (1.0)
Caregiver	16 (2.1)	740 (96.6)	10 (1.3)
Boss	1 (0.1)	756 (98.7)	9 (1.2)
Institutional relationship	9 (1.2)	748 (97.6)	9 (1.2)
Police officer	3 (0.4)	752 (98.2)	11 (1.4)
Self-directed	103 (13.4)	655 (85.6)	8 (1)
Another type of relationship	71 (9.3)	682 (89)	13 (1.7)
Did it occur at other times?	343 (44.8)	378 (49.3)	45 (5.9)

It was possible to observe that, in case of sexual violence, the most performed procedures were prophylaxis for Human Immunodeficiency Virus (HIV) 74 (9.7%), prophylaxis for Sexually Transmitted Infections (STI) 63 (8.3%) and blood collection 48 (6.4%) (Table 4).

Table 4 - Prophylaxis in case of sexual violence from reports of interpersonal and self-directed violence in a Regional Health Department. Francisco Beltrão, PR, Brazil, 2016

Variable	**Yes n (%)**	**No n (%)**	**Ignored n (%)**
Prophylaxis in case of sexual violence			
STI	63 (8.3)	112 (14.6)	7 (0.9)
HIV	74 (9.7)	101 (13.2)	7 (0.9)
Hepatitis B	27 (3.6)	147 (19.2)	8 (1)
Blood collection	48 (6.4)	126 (16.4)	8 (1)
Semen collection	13 (1.8)	161 (21)	8 (1)
Collection of vaginal secretions	20 (2.6)	127 (16.6)	59 (7.7)
Emergency contraception	43 (5.6)	104 (13.6)	59 (7.7)
Abortion provided by law	1(0.1)	127 (16.6)	59 (7.7)

DISCUSSION

It is known that violence has been present in society throughout history and is currently a worldwide problem, causing a great impact on the quality of life of victims, concerning both physical and psychological health, as well as shaking family, absenteeism at work and school, making insertion and social interaction difficult[4].

Regarding sociodemographic data, there was a higher prevalence of female victims, confirming the data published in the Protocol for Assistance to People in Situations of Sexual Violence[7], which revealed that Paraná notified, between 2010 and 2016, 103,707 cases of sexual, domestic and other types of violence, with a predominance of female victims (65.4%).

Violence against women transcends historical contexts and has strong ties to the patriarchal order in society, which is sometimes treated with little importance. It is crucial to note that factors such as financial conditions, fear and, low education contribute to the perpetuation of women in abusive relationships.

Concerning education, it was identified that most victims had less than 8 years of study. In a survey[8] carried out in the Rio Grande do Sul, it was found that the most frequent cases involved women with incomplete elementary education (33.5%). It is known that educational fragility is directly related to women's lack of knowledge about their rights.

In this context, the Maria da Penha Law represents an important achievement and an essential resource for coping violence against women, and is recognized by the United Nations (UN) as one of the three best laws to fight this type of violence [9].

Nowadays, gender-based violence remains present in many cultures. According to the WHO, one in three women in the world will experience physical or sexual violence committed by an intimate partner in a lifetime[8].

The high rates of violence can be explained by the lack of historical knowledge of the phenomenon of violence and unpreparedness of professionals working in this area, either by the manly culture present in society or by the fact that women themselves are unable to understand the reasons that lead men they love to attack them, deciding to prosecute their partners more difficult[10].

It is noteworthy that low levels of education are related to the increased incidence of cases of violence. In contrast, victims with higher education and purchasing power are likely to seek private health services and may request the omission of information, even though this is mandatory for all health providers, generating underreporting and distortion of the real profile of violence.

Regarding the victim's age, there was a predominance of adults. Similar results were found in a study[11] that pointed out 51.0% of cases represented by adults of the same age group. Although this population is more affected, it is emphasized that acts of violence are also found in vulnerable groups, such as children, adolescents and the elderly. Children and adolescents can be considered vulnerable groups and have greater difficulty in expressing the violence they suffer, because, generally, the aggressor is someone from their own family[12].

Information obtained in this research demonstrated that white individuals were the most affected. The high index of the white race is associated with the colonization of the southwest region of the State by immigrants from the Rio Grande do Sul and Santa Catarina from 1940 onwards[13].

Regarding marital status and sexual orientation, victims were predominant of violence from partners and heterosexuals. This information leads us to believe that most cases may be related to domestic violence against women, in which there is possibly a stable

relationship, and the aggressor is the partner.

Considering the place of the violent act, in the present study there was an emphasis on residence (71.3%) followed by public places (10.3%), diverging from a study[14] carried out in the urgency and emergency services of Brazilian capitals within the scope of SUS, in which 42.5% of cases occurred on public places, and 33.0% at home. The residence should be a place of safety and protection, especially for children, but it is the place where violence has been most notable[15].

In Brazil, the injuries caused by external causes correspond to the third cause of death in the general population[4]. The Atlas of Violence [16] reveals that, in the last ten years, 553 thousand individuals lost their lives due to intentional violence in the country.

We can justify the growing number of reports by associating with the representativeness of violence today through the media, social networks, creation of laws and visibility of cases, which are increasingly present in our daily lives, leading to greater discussion and empowerment of people about this subject.

Regarding the reporting source, the health unit (99.6%) stood out, as in a study[15] that sought to analyze the rates of child violence in Ribeirão Preto-SP, in which 79.3% of reports were from this same place. It is suggested that the victim seek health services due to problems caused by violence and, therefore, it is up to the professionals of health units, hospitals or emergency care to provide the victim with proper hosting and the report.

As for the number of violence experienced by the victim, the present research revealed that 55.5% suffered one type and 31.3% of two types of violence, simultaneously. It is understood that when a person experiences aggression, there is usually more than one type of violence occurring, physical and psychological, for example, making it difficult to identify them alone. In this context, it is assumed that some victims have suffered more than one violence, however, they have not identified it in a way other than physical.

Regarding the sex of the aggressor, the research highlights male (75.5%), data similar to a study[17] carried out in Belém-PA, in which the man prevailed (90.5%) as an offender.

It is also observed that the aggressor was in the adult age group (51.3%) and that the number of people involved in the case of violence was one aggressor, with 72.5%, a fact that may be associated with the spouse, being the aggressor in this study.

Throughout history, men have been seen as dominating beings, with the right to control their women and, if necessary, to use violence as a means of demonstrating power. This attitude until then was seen as something cultural and in a way, natural[12]. Currently, studies show that men still tend to use violence to intimidate and express authority[9].

Regarding the type of violence, it was observed in this research that physical violence stood out (74.8%), corroborating a study[14] in which 87.8% of the reports were of physical aggression. This type of violence is defined as any action that harms the physical or bodily health of the individual, and can affect any person and age group. It is also the one that can be perceived more easily, different from other violence such as psychological, which does not leave visible marks, going unnoticed most of the time, contributing to underreporting[14].

Regarding the means of aggression, in the current study, physical force followed by threat stood out, disagreeing with a survey[17] carried out in 2013, in which threat (59.7%) and beatings (27.4%) stood out.

The use of physical force and the threat are types of violence and characterize the aggressor's dominance and control over the victims. In this context, it is important to highlight that the victims often do not verbalize the aggressions suffered, because of fear or for feeling intimidated by the aggressor.

Considering the suspected use of alcohol by the aggressor, in this study 39.4% had

consumed alcoholic beverages. Regarding the relationship with the probable offender, the spouse was highlighted, while 44.8% of the violence occurred at other times, data that are similar to a study[11] in which 32.2% of the aggressors were suspected of alcohol use and relationship with the victim, and in which the spouse represented 27.5% of the reports.

Alcohol consumption is a risk factor, as it contributes to the occurrence of violent acts. Given this, alcoholism can be considered a seal of approval, making the aggressor more courageous and negligible[18].

As for the prophylaxis used in cases of sexual violence, there was a predominance of prophylaxis for the Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STI). In this sense, it is worth emphasizing the importance of knowledge of prophylaxis protocols on the part of health professionals and reference institutions for dealing with cases of violence, to minimize the risks of exposure to victims.

According to the Parana Protocol for Assistance to People in Situations of Sexual Violence, post-exposure prophylaxis will address the most prevalent STIs and is indicated in situations with a risk of transmission of syphilis, gonorrhea, chlamydia, trichomoniasis, hepatitis B and HIV[19].

Sexual violence can occur regardless of the victim's age or sex, causing many psychosocial losses, in addition to the risk of having Sexually Transmitted Infections such as HIV and viral hepatitis. The actual frequency of this act is not yet known, as the victims tend not to report it, due to fear, lack of knowledge of laws that support it and shame. Therefore, treatment after sexual violence is considered a priority when it comes to health care. This right is guaranteed by Law 12.845/2013, which determines that the assistance of people in situations of sexual violence is mandatory and integral [20].

Regarding the limitations of the study, despite the high rate of reported cases, the possible omissions of health services, the lack of female empowerment in the current scenario, as well as the presence of information reported as "ignored or not applicable" by health professionals stands out.

CONCLUSION

Violence is a democratic phenomenon, well-established in society and permeated in different cultures, and because it is also considered a worldwide public health problem, it is important to understand it to face and develop prevention and control strategies.

The training of the professionals responsible for filling out the report forms is considered of great importance and must be carried out correctly, providing data consistent with the reality of this grievance. Furthermore, it is expected that they are properly prepared to welcome the victims, providing a relationship of trust, favoring the creation of more effective interventions to combat violence.

In this context, it is necessary to accomplish public policies and implement programs to fight violence, which are not only focused on the legal implications of the aggressors but which are the promoters of new subsidies, thus contributing to the decrease of rates morbidity and mortality and greater awareness of the general population.

The research confirms the relevance of reporting cases and a health care practice based on the precepts of professional responsibility. Therefore, knowing the features of the cases of violence in the region studied contributes to a better understanding of the theme, as well as to new studies that address this theme.

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