The invisibility of psychological violence against children

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Abstract:

Introduction: Domestic violence is a social and public health problem and its rates are currently increasing. It is present in all social classes, ethnicities and educational levels.

Objective: To analyse the actions done by health professionals who work in Basic Health Units (BHUs) to recognise cases of psychological violence against children.

Methods: This is a qualitative, descriptive and exploratory study. It used an analysis of the thematic data content. Interviews were conducted with 24 professionals working in BHUs in a city in southern Brazil.

Results: It was observed that physical symptoms are prioritised and there is an underestimation of mental health issues, especially those relating to psychological violence.

Conclusions: It was identified that professionals from the BHUs cannot intervene effectively because of the difficulty in identifying cases of domestic violence and their lack of training for dealing with cases of violence against children.

Keywords: violence, mental health, child health public policy.

INTRODUCTION

Violence against children is worrying, since there are alarming data in relation to the increase in its incidence. Data from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) indicate that, throughout the world, 150,000,000 girls and 73,000,000 boys below 18 years suffered sexual abuse in 2002[1].

In Brazil, the Secretary of Human Rights found that, in the first half of 2014, there were 54,931 cases of violence against children. A study in a town in southern Brazil[2] shows that the most affected age group is between 5 to 9 years of age, with 5,695 cases (33.5%), with 4,840 cases (28.5%) in children between 10 to 14 years, followed by children between 1 to 4 years, with 18.1%. It is observed that external factors are associated with situations of violence, such as the use of alcohol and/or other drugs, families facing situations of vulnerability and, parents and/or caregivers who consider physical punishment as a method of discipline[3].

WHO recognises that violence is alarmingly growing in the world, women and children being the main victims[4,5]. Violence is defined as the intentional use of physical force or the power relationship, concretely or by means of threats, which may be held against oneself, against another person or against a group or community, resulting in injury, psychological damage, problems in development, deprivation of liberty or death[6].

Violence against children can be characterised as domestic and/or intra-familiar. The first includes the families and other members of everyday life in familiar surroundings, without their necessarily being related or exercising parental functions. The attackers can also be employees or people who sporadically visit the victim[7]. The second is understood as any action or omission that harms the well-being, physical health, psychological, the freedom and the right to full development of some family member. This can be committed inside or outside the home for any family member or people who go on to take over the parental role and have a power relationship with the other[8].

Generally, violence occurs in the domestic space and, most often, is configured in a familiar secret. The secrets can occur from real facts, hidden out of shame or

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guilt, or fantasies, which remain implicit. These manifest themselves in a conscious or unconscious way, are shared with family members and transmitted across generations, sometimes being confused with the family myth, the latter being, the set of beliefs shared in this social group[9,10].

There is consensus in the literature that violence has multiple causes, due to being rooted in different cultures, which requires multidisciplinary interventions, proper functioning and effective social support networks, in order to meet the needs of families who experience such a problem. Because of this, it is important to know the various factors that influence the worsening violence. Among them are the history of violence in the family, the prior victimisation, five or more pregnancies and problems with alcohol and/or other drugs.

However, cultural characteristics in relation to family and gender, such as appreciation of marriage and economic independence, appear to mediate the associations of sociodemographic characteristics, such as age, educational level and skin colour, with events of violence between couples[11].

It is noticeable that the proportion of cases of violence grows every day and, when a person suffers some kind of violence and arrives at health services showing symptoms arising from it, they do not receive proper care, possibly because the health services are unprepared to manage such a situation[12].

Faced with the difficulty for professionals in recognising psychological violence, which leads to a failure to break the cycle, the aim of this study is to identify the procedures carried out by health professionals who work in family health basic units (HBUs) to recognise cases of psychological violence against children.

METHODS

Type of study

A qualitative, exploratory and descriptive study was conducted. This type of search prioritises a universe of meanings, motives, aspirations, beliefs, values and attitudes, and facilitates the understanding of the relationship in greater depth among processes and phenomena that cannot be expressed in terms of a reduction to operationalisation of hypotheses and variables.

Participants and research site

The survey was conducted in the BHUs of a city in southern Brazil, chosen on the basis of their location, i.e. in territories with the highest percentages of families in situations of vulnerability and violence, which were identified using the map of violence published in the local newspaper.

Twenty-four (24) professionals were interviewed. For this article, the responses of seven (7) professionals were used, due to the fact that, in these responses, they refer to the feature described in this article. These interviews involved one (1) Community Health Agent, two (2) Nurses, two (2) physicians and two (2) Nursing technicians. The use of a smaller number of participants is due to the size of the article and the word-limit for publication.

Data collection

The data were collected through semi-structured interviews containing guiding questions regarding domestic violence against the child, as well as the conduct of professionals facing this problem.

The duration of interviews were around 20 minutes with each participant, showing some variations depending on the availability of respondents, since we obtained one 5 minute interview and another of 30 minutes. These were recorded with the permission and authorisation of the participants, and later transcribed.

Data analysis

Data were analysed by the method of thematic analysis of content. This was carried out in three stages, the first was pre-analysis, in which the speeches of professional participants were organised; the second step consisted in exploration of the material, when data were grouped by similarities and differences, after having been read several times; and, finally, interpretation of the speeches meanings was carried out by the participants, from the review of literature on the subject of the study.

Two categories emerged from the analysis, however in order to broaden the interpretation of the data, the following was used for this article: prioritising physical care and underestimation of mental health.

Ethical aspects

The study complied with the ethical principles established by the National Board of health in resolution No. 466, 12 December 2012. The professionals received information about the objectives and methodology of the survey. Those who agreed to participate signed to indicate their informed consent. The project was approved by the Committee of Ethics in research of the Universidade Federal do Rio Grande by means of the opinion No. 47/2015.

Participants were identified by the first letter of their profession, followed by the number of interview, as loaded by professional area.

RESULTS AND DISCUSSION

Prioritisation of physical care and underestimation of mental health

In this study it was possible to identify the detection and prioritisation of signs and physical symptoms, however, negligence relating to mental health is evident. Health professionals focus their expertise on possible diseases that can be examined and visualised. When they start to act as professionals, students do not feel sufficiently prepared to address the psychological aspects of the individual, as these are more difficult to diagnose, since there are no evaluations able to directly measure such problems, unlike with clinical evidence[1,13].

In mental health, it is possible to see that some attitudes from health professionals that are necessary for effective care, such as foster care, empathy and support, are still precarious in their execution. Mental health recovery, including psychological violence, progresses slowly, without help and support from the government. As

UBSF´s (Unidade Básica de Saúde) managers are from municipal administration, it is up to them to stimulate and oversee the training of their human resources, to find out if they are being carried out or not, and to investigate which topics are covered in continuing education for professionals in these locations.

Since this research is focused on violence against children, it is clear that attention to the mental health of children and youth is recognised as a serious public health problem, and is one of the main actions of the unified health system (SUS). With the health reform movement, cemented with the construction of SUS, and the recognition of children and adolescents as subjects of rights and responsibilities by the promulgation of the Statute of the child and adolescent (ECA), in 1990, the position of the State was reset in relation to the assistance and the drafting of public policies directed to this part of the population[14].

Because of this, it is possible to see that the federal Government is concerned with ensuring mental health care for children. It is possible to identify the suggestion for full health of the child, with no fragmentation between the physical and psychological aspects:

> There is no production of health without production of mental health. Soon, individuals have to realize that, when they receive health care, it should be considered the biological, psychological and social dimensions of individuals. If a child or a teenager presents some degree of suffering (with anxiety, fears, intense conflicts, for example), health cannot be treated without considering this emotional/relational component. Many physical symptoms situations of distress are due to various origins (in relation to institutions, with his family and himself, among others)[15].

From this new vision, the day-care centres for children and adolescents (CAPSi) were created. These include interdisciplinary teams that provide support, primarily to children with distress and/or serious and persistent mental disorders, psychoses, mood disorders, somatoform disorders and dissociative disorders, which are psychopathologies that, in most cases, hamper or hinder the establishment of healthy social relationships and the construction of life projects, as well as the creation of bonds, due to a tendency towards social isolation.

CAPSi acts in territorial form, both in crisis situations and in the case of psychosocial rehabilitation. Although it is dedicated to addressing mental health for children and adolescents, generally, the professionals of the UBSFs in the municipality where this study was carried out have difficulties in making referrals to this unit, , either due to excessive demand at that location or to ignorance of the operation of the network of health support. If these obstacles were overcome, CAPSi and the UBSF could work together in providing integral care of the child and the family.

Although 25 years have passed since the sanctioning of ECA, progress is slow in the field of mental health and, when the two contexts, children and violence, join, the advances in this area become even more difficult. Fear is one of the most influential factors in neglected cases of violence. This sentiment interferes in decision-making in relation to the cases of domestic violence, either through fear of the family, the community or the professional making an erroneous diagnosis. It is possible to explain the lack of knowledge and support relating to this issue.

A study conducted in the city of Fortaleza, Ceará, Brazil[16], in UBSFs, investigated a significant percentage of professionals who found themselves with cases of violence against the child. Of these, 62.2% said they fear legal involvement. Corroborating this, another study, accomplished in two basic health units (BHU) in Embu, São Paulo, Brazil[17], pointed out that the professionals were too afraid to get involved with cases of violence because they did not have the support of the health units and due to the family of the victim making threats, making them impotent and lacking the opportunity to make the necessary interventions.

On the assumption that, when there are obvious symptoms of violence, the professionals point out fear as one of the main features preventing decisive actions, such as notification and/or complaint, when it comes to psychological violence, whose identification is more difficult to carry out, this feeling possibly grows, leaving them even more powerless in face of these cases.

However, if interventions with these families they are not carried out, sequels will manifest in children, in short, medium or long term. Parents or caregivers will contribute to the healthy or not development of children. When caregivers are responsible for triggering psychopathologies, their conduct promotes the maintenance of the cycle of violence.

In order to assist in the conduct of professionals, the guidelines of Mental Health for Children and Adolescents, proposed by the Ministry of health (MS) suggests that this specific population must be cared for by various health services, among them, UBS, UBSFs, CAPSi, clinics and general hospitals, articulated as an inter-sectoral network, having as its main goal the social inclusion and completeness of its users[18].

However, the courses held for the professionals of the UBSFs are focused on diseases, such as sexually transmitted diseases, diabetes and hypertension, thus, not following what is recommended by the guidelines, such as comprehensive care. The absence of concern for mental health and the fact that most professionals did not receive information about handling and interventions to be carried out in cases of violence is clear from the responses in the interviewees. The UBSFs professionals, in this study, when questioned about the psychological violence, reported cases of other types of violence, showing that they don't know how to identify it.

Thus, when working in areas with high incidence of vulnerability, where everyday life is permeated by violence, urgent actions are necessary in order to manage primary, secondary and tertiary prevention, thereby seeking to promote the health of the population who resides there. Without proper training, the sessions will remain focused on physical illness, and mental health will continue to be underestimated. The following lines demonstrate the absence of training for identifying psychological violence:

"In the city government, for us, weren't any. We need to have, not only in the case of violence against a child, but even violence against woman that happens a lot, we didn't have this type of training. We don't have that capacity. So we will go more for the experience of life we've had, right?" (AC8).

"Training I didn't had. I think even the health agents, I don't know, but I don't think they had either. I think that there is training, but what I have is that I worked since 1973, I worked in the emergency room, I worked in the hospital, I worked in Pediatrics, you see terrible things in neonatology. Then you will see and will put it all together there" (Enf4).

It is necessary to extend the perspective on violence, not restricting it only to biological aspects, but also recognising it as a problem that generates social, relational, economic, historical and cultural commitment. Notifying the cases can assist in the denaturalisation and deconstruction of social behaviours still accepted within households, which impair the health and quality of life of children and adolescents[19].

Children and adolescents who are victims of violence may not show physical evidence, which makes the research of the background and history of these young people relevant and essential to the knowledge of the violent context in which they live.

An instrument that would assist in the detection of the cases is the Inventory of Phrases in the Diagnosis of Domestic Violence Against Children and Adolescents (IPDV)[20], which consists of 57 sentences about feelings with regard to everyday situations. The child should answer according to his feelings, it is easy to apply, and the child will respond "yes" or "no". Furthermore, it is not a psychological test, which is for exclusive use by psychologists, the IPDV can be used by other professionals who work directly with this reality.

The present study shows the difficulty that professionals have in identifying violence against the child. However, if training to manage such a problem were carried out and a tool for facilitating the recognition of cases were included in the inventory, professionals would become familiar with the signs and symptoms of psychological violence and would make effective diagnoses, while having the support for other necessary interventions.

Early identification of violence prevents new instances, offering the necessary protection to the victim and the appropriate assistance to the family. It should be noted that "the importance of early diagnosis is to help the family and the child, avoiding more serious consequences, allowing the treatment and preventing recurrence"[21]. In order to encourage the participation of professionals, it is necessary to take a new look at the damages from external causes, that is, one must be more comprehensive, rather than only being focused on physical symptoms because they are seen as predictable events and therefore liable to prevent[22].

Therefore, the fact that health professionals can prevent domestic violence is essential to deepening their knowledge about this topic, which should occur from the beginning of vocational training. The courses, in turn, must be permanent, and, in this way, action would be more effective against violence[23].

In this study, it was observed how the responses of respondents meet the authors' mentioned suggestions, since the professionals are still unprepared, there is no theoretical-practical support, and they only use their life experiences as a resource, which can be modified or neglected when it comes to cases of violence:

"Not to identify! But, at first, when I came to work here, 7 years ago, at this time, the Secretary of Health was providing many training courses for health workers. It was a different management, so they thought in a different way. Today it stopped. Especially in relation to strategy, I see "zero" of training, not only to work with this theme, but with so many others" (M2).

In the previous response it can be seen that both the MS guidelines and the UBSF guidelines, which define the training of professionals, are not being followed in the municipality studied, which constitutes a risk factor given the alarming situation that communities of these areas experience. The comprehensive care of the patient, which is also part of the guidelines, is fragile, as the professionals do not have the knowledge needed to act in order to promote health. The lack of training is confirmed in the following speech:

"No! Nothing! Self-taught! By experience, by reading, nothing else" (M1).

It is understandable that, although the UBSFs professionals occupy a strategic position to identify cases of violence, this practice meets challenges, especially the scarcity of professional training on the theme and regarding the actions that should be carried out, including notification. It is believed that this is due to their training, which prioritises the clinical evidence of cases of violence, such as bruises, cracks and scratches, among others.

This may constitute an obstacle for the diagnosis of psychological violence, as some of its symptoms are: low self-esteem, excessive irritability and low school performance, which usually go unnoticed. Victimisation does not always show clinical signs and, when it occurs, the injuries correspond to severe forms or cases of revictimisation[22].

However, in the following speech, even when there is a more explicit mark of violence, no action is taken:

"There was a case that I attended that I believe something may have happened, the child had a black eye. The mother said that the child had fallen, but it was shaped like a fist, right in the eye. But she didn't said anything because she said that the child fell, I haven't given any forwarding" (Enf3).

In this case, the professional identifies the physical violence, however, maintains passive conduct. If an intervention was not performed despite the visibility of the aggression, any intervention in the case of psychological violence will be unlikely to occur because its detection is even more difficult, passing unnoticed most of the time. The management should include the monitoring of this family, through the home visit (HV), notification of the case to child protective services and

the delivery of family for a referral service, if suspicions were confirmed.

Finally, the professional just omitted it, there's no way to say what the feelings involved to do this, but doing nothing leads to the generation of worsening violence. The UBSFs professionals have as the HV, which provides them with knowledge of the living conditions of users and a greater understanding of the relationship in the family context. The following speech highlights the importance of HV:

> *"I think the home visit is a very important tool. Because inside the Office, there's a lot of adult narrative about the kid, is the narrative of the adult. You can even get elements. When you make the approach at home, become evident things inside the Office you won't see there you will see the universe as they relate, which is around people's homes. Is on the street that we will see this relationship more explicit violence, in the Office is more difficult to understand "(M2).*

The importance of HV in domestic violence situations is highlighted, since "through the home visit, the manifestations of violence against children and adolescents are more noticeable, as well as allowing the understanding of family and community dynamics, and also allowing for the development of preventive and educational actions"[24].

In the case of psychological violence, the focus of this study, the difficulty of making the active search or check if there is a pent-up demand, since it does not exist at the time, subsidies for the same ID if it is recognised, there is no knowledge to handle the situation, such as fill in the notification, who can populate it and where to forward.

The situation in the location in which the study took place differs from the rest of Brazil and other countries, like the United States of America (USA). A study conducted in both countries[13] makes a correlation on the fight against violence against child, refers to a documentary search of laws, ordinances and regulations concerning compulsory notification. The result obtained in the two countries reveals the existence of laws which blame health professionals for failures of notification of suspected cases and/or confirmed cases of violence against children, and, in the USA, this is extended to religious leaders and teachers.

In both contexts it was identified that many professionals find themselves in an ethical dilemma, since, in most situations, the principle of family integrity contravenes the principle of the best interests of the child. It is observed that, in the USA, where the notification has been used for approximately 40 years, there are still difficulties with regard to the preparation of professionals for recognising indicators of violence.

In the present study, it was also identified that difficulties occur or there is no recognition of psychological violence. The lines below clarify the situation in which the professionals are:

> *"No! Nothing, nothing, nothing! In relation to this kind of thing! What would be important, because we deal a lot with this. But like I said it's more psychological, for sure it must exist, but is unnoticed. Unfortunately!" (Tec. Enf1).*

> *"As far as I know, for violence against the child there isn't. It exists about the child, but in a general way, it covers everything. Sometimes we have meetings about drugs, but that covers everything, nothing specific on the subject of violence "(Tec. Enf3).*

However, some items are important and fundamental for the development of prevention strategies: identify the high-risk population; consider the cultural and demographic context of the participants; obtain the involvement of the community and the parents in the planning of interventions; establish well-defined goals and objectives so as not to run the risk of going out of scope; develop educational materials, because they facilitate the understanding of those involved; empower/guide parents through groups, individual care and HVs[25].

This study showed that only health professionals can identify the high-risk population due to the context of vulnerability this population is inserted in. Thus, the strategies used are ineffective, as they contemplate the integral care of families who experience violence. There are actions that can be taken which specify the detection of psychological violence against the child.

The professionals have this perception so that, during the search, the limit factor was the participation of professionals. Some felt that their work was being evaluated, prompting the researcher to return another time, allowing time to take in more information on the subject.

Therefore, although at the start of this study it was believed that the visibility of psychological violence might occur, over the course of data collection it became clear that the difficulty on the ground was one of far greater complexity. The preparation of the health professionals of UBSFs intensifies the harms of domestic violence.

The visibility of violence remains fragmented and has to rely on the evidence of the physical symptoms. As psychological violence does not leave apparent marks, it is difficult to identify and, because of this, has an unfavourable prognosis with regard to the promotion of mental health.

This research presents important contributions to public and collective health, constituting an alert to health care professionals to meet a child victim of violence, because it is important to have a larger view on the context in which they are inserted, in order to obtain data to identify domestic violence, in particular the psychological, because it is not possible to measure how they interprets this experience and what emotional damage can be caused.

It was identified that the professionals of UBSFs fail to intervene effectively, due to the difficulty in identifying cases of domestic violence and the lack of training to act in cases of violence against the child. Greater supervision by the municipal, State and Federal Governments is needed regarding the effective implementation of public health policies, in order to provide the tools to health professionals to carry out interventions that reduce the incidence of violence, prevent psychological violence and promote family health.

It is believed that this work is innovative because it prioritised psychological violence, which has been hith-

erto unheralded and studied by researchers from different areas, and which is hard to find that in the national and international literature, as well as providing instruments to facilitate their identification.

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Resumo:

Introdução: A violência intrafamiliar é um problema social e de saúde pública e, atualmente, tem seus índices aumentados. Encontra-se presente em todas as classes sociais, étnicas ou grau de escolaridade.

Objetivo: Identificar as ações utilizadas pelos profissionais de saúde que trabalham nas Unidades Básicas Saúde da Família (UBSFs) para reconhecer os casos de violência psicológica contra a criança.

Método: Este trabalho é uma pesquisa qualitativa, descritiva e exploratória. Foi utilizada a análise de conteúdo temática dos dados. Realizou-se entrevistas com 24 profissionais que trabalham em UBSFs, em um município do sul do Brasil.

Resultados: Observou-se que os sintomas físicos são priorizados e ocorre a subestimação da saúde mental, principalmente da violência psicológica. Conclusões: Identificou-se que os profissionais das UBSFs não conseguem intervir de maneira eficaz, devido a dificuldade na identificação dos casos de violência intrafamiliar e da ausência de capacitação para atuar nos casos de violência contra a criança.

Palavras-chave: violência, saúde mental, criança, políticas públicas de saúde.