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# PROFILE OF USERS OF A MENTAL HEALTH SERVICE: RECORD OF VIOLENCE AND THERAPEUTIC OFFERS

# PERFIL DE USUÁRIOS DE UM SERVIÇO DE SAÚDE MENTAL: REGISTRO DE VIOLÊNCIA E OFERTAS TERAPÊUTICAS

# PERFIL DE USUARIOS DE UN SERVICIO DE SALUD MENTAL: REGISTRO DE VIOLENCIA Y OFERTAS TERAPÉUTICAS

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## ABSTRACT

**Objective**: to analyze the profile of users of a mental health service with a history of violence and the therapeutic offers made available to them. **Method**: documentary research, with data collection in the medical records of all active users of the service, between September 2017 and May 2018. Data analysis was performed using the Stata 11 program. **Results**: 389 medical records were analyzed, of these 126 (32%) have a history of violence. There was a higher prevalence of violence among women and an association between history of violence and ideation and attempted suicide. Regarding the therapies offered, more than 90% received individualized attention and prescription of psychotropic drugs. **Conclusion**: the need to broaden the discussion about the presence of violence and its relationships in the lives of people with psychological distress is evident, in order to qualify the therapeutic offer according to the precepts of psychosocial care. **Descriptor**s: Nursing; Violence; Mental health services; Mental health; Therapeutics.

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**RESUMO**

**Objetivo:** analisar o perfil dos usuários de um serviço de saúde mental com registro de violência, e as ofertas terapêuticas disponibilizadas a eles. **Método:** pesquisa documental, com coleta de dados dos prontuários de todos os usuários ativos no serviço, entre setembro de 2017 e maio de 2018. A análise dos dados foi realizada no programa Stata 11. **Resultados:** analisou-se 389 prontuários, destes 126 (32%) apresentam histórico de violência. Encontrou-se maior prevalência de violência entre as mulheres, e associação entre o registro de violência e a ideação e tentativa de suicídio. Com relação às terapêuticas oferecidas, mais de 90% receberam atendimento individual e prescrição de psicofármacos. **Conclusão:** evidencia-se a necessidade de ampliar a discussão a respeito da presença de violência e suas relações na vida das pessoas portadoras de sofrimento psíquico, para desta maneira, qualificar as ofertas terapêuticas alinhadas com os preceitos da atenção psicossocial.

**Descritores:** Enfermagem; Violência; Serviços de saúde mental; Saúde mental;Terapêutica.

**RESUMEN**

**Objetivo**: analizar el perfil de los usuarios de un servicio de salud mental con historial de violencia, y las ofertas terapéuticas que se les ponen a su disposición. **Método**: investigación documental, con recolección de datos entre septiembre de 2017 y mayo de 2018. El análisis de los datos se realizó mediante el programa Stata 11. **Resultados**: se analizaron 389 historias clínicas, de estas 126 (32 %) tiene antecedentes de violencia. Hubo una mayor prevalencia de violencia entre las mujeres y una asociación entre el historial de violencia y la ideación e intento de suicidio. En cuanto a las terapias ofrecidas, más del 90% recibieron atención individualizada y prescripción de psicofármacos. **Conclusión**: es necesario ampliar la discusión sobre la presencia de la violencia y sus relaciones en la vida de las personas con distrés psicológico, para calificar la oferta terapéutica de acuerdo con los preceptos de la atención psicosocial.

**Descriptores:** Enfermería; Violencia; Servicios de salud mental; Salud mental; Terapéutica.

## INTRODUCTION

Violence is a social phenomenon with impacts on subjectivity, individuality and collectivity. It consists of forms of violations between people, which can have negative effects on their lives and society.[1] Violence is defined as the intentional use of physical force or power, in relation to oneself, another person, group or community, which can result in individual and collective damages, such as psychological suffering, disability and death. Risk factor for health and social problems throughout life, preventable by governments.[2]

In the general panorama of the Americas, among the most common causes of violence are social inequities such as unemployment and urban segregation, especially in areas where wealth and extreme poverty coexist. The political instability of nations and ruptures in democratic institutions also favor the

increase in violence with an impact on health and well-being.[3]

In addition, there is evidence[4] of an extremely worrying process of increase in lethal violence against blacks, the population ofLesbians, Gays, Bisexuals, Transvestites, Transsexuals or transgender (LGBTTQIA+), and women, in cases of femicide.

The issue of violence is increasingly taking place on the public agendas of the health sector worldwide, given the magnitude of the direct and indirect effects, with consequences for the health of the affected populations, and the impacts on health services in the care of victims of these situations. In this way, it constitutes a public health problem, and requires global responses.[3] Violence has direct impacts on mental health associated with the production of suffering and imposes itself in different ways in the daily life of mental health care services. In this sense, the iatrogenesis of psychiatric hospitalizations experienced by the subjects, the stigmatization of madness, physical, sexual and psychological intrafamily aggressions, in addition to the mistreatment and threats suffered by subjects who experience some type of psychic suffering, stand out.

Studies reveal the direct relationship between violence, in its various forms, and psychological distress, showing that, in general, women are the ones who suffer the most from violence, especially physical and domestic violence, and those who suffer the most psychologically, with depression, social phobia and anxiety.[5]

In this context, the therapeutic offer of services is shown to be an important strategy of care in Mental Health, in the face of these cases, from the implementation of multidisciplinary therapeutic strategies that favor interaction between professionals and users, articulating actions to provide maximum autonomy, co-responsibility and protagonism of the user victim of violence.[7]

In view of the above, the weight that experiencing an act of violence has on people's lives is highlighted, whether they are already in psychological distress or who will go through it due to the trauma generated by the violent act. In this way, the assistance provided in mental health services, especially in Psychosocial Care Centers (CAPS), must highlight this reality, know its causes and who suffers from them, use this information in a critical way in the planning of therapeutic interventions can contribute to improve people's health. Therefore, this study aimed to analyze the profile of users of a mental health service with a record of violence, and the therapeutic offers available to them.

## METHOD

This is a documentary research, based on the collection of secondary data from the medical records of all active users at the time of data collection (n=389) - thus, there are no exclusion criteria - in a Psychosocial Care Center, with the use of a structured questionnaire with closed questions containing socioeconomic and therapeutic variables of the users. After selecting and training the collectors, they went to the CAPS to collect the data. A quality analysis of the data collected was performed, with correction of inconsistencies in the data when necessary. Data were collected from September 2017 to May 2018.

The outcome analyzed in this article was the presence of a record in the medical record of a history of violence, investigated by the question: History of violence: no or yes. The independent variables analyzed were: gender, age, education, marital status, source of income, diagnosis, suicidal ideation and suicide attempt. The variables related to the therapies and the aforementioned outcome were also analyzed, namely: individual care, singular therapeutic project, prescription of psychotropic drugs, home visits, family monitoring, income generation workshop, therapeutic groups and therapeutic workshops, all with type responses Yes or No.

The analyzes were performed using the program Stata: Statistical software, United States (Stata 11). The calculation of means and standard deviations for numerical variables and the determination of prevalence for all strata of the variables studied were performed using descriptive statistics. For hypothesis tests, the chi-square test was used, aiming to verify if there was an association between the independent variables and the outcome variable. A null hypothesis was considered that the variables would not be associated and an alternative hypothesis if the variables were associated. Statistical significance was defined as p-value $<0.05$. Missing data were excluded from the analysis so that only valid data were computed.

All ethical precepts were respected, according to CNS Resolution 466/2012, and the research was submitted and approved by the Ethics and Research Committee under opinion number 2,201,138. This study is part of a larger research entitled: Hearers of Voices – New approaches in Mental Health, carried out with the research group's own funding.

## RESULTS

A total of 389 medical records of active users of the Psychosocial Care Center were analyzed. Regarding socioeconomic characteristics, it was found that more than 60% were female, aged between 19 and 86

years, with a mean of 47.7 years (SD = 12.5). More than 50% of users had up to four years of study, and 60.5% received some assistance or benefit paid by the state, as a source of income. Regarding marital status, 31.6% of users were single, 40.7% had a partner and 27.6% were widowed or divorced. The diagnosis of depression was the most prevalent, found among 36.6% of users studied, schizophrenia was related to 25.1% and mental retardation to 14.3% of users.

Among the users studied, 126 (32.4%) had a history of violence. Table 1 shows the prevalence of a history of violence according to the selected variables. Although no statistically significant relationship was found between the variables described below and the outcome, there was a higher prevalence of violence among users aged between 31 and 40 years (44%), who had nine or more years of schooling (47.2 %), who were living with a partner (36.4%), and had paid work with a source of income (42.2%).

There was a statistically significant association ($p<0.05$) between gender and the record of violence, with women having a higher prevalence of violence than men, 36.3% of users had records compared to 25.7% from male users to users who had no history of violence. There was also a relationship ($p<0.01$) between suicidal ideation and attempted suicide with a history of violence, users with a history of violence have twice the prevalence of suicidal ideation (42.2%) compared to those who do not have this history ( 23.3%). The same is observed for the suicide attempt variable, where users who have a record of violence in their medical records had a 50.8% prevalence of suicide attempt, against 23.2% prevalence of users who had no history of violence.

**Table 1**- Prevalence of a history of violence among users of a CAPS in the city of Pelotas-RS according to the strata of the variables selected for the study (N=389). 2017/2018

| | No | Prevalence of violence | p-value |
|---|---|---|---|
| **Gender** | | | |
| Feminine | 89/245 | 36.3% | 0.030 |
| Male | 37/144 | 25.7% | |
| **Age** | | | |
| 18 to 30 years | 16/42 | 38.0% | 0.022 |
| 31 to 40 years | 26/59 | 44.1% | |
| 41 to 50 years | 39/104 | 37.5% | |
| 51 to 60 years | 32/122 | 26.2% | |
| 61 years or older | 11/55 | 20.0% | |
| **Marital status** | | | |
| Single | 35/111 | 31.5% | 0.664 |
| With partner | 52/143 | 36.4% | |
| Separated or widowed | 31/97 | 31.9% | |
| **Education** | | | |
| Up to 4 years of study | 46/140 | 32.9% | 0.397 |
| Up to 8 years of study | 17/42 | 40.5% | |
| 9 years of study or more | 25/53 | 47.2% | |
| **Source of income** | | | |
| Paid Work | 19/45 | 42.2% | 0.397 |
| Family income | 20/57 | 35.1% | |
| Aid or benefits paid by the state | 49/156 | 31.4% | |
| **Diagnosis** | | | |
| Schizophrenia | 23/91 | 25.3% | 0.185 |
| Bipolarity | 17/38 | 44.7% | |
| Depression | 40/133 | 30.108% | |
| Mental retardation | 19/52 | 36.5% | |
| Other neurotic disorders | 9/30 | 30.0% | |
| Other unspecified disorders | 9/19 | 47.4% | |
| **Suicidal ideation** | | | |
| No | 47/202 | 23.3% | 0.000 |
| Yes | 79/187 | 42.2% | |
| **Suicide attempt** | | | |
| No | 60/259 | 23.2% | 0.000 |
| Yes | 66/130 | 50.8% | |
| **Total** | 126/389 | 32.4% | |

With regard to therapies, shown in table 2, more than 90% of users with a history of violence received individual care and prescription of psychotropic drugs, as well as a record of participation in therapeutic groups. However, the percentage of users with a Singular Therapeutic Project (STP), who received home visits and participated in income generation workshops, did not reach 35%. A statistically significant association was found between the history of violence and PTS ($p<0.05$); users with a history of violence have a lower prevalence of PTS than users without a history of violence, with 67.3% not receiving the elaboration of the STP.

**Table 2**- Therapies performed by users with a history of violence at a CAPS in the city of Pelotas-RS according to the strata of the variables selected for the study (N=126), 2018

| | No | prevalence |
|---|---|---|
| **Individual service** | | |
| Yes | 112 | 94.1% |
| **Unique therapeutic project** | | |
| Yes | 35 | 32.7% |
| **Prescription of Psychopharmaceuticals** | | |
| Yes | 112 | 94.1% |
| **Home visit** | | |
| Yes | 26 | 24.3% |
| **Family follow-up** | | |
| Yes | 72 | 64.9% |
| **Income generation workshop** | | |
| Yes | 4 | 3.9% |
| **Therapeutic groups** | | |
| Yes | 110 | 89.4% |
| **Therapeutic workshops** | | |
| Yes | 54 | 47.4% |
| **Total** | 126 | 32.4% |

## DISCUSSION

The results of the present research reveal that more than 30% of CAPS users had a history of violence recorded in their medical records, and the highest prevalence of this outcome was found among women, aged between 30 and 40 years, with more than nine years of study, who lived with a partner and had paid work. Such data on the profile of CAPS users are in line with findings in other studies with the same public, which, however, did not assess the same outcome.[8] The recognition of these characteristics (gender, age, education, marital and working status ) of CAPS users who reported violence, becomes a potential tool for approaching the issue in their care. It is important to know who are the people who suffer the most from violent acts.

Social disadvantages such as low income, limited education and employability are associated with high rates of mental disorders, as are lack of social support, critical life events, and unemployment, issues that have also been identified as psychosocial risks that increase the chances of mental suffering.[13] Such issues are related to structural violence and concern the various actions that maintain inequalities, be they social, gender, age, ethnic and that result in misery, hunger, exploitation. This type of violence forms the basis for the occurrence of the most diverse violent acts.[14]

Gender violence, which has its roots in structural violence, is one of the most prevalent. A survey carried out in a developed country showed that an increase in family income is associated with a lower probability of women suffering violence.[15]

In addition, women with severe mental disorders have a higher prevalence of domestic violence, a fact that is also related to income. This finding is in line with studies that showed that women who reported experiencing intimate partner violence were 3.7 times more likely to have anxious depressive symptoms when compared with women who did not suffer any type of violence.[16] In the present study 36,3 % of women had records of violence in their medical records, a higher prevalence than that found in men (25.7%).

Domestic violence generates different types of suffering for the battered woman and, in this sense, attention is drawn to the need to problematize violence, gender and psychological suffering. A survey between gender and hearing voices among users of a mental health service revealed that women showed signs of violence in the content of these voices that only they heard.

The content of the voices analyzed showed that they wanted to protect the woman from a male figure, indicating a possible violence previously suffered by the woman, or they were male voices of

command for self-harm. In addition, the aforementioned study raised the question of the relationship between violence and the beginning of psychic suffering, especially the hearing of voices, by showing that violent actions can influence the beginning of the experience of hearing voices.

However, what we have in relation to public policies, gender, and psychological suffering is women's mental health inserted together with sexual and reproductive health, and in this way, psychological illness ends up being visualized and treated by the biomedical perspective, leaving aside the social context and all the implications that affect women. The history of violence (physical and sexual) associated with mental disorders, especially depression, are identified as risk factors, among adults, for suicidal attempts and ideation.[16] This association between ideation and suicide attempt and recording a history of violence was one of the results found in the present research. It is important to note that few studies address such a relationship, however, it is noteworthy that worldwide most cases of suicide are related to psychiatric illnesses.[18]

Although this relationship is present and has already been verified by other studies[14,18], there is no analysis and deepening of the issue regarding treatment. This fact was demonstrated in a study that related suicidal ideation with the provision of therapies in 828 cases treated at a mental health service.[19] Of the total, 115 had suicidal ideation and, of this number, 47 reported that they had tried to commit suicide before. However, this information was not expressed in a differentiated care, being only offered consultation with the psychiatrist and prescription of psychotropic drugs.

The authors[19] showed similar results to those found in the present research regarding the treatment of users of mental health services with a history of suicidal ideation and attempt. The study revealed that for the user who arrives at the service with a history of violence or suicidal ideation, only psychiatric evaluation and prescription of psychotropic drugs are offered. These data corroborate the findings of this research, in which the prescription of psychotropic drugs and individual care is 94.12%. No other therapy is offered the first time the user seeks the service.

The monitoring of people in situations and/or who have suffered violence in psychosocial care services, specifically women, guides health professionals in the structuring of unique therapeutic projects aimed at overcoming violence, promoting spaces for speech with actions of protection and empowerment female.[20]

The findings of the present study, discussed with the literature on the subject in question, highlight important points that

need to be taken into account in the health care of users of mental health services. In their practice, the professionals of these services have the mission of investigating, addressing and welcoming factors related to violence manifested in its various forms, especially structural violence and gender violence. Professionals, as political agents need to assume such a position, must fight for public policies that include better living and health conditions for people who are in psychological distress.

In addition, there is a need to expand the care therapies that must be articulated with the social, economic, and cultural context of the person being assisted, overcoming the existing barrier between clinical treatment (individual care, use of psychotropic drugs) and the social approach, because both are important when talking about integral care.

Finally, it is important to emphasize that this study was carried out in only one CAPS, it has a cross-sectional approach and, in addition, its data collection took place from information from the medical records, which made important variables such as the type of aggressor could not be verified and analyzed, in addition to being a completed document from the perspective of the health professional. Such questions are limitations of this research. Follow-up studies are considered to be of great value to better understand people who have suffered violence and the possible factors associated with these aggressions. However, these facts do not diminish the importance and relevance of the results of this study and of the debate on the topic of violence, the profile of users and the therapies offered.

## CONCLUSION

This article achieved the proposed objective by analyzing the profile of people in psychological distress assisted in a mental health service who had a record of violence in their medical records. The main results revealed that the people most affected by violence are adults, women and who suffer from the consequences of structural violence, especially with low income and schooling, facts that can trigger psychic suffering or that can worsen it due to being more vulnerable to violence. Furthermore, it was found that people with a history of violence have a higher prevalence of suicidal ideation.

Regarding the therapies offered, psychiatric evaluation and the prescription of psychotropic drugs were found, which indicates a limited offer of psychosocial interventions, reduced to psychiatrization and the prescription of psychotropic drugs with few initiatives of singularization of care. Practices that alone cannot address the issue of violence and its consequences in the lives and health of people who have suffered and suffer from it. Such actions cannot be

restrictive to mental health services, since violence has several roots, causes and consequences, there must be effective implementation of intersectoral public policies and, if applicable, (re)designs in the health system, that can contribute to the reduction of these aggravations and effects on the lives of these individuals and society.

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