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PREVALENCE OF TRAUMATIC CHILDHOOD EXPERIENCES IN USERS OF PRIMARY CARE IN THE MIDWEST REGION OF BRAZIL

PREVALÊNCIA DE EXPERIÊNCIAS TRAUMÁTICAS NA INFÂNCIA ENTRE USUÁRIOS NA ATENÇÃO PRIMÁRIA NO CENTRO-OESTE DO BRASIL

PREVALENCIA DE EXPERIENCIAS INFANTILES TRAUMÁTICAS ENTRE USUARIOS EN LA ATENCIÓN PRIMARIA EN CENTRO-OESTE DE BRASIL

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ABSTRACT

Objective: to analyze traumatic experiences in childhood and their association with sociodemographic, childhood and family characteristics of users of Primary Health Care. **Method**: Cross-sectional study with adults assisted at basic health units in Cuiabá, MT. A self-administered questionnaire was used, and traumatic experiences were assessed using the Childhood Trauma Questionnaire (QUESI). Chi-square and Fisher's exact tests assessed the association between variables. **Results**: Of the 463 respondents, 78.8% experienced at least one type of trauma in childhood. Abuse (physical, sexual and emotional) and emotional neglect were associated with most factors related to family and childhood. **Conclusion**: There was a high prevalence of abuse and neglect, being associated with most of the factors related to family and childhood in users of primary care in the capital of Mato Grosso and little distinction according to sociodemographic characteristics.

Descriptors: Childhood Traumatic Experiences; childhood trauma; Basic health Unit; Primary Health Care; Cross-sectional Studies.

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RESUMO

Objetivo: analisar as experiências traumáticas na infância e sua associação com características sociodemográficas, da infância e da família de usuários da Atenção Primária de Saúde. **Método**: Estudo transversal com adultos atendidos nas unidades básicas de saúde de Cuiabá, MT. Utilizou-se um questionário autoaplicável e as experiências traumáticas foram avaliadas por meio do Questionário sobre Traumas na Infância (QUESI). Os testes Qui-quadrado e Exato de Fisher avaliaram a associação entre as variáveis. **Resultados**: Dos 463 entrevistados, 78,8% vivenciaram pelo menos um tipo de trauma na infância. Os abusos (físico, sexual e emocional) e negligência emocional estiveram associados a grande parte dos fatores relacionados à família e à infância. **Conclusão**: Evidenciou-se elevadas prevalências de abusos e negligências, mostrando-se associados a grande parte dos fatores relacionados à família e à infância em usuários da atenção primária da capital matogrossense e pouca distinção segundo características sociodemográficas.

Descritores: Experiências Traumáticas na Infância; Trauma infantil; Unidade Básica de Saúde; Atenção Primária à Saúde; Estudos Transversais.

RESUMÉN

Objetivo: analizar las experiencias traumáticas en la infancia y su asociación con las características sociodemográficas, infantiles y familiares de los usuarios de la Atención Primaria de Salud. **Método**: Estudio transversal con adultos en la unidades basicas de salud de Cuiabá, MT. Se utilizó un cuestionario autoadministrado y las experiencias traumáticas se evaluaron mediante el Cuestionario de Trauma Infantil. Las pruebas de chi-cuadrado y exacta de Fisher evaluaron la asociación entre variables. **Resultados**: De los 463 encuestados, el 78,8% experimentó al menos un tipo de trauma en la infancia. El maltrato (físico, sexual y emocional) y el abandono emocional se asociaron con la mayoría de los factores relacionados con la familia y la infancia. **Conclusión**: Hubo una alta prevalencia de maltrato y abandono, siendo asociado a factores relacionados con la familia y la infancia en los usuarios de la atención primaria de Cuiabá y poca distinción según las características sociodemográficas.

Descriptores: Experiencias Traumáticas en la Infancia; trauma infantil; Unidad Básica de Salud; Primeros auxilios; Estudios transversales.

INTRODUCTION

Traumatic experiences in childhood consist of different forms oftraumas, such as physical, emotional, sexual abuse and negligence, which can, from its occurrence and throughout the life cycle, have consequences for the victim, such as post-traumatic stress disorder, anxiety, depression[1], obesity[2], disabilities and premature death.[3] In Brazil, in 2019, more than 150,000 complaints of violations of rights against children and adolescents were registered, representing an increase of 15.4% compared to 2018.[4] Of these complaints, 39.0% referred to negligence, 23, 0% to psychological violence, 17.0% to physical violence, 6.0% to sexual violence and 15.0% to other forms of violence.[4]

The occurrence of trauma in childhood is a subjective phenomenon,

affecting victims in different ways and with repercussions until adulthood. This occurrence is associated with a higher prevalence, in adults, of depression[5], bipolar disorder1, chronic pelvic pain[6], and head and neck cancer.[7]

Nevertheless, its genesis is complex, with influence of social aspects, evidenced by the higher prevalence in countries with lower income, characteristics of the family, context and individuals, such as gender, age and schooling. Due to the social, cultural and individual differences, added to the cultural transition evidenced in recent decades, which brought greater attention to this type of violence, social understanding of this phenomenon is only possible with results that represent the different regions of each country. However, population-based or representative surveys of users of the Unified Health System (SUS) are scarce in Brazil8 and there is an even greater lack of evidence from the North and Central-Oestes[4] regions. This scenario limits both the diagnosis, at national level, of traumatic experiences suffered in childhood, and limits the possibilities of creating and evaluating public policies on the subject.

Thus, the need for surveys designed to identify the prevalence of traumatic experiences in childhood and associated factors is evident, especially from the population of less studied regions. Therefore, the present study aims to analyze the traumatic experiences in childhood in adult users of primary health care, according to sociodemographic, childhood, family of origin and current characteristics.

METHODS

This is a cross-sectional, descriptive study with a representative population of primary health care users in Cuiabá, Mato Grosso, carried out between September and October 2021. The study population consisted of primary care users. of the municipality (urban and rural perimeter) accessed through the Basic Health Units (UBS).

Selection and sampling criteria

A stratified and two-stage sampling process was adopted. First, the 100 Basic Health Units (UBS) operating in the municipality in 2020 were distributed into five strata, defined as an administrative health region in the perimeter (North, South, East, West) and outside the urban perimeter (rural area). In the first stage, the number of UBS to be drawn in each stratum was determined proportionally in the regions. The UBS draw was systematic, from the calculation of the

expansion fraction (result of the division between the total number of UBS and the total number to be drawn by stratum). In the second stage, the number of users to be selected in each stratum was determined proportionally in the regions. There was no random selection of individuals, being invited to participate in the survey all those who were waiting for health care on the day of collection in the UBS drawn.

For sample planning, a list of UBS in the municipality in 2020 was provided by the Municipal Health Department (SMS) of Cuiabá, containing their location by neighborhood, administrative health region, number of the general population and users registered with the Ministry of Health. Health. The total number of people registered in the 100 UBS of the five administrative regions was 316,9899, representing 51.3% of the estimated population for the municipality in the same year.

The user sample was calculated using the OpenEpi software. A prevalence of 50% was used for the calculation, since the response variable presents different prevalences for each traumatic experience in childhood and unknown to the study population; 95% confidence level, 5% standard error; and design effect of 1.1.10 A minimum sample size of 423 users was obtained. Plus 10%, given the possibility of losses and refusals, we reached 470 users.

The eligibility criterion for participation in the study was being at the UBS on the day of data collection and being at least 18 years old. Those who were waiting for any type of health care (appointment, vaccination, medication, etc.) at the drawn UBS were invited to participate in the survey. Pregnant women who were at the UBS for prenatal care or another health service were excluded from the study, because of the possible emotional implications (risk and harm) of the research instrument for the user's mental health, as well as individuals who reported being uneducated regarding the level of education.

Those who refused to participate in the research and/or those who decided to interrupt their participation, giving up and not completing the answers to the research instrument, were considered losses.

Data collection instrument

A self-administered questionnaire was prepared for data collection and a pilot test was carried out with 40 users in a health unit not selected for data collection. Traumatic childhood experiences were assessed using the retrospective self-report instrument, adapted from the Childhood Trauma Questionnaire – CTQ1,11, which

measures the dimensions: emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect. Each of these dimensions is composed of 5 questions on a 5-point Likert scale in which the user scores the frequency of the event he/she has experienced in: never (1), a few times (2), sometimes (3), often (4) and always (5).

Traumatic childhood experiences were analyzed in three different ways: CTQ score, dichotomization of the 5 dimensions of the CTQ12 and the general assessment of the presence of some traumatic experience in childhood (total CTQ). The occurrences of traumatic experiences, by dimensions, were identified based on the following cutoff points: ≥8 points for physical abuse, ≥6 points for sexual abuse, ≥9 points for emotional abuse, ≥8 points for physical neglect and ≥10 points for emotional neglect. The CTQ score was further classified as nonexistent to minimal trauma (≤36 points), low to moderate trauma (37-51 points), moderate to severe (52-68 points), and severe/extreme trauma (≥69 points).[5,12] Finally, the presence of general traumatic experience was considered as present (yes) for those individuals who suffered some form of abuse or negligence among the 5 evaluated dimensions. In this variable, it was considered as "no" individuals who had scores below the cutoff points in all types of abuse or neglect.

Regarding sociodemographic characteristics, the following were evaluated: gender (male or female), age group (questioned in years and categorized as 18 to 29, 30 to 39, 40 to 49, 50 to 59, 60 or more), marital status (classified with or without a partner), race/color (white, brown, black, yellow or indigenous), schooling (incomplete primary education, complete primary or incomplete secondary education, complete secondary or incomplete higher education and complete higher education or more) and family income (without income, up to 1 minimum wage, 1 to 2 minimum wages, and more than 2 minimum wages).

Characteristics of parenting during childhood included: being raised by biological parents (both parents, mother only, father only, neither biological parent), whether you suffered the loss of any family members who raised you before age 18 (yes/no), if he/she experienced the divorce of parents before the age of 12 (yes/no)[13], with whom he/she slept as a child (alone or slept with someone, being considered in this last category: slept with mother, father, grandparents or sisters), if during childhood you witnessed many fights (yes/no), had a mother who was a victim of domestic violence (yes/no), experienced extreme poverty (yes/no), had

a family member sent to prison (yes/no), was sent away from home (yes/no), left parental home before age 18 (yes/no), and lived with a family member with depression, mental illness,suicide thoughts/attempts and users of alcohol, tobacco or other drugs.[13]

Regarding the characteristics of the current family, family functionality was assessed using the family APGAR.[14] A score ≥7 was considered a functional family and <7 a dysfunctional one.

Tabulation and Data Analysis

Data were entered into an Excel® spreadsheet and quality control was performed with a random sample of 10%. Statistical analysis was carried out with the support of Stata 9 and SPSS software, version 20. To assess the association of adverse experiences according to sociodemographic, economic, childhood and current family characteristics, the chi-square test and the exact test were used. Fisher, considering the significance level of 5%. Fisher's exact test was used when a percentage greater than 25% of cells smaller than 25% was observed.

Ethical aspects

This study was approved by the Ethics and Research Committee of the Faculty of Medicine of the Federal University of Mato Grosso – UFMT (Opinion: 4,167,735 of July 22, 2020). Users were interviewed after signing the free and informed consent form, following CNS Resolution No. 510, April 7, 2016.

RESULTS

During the study period, 483 users were approached. Of these, 13 questionnaires (2.7%) were partially completed and considered as losses, and seven (1.5%) were excluded because the respondent had informed that he had no education. Thus, the final sample for this study consisted of 463 individuals.

Of the 463 users, most were female (81.4%), brown (62.0%) and had a partner (55.5%) (Table 1). The median age was 44.0 years, with a minimum of 18 and a maximum of 83 years.

Table 1 - Prevalence of abuse (physical, sexual and emotional) and neglect (physical and emotional) in childhood, according to sociodemographic characteristics of primary care users in Cuiabá-MT, 2021 (N= 463).

	General n (%)	**Physical abuse** n (%)	**Sexual abuse** n (%)	**Emotional abuse** n (%)	**Physical neglect** n (%)	**Emotional neglect** n (%)
Total	**463**	**45 (9.7)**	**33 (7.1)**	**44 (9.5)**	**227 (59.8)**	**180 (38.9)**
Gender						
Feminine	377 (81.4)	37 (9.0)	30 (8.0)	39 (10.3)	221 (58.6)	152 (40.3)
Masculine	86 (18.6)	11 (12.8)	3 (3.5)	5 (5.8)	56 (65.1)	28 (32.6)
p-value		0.29	0.15	0.20	0.27	0.18
Age group						
18- 29	95 (20.6)	5 (5.3)	7 (7.4)	9 (9.5)	58 (61.1)	42 (44.2)
30-39	100 (21.6)	8 (8.0)	11 (11.0)	11 (11.0)	56 (56.0)	41 (41.0)
40-49	107 (23.1)	9 (8.4)	5 (4.7)	6 (5.6)	59 (55.1)	35 (32.7)
50-59	96 (20.7)	14 (14.6)	6 (6.3)	11 (11.5)	60 (62.5)	35 (36.5)
≥60	65 (14.0)	9 (13.8)	4 (6.2)	7 (10.8)	44 (67.7)	27 (41.5)
p-value		0.16	0.48	0.61	0.46	0.48
Marital status						
No partner	206 (44.5)	24 (11.7)	16 (7.8)	25 (12.1)	126 (61.2)	89 (43.2)
With partner	257 (55.5)	21 (8.2)	17 (6.6)	19 (7.4)	151 (58.8)	91 (35.4)
p-value		0.21	0.63	0.08	0.60	0.09
Race/color						
White	79 (17.1)	9 (11.4)	2 (2.5)	7 (8.9)	50 (63.3)	28 (35.4)
Brown	287 (62.0)	29 (10.1)	23 (8.0)	28 (9.8)	175 (61.0)	111 (38.7)
Black	79 (17.1)	6 (7.6)	7 (8.9)	7 (8.9)	44 (55.7)	32 (40.5)
Yellow	14 (3.0)	1 (7.1)	1 (7.1)	2 (14.3)	6 (42.9)	7 (50.0)
Indigenous	4 (0.9)	-	-	-	2 (50.0)	2 (50.0)
p-value		0.87	0.37	0.87	0.57	0.84
Education						
Teaching background. Incomplete	98 (21.2)	18 (18.4)	6 (6.1)	13 (13.3)	58 (59.2)	40 (40.8)
Teaching background. Complete / incomplete medium	81 (17.5)	6 (7.4)	5 (6.2)	7 (8.6)	44 (54.3)	32 (39.5)
Teaching high school complete / high school incomplete	194 (41.9)	11 (5.7)	18 (9.3)	17 (8.8)	120 (61.9)	80 (41.2)
Higher complete or more	90 (19.4)	10 (11.1)	4 (4.4)	7 (7.8)	55 (61.1)	28 (31.1)
p-value		**<0.01**	0.46	0.55	0.67	0.41
Family income						
No income	29 (6.3)	5 (17.2)	4 (13.8)	5 (17.2)	20 (69.0)	14 (48.3)
Up to 1 minimum wage	167 (36.1)	20 (12.0)	16 (9.6)	20 (12.0)	99 (59.3)	71 (42.5)
More than 1 to 2 minimum wages	136 (29.4)	11 (8.1)	8 (5.9)	14 (10.3)	87 (64.0)	56 (41.2)
More than 2 minimum wages	131 (28.3)	9 (6.9)	5 (3.8)	5 (3.8)	71 (54.2)	39 (29.8)
p-value		0.24	0.12	**0.04***	0.29	0.08

P-value for Chi-square test or Fisher's exact test. Values in bold indicate statistical significance at the 5% level

As for traumatic experiences in childhood, the prevalence was 29.4% (n=136) for nonexistent or minimal trauma, 55.5% (n=257) for low to moderate trauma, 14.9% (n=69) for moderate to severe trauma and one individual classified as severe to extreme (0.2%) (data not presented in tables). In the

present study, 78.8% of the participants experienced at least one type of traumatic experience of abuse or neglect during childhood. There was a prevalence of 9.7% for physical abuse, 7.1% for sexual abuse, 9.5% for emotional abuse, 59.8% for physical neglect and 38.9% for emotional neglect.

The analysis of the association between the variables of abuse and neglect in childhood with sociodemographic characteristics showed a statistically significant relationship between physical abuse and education, with a higher prevalence among those who reported having completed elementary school. Regarding income, there was a higher prevalence of emotional abuse among those with lower income. Gender, marital status and race/color were not statistically significant (Table 1).

Of the respondents, 60.3% were raised by both biological parents and 30.5% reported parental divorce before age 12. The loss before the age of 18 of those who created it was reported by 18.4% of people. Approximately one third of respondents reported having witnessed many fights in the family or leaving their parents' home before the age of 18. In addition, it is noteworthy that approximately 20% reported that their mother was a victim of domestic violence or experienced extreme poverty and 25.1% reported living with a family member who had depression (Table 2).

Table 2 - Prevalence of abuse (physical, sexual and emotional) and neglect (physical and emotional) in childhood, according to characteristics of childhood upbringing and current family of users of primary care in Cuiabá-MT, 2021 (N= 463).

	General	**Physical abuse**	**Sexual abuse**	**Emotional abuse**	**Physical neglect**	**Emotional neglect**
	n (%)	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Raised by biological parents*						
Both parents	279 (60.4)	17 (6.1)	12 (4.3)	18 (6.5)	174 (62.4)	89 (31.9)
Just the mother	136 (29.4)	18 (13.2)	16 (11.8)	16 (11.8)	75 (55.1)	67 (49.3)
Just the father	11 (2.4)	3 (27.3)	1 (9.1)	2 (18.2)	5 (45.5)	4 (36.4)
By none of the biological parents	36 (7.8)	7 (19.4)	4 (11.1)	8 (22.2)	14 (38.9)	20 (55.6)
p-value		**<0.01**	**0.02**	**<0.01**	0.54	**<0.01**
Loss before age 18 of someone who raised you						
No	378 (81.6)	37 (9.8)	24 (6.3)	34 (9.0)	221 (58.5)	142 (37.6)
Yes	85 (18.4)	8 (9.4)	9 (10.6)	10 (11.8)	56 (65.9)	38 (44.7)
p-value		0.92	0.17	0.43	0.21	0.22
Divorce of parents before age 12**						
No	296 (67.7)	17 (5.7)	14 (7.4)	18 (6.1)	179 (60.5)	83 (28.0)
Yes	141 (32.3)	24 (17.0)	15 (10.6)	21 (14.9)	81 (57.4)	84 (59.6)
p-value		**<0.01**	**0.02**	**<0.01**	0.55	**<0.01**
Who slept with						
Alone	200 (43.2)	18 (9.0)	9 (4.5)	20 (10.0)	117 (58.5)	81 (40.5)
Sleep with someone†	263 (56.8)	27 (10.3)	24 (9.1)	24 (9.1)	160 (60.8)	99 (37.6)
p-value		0.65	0.05	0.75	0.61	0.53
With the family that was raised...						
witnessed many fights						
No	300 (64.8)	17 (5.7)	11 (3.7)	16 (5.3)	182 (60.7)	85 (28.3)
Yes	163 (35.2)	28 (17.2)	22 (13.5)	28 (17.2)	95 (58.3)	95 (58.3)
p-value		**<0.01**	**<0.01**	**<0.01**	0.62	**<0.01**
Had a mother who was a victim of domestic violence						
No	376 (81.2)	29 (7.7)	24 (6.4)	28 (7.4)	228 (60.6)	122 (32.4)
Yes	87 (18.8)	16 (18.4)	9 (10.3)	16 (18.4)	49 (56.3)	58 (66.7)
p-value		**<0.01**	0.20	**<0.01**	0.46	**<0.01**
Experienced extreme poverty						
No	368 (79.5)	23 (6.3)	21 (5.7)	26 (7.1)	232 (63.0)	120 (32.6)
Yes	95 (20.5)	22 (23.2)	12 (12.6)	18 (18.9)	45 (47.4)	60 (63.2)
p-value		**<0.01**	**0.02**	**<0.01**	**<0.01**	**<0.01**
Had a family member sent to prison						
No	434 (93.7)	39 (9.0)	30 (6.9)	39 (9.0)	265 (61.1)	163 (37.6)
Yes	29 (6.3)	6 (20.7)	3 (10.3)	5 (17.2)	12 (41.4)	17 (58.6)
p-value		**0.04**	0.34	0.13	**0.04**	**0.02**
Was sent away from home						
No	418 (90.3)	31 (7.4)	25 (6.0)	28 (6.7)	251 (60.0)	145 (34.7)
Yes	45 (9.7)	14 (31.1)	8 (17.8)	16 (35.6)	26 (57.8)	35 (77.8)
p-value		**<0.01**	**<0.01**	**<0.01**	0.77	**<0.01**

Table 2 - Prevalence of abuse (physical, sexual and emotional) and neglect (physical and emotional) in childhood, according to characteristics of childhood upbringing and current family of users of primary care in Cuiabá-MT, 2021 (N= 463).

(Continuation)

	General n (%)	Physical abuse n (%)	Sexual abuse n (%)	Emotional abuse n (%)	Physical neglect n (%)	Emotional neglect n (%)
With the family that was raised...						
Left parental home before age 18						
No	316 (68.3)	18 (5.7)	16 (5.1)	20 (6.3)	184 (58.2)	103 (32.6)
Yes	147 (31.7)	27 (18.4)	17 (11.6)	24 (16.3)	93 (63.3)	77 (52.4)
p-value		**<0.01**	**0.01**	**<0.01**	0.30	**<0.01**
Lived with a family member with* **						
Depression						
No	347 (74.9)	30 (8.6)	22 (6.3)	28 (8.1)	210 (60.5)	129 (37.2)
Yes	116 (25.1)	15 (12.9)	11 (9.5)	16 (13.8)	67 (57.8)	51 (44.0)
p-value		0.18	0.25	0.70	0.60	0.19
Mental disease						
No	421 (90.9)	35 (8.3)	29 (6.9)	35 (8.3)	251 (59.6)	157 (37.3)
Yes	42 (9.1)	10 (23.8)	4 (9.5)	9 (21.4)	26 (61.9)	23 (54.8)
p-value		**<0.01**	0.53	**<0.01**	0.77	**0.03**
Suicide thoughts/attempts						
No	417 (90.1)	38 (9.1)	25 (6.0)	36 (8.6)	254 (60.9)	151 (36.2)
Yes	46 (9.9)	7 (15.2)	8 (17.4)	8 (17.4)	23 (50.0)	29 (63.0)
p-value		0.19	**<0.01**	0.05	0.15	**<0.01**
Lived with user member of...						
Alcoholic beverage						
No	213 (46.0)	19 (8.9)	8 (3.8)	21 (9.9)	130 (61.0)	61 (28.6)
Yes	250 (54.0)	26 (10.4)	25 (10.0)	23 (9.2)	147 (58.8)	119 (47.6)
p-value		0.59	**<0.01**	0.81	0.62	**<0.01**
Tobacco						
No	269 (58.1)	23 (8.6)	18 (6.7)	23 (8.6)	165 (61.3)	106 (39.4)
Yes	194 (41.9)	22 (11.3)	15 (7.7)	21 (10.8)	112 (57.7)	74 (38.1)
p-value		0.32	0.67	0.41	0.43	0.78
Other drugs						
No	411 (88.8)	34 (8.3)	24 (5.8)	33 (8.0)	248 (60.3)	145 (35.3)
Yes	52 (11.2)	11 (21.1)	9 (17.3)	11 (21.2)	29 (55.8)	35 (67.3)
p-value		**<0.01**	**<0.01**	**<0.01**	0.53	**<0.01**
Family Functionality*						
dysfunctional	165 (35.7)	22 (13.3)	14 (8.5)	22 (13.3)	98 (59.4)	96 (58.2)
Functional	297 (64.3)	22 (7.4)	18 (6.1)	22 (7.4)	179 (60.3)	83 (27.9)
p-value		**0.04**	0.32	**0.04**	0.85	**<0.01**

*Lack of information for one respondent **Lack of information for 26 respondents who reported not remembering *** Values do not complete 100% for accepting more than one answer option. †Slept with mother, father, grandparents or sisters. Values in bold indicate statistical significance at the 5% level.

Being raised by only the father was associated with physical abuse ($p<0.01$), by only the mother with sexual abuse ($p=0.02$), by none of the biological parents with emotional abuse ($p<0.01$) . Emotional neglect had a higher prevalence for those raised by none of the biological parents ($p<0.01$). The prevalence of physical, emotional and sexual abuse, as well as emotional neglect, was higher among those who reported parental divorce before age 12 (Table 2).

The prevalence of physical abuse was statistically higher among those who witnessed many fights, had mothers who were victims of domestic violence, experienced extreme poverty, had a family member deprived of liberty, were sent away from home, left their parents' home before age 18, lived with family member with mental illness or user of other drugs (Table 2).

On the other hand, the prevalence of sexual abuse was higher among those who witnessed many fights, experienced extreme poverty, were sent away from home, left their parents' home before age 18, lived with a family member with thoughts or who attempted suicide, and drinkers. alcohol and other drugs (Table 2).

The emotional abuse component showed a statistically significant association with: having witnessed many fights, having a mother who was a victim of domestic violence, having experienced extreme poverty, having been sent away from home, having left the parental home before age 18, having lived with a family member with mental illness and user of other drugs. Associations similar to those observed for emotional negligence, with the latter still being associated with having been raised with members who were arrested, thought about or attempted suicide, and consumed alcohol. Physical negligence was associated with not having suffered extreme poverty and not having had a family member arrested for arrest (Table 2). In 35.6% of the interviews, the family was classified as dysfunctional, which was associated with physical abuse,

DISCUSSION

In this study, a prevalence of 55.5% of traumatic experiences in childhood classified as low to moderate was observed, with negligence being the most prevalent, followed by abuse. In general, abuse (physical, sexual and emotional) and emotional neglect were associated with most factors related to family and childhood. As for sociodemographics, only education and income were associated with physical and emotional abuse, respectively.

In an unprecedented way, primary care users of the Unified Health System were evaluated, without defining a specific

health problem as an outcome possibly associated with exposure to abuse and neglect traumas in childhood. This design differs from most studies carried out in Brazil with the same instrument, in which the objective was to evaluate the associations of trauma with health problems and specific populations, such as women with depression[5] or pelvic pain.[6]

Thus, comparisons of the results regarding the magnitude of traumatic experiences in childhood should be performed considering this diversity in the study population. Among the primary care users evaluated, more than half were classified with low to moderate traumatic experiences, while in the control group of the Del Bianco[5] study, composed of women without depression, the prevalence for this category was 21.6%. Still, in the present study, 78.8% of the participants experienced at least one type of traumatic experience of abuse or neglect during childhood, a value close to that verified by Tawasha6 with 77.9% for women with chronic pelvic pain and 64,9% for women without this condition. In other studies, on abuse and neglect associated with panic disorder, bipolar disorder, chronic pain, pelvic pain, cancer or depression, no results of prevalence of severity were described in the general QUESI calculation.[1,2,7]

The prevalences observed in the international literature show significant variation, such as Schulz et al.[15], when evaluating Polish adults, who revealed that 57.0% of the individuals reported at least one form of childhood trauma at a mild, moderate or severe level, with the higher prevalences for emotional neglect (62.5%) and for physical neglect (61.7%). Dovran et al.[16] found that 22.0% of the assessed Norwegian adolescents and adults did not show any positive abuse or neglect subscale.

The fact that the highest prevalences were found for negligence, when compared to abuse, may be related to the methodology used in data collection, favoring the reporting of traumatic experiences associated with negligence, such as lack of care, affection and protection, poverty and abandonment, a since, when compared to reporting traumatic experiences of abuse, they require a lower level of embarrassment and greater acceptance of answers to the questions in the research instrument.[7] Regarding the lower prevalence observed for sexual abuse, compared to other types of abuse, in addition to being similar to that observed in other Brazilian studies[1,2,6], the possibility of underreport should not be discarded as a form of protection, due to the fact that it is a retrospective report of an affective and intimate nature, which

consists of content of exposure to humiliation and embarrassment of the interviewee when revealing or remembering a traumatic experience, often not confidential to anyone.

Studies reveal that the subcategories of abuse characterized as forms of maltreatment, violence and intrafamilial stress are interrelated, so that individuals who have suffered sexual abuse are more likely to also suffer emotional abuse than individuals not affected by this form of abuse. -treatment in childhood, just as emotional abuse is implicit in all forms of abuse.[17]

In the present study, no significant differences were found in relation to sociodemographic and economic characteristics with regard to traumatic experiences in childhood, with the exception of physical abuse and physical neglect, with a higher prevalence among those with lower education and lower income, respectively, which, in turn, it differed from what was verified by Zanoti-Jeronymo et al.[8], in a nationwide study with individuals aged 14 years or older, in which no significant differences were found in terms of physical abuse according to family income and schooling. However, as in the present study, the absence of statistically different prevalences was also verified for the variables of gender, age group, skin color and marital status, even considering the severity of the physical abuse suffered. Viola et al.[18], in a meta-analysis with studies from all continents, found that the prevalence of physical neglect in childhood was higher in low- and middle-income countries when compared to high-income countries. Furthermore, per capita GDP was negatively associated with estimates of child neglect. Another explanation pointed out by the authors is that sociodemographic and methodological factors can strongly influence the heterogeneity of results in studies.

The relationship of traumatic experiences and characteristics of the family of origin observed in this study, such as raising by biological parents, divorce of parents before age 12, bereavement, dysfunctional family, family violence, family member with mental disorders or history of drug abuse or alcohol, form the complex combination of individual, family, social factors and other traumatic events reported in the literature that are characterized by a cumulative factor and severity in terms of the number of occurrences, diversity of adversities and traumatic stressors, considered as a multiple-traumatic experience.[19] This multiple-traumatic experience prevents the child from receiving the essential protection factor for their healthy

development, exposing them to fear, insecurity, humiliation and shame.[15]

It is known that the family structure and functioning has continuous development, as well as the values and customs, generational stressors transmitted by it.[19,20] Thus, it is possible that the information on family functionality presents a certain bias, especially among the older ones, as the interviewee may have retrospectively considered their family experiences as rigid and severe, having the current family model as a comparison. Furthermore, this can be identified in the results regarding family functionality, assessed using the APGAR scale, in which the prevalence of emotional abuse (13.3% vs. 7.4%), physical abuse (13.3% vs. 7.4%) and emotional neglect (58.2% vs. 27.9%) were higher among those classified as dysfunctional current family, when compared to those classified as functional.

The possible relationship between the current dysfunctional family with abuse and neglect traumas may suggest repetition of dysfunctional relational patterns between generations presented in the literature as transgenerational inheritance.[20]

Among the limitations of the present study, it should be considered that the interviews were carried out in the Health Unit itself, where people were waiting to be seen, since it was a non-private environment, understanding the respondent's concern about the time to respond to the questionnaire and with the distancing measures to prevent COVID-19. Furthermore, as a self-administered questionnaire was used, possible comprehension difficulties should be considered according to the participants' education.

Also, questions regarding childhood may have implications for the respondent's memory bias, in addition to the possible cohort effect, in which, as expected, older populations tend to have greater accumulated exposures.

This study highlighted the high prevalence of abuse and negligence, showing to be associated with most of the factors related to family and childhood in users of primary care in the capital of Mato Grosso and little distinction according to sociodemographic characteristics. The results obtained provide essential elements of the health situation of this population and, to the extent that the occurrence of these events is known and in which scenario it occurs, it is possible to intervene at an individual level, in the elaboration, follow-up and management of singular therapeutic projects, as well as and at the collective level, since it provides tools for planning strategies for prevention and health promotion.

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