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# Violence and health: recent scientific studies

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## ABSTRACT

An outline and critical analysis of scientific studies on Violence and Health is presented. On the basis of a non-exhaustive review, the construction of violence as a national and international field of knowledge and intervention is broached. Outbreaks of violence are shown to occupy a broad domain of social life that reaches practically everyone, in situations of both war and supposed peace. The unity of violence as an ethical-political question is highlighted and its extreme diversity as concrete situations for study and intervention is demonstrated. Through situating violence as related to collective, interpersonal and self-reported individual dimensions, and taking it to be intentional acts of physical force or power, resulting in physical, sexual or psychological abuse, and in negligence or deprivation, the studies examined mostly demonstrate a concern to respond to the widespread sense that violence is invisible, naturalized and inevitable. In order to do it, the studies show the high magnitude of violence, and the possibilities for controlling violence and attending to the multiplicity of harm to health. The initial approaches flow from a theoretical-methodological point of view related to social inequalities, family maladjustment, gender inequalities and, less frequently, race or ethnic inequalities. These imply reconstruction of the classical concepts of family, generation and social class. In conclusion, this problem is considered to be interdisciplinary and, returning to the notion of social-medical matters within Social Medicine, updating of this notion is recommended for topics that are as complex and sensitive as violence.

**KEYWORDS:** Violence. Domestic violence. Spouse abuse. Child abuse. Elder abuse. Intimate partner violence.

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## INTRODUCTION

Violence is recognized nationally and internationally as a social question within public health. Around the world, it is considered to be a violation of rights, although with a variety of expressions within different contexts. Today, there is debate about the expansion of the domains of violence, paradoxically in relation to the expansion of human and social rights. From violence by the State itself, such as in war crimes or institutional abuse and negligence, it extends to situations of an interpersonal nature within the private world. To control violence, it is not enough simply to appeal to individuals' senses of ethical and social responsibility. It is firstly a matter of redefining these senses, from a moral and legal point of view. These considerations point towards the connection between any approach on violence and human and social rights, from the ethical and juridical perspective. Similarly point towards the need of reflection on the major approaches to violences, as spheres of knowledge and social intervention.

From health perspective, it was mapped a non-exhaustive survey the studies on violence, with the objective of presenting the movement produced, by gathering references to gender, race/ethnicity and life cycles, as specific domains of vulnerabilities, that are added to the traditional markers for social inequality, poverty, family structure or age group.

The increase in scientific production and the changes or expansions of viewpoint that approach violence as a question of knowledge and intervention are dealt with, taking into account the perspective of violence as a complex and sensitive topic that constitutes a medical-social subject within health, and restoring the approaches operated by social medicine within public health.<sup>11</sup>

## VIOLENCE AND HEALTH: GENERAL PANORAMA

The first question that can be posed relates to the crisis of sociability. This is the failure of the current processes of socialization, produced by contemporaneous difficulties in maintaining social structures in the light of the growing dominions of violence. Violence is now identified in public and private spaces, in institutional, group or interpersonal relationships, in times of war or during supposed peacetime. There are not enough means for dealing with such a wide dominion that is fed by interconnections that are still little known.

The impasse in dealing with freedom to exercise social and human rights in a connected way with corre-

lated social commitments and ethical and civil responsibilities constitutes the center of this crisis. It is expressed by a paradoxical broadening of the notion of rights that, in practical terms is formed by the blurring of limits in exercising them, in parallel with a big expansion of these rights. This occurs because exercising them has been disconnected from the relational sphere and become increasingly placed as an individual question, thereby silencing the relational counterparts: duties and commitments. The achievement of rights is confounded with the satisfaction of individual desires.

Within this equivalence, "the other" matters little, and freedom to exercise rights is associated with objectification of "this other", a break with interactivity that violence is founded on. An ethically ambivalent way of acting is established, informed by an agenda of fluid values that replace the defined and delimited value scales. This is malleable according to the opportunities (almost always market opportunities) and therefore cannot be long-lasting. It is the adoption of values that are adaptable to desires and to the expansion of what may or may not be rights. This movement accompanied the establishment in the 1980s of the era of collapses,<sup>19</sup> with the failure of policies and interventions that were precisely for protecting the rights achieved.

For this reason, it is relevant to point out the movement among international bodies like the World Health Organization (WHO), which in 2002 published the World Report on Violence and Health.<sup>21</sup> International movements on the one hand have made the problem of violence public and known around the world, thus expanding the debate and allowing the construction of references for the various regional movements. On the other hand, they add value and significance to the problem of violence, conferring unity to the problem as a question to be faced, while at the same time defining types of violence as diversity within this plural question.

The Report reorientates the traditional way of dealing with health diagnoses for populations, separating deaths due to violence (homicides and suicides) from other external causes, and associating these with morbidity data. This reorientation was accompanied by incorporating new possibilities for approaching the problem, such that other inequalities were brought in, alongside the socioeconomic ones that are always mentioned. Of these, the most frequent ones are gender and, more rarely but still pertinently, race and ethnicity. This other outlook is guided by criticism of the traditional concepts that explain violence: family, generation, social class or nationality-based iden-

tity, which now seem to be insufficient for dealing with the problem.

The WHO definitions summarize many of the achievements and also influence the health field in almost all countries in the world. Their symbolic impact and the interventions that they may evoke therefore cannot be disregarded. And in this, the great contributions of the various social movements and militant actions towards this end cannot be disregarded.

Thus, it is worthwhile exploring this World Report a little better.

The broadest collocation is violence as a universal challenge, and the Report is made available as an “instrument against the taboos, secrets and feelings of inevitability that surround it”.<sup>21</sup> It is highlighted as an undertaking against the invisibility of violence and its acceptance as a trivial event, to which “we should more respond to than prevent”. It is placed at the service of the health field, as a critical response to the usual acceptance of violence as a question essentially relating to “law and order”, in which health professionals just deal with its consequences. It therefore calls on health professionals and scientists to also take responsibility for concerning themselves with and intervening in the fight against violence, in conjunction with other sectors of society. It thus defines interdisciplinary knowledge and intersectoral actions in multiprofessional teams for interventions as urgent topics for healthcare sciences, policies and programs.

It is evident that there is an alliance at an ethical-political level and an intersection at the level of knowledge and practice, promoted between health and human and social rights. And, insofar as this has a repercussion on health services, in the search for integration with justice, public security, education or social assistance, or in scientific production, it points towards the construction of interdisciplinary references to found a basis for cooperation between practices and for solidarity between disciplines.

In defining violence as the “intentional use of real or threatened physical force or power against oneself, against another person, or against a group or a community, that results or has the possibility of resulting in injury, death, psychological damage, development deficiency or privation”, the intentional nature of the violent act is emphasized and non-intentional incidents are excluded. The use of power is included, exemplified by threats of aggression or intimidation, and by neglect and omission.

However, the Report is unclear regarding the con-

cepts of power and violence themselves, overlapping violence and power, often leading to the belief that violence is an inexorable part of power. It thus inadvertently reiterates the inevitability of violence that it wishes to deny. Another possible confusion is that, contrariwise, it denies viability to the concept of power as giving rise to non-violent relationships, thus equally obscuring the role of social responsibility intrinsic to these power actions.<sup>42</sup>

The Report also proposes the recognition of the immense proportion of hidden violence that does not result in deaths or serious injuries, but oppresses and causes physical, psychological and social damage to individuals who are subjected to chronic abuse. This is the case of violence within the home and family, with physical, sexual and psychological aggression, and also privation and neglect, which especially affect women, children and old people.

A rate of 28.8 violent deaths per 100,000 inhabitants was estimated in 2000, in a worldwide index adjusted for age. Out of the total for these deaths, 49.1% were suicides, 31.3% were homicides and 18.6% resulted from wars. Lower-income countries represented 91.1% of the total of these deaths, with a concentration of homicides. There was also a variation according to sex and age: 77% of the homicides took place among men and their rate was more than three times the rate for women. It was greatest in the age groups of 15-29 years (19.4 per 100,000) and 30-44 years (18.7 per 100,000). Sixty percent of the suicides also occurred among men, and this rate increased with age, such that in the age group of 60 years or over, it was twice what it was for women (44.9 per 100,000 *versus* 22.1 per 100,000 for women).<sup>21</sup>

If taken from the perspective of non-fatal violence, several authors have pointed out that the data present great difficulties in comparisons, and variability in their measurements. What is known is the fruit of surveys on occurrences reported by the individuals studied, thereby producing underestimates of the aggression or abuse, as in the case of violence against women,<sup>17</sup> children and old people.<sup>21</sup>

On the one hand, it is recognized that the invisibility of violence increases in countries that have a culture of accepting this way of resolving conflicts, especially domestic ones. This injects fatality regarding violence in interpersonal relationships in private life or even punishes the victim of the violence with death. This is the case of deaths among women who have suffered rape, which is justified in the name of the family's honor.<sup>17,50</sup>

On the other hand, even though analyses dealing with

the ethnic dimension of violence are very rare, there are questions that are of ethnic-cultural nature. One example is the polysemy of the term violence in different cultures, and the different contextual possibilities of its revelation.<sup>12,42</sup>

The result from this is great variation in the rate encountered. The example of physical violence by an intimate partner against a woman can be cited, in which this partner is her principal aggressor. Independent studies show a range from 21% in Holland and Switzerland, 22% in the United States and 29% in Canada, to 34.4% in Egypt and 40% in India,<sup>17,50</sup> a variation that could be attributed to differences in designs and samples. Nevertheless, a comparative study in 15 regions of 10 countries, including two regions in Brazil – the municipality of São Paulo (SP) and the Forest Zone of Pernambuco (ZMP) – and making use of the same questionnaire, which was always applied to women aged 15 to 49 years and had standardized training for the researchers and standard sample definition, presented a range from 13% (Okahama, Japan) to 61% (Cuzco, Peru), while most of the regions were between 23% and 49%.<sup>12</sup> Brazil was part of this majority group: SP presented a rate of 27% and ZMP 34%.<sup>12,42</sup> Thus, the study added variations within the same country, as in the Brazilian case, to those observed between countries.

A great degree of overlapping between physical, sexual and psychological violence has been found, which should also be expected in relation to violence against children and old people. In the case of children, which was the first type of violence to be studied, in the 1960s,<sup>42</sup> there has been an accumulation of information that is not seen for old people, who only become the target of research during the second half of the 1990s. The World Report, with data from only five surveys in developed countries, estimates that 4% to 6% of the elderly population experience some form of domestic abuse. Among old people, bad treatment in institutions also has to be taken into consideration, a topic that has rarely been researched. Questions of gender or race/ethnicity remain unexplored within this population group.

With regard to children, attention is drawn to the high mortality rates that are also unequal according to country and sex.<sup>21</sup> The homicide rate among children aged zero to four years (5.2 per 100,000) is more than twice the rate for those between five and 14 years (2.1 per 100,000). For children aged less than five, the homicide rate in high-income countries is 2.2 per 100,000 boys and 1.8 per 100,000 girls, while for poorer countries the rate is two to three times higher (6.1 per 100,000 boys and 5.1 per 100,000 girls). The greater occurrence

of this violence among boys is reiterated here. With regard to morbidity, younger children are more exposed to physical violence (75% in the Philippines and 47% in the United States, in reports from the parents), while it has been calculated that around 20% of women and 5 to 10% of men suffered sexual abuse when they were children. Social inequalities and gender questions are therefore implicated in violence against children and adolescents.

Finally, juvenile violence (10 to 29 years) needs to be commented on, because of what it represents socially. It is mentioned by the World Report itself as the most visible form of violence and it also has peculiar characteristics, since young people are the main aggressors and victims. Studies on this are the ones that most point towards the interlinking of fatal and non-fatal violence; violence in public and domestic spaces; violence of interpersonal and collective types. Experience of violence during childhood, belonging to gangs and having access to arms, living under prolonged war and under conditions of social exclusion and great poverty, are situations that increase the indices for such violence, which is greatest in Latin America and Africa and least among the countries of Eastern Europe.<sup>21</sup>

Following this general panorama, the Brazilian production regarding violence and health needs to be considered.

## VIOLENCE AND HEALTH IN BRAZILIAN STUDIES

Data on the Brazilian production on violence and health were gathered during the first week of April 2006 from SciELO (Scientific Electronic Library Online), which among others indexes the principal Brazilian journals with the field of public health. A total of 234 articles published between 1980 and 2005 were found, and this last year alone accounted for 20% of this publication. The first surge began in 1994, with the publication of a supplement by *Cadernos de Saúde Pública*<sup>29</sup> relating to this topic. A second surge began in 2002.

From reading the abstracts, 108 health-related articles that dealt with Brazilian realities were selected. The points considered in the following are based on this production, with the addition of a few complementary studies that are considered to be sources of relevant original data.

In these Brazilian studies, the international trend was verified: the first studies were based on data on mortality due to external causes. Such mortality affects

males more than females, and thus, explaining why the studies focus more on homicide among males, mediated by the question “external causes”. Both the distinction of type of violence and gender-based approaches begin at the end of the 1990s.<sup>22,25</sup>

In the 1990s, most of the studies were based on the premise that violence was growing: from 1980 onwards, external causes occupied second place among the causes of death in Brazil. It was therefore the external causes that marked the presence of violence, particularly among men.

During the first part of the decade, the studies sought to characterize the magnitude and importance of these causes of death in relation to others, discussing rates and years of life potentially lost, and stratified by groups of causes, sex and age.<sup>26,38,46</sup>

One of the first explanatory systematic studies to emerge regarding the notion of violence took the understanding that it is a process with multiple causes and non-linear causality, with specific and general, micro and macrosocial characteristics that are differentiated and interlinked.<sup>46</sup> This argument was incorporated in Minayo’s conceptual references and violence categories: “structural”, “resistant” and “delinquent”.<sup>29</sup>

In the second part of the decade, the number of publications decreased. However, there was a shift in approaches. Barata et al<sup>2</sup> focused on the segments of adolescents and young adults of both sexes in São Paulo, and applied analysis of the correlation between living conditions and homicide rates. The analytical mark utilized was structural violence resulting from the development of metropolises, urban deterioration and inequalities in living conditions.

The period from 2000 to 2005 presented growth in the numbers of publications within the health field. They mostly investigated specific cities and dealt with the increases in mortality due to external causes that were especially the product from the homicide rate, thus demonstrating that this is one of the biggest present-day problems within public health.<sup>10,13,31,40</sup> Among this group of studies the trend towards spatial analysis of mortality stands out, in an approach towards urban violence related to inequalities in occupying the spaces within cities.

Another question that arose during this period was a more detailed focus on homicides among young males. A study carried out in different Brazilian states and their capitals in 2000 showed that there was general growth in the homicide rate in the country, with

figures of between 11.83 per 100,000 inhabitants in Salvador and 67.4 per 100,000 inhabitants in Recife, thus denoting significant differences in the risk of death between Brazilian cities.<sup>35</sup>

This focus was repeated by other studies during this period. The main reference point for them was analyses supported by the concept of structural violence and violence in and due to public space affected by social inequalities, or according to WHO typology, interpersonal community-based violence.<sup>21</sup> Macedo et al<sup>23</sup> summarized the principal determining factors for this violence: “(...) growth in socioeconomic inequalities; low salaries and family income that lead to loss of purchasing power; absence of integrated public policies in keeping with the population’s health, education, housing and security needs; priority for economic development to the detriment of social development, with sacrifice for the population and greater burdens on the poor; and intense appeals to consumption that conflict with the impoverishment of the country”. In addition to these factors, there is the consolidation of organized crime, especially in the metropolitan regions.

Nonetheless, the possible approaches, whether as violence of delinquency,<sup>29</sup> or gender questions among male peers,<sup>43</sup> or ethnic-racial questions,<sup>3</sup> do not significantly appear. It was also between 2000 and 2005 that studies on external causes using morbidity data gained greater visibility. Some were highlighted by combining mortality and morbidity data.<sup>15,24,47</sup> In 2000, external causes represented 5.2% of all hospitalizations in Brazil.<sup>15</sup>

One noteworthy study using the gender category took violence as a constitutive trait of masculinity and made men both the villains and victims of violence.<sup>47</sup> Using data relating to external causes, for Brazil and state capitals from 1991 to 2000, the study showed that the homicide risk was almost 12 male deaths for every female death.

Age groupings in morbidity-mortality studies on external causes have, as already shown, focused on male populations, especially younger males. This was justified by the magnitude and seriousness of the problem among these populations. Two references to deaths and hospitalization among elderly people must also be highlighted among these general studies on external causes. One of them,<sup>14</sup> showed that the mortality among people aged 60 years or over due to external causes was 92.1 per 100,000 inhabitants (135.3 per 100,000 for men and 56.8 per 100,000 for women) in 2000. In terms of morbidity, the study revealed that most hospitalizations resulted from injuries and trauma caused

by falls and crushing. The other study<sup>30</sup> took the period 1980-1998 and showed that, among the external causes, the ones responsible for most elderly victims were traffic and transport accidents, falls and homicides. Focusing on the latter cause, this study showed growth from 7.2% in 1980 to 9.6% in 1988.

In these studies, violence is dealt with as a question within the everyday life of families, institutions and society. Approaches like gender or race/ethnicity do not appear.

Studies on women, on the one hand, and on children and adolescents, on the other, have a much greater presence than studies on the elderly. The first studies on these two fields (women and children/adolescents) were published in 1994.<sup>29</sup> Thus, even though they began before studies on the elderly, they are very recent.

Although these two fields are not mutually related, they have points in common: a concern for giving visibility to the problem, the high rates encountered and the difficulties that health professionals have in dealing with the question in their daily routines. The great majority are studies in services specializing in dealing with violence and health services, and they investigate prevalences, the nature of the violence and the aggressors. They also explore questions such as: records and notification, assessment of the service, reports on experiences, and proposals and criticisms relating to intervention practices. The need for multiprofessional teams, intersectoral characteristics and the defense of violence as a public health problem, interlinked with care and the preservation of human and social rights, have been constant arguments. References to laws, conventions, statutes and other regulations, and to international treaties to which Brazil is a signatory, have also been cited among these studies.

In the studies on violence against women, great importance was given to the notion of gender, and this was also utilized in a small proportion of the studies relating to children and adolescents. Both fields utilized the terms of violence within the home or family, but the approach and emphasis given to the idea of family differed greatly, as did the defense of the individual rights of the subjects involved in defending the family and its integrity. The topic of family had little presence in the scientific production on violence relating to women, but was almost obligatory in the field of children and adolescents, in which mothers and fathers were recalled as aggressors and subjects fundamental in interventions.

Poverty and social inequality were important refer-

ences, and were recalled and placed in relation to the topics of family and gender.<sup>6,7</sup> Ethnicity and race were topics absent from both these fields. When cited, these questions appeared in the plans for future studies or for characterizing the sample studied, and were little used in the analysis. In the few cases in which skin color was a variable analyzed, it did not present an association with the forms of violence studied.<sup>44</sup>

It was noteworthy that there was a virtual absence of studies making in-depth analyses of the prevention of violence and the role of health in this topic. The only article found discussed the lack of such policies in the public health sector in Fortaleza.<sup>37</sup>

The methodologies utilized in the studies on women, children and adolescents varied. The studies were presented as quantitative analyses for identifying occurrences and defining associated factors, and as qualitative analyses in studies on representative bodies for women and professionals. Several studies combined these methodologies, thus indicating the complexity of the subject and the innovation in the approach.

Focusing on violence against women, two articles can be highlighted as references for this field,<sup>16,18</sup> in which the inequalities in gender relations are a central concept present from the outset of this production. The violence suffered by women is explained from the historical and social conditions of the relational construction of the male and female. Thus, attributes, positions and diverse expectations are generated for the sexes in related to sexuality, position in the core of the family, work and public space, thereby giving rise to specific forms of violence: in private spaces against women and in public spaces against men.<sup>16</sup> This division of the spaces for violence and the appeal for a gender-based approach also in studies on men was already indicated in these first publications. However, studies on men from this gender perspective only appeared at the end of the period.<sup>43</sup>

The designation gender violence itself has not always been used. Imprecision of the terms has continued and, although gender is a fundamental category, the perspective directly relating to violence has been little studied. There has also been little differentiation between power and violence in gender relations.

Most studies on violence against women were conducted in health services, basic health units,<sup>20,41</sup> hospitals,<sup>8</sup> maternity hospitals<sup>28</sup> and emergency services.<sup>44</sup> They have been restricted to the clientele of the *Sistema Único de Saúde* (Brazilian National Health System). They mainly present "violence against women": some delimited to domestic vio-

lence<sup>8</sup> and other to violence by an intimate partner.<sup>1,20</sup> Up to 2005, the only population-based study published presented the topic of violence against women as part of an investigation on women,<sup>49</sup> showing that 43% of Brazilian women declared that they had suffered violence from men at some time in their lives, 33% some form of physical violence, 13% sexual violence and 27% psychological violence.

The studies in services indicated higher rates: between 36% and 45% suffering physical violence at least once in their lives and between 9% and 19% sexual violence,<sup>20,41,44</sup> with the partner as the most frequent aggressor. The rate of violence during pregnancy has been estimated to be 7.4%.<sup>28</sup>

Overlapping of the physical, sexual and psychological forms has been indicated, and combined forms prevail: physical with psychological violence and sexual with physical violence.<sup>20,41</sup>

Studies dealing with sexual violence against women are centered on the quality of the services that attend to such cases, and on the representative bodies for professionals and women regarding legal abortion.<sup>33,45,48</sup> However, these services tend to especially receive cases of violence committed by strangers, whether identifiable or not. These cases are very different from sexual violence in conjugal relations, which is more frequent and more invisible.<sup>6</sup>

With regard to the segment of children and adolescents, the studies were also located in specialized services and attendance for victims of violence (shelters, centers for attending to accusations, or referral centers). Their clientele was therefore composed of victims of violence. Without being prevalence studies, these studies showed differences according to the sex and age of the children and adolescents who suffered these attacks, and mostly indicated greater frequency of sexual aggression against girls<sup>39</sup> and physical violence against boys.<sup>4,7</sup> They indicated the mothers as the main aggressors regarding physical violence, followed by the father.

Regarding sexual violence, which has been greatly studied, fathers and stepfathers were the main aggressors. Criticisms of families and analysis from gender references had little presence, with rare combined approaches towards violence against children and mothers within families.<sup>27,32</sup>

Studies on the prevalence of violence against children and adolescents were based on schools, thus coming close to population-based studies. One of them, in Porto Alegre, found that 2.3% of the adolescent subjects reported sexual violence, 4.5% had wit-

nessed this type of violence and 27.9% knew some victim of sexual violence, among 1,193 eighth-grade students in state schools.<sup>36</sup> Another study in São Paulo,<sup>5</sup> on 993 adolescents (12-18 years old) in the state network and 815 in the private network, found that 8.6% of them reported suicide attempts, 7.9% aggression against them or others and 4.8% were carrying firearms.

## FINAL CONSIDERATIONS

Taking all the points considered together, the diversity of the approaches and some important absences can be highlighted. The absences relate to specific population segments and important focuses that have not been dealt with, such as race/ethnicity and even gender. If on the one hand this shows the complexity of the topic of violence, in which great dispersion of treatment is required for its concrete and particular expressions, on the other hand there is an understanding that studies on violence and health are still at an initial stage of their production.

Most of the present efforts appear to be concentrated on the concern for making the problems visible, the emphasis on magnitudes or the difficulties in transforming this into a question for the health field. Even if momentarily, this shifts undertakings that examine the conditioning factors for violence, particularly in relation to impasses, aforementioned, to dealing with rights and commitments, freedoms and ethics, simultaneously.

The research accomplished has certainly contributed towards progressive comprehension of the problem from the concrete and particular perspectives of the situations studied. It has also to a certain extent contributed towards comprehending the participation of violence in social structures, in a general manner. However, there is a pressing need for a more direct approach in this direction, to expand the still hesitant critical construction of classical concepts that in studies on violence may obscure important aspects of relationships between subjects, relationships relating to power and concomitant exercising of rights.

Because of this plurality that violence signifies; or the radical human experience that it represents, through invalidating the subject; or furthermore, the exposure of spaces and moments of great intimacy and privacy of each person, there is an understanding that there cannot be progress in studying it without taking it as a complex and sensitive study subject. This relates to solidarity between disciplines and not competition, and requires a particular scientific approach in which methodology combines with ethics.

The traditional debate between natural sciences (and their manner of objectifying the event studied) and human and social sciences, in which the field of public health is situated has characterized the interdisciplinary perspective of topics that are as much medical-health as social. In this light, the concept of “medical-social study subjects” is highlighted for postulating the integration of medical and health disciplines, through a historical rereading of the reference that has already served for public health. With this designation, violence can certainly be recognized, as can other topics (exercising of sexuality or drug abuse, for example), in a way that is more connected to development of health than as a response to disease.

The term medical-social, coined from social medi-

cine, represented the need to create a field that would be concerned with the social aspects of the health-disease process and health services. It had the aim of questioning the reduction of social matters through the natural science approach, which reproduces the medical interpretation of illness and health interventions, thereby subjecting scientific knowledge to the supremacy of biology and all health practices to the supremacy of the clinical approach, with all the implications that this carries in terms of the health care and health work model.<sup>9,34</sup>

The way violence is studied now needs to be updated because of the ethical requirements of the methodologies, the pluralism of this study subject and the relational aspects of human interactivity that are inherent to it.

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