"VIOLENCE AS A MEDICAL AND LEGAL PROBLEM"

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INTRODUCTION

We can understand violence as the use of physical force or psychic coercion exerted over a person or group of persons, against the self, against a person or against the group of persons, other live beings, things, or objects.

The emerging result is the destruction or damage, to things or objects, the injury or death of people or other live beings, as a consequence of the violation of their rights.

As a rule, violence obeys the purpose of maintaining, changing, or destroying a given order of things, situations or values.

No doubt, we believe that violence is propitiated or facilitated where there are inequalities in rights and opportunities. This behavior must be studied within its own context, because its intensity, propagation and form of expression change according to time periods, circumstances, and social structure. It stands out as a form of human behavior. Its physical form is the most evident expression, and may lead to injuries, handicap and even death.

In general, violence is detrimental to quality of life, but it is important to emphasize that, in the concept of violence, we must include not only the ascertained act of violence, which often ends tragically, but also the social conditions and circumstances of both the victims and the perpetrators, which made it possible. The study of the subject forces us to consider the causes, the agents that unleash it, its forms of expression, and its consequences.

From the above, we may infer that in a classification outline, we could make a distinction between the various categories of violence, according to form, expression, severity, groups involved, weapons used and predominant consequences.

- Form: political, racial, generational (juvenile), sexual, domestic and sports violence.
- Expression: suicide, homicide, accident, abduction, torture, “disappearing.”
- Severity: mortal, with effects, mild.
- Groups involved: youths, children, women, workers, minorities, ethnic groups.
- Weapons used: firearms, cutting and thrusting weapons, chemical, biological, electrical, or nuclear weapons.

Violence affects all of the fields in individual and social life and is associated with the various fields of knowledge and disciplines.

The medical field the one that is most closely related to this problem; however, we believe that, despite the seriousness of the subject, response from the medical point of view has been mostly limited to recording violent acts, arriving at health care centers, victim care in emergency situations, medical-legal qualification of violent acts in injured persons, autopsies of fatality victims, psychiatric rehabilitation, and care.

Although this answer is of tremendous value, I believe that it does not address the problem in its whole extent.

Today, it is increasingly necessary to take up, with urgency, creativity, and adequate resources, the responsibilities that may allow us to diminish the rate of violence, with a primary prevention approach.

The cases of death and injuries as consequences of violence are more and more frequent. Mortality by acts of violence tops the list of causes of death and is especially significant as regards potential years of life lost.

When violence does not result in death, it causes psychological disorders and physical damage, which limit the functionality of the person or group, with individual and social consequences. In addition to the significant demand caused in the medical area, violence generates high costs in care with the subsequent use of resources, often making it necessary to allot additional resources, or even to redirect resources that could have been assigned to prevention.

The fact that violence increases and expands has consequences for the entire population; however, those most affected are people living in socially disadvantaged or poverty-stricken environments, either as victims or perpetrators. It should also be noted that young adult males and children are the ones who are most frequently affected. The former are the main victims and/or agents of homicidal violence, while the latter are victims of abandonment, living on the streets to work or beg, without receiving proper care or protection; they are often victims of physical and/or sexual abuse, and ultimately they are the most defenseless in such circumstances.

Violence against women is a significant problem, in the form of domestic violence. It affects the physical and emotional integrity of women, diminishing their rights, and points to their asymmetrical relation to men.

Seniors or the elderly, as well as persons with disabilities, are a very fragile group when it comes to abandonment. We should note that they are physically, psychologically and economically abused, and their rights are violated.

Although the health sector has traditionally intervened in the medical-legal aspects of violence, as I mentioned above, its role has been unimportant in terms of care, prevention, and dissemination of

cultural guidelines aimed at inculcating respect for life, and for the physical and psychosocial integrity of the individual.

Etymology of violence

Violence (from Latin *vis*: “strength”), carries the implicit idea of aggression on the part of the person who uses it.

To explain its etiology only according to personal biological or psychological characteristics would mean leaving out significant effects determined by the relationship and interaction processes between people, and between people and their social environment.

Thus, the reason for this violence should be sought at the crossroads between negative factors coming either from individuals or society.

Violence is fed by many sources; it is multicausal. Marcuse points out that dehumanization, which translates into the personal need to consume superfluous goods, through increasingly alienating forms of earning a living, generates frustration, which builds up constant aggressiveness.

Agglomeration, overcrowding, malnutrition, unemployment, and family breakdown imposed by inequality and poverty are to a great extent the promoters of the development of violent behavior as the means to resolve conflict. To maintain these conditions would involve using violence.

The loss of ethical and cultural references may generate or reinforce cultures of violence, which make it legitimate to exert force to solve frustrations, disagreements or conflicts.

The maintenance of unequal conditions, and the subsequent weakening of the apparatus of justice and legal control, as well as the persistence of social conditioning factors, also generate cultures of violence.

Violence is expressed both in private and public life: for example, promoting the use of force to allegedly control violence may threaten the construction and consolidation of democratic systems.

One particular characteristic of violence is its ability to multiply itself, generating more violence and expanding its dynamic forces and consequences.

From the medical-legal point of view, this is a complex syndrome that integrates various forms of aggression and affects diverse social groups.

Permissiveness and dissemination of the ownership of firearms, and the abundant use and abuse of alcohol and other substances, and even the media's indiscriminate dissemination of acts of violence, are some of the factors that contribute to creating, maintaining and/or reinforcing violent behavior.

The dissemination of these violent acts in the media facilitates the establishment of a violent culture or stereotype where the bravest, the best, and the strongest are often

associated with the most violent, instead of being associated with the most peaceful, the most calm, and most discerning, with the most aplomb and sense of justice.

The elements I have pointed out are merely a sample of the multiple factors often associated with violence, but they are enough to show a pluricausal etiology.

Although aggressiveness has been considered to be an instinct that is genetically transmitted and appears in all individuals of the species, independent of their upbringing, a distinction has been made between this instinctive aggressiveness, which is necessary to face the challenges of life, and the aggressive or violent (pathological) act, which often ends up with the destruction of one by the other.

Aggressiveness may be human, but aggression and violence are culturally learned and socially determined.

It does not end with the suspension of its external manifestations. The consequences and effects continue and become part of a new process that branches out and does not stop, resulting in victims.

Morbidity by violence

Violence and its consequences may be considered a disease, since it negatively alters the corporal integrity or the organic and/or emotional functioning of the victim.

The use of one's own body, known as humanity's natural weapon, the excess of strength through another kind of weapon or instrument, and even chemical means, mutilates and imbalances individual functioning, causes wounds and leaves effects which limit or impede personal functioning and produce certain degrees of inability, pain and invalidity.

Child abuse, elder abuse, spousal abuse, sexual violence, and torture are some of the typical expressions of concrete physical violence, but they may also cause very significant psycho-emotional disorders, either individual or collective. The psycho-affective breakdown of a girl who has been raped is an example of this, since it brings about grave individual effects within the family environment, the neighborhood, and the school. Another example would be the severe disorder of a person who has undergone torture, whose consequences are not only physical but fundamentally characterized by pain that may be lesser than the disorders of his/her psycho-emotional, affective, and intellectual structure.

It seems evident that it is necessary to create indicators that achieve or facilitate an adequate recording of morbidity by violence, which, in my opinion, seems today to be unspecific and dispersed as to medical diagnoses which point out, for example, the affected organ or the disorder in the function without clearly recognizing its violent origin.

It is difficult to quantify the magnitude and complexity of violence, and available information is limited to death statistics. Information on violence that does not kill but does cause physical and mental damage is

still scarce. It is for this reason that, concerning its magnitude, a distinction should be made between extrapolated estimations based on precise studies. Sometimes it is only possible to consider impressions without sound scientific foundation.

Mortality by violence

Mortality by violence is construed as all events that appear in the international classification of diseases in the chapter on external causes, and thus I include homicide, suicide, accidents and injuries leading to death, whether or not they were intentional or accidental, as well as injuries caused in armed conflicts.

I truly believe – and this should be emphasized – that every accident is an act of violence, although there may be some difficulty (more legal than medical) in establishing the exact borderline between an accident *per se,* with no liability, and an accident with liability (with intent). This difficulty, whose resolution does not lie in the medical field, complicates the analysis of the problem when processing and interpreting the information available. There is no doubt that many of the published work on violence only include intentional acts of violence, and not accidents. Accidents are the leading cause of death among young people between the ages of 1 and 35. In people aged 35 to 39, rates of death by accident are lower than rates of death by cancer; in people over 39, rates of death by accident are in third place, after cardiovascular disease and cancer. However, in terms of potential years of life lost, death by accident is always in third place, and we should consider this the most relevant indicator.

Homicides are obviously the most compelling, explicit and quantifiable product of violence. Mortality by homicide is a significant indicator of the prevalence of violence, and increases may be connected to the increase of economic and social inequalities, easy access to firearms, and the growth of trafficking and consumption of addictive substances. Homicides occur more frequently among males between 15 to 30 years of age.

Violence against the self – suicide – is demanding more and more attention, since it is a form of violence with a very high rate in our country, with a slight general increase (12.7 in 1996 to 14.1 in 1997). It is affecting young people more and more. It seems evident that these acts are not only contingent on the individual personality features of the person committing suicide, but also on processes resulting from external social agents. Males are most affected by this type of violence, in terms of successful suicide attempts; however, some studies do indicate a slight decrease in this difference and underscore the predominance of females in suicide attempts. In any event, the differences between female and male suicide, successful suicide attempts, are smaller than those differences between homicide and other forms of violence. It is a sufficient point of concern that suicide is present as cause of death in the 5-14 age group, a new phenomenon that has never before been seen in our country. High suicide rates in seniors also bring up social questions

that are complementary to psycho-physical aspects.

According to 1996 official data from the Statistical Department of the Ministry of Public Health (MSP), among the principal causes of death, classified by age, violence is located within the top 5 positions, as shown below.

Principal causes of death:

- 1 to 4 years of age

All causes	**Rate per 100,000 people**
1. Accidents and adverse effects	18.7
2. Congenital abnormalities	12.2
3. Respiratory diseases and pneumonia	9.8
4. Infectious and parasitic diseases	7.5
5. Malignant tumors	4.2

- 5 to 9 years of age

All causes	**Rate per 100,000 people**
1. Accidents and adverse effects	8.7
2. Malignant tumors	3.4
3. Infectious and parasitic diseases	2.3
4. Circulatory system diseases	1.9
5. Congenital abnormalities	1.9

- 10 to 14 years of age

All causes	**Rate per 100,000 people**
1. Accidents and adverse effects	14.2
2. Malignant tumors	3.8
3. Congenital abnormalities	3.1
4. Suicide and self-inflicted injuries	1.9
5. Circulatory system diseases	1.5

- 15 to 19 years of age

All causes	**Rate per 100,000 people**
1. Accidents and adverse effects	41.3
2. Suicide and self-inflicted injuries	9.9
3. Homicide and injuries intentionally inflicted by others	6.5
4. Malignant tumors	4.6
5. Circulatory system diseases	

- 20 to 24 years of age

All causes	**Rate per 100.000 people**
1. Accidents and adverse effects	53.2
2. Suicide and self-inflicted injuries	12.7
3. Homicide and injuries intentionally inflicted by others	9.4
4. Malignant tumors	8.6
5. AIDS	3.7
6. Circulatory system diseases	3.3

- 25 to 29 years of age

All causes	Rate per 100,000 people
1. Accidents and adverse effects	38.2
2. Malignant tumors	15.2
3. Suicide and self-inflicted injuries	13.3
4. AIDS	11.0
5. Circulatory System diseases	6.9
6. Homicide and injuries intentionally inflicted by others	5.1

- 30 to 34 years of age

All causes	Rate per 100,000 people
1. Accidents and adverse effects	33.6
2. Suicide and self-inflicted injuries	21.6
3. Homicide and injuries intentionally inflicted by others	14.3
4. Malignant tumors	11.5
5. AIDS	10.6
6. Circulatory system diseases	6.4

- 35 to 39 years of age

All causes	Rate per 100,000 people
1. Malignant tumors	37.0
2. Accidents and adverse effects	35.1
3. Circulatory System diseases	28.4
4. Suicide and self-inflicted injuries	12.3
5. AIDS	8.5
6. Homicide and injuries intentionally inflicted by others	5.7

- 40 to 44 years of age

All causes	Rate per 100,000 people
1. Malignant tumors	70.4
2. Circulatory System diseases	54.3
3. Accidents and adverse effects	43.3
4. Suicide and self-inflicted injuries	20.4
5. AIDS	8.3

- 45 to 49 years of age

All causes	Rate per 100,000 people
1. Malignant tumors	131.4
2. Circulatory System diseases	96.5
3. Accidents and adverse effects	49.4
4. Infectious and parasitic diseases	11.0
5. Mallitus Diabetes	8.1

- 50 to 54 years of age

All causes	Rate per 100,000 people
1. Malignant tumors	244.2
2. Circulatory System diseases	192.4
3. Accidents and adverse effects	55.1
4. Suicide and	23.4

self-inflicted injuries	
5.Cirrhosis and other liver diseases	20.2
6. Acute respiratory diseases and pneumonia	12.0
7. Chronic obstructive lung disease	11.4

- 55 t0 59 years of age

All causes	**Rate per 100,000 people**
1. Malignant tumors	364.3
2. Circulatory System diseases	278.3
3. Accidents and adverse effects	61.6
4. Cirrhosis and other liver diseases	32.5
5. Suicide and self-inflicted injuries	23.0
6. Mellitus Diabetes	25.1
7.Chronic obstructive lung disease	25.1

- 60 to 64 years of age

All causes	**Rate per 100,000 people**
1. Malignant tumors	558.7
2. Circulatory System diseases	517.7
3. Accidents and adverse effects	63.8
4. Mellitus Diabetes	39.6
5. Chronic obstructive lung disease	39.6
6. Cirrhosis and other liver diseases	35.4

- 65 to 69 years of age

All causes	**Rate per 100,000 people**
1. Circulatory System diseases	822.0
2. Malignant tumors	461.5
3. Accidents and adverse effects	91.4
4. Chronic obstructive lung disease	80.4
5. Mellitus Diabetes	59.7

- 70 to 74 years of age

All causes	**Rate per 100.000 people**
1. Circulatory System diseases	1344.6
2. Malignant tumors	656.2
3. Chronic obstructive lung disease	161.7
4. Mellitus Diabetes	103.1
5. Accidents and adverse effects	99.3

- 75 to 79 years of age

All causes	**Rate per 100,000 people**
1. Circulatory System diseases	2259.6
2. Malignant tumors	792.6
3. Chronic obstructive lung disease	213.7
4. Mellitus Diabetes	152.7
5. Mental disorders	138.1
6. Acute respiratory diseases and pneumonia	130.1
5. Accidents and adverse effects	99.3

- 80 to 84 years of age

All causes	Rate per 100,000 people
1. Circulatory System diseases	4000.2
2. Malignant tumors	928.8
3. Chronic obstructive lung disease	406.6
4. Mental disorders	412.6
5. Acute respiratory diseases and pneumonia	279.0
6. Mellitus Diabetes	193.3
7. Accidents and adverse effects	164.4

- 85 years of age and more

All causes	Rate per 100,000 people
1. Circulatory System diseases	7.955.6
2. Malignant tumors	980.3
3. Mental disorders	793.2
4. Acute respiratory diseases and pneumonia	608.7
5. Accidents and adverse effects	345.2
6. Mellitus Diabetes	263.5

General Principles for Prevention

All the above-mentioned aspects provide us with a minimal idea of the general scope of the problem of violence, its severity, and the need to take actions to revert it.

Violence as a subject should be integrated into education. It should be emphasized that in our specialty – legal medicine – we have incorporated it in our curricula, although we consider that it should be present in the curricula throughout all of medical training.

The complexity of violence should not be a pretext to remain passive in the face of this problem. It should not be construed as one more fatality that we have to live with, but rather as a social reality, almost omnipresent, but in any event transformable or at least controllable.

Although it crosses every sector individually, the health sector must participate in the work to eradicate violence, through: reporting and inquires concerning child abuse and other forms of domestic violence; research work with the participation of an interdisciplinary team; and preparation of plans and education program proposals.

Health is the result of a conjunction of factors such as protection and promotion, prevention of disease, care, and finally rehabilitation. Health development should be approached through promotion and prevention plans, healthy lifestyles, supply of adequate treatment services to restore health, as well as rehabilitation. The development of any health plan depends on the definition of its objectives and the successful attainment of its goals with a view to the reduction of disease, injuries and death, and the improvement of living conditions.

Health promotion involves social action that will make it possible to provide the environment with the capability to care for and increase health. It is a process whose orientation is targeted to influencing those factors that go against general well-being. In sum, as stated by the WHO, health is not only the absence of disease, but the presence of physical, psychical and social well-being.

We may argue that such a health concept is lost when we are in a context of violence. Health promotion also implies education oriented to "non-violence."

Prevention establishes concrete strategies to reduce identified risks, as well as to strengthen conditions that diminish the probability of their occurrence. Then, prevention refers to avoiding the development of factors that trigger violence as well as preventing the occurrence of violence itself.

In the medical field, we have almost always dealt with victim care and rehabilitation. We believe that this is the time to place more emphasis on promotion and prevention, as the only way to reduce the impact of violence on society. No matter how well implemented victim care and rehabilitation may be, there will still be a growing number of victims if we do not address our efforts to promotion and prevention.

The multifaceted and multicausal nature of violence, demands a multi-sectoral and interdisciplinary approach to integrate knowledge and institutions associated with the promotion of "non-violence." This joint venture may bring about social changes as well as changes in attitudes. I believe that the following are general principles for a plan to address violence:

- Integration – because of its multicausal origin, the participation of the various sectors involved is necessary.

- Equality – from the perspective of lessening the vulnerability of certain persons or sectors, the equality of rights and opportunities is considered very important.

- Commitment – for the plan to be successful, especially because of the importance of the subject, all sectors in society should be incorporated.

- Participation – the public should intervene in the analysis of the situation, as well as proposals and execution of actions.

- Education, strengthening of values, non-violent attitudes about conflict resolution; reporting on risk factors, aggressive behavior indicators, and manifestation of violence.

- Resilience – to redirect our attention towards some individuals' attitude of reacting positively despite difficulties.

Why redirect our attention to resilience?

Resilience is not a magic solution, but rather a source of inspiration and new knowledge which should serve as a stimulus for reflection.

It may be defined as certain individuals' capability to do well despite adverse circumstances. It involves the ability to resist difficulty and the power to construct positively.

In facing the problem of violence, we often look at the victims and the violent acts. Why not stop and learn from those individuals who deal appropriately with adverse circumstances? Why are some people healthy despite their unfavorable circumstances? Why do some individuals in at-risk groups not respond with violence or develop behavioral problems in spite of the fact that they are exposed? What can we learn from these resilient people to prevent and intervene for those who are less fortunate?

This capability called resilience takes place in a healthy interaction between the individual and the surrounding circumstances. This is not an absolute or temporarily stable concept, but it is imperative to promote it within its specific cultural context and extend it to the largest number of people possible.

The fact that there are differences in individual and group behavior, and different reactions by an individual or group to adverse circumstances, far from justifying situations of violence, should be a stimulus to search for actual solutions.

We should ask ourselves: what have been the determining differences between the behavior of some as compared to others, that allowed some individuals to cope with the adverse situation in a balanced and constructive way, while others had to resort to violence and destruction?

From the point of view of action, resilience includes two elements:

- An aptitude to resist destruction – that is, to preserve integrity under difficult circumstances; and
- The attitude of reacting positively despite difficulties.

The concept of resilience acknowledges of the existence of the problem, but presents a realistic optimism. It also includes creative interaction between personal resources and social resources. It involves the acceptance of unfavorable circumstances and a positive attitude as the response.

Resilience does not replace social policy. They must both be perfected independently, as much as possible, as two means to the same end; the development or perfection of one over the other should also act as a stimulus.

From the standpoint of resilience, we find a concept in which we cannot hold either society or the individual entirely responsible. This is a shared responsibility, where no one should carry the whole burden; rather, all involved should carry part of the weight.

This concept opposes the wish for perfection, which in the best of cases leads to disillusionment, and in the worst of cases to escapism and drugs. Resilience opens doors to possible improvements, since it accepts the actual limitations of the environment. Likewise, it suggests a redefinition of health as *"the ability to solve problems or find constructive ways to live with unresolved problems,"* an ability which grows in the interaction between the individual and the surrounding circumstances.

There is much work ahead, essentially long-term work, particularly oriented to prevention, without neglecting specialized and immediate emergency interventions.

BIBLIOGRAPHY

- Depto. de Estadística. Dir. General de la Salud. MSP. Tasas de Mortalidad, 1997.
- BICE, La infancia en el mundo. Vol. 5, N° 3, 1994.
- VANISTENDAEL, Stefan - "Como crecer superando los percances. Resiliencia: capitalizar las fuerzas del individuo". BICE, Ginebra, 1996.
- OPS, Boletín Epidemiológico. "La violencia como problema de salud pública". Vol. 11, N° 2, 1990.
- OPS, Las Condiciones de Salud en Las Américas. Publicación Científica. Vol. 1, N° 549, 1994.

Commentary*:*
Dr. Luis Eduardo Morás

For several reasons, the work presented by Dr. Guido Berro is a very interesting outline of the problem of aggressiveness and violence. First, it is a comprehensive approach to the phenomenon in its multiple facets, since it does not restrict the subject exclusively to traditional medical-legal practices.

The theoretical effort to arrive at a definition of the terms is very valuable because, in view of its complexity, the problem contains an evident tension: simplistic definitions that do not describe this complexity, or definitions that, because of their level of abstraction, are inoperative.

In this sense, the work is outstanding, because it provides input for theoretical reflection, because while it contributes relevant and clarifying empirical data, it also provides guidelines for delineating preventive actions, invoking the essential need for interdisciplinary collaboration as well.

The presentation of violence as a health problem, both individual and collective, as a result of social inequality and multiple asymmetries (tension between possession/non possession of material goods, male/female, women/children, etc.) allows us to see that these asymmetries are also reproduced where there is unequal access to the apparatus of justice administration and the distribution of citizens security. It is in this direction that I believe Dr. Guido Berro is suggests a line of analysis, which is scarcely approached in academic spheres: the deterioration of coexistence patterns is accelerated when a demand such as security, which is homogeneously spread throughout society, may be satisfied only by those sectors with sufficient economic capacity to have access to it. In other words, egalitarian access to democratic social control and justice

administration mechanisms also becomes a priority for the design and implementation of a social policy, relativizing the historical tension concerning "criminal" policy.

Another outstanding aspect is that the work includes a phenomenon hardly taken into account in approaching the subject: self-aggression shown by suicide rates.

Perhaps one of the disconcerting and less quantifiable characteristic (due to lack and/or insufficiency of indicators) results from the multiplication of daily relationship violence. Until some time ago, we could build theory taking into account only the characteristics of instrumental violence, violence as a means to attain a goal; to a large extent, these were expressed in crime statistics.

The presumable extension of new forms of behavior singled out by daily violence, as suggested in this work, is expressed on various levels: from a diffuse loss of generic quality of life (whose probable indirect expression may be accidents in the top position in deaths of the 1-34 age group), to the most evident direct death indicator: in the 15-24 age group, suicide and homicide hold relevant 2nd and 3rd positions as causes.

In terms of designing specific policies to address the subject, and sharing all of the recommendations made by Dr. Berro, I wish to suggest emphasizing two major areas. These suggestions are based on the Freudian perspective of the manifestation of violence by deficiencies in two mechanisms: coercion and identification.

Hence, the first proposal that I am making is to "disseminate" democratic mechanisms of social control and justice administration. The reaffirmation of the legitimacy of authority, reducing the multiple uncertainties caused by unequal access to democratic social control and legal institutionalization, although it is a problem affecting all citizens alike, adolescents and young people in particular see the broadening of their "uncertainty zones" entailed by contact with the arbitrary exercise of power. The "discretionality" of the authority often discredits the institutions, resulting in a loss of trust, a broader sense of frustration, and therefore an element that facilitates the loss of limits and, ultimately, the violent resolution of conflict.

Second, I believe it is essential to intensify actions to strengthen community ties with dialogue in the community, at the family, intra-generational and inter-generational levels.

The absence of "identification" mechanisms for young people is particularly noteworthy at this turn of century. It seems reasonable to put our efforts into community spaces, where the possibility for dialogue may translate into a greater level of trust among individuals (translated into a lesser disposition to frustration and subsequent aggression) as well as in the community itself (translated into a disposition to solve conflicts through dialogue, thus avoiding violent confrontation).

The equilibrium between both suggestions (legitimacy of coercion

and identification mechanisms) aim to raise the "costs" of violent acts through increasing the benefits offered by dialogue.