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PREGNANT AND VICTIM OF VIOLENCE

Biological Sciences

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ABSTRACT

Objective: to analyze the emotional violence perpetrated against pregnant women and their associations with social, psychological, behavioral and obstetric characteristics in puerperal women. Method: this is a cross-sectional study. the sample consisted of 260 puerperal attended at a public hospital. the verification of anxious symptoms, the scale was used ***Anxieand Depression Scale*** (HAD A) was used to check for anxious symptoms and Edinburgh Postnatal Depression Scale (EPDS) was used to assess depressive symptoms. A descriptive statistical analysis was performed with the Epi Info programs version 7.1.5. (r) Results: they presented probable symptoms of depressives 26.92% and anxious 38.08% of the interviewees respectively. (OR=0.478 IC95%=0.250 0.915). "previous gestation" (OR=0.486 IC95%=0.262 0.900). "depressive symptoms" (OR=0.109 IC95%=0.027 0.435) and "pregnancy risk" (OR= 0.47 IC95%=0.250 0.885). Conclusions: The prevalence of emotional violence is 35.11%. The main factor associated with this type of abuse is postpartum depression.

KEYWORDS:

Domestic violence, Pregnancy, Postpartum depression, Prevalence.

INTRODUCTION

Psychological violence is defined as any act or omission aimed at and involves offenses that impair an indidua's identity, development or confidence and involve gross offense, humiliation, blackmail, devaluation, exploitation, manipulation, neglect, theats, deprivation of liberty, lack of affection[1].

In the world, every three women suffer some kind of physical or sexual violence, most practiced by their intimate partner[2].

The data indicate that about 81% of de rural American female population suffered some type of violence during pregnancy[3]. In this sense, a survey conducted in Brazil with pregnant women using Unified Health System (SUS) in São Paulo (Brazil) detected that psychological violence was found in 19.1% of women and physical and sexual violence together occurred in 6.5%of women surveyed4. Nevertheless, a current research conducted in Recife (Brazil) found a prevalence of 52.7% for emotional violence. 46.1% for physical and 13.6% sexual[5].

Among the main risk factors for gender violence are abusive use of alcohol, easy access to weapons, unemployment, low salary levels, social and gender inequalities[6].

In relation to the obstetrical characteristics that have suffered violence. They are subject to worse reproductive health, increased infant mortality, abortion and future problems with the newborn7,8. low birth weight and preclinical problems[9].

In spite of gestational depression, it is also know that it is related to emotional violence[10] and physical[11] Other scholars affirm that in situations of greater severity these aggressions may be related to female mortally[12] In this case it should be denounced at the beginning, as soon as perpetrated the first aggression or threat[13]

The problem usually goes unnoticed by health services, usually by unprepared professionals or when the victim does not denounce the aggressor. It is know that underreporting is higher (80%) when the abuser is a former or current partner14. Finally, it is should be emphasized that prenatal care is the ideal time for screening of mental disorders and abuse[15].

In view of the thematic relevance exhibited, the objective was to analyze the prevalence of emotional violence and its association with demographic factors, social, psychological and obstetric.

METHODS

This is a cross-sectional descriptive study. The research involved puerperal in the postpartum (between the second and third day postpartum) hospitalized in a Hospital and Maternidade Municipal de Barra do Garças –MT, Brazil.

The data were collected in the period from August 2015 to November 2016. Based on probalistic selection where alternate days were chosen for collection. The sample was made up of parturient aged 18 years or older. For the calculation of sample size, the estimated population of births was 68916 , a proportion of 20%17, a type 1 error of 5% and a 95% confidence interval. The minimum universe was 182 women, but the final number of 260 postpartum women was defined, due to possible absence of responses[18].

For the data collection a self-applied instrument was used, with the inclusion of complementary information in order to facilitate the application, filling and typing.

The instrument with data on the social and economic profile presented questions containing age, schooling, and joint situation and economic situation. It was estimated as low schooling that minor or to eight years of study. In relation to the economic situation, the families classified, according to the socioeconomic stratum, in the "E" to "C" classes with income up to three monthly minimum wages were considered low income[19]. Through questions proposed by the authors, several stressors were investigated as episodes of physical and sexual and emotional/psychological violence, obstetric complications, pregnancy and the previous psychiatric history of the pregnant woman and her family.

The pilot was previously applied to ten puerperal in order to detect possible errors in the investigation, as well as ambiguities in the questions elaborated by the authors of this study and difficulties of understanding. Once the errors were verified, the correct corrections were made.

To detect axioms symptoms the Hospital Anxiety and Depression Scale (HAD-A) of Zigmond and Snaith (1983)20 validated in Brazil for ambulatory patients[21] was used to detect anxious symptoms.[22]

This scale consists of 14 items that mention the emotional state and do not approach somatic symptoms, thus indicating a greater chance of diagnosis of depression. Of these, seven were related to anxiety (HAD-A) and other half to depression (HAD-D) with a seven and eight cut for anxiety and depression, respectively.

Each question has four alternatives with a score ranging from zero to three, and the sum of the total score can range from zero to 21 points for each of the disorders. The higher the score the higher the Minor Disorders Mental (MDM).

According to the results obtained, each subscale was written in three levels: unlikely case (zero to seven points), possible/doubtful case (eight to ten points) and probable case (eleven to twenty one points)20. To track down depressive symptoms the Edinburgh Postnatal Depression Scale (EPDS), originally from Cox and Holden (1987)22, was based on the Portuguese version of Augusto et al.(1996)23This scale deals with depressed mood, behavioral changes, sleep disturbances, lack of pleasure, thoughts of death, suicide, and feelings of guilt. The consists of 10 questions, scored from zero to three, with a sum equal to 12 or even higher, according to the severity and frequency of the symptoms, evaluating in the last seven days in the pre24 and postpartum periods, the emotional aspects of the woman.

Parturient who did not have the physical or psychological conditions to respond to the questionnaire were excluded, those under 19 years old and those who agreed to sign.

Data were analyzed using the EPI-INFO programs version 7.1.5. For the descriptive analysis of the quantitative variables we used measures of central tendency (standard deviation) and simple and absolute frequency for ordinal variables, In order to verify the association between variables and emotional violence, we performed a bivariate analysis using the x2 test, Fisher's Exact and Prevalence Ratio (PR). We opted for logistic regression analysis. The hi-input of the hierarchical type and the explanatory variables were based on the p-value borderline (<0.05) and clinical importance25 For all tests, a p-value of less than or equal to 5% (<0.05) was considered of statistical significance in 95% confidence interval. The variable "emotional violence" was defined as dependent.

The Research Ethics Committee, CEP/UFMT/2015 process N º 975.413, approved the research. The determinations of resolution Nº466/12 were respected.

RESULTS

The age of the puerperal ranged from 18 to 42 years, with a mean of 25 years (5.42). The majority were amassed (43.85%) living in their own home (63.33%), had more than eight years of schooling (78.82%) and received more than a minimum wage (75.90%). Bull average per capita income was 483 (411). Prevalence emotional violence was (35.11%), followed by physical (7.34%) and sexual (2.73%).

In the bivariate analysis, we detected an association between emotional violence and socioeconomic and cultural variables (PR=0.645;p=0.034) and "housing" (PR= 1.714; p=0.020). The variable with an inverse association and a higher index of association was found among women who were almost twice as likely not to suffer emotional violence.

Table 1- Socieconomic and cultural characteristics and their associations with emotional violenve puerperas attended at a public maternity in the middle Araguaia, Brazil, 2017 (n=260)

Characteristics	Emotional Violence				Statistic	
	Yes		No			
	n	%	n	%	RP(CI 95%)	*P*
Age range*						
18 to 24 years	40	31.75	86	68.25	1.066 (0.738-1.539)	MH = 0,1.17
25 to 42 years	39	29,77	92	70.23		
Marital status*						
single/separated	22	43.14	29	56.86	0.645 (0.438-0,947)	MH = 0.034
Married/ amassed	57	27.80	148	72.20		
Year of schooling*						
≤ 8 years of schooling	20	37.04	34	62.96	1,283 (0,851-1.934)	MH = 0.247
> 8 years of schooling	58	28.86	143	71.14		
Family income*						
Above a minimum wage **	53	28.04	136	71.96	0.765 (0.511-1.144)	MH = 0.205
Up to minimum wage**	22	36.,67	38	63.33		
Housing*						
House loft	33	36.26	58	63.74	1.714 (1,081-2.716)	MH = 0,020.
Proprty	22	21.15	82	78.85		
Do you have religion*						
No	8	27.59	21	72.41	0.994 (0.526-1.879)	MH = 0.985
Yes	48	27.75	125	72.25		

RP = Prevalence ratio; CI = Confidence Interval; MH =Mental Haenszel; *"some subject did not respond"; **Minimum Wage" - R$880,00 – Brazil in 2016 = US$ 284.00.

Wirth regard to the anxious symptoms, the prevalence of 38.08% for the probable anxiety was observed, whereas the prevalence of depressive symptomatology was of 26.92%.

Table 2 – Prevalence of anxious symptoms detected in the HAD-A Prevalence Scale (EPDS) applied in pueperal assisted at a public maternity in the Middie Araguaia Brazil, 2017 (n=260).

HAD-A Subscale (7 items)*	n (%)	range Obtido	median	Averange (SD)***
Unilikely (0-7 points)	82 (31.54)	0-19	5	6,100 (4,179)
Possible/Doubtful 8-11 points)	79 (30,.8)			
Probable (12-21 points)	99 (38.08)			
EPDS Scale (10 items) **	n (%)	range Obtido	median	Averange (SD)***
Non-suggestive of depressive symptomss 0-9 points	190 (73.08)	0-26	6	6.880 (5.266)
Suggestive of depressive symptoms above 10 point	70 (26.92)			

*Score> 12 on the Hospital Anxiety and Depression Scale (HAD); ** Score 10 in the depression subscale of the Depressiom Scale Edimburg Postnatal (EPDS); ***Standart Deviation.

According to table 3, bivariate analysis detect an inverse associations between emotional violence and "smoke" variables (PR=0.388:p=0.001); "uses illicit drug" (PR=0.292;p=0.007); "anxiety" (RP=0.528; p=0.003);"depressives symptoms" (PR=0.422; p=0.001)and "suffered physical violence" (PR= 0.289; p= 0.002). However, the variables with the highest indicative of inverse association with emotional violence were "using illicit drug" and "suffered physical violence", where both demonstrated almost three times and were more likely to be protected (1/PR) against emotional violence.

Table 3 – Distribuition of the behavioral, phychological,stressors nad violence variables and their associations with emotional violence in puerperas attended at public maternity in the Middle Aragauia, Brazil, 2017 (n=260).

Characteristcs	Emotional Violence				Estattistics	
	Yes		No			
	n	%	n	%	PR (IC 95%)	*p*
Behavioral andsocial variables						
Smokers *						

Yes	12	70.59	5	29.41	0.388 (0.563-0.562)	MH=0.001
No	65	27.43	172	72.57		
Uses illicit drugs*						
Yes	4	100	0	0.00	0.292 (0.241-0.354)	TEF=0.007
No	73	29.20	177	70.80		
Phyquiatric history						
Anxiety						
Yes	43	49.43	44	50.57	0.528 (0,371-0.751)	MH=0.003
No	36	26.09	102	73.91		
Depressive symptoms						
Yes	37	60.66	24	39.34	0.422 (0,304-0.587)	MH=0,001
No	42	25,61	122	74,39		
Variiables violence*						
Sufferred physical violence						
Yes	7	100.00	0	0.00	0.289 (0.238-0.351)	FET=0,002
No	72	28,92	177	71,08		
Suffred sexual abusel						
No	74	34.26	142	65.74	0.799 (0,333-1.918)	FET=0,457
Yes	3	42.86	4	57,14		

PR – Prevalence Ratio, MH = Mental- Haenszel; FET = Fisher's Exact Test ; Some didi not respond.

In table 4, there was an association between emotional violence and variables "previous gestation" (PR=0.590; p=0.012) and " risk pregnancy" (PR=0.618; p= 0.014). Postpartum women with more than one gestation presented an indicative of an inverse association with emotional violence of almost two times more chances.

Table 4 – Frequency of obstetrical and gestational characteristics in puerperas teatred at public materny in Midlle Araguaia, Brasil, 2017 (n = 260).

Characteristics	Emotional Violence				Statístics	
	Yes		No			
	n	%	n	%	PR(CI 95%)	*P*
Previous Gestation*						
Yes	57	36.31	100	63.69	0.590 (0.383-0.909)	MH=0.012
No	21	21.43	77	78.57		
Planned pregnancy						
Yes	17	22.67	58	77.33	1.415 (0.880-2.276)	MH=0.132
No	51	32,08	108	67,92		
Pregnancy risk*						
Yes	28	43.08	37	56.92	0.618 (0,428-0.893)	MH=0.014
No	49	26.63	135	73.37		
Complication during pregnancy						
Yes	28	37.84	46	62.16	0.745 (0.513-1.082)	MH=0.131
No	51	28,18	130	71,82		
History of abortion *						
Provoked abortion						
Yes	2	16.67	10	83.33	1.890 (0.526-6.793)	FH=0.227
No	75	31.51	163	68.49		
Sponteneous abortion						
Yes	17	40.48	25	59.52	0.709 (0.464-1.084)	MH=0.132
No	60	28.71	149	71.29		

PR = Prevalence Ratio; CI = Confidence Interval;; MH = Mental-Haenszel; FET = Fisher's Exact Test; * Some did not respond.

After the multivariate analysis, there was the association between emotional violence and the variables "housing" (OR=0.478;p=0.026); " depressive symptoms" (OR=0.109: p=0.001); "previous gestation" (OR= 0.486; p=0.022); and "risk pregnancy" (OR=0.0471; p=0.019).

The variable with the most significant inverse association revealed that puerperal who do not have depressive symptoms are almost 10 times more protected (1/OR) against emotional violence.

Table 5 – Logistic regression analysis of events associated with emotional violence ccordin to socieconomic, cultural, behavioral, psychological, obstetric and gestational variables, 2017 (n = 260).

Characteristics	Statistical		
	OR	(95%CI)	*P*
Socieconomic and cultural variables			
Housing	0.478	(0.250-0,915)	0.026
Marital Status	1.912	(0.915-3,994)	0.085
Behavioral, psychiatric and stress variables			
Smoker	1.856	(0.287-12,019)	0.516
Depressive symptoms	0.109	(0.027-0.435)	0.001
Anxiety	1.122	(0.326-3.863)	0.855
Obstetrical and gestacional variables			
Previous gestation	0.486	(0.262-0.900)	0.022
Risk Pregnancy	0.471	(0.250-0.885)	0.019

OR=*Odss Ratio*; CI = Confidence Interval

DISCUSSION

Emotional abuse in pregnancy affects the quality of live and reproductive health, and can bring many curses to both the mother and the newborn. The present study found the prevalence of 35.11% of emotional violence .In addition, in the multivariate analysis, the variable with the highest associations was having depressive symptoms.

In relation to socioeconomic aspects, It was found that married couples were twice as protected against emotional violence. This is a research done in Scotland with pregnant women, where single women were 6.9 times more exposed to domestic violence[26]. The typical hormonal changes of pregnancy may contribute to mood swings. Thus, marriage could protect them emotionally against financial worries and loneliness. Likewise, the type of housing was another factor that was able to directly influence the health and well-being of the studied population. A study conducted in Canada with women between 18 and 45 years showed that having a fixed residence is determinant for the physical and mental health of the pregnant woman[27]. These results corroborate with the data found in our study where, protects against emotional violence, confirmed multivariate analysis. In this perspective, surplus expenditures on housing and pregnancy are likely to increase the partner's insecurity and make him more aggressive with his wife, for fear of looking after the necessary expenses for the family.
In underdeveloped countries such as Kenya and Iran, the prevalence of emotional abuse was 29% and 43%, respectively. In Brazil, this frequency ranged from 19.1% in São Paulo (Brazil), southeast region, (Maria, 2008)4, to 52% in Recife (Brazil), northeast region, (Barros, 2016)5. However, in present study, conducted in the mid-west region (Brazil) of intermediate socioeconomic levels, the prevalence of emotional violence was 35.11%. Variations can be justified by methodological, Instrumental and cultural diversity differences in the samples[28].

To evaluate the anxiety symptoms the HAD scale20 was used 20 and to estimate the depressive symptoms the EPDS, both considered of easy application, was applied. Indicated for use by postpartum health professionals' (Immediate and late), to investigate the symptoms of anxiety and depression respectively29. For EPDS scale, a cutoff point <10 points, Santos et al. (2007)30, affirm that this is the best cutoff pointe for early diagnosis of depression symptoms in the immediate postpartum period (second or third day after the childbirth).

The prevalence of MMS in this study was 26,92% for depressive symptoms and 38,08% for anxiety. Another study involving Brazilian women in the postpartum period found a prevalence of depression of 26,3%, close to this survey 31, which shows that it is reliable.

Also an inverse association between the variable emotional distress experienced during gestation and symptomatology of PPD was observed among MMR.This relationship was confirmed in the bivariate e multivariate analyzes. In Brazil, a study with a similar result

carried out in Recife (Brazil) found that the most common form of partner violence was psychological. In addition, she found that postpartum depression was associated with psychological violence, even when it occurred without physical and sexual violence. This finding has an important aspect, and in general social policies seek to prevent and treat physical violence[32]. Psychological abuse damages woman's self-esteem, promotes the onset of mental illness, depression, post-traumatic stress, suicidal tendencies, and substance psychoactive 33.

In Iran, in study of 266 pregnant women, emotional abuse was associated with precarious mental health impairment of quality of live[34]. It is important to mention that the association between emotional violence and depression was documented by several Brazilian authors[35], 10, which demonstrates the seriousness of the problem in develop countries.

Considering the negative impact of mental disorders, several studies point out that in order to avoid its future aggravation, prenatal care is essential for the early screening of anxious and depressive symptoms[5].

It is worth emphasizing that psychological abuse, although not leaving visible marks can be equally harmful to the psychological health of woman in postpartum.

In this context, health professionals become important parts in screening for prenatal and postpartum violence.

In general, psychosocial factors have a strong influence on pregnancies, with increases the chances of consuming alcohol and other drugs[36]. In addition, women exposed to intimate partner violence are more likely to experience perinatal depression and smoking [37].

It should be noted that the excessive use of smoking by pregnant women impairs their immunity, leading to the occurrence of abortions and nicotine may increase the frequency of fetal heart beats [38].

Attentions is draw to a study of 104 women who found an association between emotional distress and difficulties in quitting or reducing their use during pregnancy3. Smoking is directly associated with emotional distress and, consequently, alcohol consumption during pregnancy and drug use39. Although in our study bivariate analysis has indicated an association between emotional violence and illicit drug use and smoking, when one took in to account the analysis of the set of independent variables, this relation was not confirmed. But it is imperative to recognize that neglected violence favors the consu mption of alcohol that leads to chemical dependence. Given this, necessary to identify and follow these women with a differentiated approach [33]. Moreover, although the association is not confirmed, it is known that psychosocial factors added violence in pregnancy may predispose to the consumption of legal and illegal substances. This is justified by the fact that the woman who is emotionally assaulted feels humiliated and annoyed life and thus uses alcohol, tobacco and illicit drugs as a way of escape for marital problems.

The present investigation found that in both bivariate and multivariate analyzes, the primiparous women who did not have a risk pregnancy were twice as protected against emotional violence. On the other hand, recent research in Egypt with pregnant women who had been abused by an intimate found that 44% of them were physically assaulted and that emotional abuse occurred with 32% of the women, especially the youngest and the largest number of children8. In addition, a cross-sectional study carried out in the Brazilian Northeast with 1.026 women, observed one more aggravation, since the victims of physical violence by the intimate partner were more likely to perform an improper prenatal care with fewer consultations[40]. The occurrence of violence in pregnancy and postpartum may be related to emotionality and the specific changes of the moment. This fact can generate disagreements with the partner who does not perceive the new condition of the woman and requires the same attention received previously. In this context, when feeling deprived can avoid it, you begin to drink and have extramarital affairs that would lead to conflicts and aggression. The results of this study are in accordance with data confirmed in some studies suggesting that women who suffer violence are subject to worse reproductive health, increased infant mortality and future problems with the newborn[7,8]. This scenario highlights the importance of the attention paid by the teams to the puerperias and to the newborns who must be attentive.

It may be cited as limitations of this research the fact that it was performed in a public hospital. Thus our results can not be extrapolated to general population. The fact is that the type of cross-sectional study is timeless, that is it does not allow us to infer cause and effect. However, these episodes did not interfere with the importance of our findings.

The survey was relevant and unprecedented in the region. In addition, it had several positive characteristics such as adoption of varied and globally recognized instruments calculation.

It is concluded that prevalence of emotional violence among pregnant women is 35.11% a circumstance that probably in transition.

There is a strong association between emotional abuse and PPD.

Finally, it is important to track the possibility of association of emotional violence in pregnant women who are single, rent, smoke, are multiparous and present at-risk pregnancies.

In view of the seriousness of the situation, it necessary to screen pregnant women during the prenatal care and evaluate the possible occurrences for specialized justice. The curtailment of violence could bring a number of benefits to mothers an newborns.

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