

Marital violence and its implications to the mother–child binomial: the female speech

Violência conjugal e suas implicações para o binômio mãe–filho: o discurso feminino

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ABSTRACT

To expose the signs and symptoms that indicate implications to the mother–child binomial in women experiencing marital violence. A qualitative study where the data was organized from the Speech of the Collective Subject. Interviews were conducted with 11 women who were in legal cases with the 1st and 2nd Courts of Justice for Peace at Home of Salvador, BA, Brazil. From the female speech, two Central Synthesis Ideas emerged, referring to the psychic and physical signs related to the violence experienced, indicating implications for the mother–child binomial. The sleep disturbances, emotional tension, depressive behavior, marks of physical aggression, cephalgia were pointed as symptoms associated with marital violence that can predispose the pregnant and puerperal women to complications. Considering such signs and symptoms, it becomes necessary to prepare the professional to early identify the marital violence, overall in spaces of pre-natal and puerperal follow-ups.

Descriptors: Intimate Partner Violence; Pregnancy; Postpartum Period; Women's Health; Maternal-Child Nursing.

RESUMO

Desvelar os sinais e sintomas indicativos de implicações para o binômio mãe–filho em mulheres em situação de violência conjugal. Pesquisa qualitativa em que a organização dos dados se deu a partir do Discurso do Sujeito Coletivo. Realizou-se entrevistas com 11 mulheres em processo judicial junto às 1^a e 2^a Varas de Justiça pela Paz em Casa de Salvador, BA, Brasil. Emergiram do discurso feminino duas Ideias Centrais Síntese referentes aos sinais e sintomas psíquicos e físicos relacionados à vivência de violência, que indicam implicações para o binômio mãe–filho. Os distúrbios do sono, tensão emocional, comportamento depressivo, marcas da agressão física, cefaleia foram apontados como sintomatologias associadas à violência conjugal que podem predispor gestantes e puérperas à complicações. Diante de tais sinais e sintomas, torna-se necessário um preparo profissional para identificação precoce da violência conjugal, sobretudo nos espaços de acompanhamento pré-natal e puerperal.

Descritores: Violência por Parceiro Íntimo; Gravidez; Período Pós-Parto; Saúde da Mulher; Enfermagem Materno-Infantil.

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INTRODUCTION

Marital violence consists of any action or omission anchored in gender inequality; it can be experienced by women around the world and in any phase of their lives. When it occurs in the pregnancy-puerperal period, such violence makes the mother-child binomial vulnerable to obstetric and/or neonatal complications, requiring the professional to be prepared to identify women early in this situation.

Researchers from many countries focus on studies about the relationship between being pregnant and experiencing violence, in which many have pointed to the pregnancy as a risk factor for domestic violence⁽¹⁻⁴⁾. A Swedish study corroborates that previous violence history makes the woman vulnerable to experience it during pregnancy, considering that all studied women were exposed to domestic violence before pregnancy and experienced it also during this period⁽⁴⁾.

A study conducted in South Africa followed 263 pregnant women since the 20th and 24th weeks until two years after the delivery found that approximately one-third of them (32%) reported a history of emotional violence and 28% of physical abuse during the past 12 months⁽⁵⁾. In the postpartum, the prevalence was 3.3% from a total of 697 Swedish women⁽⁴⁾. In Brazil, a study conducted in Ribeirão Preto/SP, Brazil, with 232 pregnant women aged between 15 and 49 years showed that 15.5% of women suffered violence from their intimate partner in this period⁽⁶⁾.

Despite the lack of consensus on pregnancy, to behave or not as an aggravating factor to suffer violence, it is necessary to ponder that when generating a child, women have chances to suffer abuse, which can trigger severe consequences for the mother's and fetus/neonate's health. Among the complications, there are infections, placenta previa, bleeding, premature amniorrhexis, abortions, intrauterine and neonatal deaths, premature births, low Apgar scores, low-weight at birth^(7,8).

Taking into account the consequences of marital violence to the women's and fetus/neonate's health, it is incredibly relevant for health professionals to recognize early the signs and symptoms indicative of such risks, overall in the pre-natal and obstetric attention. Thus, considering a close look at pregnant and puerperal women as a meaningful sign of the experienced aggravation, we designed the aim: To expose the signs and symptoms indicating implications for the mother-child binomial in women experiencing marital violence.

METHODS

This is a qualitative study, part of the leading project "Re-education of men and women involved in a criminal process: coping strategies for marital violence", financed by the Research Support Foundation of Bahia State (FAPESB) in partnership with the Public Safety Secretariat of Bahia State.

The study scenario was the 1st and 2nd Courts of Justice for Peace at Home in the city of Salvador, Bahia. Eleven women with a history of marital violence during their pregnancy and/or puerperal period (45 days after labor) participated in the study. Before the data collection, the women signed Informed Consent. In all steps of this study, we considered the bioethics principles, as ruled by the Resolution n° 466/2012 from the National Health Council. The Ethics in Research Committee (n° 039699/2014 and CAAE n° 877.905/2014) approved the study.

The data collection occurred during June and August of 2017. Interviews were used as data collection technique, guided by a semi-structured form with closed questions, that allowed to characterized the participants; and the open questions came from the following direction: tell me about the marital violence experienced during the pregnancy-puerperal period and the implications for your obstetric health and child's life. To respect the anonymity, we identified the speeches by the letter "W", referring to the word "woman, followed by an Arabic numeral. The data were systematized based on the Collective Subject Discourse (CSD). This method was chosen for the study because it consists of a modality that allows the emersion of a unique discourse representing the collective from the speeches coming from thoughts and opinions of many participants, therefore written in the first person, singular (active voice)⁽⁹⁾. Thus, the women's speeches allowed the design of discourses referring to the implications of marital violence for the woman and child during the pregnancy-puerperal period.

RESULTS

The discourse was built from the speeches of 11 women, aged 23 to 56 years, with children, where seven of them experienced spontaneous or provoked abortion. From these, the following Central Ideas (CI) and Syntheses Central Ideas (SCI) were organized:

CI 1 – Signs and psychic symptoms

The discourse revealed that the marital violence experience during pregnancy and the puerperal phase compromise the mental health of women, triggering sleep disturbances, emotional tension, and depressive behavior. Such events can culminate in implications for the mother-child binomial's health.

SCI 1A – Sleep disturbances

The discourse content demonstrates that, when experiencing sexual abuse and death threats during pregnancy and puerperal phases, women can develop symptoms that characterize sleep disturbances, such as insomnia, nightmares and somnambulism. These can predispose obstetric complications like a spontaneous miscarriage.

During the pregnancy and the puerperal phase, I started to stay more awake because I was always very tense, fearing him. [...] because for 12 years, he forced me to have sexual intercourse and I had to be awake to try to defend myself. Insomnia worsened when he began to threaten me to death because he did not want me to have the child. The few times that I could fall asleep, I had many nightmares with violent people, shooting and knives. It also happened that, while sleeping, I would stand up from the bed, hit people, open the door and leave. [...] the issue is that I do not recall doing these things! I felt so bad that I almost had an abortion. (W1; W8; W9)

SCI 1B – Emotional tension

The emotional tension present in the discourse was manifested through stress, anxiety, agitation, and trouble concentrating. When somatized, it triggers other symptoms; for example, bruises through the body, lack of appetite, diarrhea, and respiratory discomfort. Such illness unveiled as the indicative incidence of implications for the mother–child binomial, such as premature delivery.

Of such annoyance, anger, and stress during pregnancy, I noticed that I started to feel tense, anxious, agitated, having trouble to concentrate and even diarrhea. Also, those bruises that are stress-related appeared. [...] I lost my appetite; I felt weak. I, too, could not eat and I felt terrible for that. I think this was bad for the child. [...] I used to get so angry that I used to have shortness of breath just by looking at him. Even my eyes used to get red as if I was having a stroke. I was concerned because I did not want to pass what I was feeling to the baby. Another time, I felt so angry when we argued that my water broke and I had early labor. (W1; W5; W7; W8; W9)

SCI 1C – Depressive behavior

Linked to emotional tension, women can have symptoms as somnolence, prostration, social isolation, emotional lability, and profound sadness. Such characteristics of depressive behavior are more noticed, considering that women know that during pregnancy, they are more emotionally fragile, and they even experience provoked miscarriages and suicidal attempts.

The violence already made me more depressive, but with the pregnancy, it worsened because I was more fragile [...] I did not want to see anyone; I stayed locked inside the bedroom; in the dark; I did not want to leave the bed; I spent the whole day sleeping; I felt so bad; I used to cry a lot daily. To not have another child from him, I decided to abort, but with this

decision, my depression worsened. [...] when I found out that I was pregnant for the second time, I wanted to kill myself. I was a sad person; I did not wish to live. I even tried to cut my wrists because I could not stand the life I was living. (W1; W4; W5; W8; W10; W11)

CI 2 – Physical signs and symptoms

Beyond the psychiatric symptoms, physical signs and symptoms emerged the collective discourse, indicating implications for the mother and child, such as marks of physical aggression and cephalgia.

SCI 2A – Marks of the physical aggression

The discourse reveals lesions resulting from physical aggressions that occurred during the pregnancy and puerperal phases. These alert us that although women felt ashamed to attend public places due to visible marks, women emphasize them during prenatal appointments. It calls our attention that the traumatic experience of the physical violence relates to the woman's decision to interrupt the pregnancy, and to deliver the offspring to the father.

He punched in the eye, which bruised and I was swollen for a week. I did not want to leave the house due to such embarrassment. I used to leave only to attend the prenatal appointments, but I used concealer to hide the bruise. I did not want people to see it. Once, I had just miscarried and he kicked me in the back. I was so painful that I have never forgotten and until today, I feel it just from remembering it. In another circumstance that he hit me, I decided to abort the baby. [...] I put the Cytotec, but it did not work. When he was born, I gave him to the father. (W2; W4; W5; W6; W7; W8; W9)

SCI 2B – Cephalgia

The female discourse demonstrates that experiencing violence during pregnancy and the puerperal phase can contribute to the appearance of cephalgia. It can be associated with hypertensive syndromes during this period, which is aggravated by the emotional stress coming from violence, leading to cases of pre-eclampsia and consequently, a more extended admittance period after the delivery.

I already had headaches due to violence, but during the pregnancy, I felt it more frequently. When he troubled me, the pain worsened, and my blood pressure elevated. [...] but my high blood pressure is emotional! I used to feel pain in the back of my neck. I used to take analgesics every hour. I believe that it was related to concerns about being pregnant and still under tension all the time. Because of the anger that

I felt with him, I had pre-eclampsia twice. [...] as the blood pressure did not lower, I stayed four days admitted in the maternity although my child was already discharged. (W5; W7; W8; W9; W10)

DISCUSSION

The discourse of women with a history of marital violence shows that such experience during the pregnancy and/or puerperal phase can bring implications about the obstetric and fetal/neonatal health. This occurs because it reveals signs and symptoms that can compromise the mother-child binomial, and are related to the mental and physical illness resulting from marital abuse.

Concerning the mental health implications, the discourse signals to the relation between experiencing marital violence during the pregnancy-puerperal period and sleep alterations. The reports reveal that the fear of being raped another time by the partner and the fear of death threats related to the not acceptance of the pregnancy leads to the development of insomnia, nightmares and/or somnambulism. A study corroborates that such sleep disorders are common during pregnancy due to more estrogen and progesterone hormones⁽¹⁰⁾ and due to the body changes from pregnancy that causes discomfort when sleeping. Such changes tend to compromise the fetus's healthy growth and development, and in puerperal women, it can impair the production and delivery of breast milk⁽¹¹⁾.

Other events that provoke or intensify sleep disturbances consist of annoyance and anger felt by pregnant and puerperal women when experiencing marital violence. In the face of these psychological symptoms, is it common to develop stress, anxiety, agitation and trouble to concentrate, characterizing emotional tension. A study conducted in Bangladesh points to the emotional stress of pregnant women in a violent context⁽¹²⁾, an aggravation that results in premature labor.

Other signs and symptoms linked to emotional tension resulting from marital conflicts, also unveiled in the discourses, consist of bruises throughout the body, lack of appetite, diarrhea, and breathing discomfort. These can result from the experienced somatization process, considering that because they cannot deal with stressful situations in the psychic level, the woman begins to manifest symptoms of diseases in the body⁽¹³⁾. For the interviewed women, the stressing events relate to the abuse and/or the concern with fetal development.

Corroborating about the psychosomatic process, a Brazilian study conducted in Salvador, Bahia, pointed to the interface between aggravation experienced and the changes in body weight, cephalgia, nausea, dizziness, increased blood pressure, sleep disturbances and dyspareunia⁽⁸⁾. Such psychosomatic diseases result from a series of changes that the body presents when dealing with emotions, such as

anger, sadness and fear. Such changes emerge from the release or inhibition of substances such as adrenaline and cortisol that, when interfering with the Autonomic Nervous System (ANS), the substances trigger respiratory, cardiac, digestive, immunologic and endocrine changes in the body⁽¹⁴⁾.

Regarding the interference of the marital violence in the eating pattern of pregnant women, it is needed to ponder the modifications caused by pregnancy, resulting from the elevation of progesterone rates and the increase of the intra-abdominal pressure over the stomach, due to the uterine growth, which decrease the appetite⁽¹⁰⁾. Therefore, the lack of appetite as a psychosomatic dysfunction intensifies a typical issue of the gestational process.

It is noteworthy that the women in the study noticed that the lack of appetite could have affected the healthy growth and development of their child. This condition can result in restriction of the intrauterine growth, and consequently, the birth of small newborns for the gestational age⁽¹⁵⁾. Although not relating the lack of appetite to the experience of violence as a factor to compromise fetal development, a study conducted in Tanzania showed that pregnant women who experienced marital violence have a higher risk of having low-weight newborns⁽¹⁵⁾.

The lack of appetite can predispose the cephalgia, which is one of the most common manifestations of somatization and, that represents an important indicator of systemic hypertension⁽¹⁶⁾. Although the study is limited for not establishing a causality relationship between experiencing marital violence and hypertension, the discourse signals to the female comprehension that hypertension developed due to the experience of marital violence. In India, an investigation conducted with women who suffered violence from their husbands and fathers-in-law also related the worsening of hypertension⁽¹⁷⁾. It is once again noted that the transfer of stress to the body with repercussions in the body can be extended to the puerperium.

The depressive behavior is another condition associated with psychosomatic disorders triggered by the tension of marital conflicts during pregnancy and puerperium. It occurs because during the pregnancy, there is a higher release of cortisol, a hormone linked to the physiopathological processes of somatization, because it acts over the emotional stress interfering in the depressive processes, as shown by a study from Chicago⁽¹⁸⁾. Other studies with women in a situation of violence, including international studies, ratify the depressive behavior during pregnancy, mentioned symptoms such as discouragement, fatigue, lethargy, decreased self-esteem and isolation, resulting from this process^(8,19).

The depressive behavior was also unveiled in the women's speeches who mentioned somnolence, prostration, social isolation, emotional lability, and profound sadness. Considering that few changes are already part of the gestational and puerperal periods; for example, the sleep and changes of

humor, it can be inferred that the violence experienced in this phase tends to potentialize the depressive behavior⁽¹⁹⁾. Such sickness can result in more severe psychopathologies, for example, suicidal attempts⁽¹²⁾.

Specifically, during the puerperium, the depressive behavior, named postpartum depression, represents a threat to the newborn's life, especially due to cases of filicide, as shown in a Malaysian study⁽²⁰⁾. In situations that did not reach such extreme outcomes, the maternal mental sickness in the puerperium due to the violence context can echo in other implications to the neonate, such as issues with hygiene and breastfeeding, besides affecting the cognitive, social and emotional development of the child⁽¹⁹⁾.

Depression was equally associated with provoked abortion in the context of violence, a finding of studies of countries with legal abortion^(21,22). A study conducted in Brazil indicates that women with a history of domestic violence and provoked abortion experience feelings of guilt, fear, insecurity, sadness and shame, reflecting in their mental health and favoring the development of low self-esteem, anxiety, depression, post-traumatic stress disorder and suicidal attempt⁽²³⁾.

It is important to point out that this interface was similarly shared by women where abortion is legal. In the United States, for example, a study with women who had a history of marital violence and searched for services to interrupt the pregnancy show that these women had a previous history of anxiety, stress and depression; symptoms also triggered due to fear of social stigma over abortion⁽²¹⁾. In Tunisia, another country where there is legal abortion, women who experienced violence by their intimate partner are more pre-disposed to have consecutive abortions and a still higher probability of developing common mental disorders such as anxiety and depression⁽²²⁾. Although the female discourse does not allow to identify if the depression motivates the abortion or if it is its consequence, it alerts to the relevant aspect of investigating this interface.

It is relevant to consider that the provoked abortion predispose situations with risk for hemorrhage, infection, within other complications that increase the chances of maternal death⁽¹⁸⁾. We cannot disregard that such complications are related to the insalubrious conditions that women go through abortions in Nigeria, considering that it is an illegal practice⁽²⁴⁾. In other countries of Latin American and Sub-Saharan Africa, where abortion laws are also restrictive, many women go through illegal abortions, increasing the chance of maternal death⁽²⁵⁾.

Another characteristic signal of the marital violence experience that can compromise the obstetric and neonatal health relates to social isolation. This condition, which is related to the mental illness caused by depression, was also punctuated by the women as a situation resulting from the physical aggression caused by their partner. This violence, especially in the region of the face, tends to restrict women to

their residence, which results from the shame that their daily abuse will be exposed. It is noteworthy that because it occurs during the gestational period, this embarrassment can inhibit their presence in prenatal appointments⁽²⁶⁾.

Although the violence experience is a factor affecting their attendance in prenatal appointments, the discourse demonstrates the importance given to this follow-up at the moment where the woman declares to leave the house only to attend this service, trying to mask the physical mark by using concealer. Such significance can be linked to the idea that women, despite the embarrassment of the evident sign of aggression, try to maintain the care with the pregnancy to not compromise the child's health. This finding converges with a study conducted in Uberaba, Minas Gerais, that identified that pregnant women attend prenatal consultations due to concerns with their children's health⁽²⁷⁾.

Still, in the scope of absence in the prenatal consultations, it is essential to mention that such context impairs the early identification, and later intervention, of common aggravations during pregnancy⁽¹⁷⁾. Their absence in health services caused by shame of physical aggravation specifically affects the professional suspicion of physical and psychic signs and symptoms indicative of marital violence.

Considering this reality, it becomes relevant for health professionals who work in the prenatal appointments to have an attentive sight for early detection of signs and symptoms related to marital violence. Through such identification, professionals can base their conduct, prioritizing the prevention of illness and health promotion. In this process, the action of physicians and nurses working in the Family Health Strategy (FHS) is noted, considering that these professionals also follow-up the puerperal women through home visits and attention in the services — moments that can favor the recognition of this phenomenon.

FINAL CONSIDERATIONS

The study pointed out that women in situation of marital violence present psychic and physical signs and symptoms caused or worsened by such violence, that make them vulnerable for gestational hypertension, abortion, premature labor, within other issues, depressive behavior, and suicidal attempt during the puerperium, besides the consequences in the fetus/neonate's health.

In this context, professionals who attend to women in the gestational and puerperal phases, overall in the FHS scope, when identifying clinical signs and symptoms, should investigate the experience of marital violence, to intervene early in this process, and to avoid obstetric and neonatal implications. It is also important to alert pregnant women about the possible risks to theirs and the fetus/neonatal's health and to think about articulation strategies with other

spaces, such as referrals to Family Health Support Centers and Centers of Reference to women in a violent situation and other services composing the Attention Network for women's health.

Regarding the study limitations, the female report referring to the worsening of the depressive case after a provoked abortion. There was no investigation about the feelings of women who provoked an abortion, considering the scientific evidence regarding psychosomatic diseases related to the voluntary interruption of the pregnancy.

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