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DOMESTIC VIOLENCE PERFORMED BY INTIMATE PARTNER IN WOMEN IN THE REPRODUCTIVE CYCLE

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ABSTRACT

Domestic violence perpetrated by the intimate partner has been considered a public health problem that has been affecting women in the age group corresponding to the reproductive cycle. Pregnancy is not a protective factor for domestic violence and in this period, women may become more vulnerable to physical, sexual and psychological abuse. Domestic violence is defined as acts performed by partners or former partners who lived or not in the same household, with violence perpetrated in this or another place. This study aimed to describe the intimate partner violence perpetrated in women who are in the age group corresponding to the reproductive cycle. This is a literature review study based on scientific articles. It was concluded that considering the negative impact that domestic violence has on the health and quality of life of victims, intimate partner violence should be systematically investigated by professionals who make up the Health Care Network, since the care considered low complexity in Basic Health Units to medium and high complexity services. Special attention should be directed to pregnant women, especially those whose partners have a drinking habit.

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INTRODUCTION

Violence against women is considered a serious public health problem because it increases morbidity (BOZZO *et al*., 2017) and mortality rates (VIEIRA *et al*., 2011), as well as causing significant impacts on physical and mental health (WORLD HEALTH ORGANIZATION, 2014a; SILVA and ASSIS, 2018) and the welfare of the battered person (WAISELFISZ, 2012; NISHIDA and CASTRO, 2016). In addition, violence is a problem faced by a significant number of women, the World Health Organization estimates that, worldwide, one in three women is or has been a victim of domestic violence, caused mainly by intimate partners (WORLD HEALTH ORGANIZATION, 2018). The term violence often represents the idea of attitudes that use only physical force, however the definition considers as acts of violence the intentional use of physical force or power, real or threatened, against oneself, against another person, or against a group or community that results or is likely to result in injury, death, psychological harm or deprivation (BRASIL, 2012). Intimate partner violence has a prevalence of approximately 30% compared to other violence (WORLD HEALTH ORGANIZATION, 2013) and in most cases is practiced in the home environment through

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physical aggression, sexual coercion, psychological abuse and control behaviors (WORLD HEALTH ORGANIZATION, 2014b), as it occurs in a private space, victims become more susceptible to aggression (BRAZIL, 2006; LÓPEZ and SANTOS, 2018). Violence against women occurs mainly in the age group that corresponds to the reproductive cycle, including the gestational period, which results in serious consequences for both mother and baby (LAFAURIE, 2015). It has been reported in the literature that violence perpetrated during pregnancy increases the likelihood of miscarriage, stillbirth, premature birth and low birth weight babies (SHAH, 2010; WORLD HEALTH ORGANIZATION, 2014a; LAFAURIE, 2015), in addition to prenatal bleeding, fetal fractures and maternal infections (AKYÜZ *et al*., 2012; BAILEY, 2010). The aggressions suffered during the gestational period also affect maternal mental health and victims may present depression (WORLD HEALTH ORGANIZATION, 2014a; FINNBOGADÓTTIR *et al*., 2014; GUIMARÃES *et al*., 2018), decreased self-esteem (GUIMARÃES *et al*., 2018; MARCACINE *et al*., 2018), anxiety, postpartum stress (HOWARD *et al*., 2013; LAFAURIE *et al*., 2015) and feeling of helplessness (LUDERMIR *et al*., 2014). In Brazil, between 2009 and 2017, 739.262 women aged 15-49 suffered violence, data provided by the Notified Health Information System (BRAZIL, 2017). In 2017, more than 221,000 women sought police stations to report episodes of aggression (intentional bodily harm) as a result of domestic violence, a figure that may be greatly underestimated as many victims are afraid or ashamed to report (ATLAS DA VIOLÊNCIA, 2019). Domestic and family violence against women can be committed by people who had or have an intimate relationship with the victim (INSTITUTO DATA SENADO, 2017). Although perceived by women as negative attitudes that cause injury and pain, it is tolerated due to fear of physical, psychological and economic reprisals by the perpetrator, as well as the absence of networks and victim support mechanisms (BEDOYA, 2017). Considering that both immediate and long-term consequences for victims result in serious and chronic injuries and involve the family network, especially when the victim is a pregnant woman, there is a need for studies to understand this phenomenon in order to develop prevention programs and assistance to families. Thus, this study aims to describe the intimate partner violence perpetrated in women in the age group corresponding to the reproductive cycle.

MATERIALS AND METHODS

The present study is a narrative review of the literature, based on scientific articles published in journals indexed in national and international databases. Articles were selected from the Scientific Electronic Library Online (SciELO) virtual library, the United States National Library of Medicine (PubMed) and the Latin American and Caribbean Health Sciences Literature (LILACS), published from 2011 to 2018. To search the articles, the descriptors listed in the structured and multilingual vocabulary of the Health Sciences Descriptors (DeCS) available in the Virtual Health Library were selected. We used the following combinations: violência contra a mulher e violência doméstica, in addition to their equivalents in English: violence against women and domestic violence; and in Spanish violencia contra la mujer e violencia doméstica. Articles related to the research theme were included. After reading, the descriptive and content analysis was performed.

Violence against women performed by intimate partner: Violence against women has historically been characterized as a manifestation of unequal power between men and women and is one of the most widespread forms of human rights violations, as it denies women equality, security, dignity and the right to enjoy freedoms fundamental (PAULA, SILVA, BITTAR, 2017). Violence against women is present in all countries and involves cultural, social, educational, economic, ethnic and generational aspects (WORD HEALTH ORGANIZATION, 2014a). This type of violence can be postulated as any conduct or action based on gender that causes death, harm or physical, sexual and psychological suffering to women (LIMA *et al*., 2015; SUGG, 2015). Domestic violence is committed, in most cases, by one's partner, and often occurring in the victims' domestic environment, which contributes to making them even more susceptible to aggression as it involves an intimate relationship. On the one hand, women fear harming their partner because of their emotional and/or financial dependence (BRASIL, 2006a; LÓPEZ and SANTOS, 2018) and, on the other hand, the aggressor uses this condition to assault constantly the victim (BITTELBRUN, 2017). This type of violence contributes to the reduction of quality of life, increased costs with health care and absenteeism at school and at work (SONEGO *et al*., 2013). Violence against women is classified into physical, sexual and psychological, according to the nature of aggression (SOUSA *et al*., 2016). Physical violence can be defined as any conduct that offends the integrity and/or body health of the aggressed subject (OLIVEIRA *et al*., 2018), causing non-accidental damage that causes external or internal injuries or both (BRAZIL, 2002a). Therefore, aggressions are manifested in various ways such as punches, slaps, kicks, burns, cuts and use of piercing objects and weapons, (BRAZIL, 2002a; OLIVEIRA *et al*., 2018). Sexual violence occurs when intimate partners engage in unconscionable sex through intimidation or force, as well as preventing the use of contraception or forcing pregnancy or abortion (WORLD HEALTH ORGANIZATION, 2014a; MONDIN *et al*., 2016). It is also considered as sexual violence: forced exhibitionism and masturbation, obligation to participate in or witness sexual relations with other persons than the couple, unwanted caresses, oral, anal or genital penetration with penis or other objects of forced form, compulsory exposure to pornographic material, impediment to the use of contraceptive method (BRASIL, 2002b; OLIVEIRA *et al*., 2017) and unwanted participation in sexual photographs or videos (OLIVEIRA *et al*., 2017).

Sexual assault, in addition to physical and psychological harm, can lead its victims to inadequate alcohol and other drug use, depression, suicide, truancy, unemployment and recurring relationship difficulties (ASSIS *et al*., 2014). According to a study by Sugg (2015), more than 1 in 3 women suffered rape, physical violence and / or intimate partner persecution throughout their lives. Psychological violence is understood as any conduct that causes harm to psychological health and self-determination, as well as emotional damage and decreased self-esteem, through conduct such as threat, embarrassment, humiliation, isolation, constant vigilance, ridicule, deprivation or food and / or health care control (MACHADO and GROSSI, 2015). Between spouses, the partner makes the other feel inferior, dependent and guilty, treating him as incompetent, establishing a relationship of subordination and dependence, motivated by the aggressor's desire to control his partner (OLIVEIRA *et al*., 2017). Psychological violence has

less visible behaviors of aggression, therefore difficult to detect and subject to misinterpretation or denial by the victim (OLIVEIRA *et al*., 2017). Unlike physical aggression, which leaves marks on the body (LÓPEZ and SANTOS, 2018), psychological aggression may also involve surname statements and derogatory attitudes or the use of intense anger as a means of control (COLOSSI and FALCKE, 2013). Threatening behaviors can range from threats to pets or property to death threats (SUGG, 2015). The presence of fear on the part of the partner and the repression of emotional expression is also characterized as a psychological violence, as the marital space becomes unfavorable to intimacy and communication between spouses (PAULA, SILVA, BITTAR, 2017). Silences regarding dissatisfaction bring up gestures, words or expressions that do not leave marks on the body, but generate suffering, to the point of hurting self-esteem and the ability to recognize one's own potential (COLOSSI and FALCKE, 2013). The invisibility of psychological aggression means that it is less likely to be considered a public order problem and its conduct less likely to attract attention to the victim than the visible signs produced by physical aggression, leaving the victim in a situation of emotional and emotional destabilization of impotence on (WILLIAMS *et al*., 2012). For this reason, psychological violence becomes more difficult to be included in quantitative studies, which hinders the in-depth analysis of the hidden faces of emotional abuse (GOLU, 2014), as well as the patrimonial violence that constitutes retention and abuse destruction of property and personal effects and work tools (LIMA, SOUZA, SILVA, 2018; SANTOS *et al*., 2019).

It is important to consider that domestic violence has three phases: tension accumulation, explosion and honeymoon, being called the "Cycle of Violence". The phase of tension accumulation occurs through verbal aggressions, provocations and discussions until the occurrence of mild physical aggressions that increase the disagreement and result in a fury attack by the aggressor that commits the severe physical aggression, characterizing the explosion phase that, in turn, is followed by the honeymoon phase. In this third phase, the aggressor seeks to compensate the victim for the aggression caused by him demonstrating regret; however, this cycle of violence is restarted and over time becomes more frequent (LIMA *et al*., 2015). Although no single factor or theory explains the causes of violence, several risk factors associated with the perpetration of aggression have been described, including low income, unemployment and sexual abuse in childhood (ORAM *et al*., 2014), as well as the abuse of alcohol and other drugs (FAZEL *et al*., 2018). Alcohol consumption is related to less cohesion and less organization in the family environment and, consequently, to high levels of domestic violence (GOLCHIM *et al*., 2014). Conjugality permeated by violence becomes even more complex when there is alcohol consumption, which, in turn, was associated with increased episodes of aggression between spouses (FEIJÓ *et al*., 2016). Factors such as anger, hostility, low empathy, relationship conflicts, attitudes towards tolerance for violence and support for gender roles should also be considered in understanding the phenomenon of violence against women (MANCERA *et al*., 2017; CAFFERKY *et al*., 2018). From the results of an integrative review on domestic violence conducted by Oliveira *et al*. (2017) it was possible to verify that men who committed domestic violence had a previous history of violence perpetrated by their parents, and that such episodes led them to reproduce violent acts in society and especially in the family. It has been reported in the literature that women who were victims of physical abuse and / or who witnessed violence among their parents in childhood or adolescence were more likely to be victimized in their marital relationships in adulthood (COLOSSI and FALCKE, 2013; PAIXÃO *et al*., 2015).

In addition to causing death, as has been widely documented, domestic violence results in both immediate and long-term consequences for victims as it results in serious and chronic injuries, physical, sexual and mental suffering that interfere with family dynamics and social relationships. (WORLD HEALTH ORGANIZATION, 2013; LUCENA *et al*., 2016). Intimate partner violence against women can have fatal outcomes, such as homicide or suicide, as well as unintended pregnancy, induced miscarriages, gynecological problems and sexually transmitted infections, including the human immunodeficiency virus (WORLD HEALTH ORGANIZATION, 2014a). Pregnancy is not a protective factor for domestic violence, so violence against women occurs throughout the reproductive cycle. A study using meta-analysis as statistical method, integrating 55 independent studies results, revealed that the main domestic violence predictor against pregnant women was the experience of aggression episodes prior to pregnancy, which increased the possibility of aggression by four times in the gestational period, when it was compared to pregnant women who had no history of marital violence (JAMES *et al*., 2013). As well as the history of violence against women, depressive symptoms also need to be detected at the beginning of the gestational period, as the association between high levels of depressive symptoms and domestic violence during pregnancy has been reported (FINNBOGADÓTTIR *et al*., 2014). Therefore, it is necessary to increase the attention and vigilance of women living in dysfunctional and violent relationships and the inclusion of data on personal and family habits in health history in prenatal care. According to the World Health Organization (2013) the overall prevalence of physical violence against women perpetrated by an intimate partner was 30%. In Brazil, a multicenter study on women's health and domestic violence, coordinated by the World Health Organization, revealed that in São Paulo, 41.8% of women reported psychological violence at least once in their lives, 27.2% reported physical violence and 10.1% reported sexual violence (WORD HEALTH ORGANIZATION, 2013). Regarding the prevalence of violence perpetrated against pregnant women, the results ranged from 0.9% to 57.1%, depending on the methods used for measurement (SHAMU *et al*., 2011).

The aggressions resulting from intimate partner violence during pregnancy increase the likelihood of miscarriage and stillbirth and also impact the mental health of victims predisposing to the onset of depressive symptoms, posttraumatic stress disorder, feeling of helplessness, difficulties of sleep, eating disorders, emotional distress and suicide attempts (WORLD HEALTH ORGANIZATION, 2014a; LUDERMIR *et al*., 2014; GUIMARÃES *et al*., 2018). Postnatal sadness and postpartum depression can be aggravated in women victims of domestic violence (HOWARD *et al*., 2013; LAFAURIE *et al*., 2015). It is important to highlight that gestational violence is an aggravating factor for late onset and / or interruption of prenatal care (VAN PARYS *et al*., 2014). Okada *et al*. (2015) confirmed the importance of screening women victims of domestic violence by health professionals, as well as

identifying the risk of pregnant women suffering violence perpetrated by their intimate partner, in order to ensure pregnancy outcome without complications and complications resulting from it of assaults. Ramalho *et al*. (2017) documented the lack of records on health care for pregnant women in situations of violence. Based on the understanding that violence against women is not a natural phenomenon, nor a private matter, on August 7, 2006, Law No. 11.340, known as the Maria da Penha Law, which typified violence was enacted in Brazil as a form of human rights violation (BRAZIL, 2006a). This law aimed to curb and prevent domestic and family violence against women in Brazil and provided for stricter penalties for aggressors and greater judicial and police protection for women victims of violence (TAVARES, 2015; VIEIRA and HASSE, 2017). The Maria da Penha Law also provided protection measures for victims such as the removal of the aggressor from the family environment, greater punishment due to the aggressions perpetrated against women and the arrest of the aggressor when it threatens the physical integrity of the victim (BRAZIL, 2006; BRUM *et al*., 2013; ZANCAN, WASSERMANN, LIMA, 2013). According to Pasinato (2015), the great importance of the Maria da Penha Law lies in the fact that it has established limits for the perpetrator and created a safety net for the victims through protective measures. Although mechanisms have been put in place to avoid harassment and continuing threats, victims of domestic violence have reported a lack of information about legal rights, a lack of trust or fear of the legal system and the legal costs involved as difficulties in leaving the abusive relationships (GOLU, 2014). Faced with fear and economic dependence, some women seek help from family or friends, but others remain silent (OKADA *et al*., 2015).

Conclusion

Given the scenario presented and the negative impact that domestic violence has on the health and quality of life of victims, intimate partner violence should be systematically investigated by professionals who make up the Health Care Network, since the care considered from low complexity performed in the Basic Health Units to medium and high complexity services. Special attention should be directed to pregnant women, especially those whose partners have a drinking habit. It is necessary to develop programs and strategies aimed at promoting the health of both women victims of domestic violence and their partners, as both may present psychological distress that compromises not only the marital relationship but also the family dynamics involving their children and perpetuating the transgenerationality of violence.

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