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RESEARCH

VIOLENCE PRACTICED BY INTIMATE PARTNERS TO WOMEN WITH DEPRESSION

VIOLÊNCIA PRATICADA POR PARCEIROS ÍNTIMOS A MULHERES COM DEPRESSÃO

VIOLENCIA EJERCIDA CONTRA LA MUJER CON DEPRESIÓN POR SU PAREJA ÍNTIMA

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ABSTRACT

Objective: to identify violence practiced by intimate partner violence to women with depression. ***Method:*** qualitative research conducted from January to April 2017 with 29 women who had depression and were followed up at a Center for Comprehensive Health Care (*Centro de Atenção Integral à Saúde* - CAIS) in *João Pessoa, Paraíba*. Data were collected through interviews, using a semi-structured script. The speeches were processed by the IRAMUTEQ software and analyzed using the content analysis technique. ***Results:*** among the participants, 29 reported a history of violence, with most of the aggressions being committed by intimate partners. The analysis of the speeches allowed the subdivision of the content in three thematic groups: types of violence suffered, denunciation of the aggressions and lack of family support. ***Conclusion:*** there was a close relationship between violence perpetrated by an intimate partner and the diagnosis of depression, with harmful consequences for women and their family relationships.

Keywords: Intimate Partner Violence; Violence Against Women; Depression; Women's Health.

RESUMO

Objetivo: *identificar violência praticada por parceiro íntimo a mulheres com depressão.* ***Método:*** *pesquisa qualitativa realizada de janeiro a abril de 2017 com 29 mulheres que apresentavam depressão e eram acompanhadas em um Centro de Atenção Integral à Saúde em João Pessoa, Paraíba. Os dados foram coletados por meio de entrevistas, utilizando-se um roteiro semiestruturado. As falas foram processadas pelo software IRAMUTEQ e analisadas por meio da técnica de análise de conteúdo.* ***Resultados:*** *entre as participantes, 29 relataram história de violência, sendo a maior parte das agressões praticada por parceiros íntimos. A análise das falas permitiu a subdivisão do conteúdo em três núcleos temáticos: tipos de violência sofrida, denúncia das agressões e falta de apoio familiar.* ***Conclusão:*** *percebeu-se estreita relação entre a violência perpetrada por parceiro íntimo e o diagnóstico de depressão, com consequências danosas para a mulher e suas relações familiares.*

Palavras-chave: *Violência por Parceiro Íntimo; Violência contra a Mulher; Depressão; Saúde da Mulher.*

RESUMEN

Objetivo: *identificar la violencia ejercida contra la mujer con depresión por su pareja íntima.* ***Método:*** *investigación cualitativa llevada a cabo de enero a abril de 2017 con 29 mujeres con depresiónatendidas en un centro de atención integral a la salud de la ciudad de João Pessoa, estado de Paraíba. Los datos se recogieron en entrevistas por medio de un guión semiestructrado. Los discursos se procesaron en el software IRAMUTEQ y se analizaron según la técnica de análisis de contenido.* ***Resultados:*** *las participantes tenían un historial de violencias, la*

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mayoría por agresiones de su pareja. El análisis de los discursos permitió agrupar el contenido en tres nucleos temáticos: tipos de violencia, denuncia de las agresiones y falta de respaldo familiar. ***Conclusión:*** *se observó que la violencia ejercida por la pareja íntima y el diagnóstico de depresión están estrechamente vinculados, con graves consecuencias para la mujer y sus relaciones familiares.*

Palabras clave*: Violencia de Pareja; Violencia contra la Mujer; Depresión; Salud de la Mujer.*

INTRODUCTION

Violence against women has been approached as a historical construction associated with the role of inferiority and submission to the power of men in society. This type of aggression is considered a complex problem, as it has a negative impact on the individual and collective scope of the victims, in addition to generating losses for the legal, economic, social and health sectors.[1]

In this scenario, violent acts are often practiced by the intimate partner. According to the World Health Organization, one in three women suffered sexual and/or physical violence committed by an intimate partner, which corresponds to approximately 35% of women worldwide. In addition, cases of psychological and patrimonial aggressions are also frequent.[2,3] Victims tend to express a feeling of incapacity and an attitude of isolation, which can favor the continuity of the violent relationship, both because of the woman's insecurity and because of the difficulty of identification of assaults by other people.[4]

Violence against women is responsible for organic injuries of different intensities, causing emotional damage, reduced productivity, absenteeism from work, job loss, social isolation, decreased self-esteem and death. Emotional abuse can be as damaging as physical aggression, weakening the role of women in the home, negatively impacting their children's health and resulting in increased social violence.[5]

The use of medications in an abusive way is quite common among women who experience situations of aggression, due to insomnia, nightmares, anxiety, difficulty in making decisions, depression and suicidal thoughts.[4,5] Depression has been mentioned in some studies such as most frequent consequence among victims,[6,7] due to constant suffering and episodes of depreciation and self-depreciation.[6]

The low demand for health services is a common reality among victims of violence, since many women do not reveal that they are being assaulted, due to fear, shame and the hope that the partner will not repeat the attacks. In this sense, it is essential that health professionals identify the situation of violence and act in the prevention of new episodes and harm reduction.[8]

The nurse, among other duties, must understand the dimensions that involve violence, seeking to provide humanized assistance directed to the needs of victims and their family members.[1] However, for this to occur, it is essential that the Nursing professional is prepared to identify the signs indicating situations of aggression and present a sensitive and empathetic posture to address the issue with the victim, offering the appropriate support so that she can speak and receive help.[9]

Considering the implications of intimate partner violence for women's health, it is necessary to understand the scope of this phenomenon and its psychosocial consequences for victims and for society. In addition, although the tendency to carry out studies that address violence practiced by an intimate partner has been increasing, national and international productions investigating the history of aggression in women with psychological distress are scarce. Therefore, the question is: do women diagnosed with depression have a history of intimate partner violence? Thus, the present study aims to identify violence committed by an intimate partner to women with depression.

METHOD

This is an exploratory, interpretative and cross-sectional study, with a qualitative approach, in which the Consolidated criteria for reporting qualitative research (COREQ) was used to guide the structuring of the method.[10]

The research was carried out in a Center for Comprehensive Health Care (*Centro de Atenção Integral à Saúde* - CAIS) in the city of João *Pessoa, Paraíba*, Brazil. This service performs, on average, 50 psychological visits per month to women, with depression as the main cause for seeking and following up.

For the selection of the participants, a rigorous reading of the psychological assistance forms was carried out, seeking to identify the users with the diagnosis of depression, totaling 32 women.

Inclusion criteria were defined as: female, aged 18 years or older and who manifested depression. Women with mental or behavioral disorders associated with depression were excluded from the study. Among the selected users, two refused to participate in the study, resulting in the selection of 30 women.

The research was carried out between the months of January and April 2017. The data were collected by researchers who had an undergraduate or master's degree in Nursing. Initially, training was carried out among all those involved in this process, with the presentation, explanation and application of the instrument being carried out among the interviewers to standardize the collection. Women who met the inclusion criteria were invited to participate in the study, and the interview was conducted before the follow-up consultation, in a reserved room of the service, with an average duration of 10 to 15 minutes.

Data collection was carried out through an interview with a semi-structured script, containing questions related to

sociodemographic data and questions for the identification of violence, which was built from searches in the literature, aiming at understanding the facets that involve the theme of violence against women.

The speeches were transcribed in full, being processed using the software IRAMUTEQ (Interface of R pourles Analyzes Multidimensionnelles de Texte set de Questionnaires) and the content of the speeches was analyzed using the content analysis technique, seeking to identify the themes of more relevance to the investigated issue.[11]

The research respected all ethical and legal aspects recommended by Resolution Nr. 466/12 of the National Health Council (*Conselho Nacional de Saúde* - CNS), which involve studies with human beings. The project was approved by the Research Ethics Committee under Opinion Nr. 1,854,121. To maintain anonymity, the statements were identified in the text with the letter "M" followed by the ordinal number corresponding to the order of the interview (M1, M2 ... M30).

All participants were informed about the research rationale, its purpose, risks and benefits, necessary procedures and guarantee of secrecy and confidentiality of the information provided. They were also informed that their participation was voluntary, and that the refusal would not bring any type of penalty. Then, the women who agreed to participate signed the Free and Informed Consent Form and received a copy of that document.

RESULTS

Thirty women diagnosed with depression participated in this study, aged between 28 and 45 years. Most were married or living in a stable relationship and had completed high school. Among the participants, 29 had a history of violence, with most aggressions being committed by intimate partners. The analysis of the speeches allowed the subdivision of the content in three thematic groups: types of violence suffered, denunciation of aggressions and lack of family support.

Types of violence suffered

When investigating the types of violence practiced by an intimate partner, the most frequent ones were physical, sexual and psychological violence. The interviewees reported the occurrence of physical aggressions from their partner, such as slaps, punches and jerks. In addition, they reported using a broom and screwdriver during the episodes, which increased their severity. In many situations, violence was associated with the consumption of drugs and alcoholic beverages, being witnessed by the children, who, in some cases, grew up with traumas resulting from the suffering experienced:

> *I was beaten up a lot by my husband, he came home drugged and drunk and hit me with the screwdriver. I was beaten in the face, punched, beaten with a broom handle, beaten up with everything. Several times I was supposed to be dead, but my daughters had arrived, helped me and took the screwdriver from him* (M2).

> *I was a victim of my ex-husband; he used to come home drunk and beat me in front of my young children. My daughter has trauma today because she saw me being beaten many times, she suffered with me. It hit me in the face, sometimes he hit me with my son on the arm, the neighbor took the children and he kept hitting me* (M13).

> *My ex-husband beat me a lot, threw me on the wall, hit me a lot. My daughter saw this every day, she was two years old, she was afraid, and she held my skirt, he strongly pulled her away. She was traumatized by seeing this suffering so much, today she is nervous* (M19).

In the women's testimonies, sexual violence in the form of rapes and cruelty attitudes was also mentioned, resulting in intense suffering referred to in the interviewees, as shown in the following speeches:

> *He* [husband] *said that when I got home, if he came to me and I did not want to, he would tear me up, tear my clothes. He forced me several times* [...] (M8).

> *The father of my children forced me to have sex, he came home at night and forced me, dragged me on the floor, threw me on the bed* (M12).

> *Sometimes he got drunk and forced me to have sex, I gave in. He said that I was an object. I lived in anguish; I did not feel any pleasure* (M13).

Psychological violence was the type of aggression that occurred most frequently, being characterized by insults, humiliations, threats, prohibitions and the imposition of restriction of freedom, causing significant emotional damage, decreased self-esteem and social isolation of these women, as expressed in the excerpts as follow:

> *My husband said: "starting today, if you want to be with me, you are prohibited from talking to other people, you will not be friends, you will be watched 24 hours a day". I cannot have an internet network, I cannot have anything, he looks for everything* (M1).

My husband was older than me, he was very jealous, he held me a lot, I started to feel suffocated, I totally lost the will to live. He prevented me from doing the things I liked, which was working and studying (M6).

My ex-husband mistreated me a lot, spit me out, cursed me, said I was ugly, fat, that he wanted nothing to do with me. I had bariatric [surgery], I got depressed, he kept giving me contempt and humiliating me. Everything I wore he said it was ugly, I liked him a lot, he was the only man I loved, but he humiliated me a lot, sometimes he said things that no human being deserved to hear (M24).

Denunciation of aggregions

When questioned about the denunciations of the aggressions suffered, many women stated that they had not received the necessary support from the competent authorities, having their complaints neglected and in some cases being ridiculed by the competent authorities. On the other hand, others refused to denounce partners for fear of retaliation, especially attempted murder:

I denounced him [husband] *once, but his friend was a police officer and took him out of jail. I did not receive support, the police laughed and said: boy, leave that woman who came to denounce you* (M1).

I denounced him, used the Maria da Penha Law, but he must be caught in act. The police arrived and he had already left the house, so nothing happened. The police told him to keep 100 meters away, but I do not trust him, I see a lot of women dying, I do not trust him, I am afraid he will do something (M2).

If I speak, it will end up in jail when we take it in court, nothing happens. I am afraid he knows that I am talking about this, when they find out that we denounce, kill or order to killed. Justice only that of God, here on earth it is slow, I am afraid of dying, so I prefer to remain in silence, suffering in silence (M3).

Lack of family support

The lack of family support was evidenced through the speeches, in which the women expected, but did not receive support from the family, especially from parents and siblings. Such social network proved to be precarious, with limitations in the support offered to meet the needs and frequent incentives for the victims to endure the aggressions suffered, as expressed in the following excerpts:

My mother could have reacted and supported me, she knew that he mistreated me, but she did nothing [...] (M1).

I had no support from my mother and father, my mother gave me advice to endure the things he [husband] *did, I was disgusted* (M2).

My family said that was it, that every marriage had problems, so I had to put up with everything. I told them what happened to me, but nobody was on my side [...] (M12).

DISCUSSION

Although there has been an intensification in the number of studies addressing intimate partner violence, this problem still occurs with high frequency worldwide.[12] This type of aggression causes the victims and their families to become ill, favoring the emergence of chronic diseases and disabling, like depression, and in many cases resulting in death.[13]

Violence, when perpetrated by the partner, is characterized as degrading when considering that it comes from a person with whom the victim has or had a relationship of intimacy and affection. In addition, it usually occurs in environments that should be places of comfort and welcome, but they become scenarios for the practice of violent acts. In this context, the naturalization of male power towards women is observed as a result of cultural stereotypes, which only serve to legitimize the practice of this type of violence.[1] In the present research, from the analysis of women's reports, three types were identified of violence: physical, sexual and psychological.

Physical violence is defined as any type of violent act that causes some physical damage, which in most cases leaves explicit marks on the victim's body, being valued and reported by society. In contrast, given the absence of physical evidence that might suggest violence, many professionals do not question users during consultations, which results in communication problems and underreporting of cases.[5]

Physical violence often occurs in intimate relationships, resulting in more difficulties in identification and prevention, since the victims are emotionally involved with the aggressor and are afraid of judgments of others, as well as of the partner's reaction.[12] The repentance of the partner who attacks it is a common fact in these cases, being evidenced by studies.[14,15] Many aggressors recognize the error and promise not to perform such acts again, however, the situation of violence continues and tends to increase the severity of injuries with each new episode.[15]

It is highlighted the importance of health professionals, among them the nurse, analyzing the entire family context in which the

aggressions happen, also appropriating the life history of the victim's partner and, thus, being able to recognize when aid or treatment are needed,[16] with the aim of promoting the interruption of the cycle of violence.

Some women revealed that episodes of physical aggression occurred in the presence of their children, which represents a situation that can cause direct damage in their children's lives.[17] A study conducted with 115 adolescents in *Porto Alegre* - RS identified that the more exposed the child was in relation to interparental violence, more internalizing and externalizing symptoms are manifested, such as social isolation, somatic complaints, anxiety, depression, problems with attention and thinking, aggressive behaviors, repetition of violent patterns, delinquency and drug abuse.[18]

Sexual violence was also present in the interviewees' speeches, being perceived as a criminal act on the part of women, while for men it was understood as an "obligation" of the relationship. This context could be related to the historical roots of socio-cultural construction, in which sexual relations were part of the conjugal contract. Issues involving gender theories favor the support and legitimization of the practice of sexual violence against women.[19]

Psychological violence was the most cited by the participants, being characterized by insults, humiliations, threats and prohibitions/restrictions of freedom, which caused them to reduce their self-esteem and social isolation. Although this type of aggression is quite common, it is still often underreported, particularly as it does not result in visible damage that may indicate its occurrence.[20]

However, the consequences of psychological violence can significantly affect the victims' self-image and self-esteem,[5] in addition to frequently triggering processes of psychological illness, depression being more common. This is seen as one of the main consequences of conjugal violence for women, causing anguish, deep sadness, discouragement, impotence and behavioral changes, suicide attempts, among others.[21]

It is worth noting that the fact that the woman fails to recognize that she is suffering from a type of violence causes her to remain involved for a long time with her aggressor, and may present feelings of sadness and incapacity.[19] Another relevant factor is that psychological violence precedes, in the most cases, physical and sexual, which refers to the importance of health professionals investigating psychological violence during consultations.[22,23]

In the category about the denunciations of the assaults, the women stated that they had not received the necessary support from the responsible authorities, having their complaints neglected and/or underestimated. Others refused to report for fear of retaliation and threats of murder. However, since 2006 there has been a specific law to curb violence against women, the *Maria da Penha* Law (Law 11.340/06), which establishes measures to protect physical integrity, rights and assistance to women. This law also defines that care for women in situations of violence must take place in a comprehensive manner, including actions from different sectors.[1,14]

Although there are police stations specialized in receiving the report of battered women, the victims do not feel secure in seeking help.[17] The search for care services for victims of violence usually occurs after years of daily coexistence with the aggressions, thus, it is noticed need to provide adequate assistance, allowing women to feel protected.[23]

Regarding the support network, there was a lack of family support, especially from parents and siblings. This is an important factor, since receiving support in cases of violence against women favors the interruption of the abusive relationship.[24] On occasions when the people closest to the couple are unable to identify the aggression, or when they do not place themselves available to help her break the violent cycle, they are taking the risk of the consequences, which is often fatal.[25] The lack of family support is among the main reasons that keep the victim in the situation of submission of violence.[5,22]

In view of the above, the need for health and protection services professionals, family members and society to understand the seriousness of violence against women, perceiving it as a public health problem that affects everyone involved.[23] High number of cases of violence requires the need for a support network with a multidisciplinary approach, aiming at the identification of the situation and immediate intervention in the health-disease process of the female population, being a prerequisite for the breaking of cultural barriers and prejudices in relation to this theme.[1]

It is assumed that the knowledge of the victims' reports can contribute to raising awareness about the seriousness of this problem, which can promote the commitment and dedication of Nursing professionals to reduce obstacles that may prevent effective assistance with actions of co-responsibility for the care and reception with qualified listening, that value the complaint, so that women have sufficient autonomy to make decisions.[1,14]

In this sense, it is necessary that nurses are prepared to recognize the signs and symptoms indicative of a possible aggression, with a critical eye to identify any sign of fear, unconditional submission or any other situation in which the woman needs to be welcomed to reveal what she and/or her children experience.[7,9] In addition, as they are professionals who provide direct care to users, nurses are more likely to identify violence and encourage a break in the victim's silence through guidance to respect for support services and the promotion of women's empowerment.

Regarding the legal aspects, the mandatory notification in these cases, whether suspicious or confirmed, stands out, providing more visibility to the problem,[5] in order to draw the attention of political authorities to the need to solve it in the most convenient way.

The findings of this study cannot be generalized to all women diagnosed with depression, given that the process of psychic

illness may be the result of other social and health conditions that do not involve a history of violence by an intimate partner. The limitations of the research were related to the selection of women who presented only the medical diagnosis of depression, without association with other types of mental or behavioral disorders, which could restrict the reflections on the theme.

The results evidenced and the reflections developed from the statements can contribute to the development of strategies to subsidize assistance to victims, adding elements for the creation or reformulation of actions, training of professionals and articulation between the health network and social institutions, in addition to raising the need to deepen the debates on the theme, with a focus on facing and preventing aggression.

CONCLUSION

The results revealed that, although advances have been made in the health and protection policy for women, such as the sanction of the *Maria da Penha* Law in 2006, the issue of intimate partner violence is still marked in society, leaving serious consequences for victims and their families. Thus, it is necessary to formulate and/or strengthen political measures in order to guarantee effective protection for women.

Health professionals must be able to deal with the situation of domestic violence, with the purpose of developing skills to recognize violent acts in their various modalities, identifying the needs of the people being attacked and, therefore, offering humanized and resolving assistance. It is also evident that if the actions are directed only at women, the problem of violence will remain continuously unsolved. In this sense, it is necessary that aggressive men are also included in actions to combat the prevention of violence against women.

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