Original Article

Violence against women and its consequences

Violência contra a mulher e suas consequências

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Abstract

Objective: To analyze the consequences of intimate partner violence, from the perspective of women, as an intervention proposal for nurses in health care.
Methods: Qualitative, descriptive and exploratory research. Theoretical framework supported by Levine's Nursing Theory. Sixteen women who had experienced intimate partner violence participated in the study. The Collective Subject Discourse was used for the analysis.
Results: The consequences of violence against women were sleep disorders, improper diet, lack of energy, body aches, bruises, abrasions, panic attacks, sadness, loneliness and low self-esteem, constituting psycho-emotional and physical harm.
Conclusion: Assaults upon the integrity of women were evidenced, based on Levine's conservational principles, in terms of conservation of energy and conservation of structural, personal and social integrity, where the intervention of the nurse is essential for support, promotion and rehabilitation of women's health.

Resumo

Objetivo: Analisar as consequências da violência contra a mulher praticada pelo companheiro, na perspectiva das mulheres, como proposta de intervenção do enfermeiro na atenção à saúde.
Métodos: Pesquisa qualitativa, descritiva e exploratória. Referencial teórico sustentado pela Teoria de Enfermagem de Levine. Participaram 16 mulheres que vivenciaram violência pelo companheiro íntimo. Para análise, utilizou-se o Discurso do Sujeito Coletivo.
Resultados: As consequências da violência à mulher foram distúrbios do sono, alimentação inadequada, falta de energia, dores pelo corpo, hematomas, escoriações, síndrome do pânico, tristeza, solidão e baixa autoestima, que determinaram danos psicoemocionais e físicos.
Conclusão: Foram constatados agravos à integridade da mulher frente aos princípios da conservação de Levine na conservação de energia e integridade estrutural, pessoal e social, considerando a intervenção do enfermeiro essencial ao apoio, à promoção e à reabilitação da saúde da mulher.

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Introduction

The saga of violence against women is recurrent and enslaving. It strikes at autonomy, destroys self-esteem and reduces Quality of Life, with consequences for personal, family and social structuring. The aggressions committed are threatening, and generally associated with disturbing social problems, such as unemployment, marginalization, social inequalities and the use of alcohol and drugs, creating an impact on the morbidity and mortality of this population. It contributes to loss of Quality of Life, increased health care costs and school and work absenteeism, in addition to being one of the most significant ways in which personal, family and social structures are broken down.[1]

Violence is any act of aggression or negligence toward a person, group or community, which produces or can produce psychological damage, physical harm or sexual suffering, and includes threats, coercion or arbitrary deprivation of liberty, whether in a public or private setting.[2,3]

To understand the complexity of violence against women, it is necessary to uncover its structures involving the concept of gender. Gender is understood as a historical and sociocultural construct, which assigns roles and behaviors to the sexes. For women, it is defined as passivity, fragility, emotion and submission, and for men, activity, strength, reason and domination. The dimension of gender is structured as a power relationship, resulting in a usurpation of the body of the other, and is generally framed between men and women.[4]

Research conducted in Brazil by the Perseu Abramo Foundation, on violence against women and gender relations in public and private places, estimated that of the 2365 women from 25 states in the country, 34% had been subjected to violence in the domestic realm.[5] Every two minutes, five women are violently assaulted. Violent acts result in the loss of one year of healthy life, for every five years of being subjected to aggression.[6]

This violence, regardless of the gender perspective, is currently permeated by various physical, psychological and sexual aspects, and is considered a public health problem, constituting a violation of human rights.[7] Interventions for solving this problem should not necessarily dispense with the clinical approach, but measures need to be taken to promote the conservation of health. This is because clinical actions are not sufficient for addressing all the varied dimensions of the problems and the health needs of women. The strengthening of cooperation between sectors and collective action is essential for overcoming the helplessness reported by many health professionals in situations involving violence.[8] Such actions, in health/nursing, require a broader approach, emphasizing intervention proposals for the follow-up care of these women in health facilities, in social support networks and with comprehensive, humanized care.

Women, being the primary target of this type of violence, have received attention from governmental authorities (national and international) and health professionals, especially nurses who, in their jobs and any work environment, encounter this situation, which requires specific knowledge and skills for providing care.[9]

Many theories have been proposed in Nursing, but in terms of battered women, a theoretical framework was sought that provides a comprehensive view of the individual. On the basis of this premise, the Theory of Nursing of Myra Strin Levine was used,[10] seeking connections with the comprehensive care of women's health. Levine's conceptual model characterizes the individual as a dynamic whole, in constant interaction with his or her environment, and focuses on patients who enter a health establishment in need of care due to their altered state of health.

The discussion here is guided by principles related to the debilitated health of women who suffer intimate partner violence in a private realm, hidden from the public. This theory presents sickness as a stressful situation in which the individual attempts to adapt to his or her altered state of health. This adaptation is manifested by an organic reaction, which includes negative changes in the behavior of the body or degeneration in the levels of its functioning. The purpose of this adaptation is so that the individual can regain a state of complete independence.[11]

The nurse provides the woman with appropriate care, bearing in mind her wholeness and encouraging her to participate in the restoration of her well-being. The function of the nurse is to transmit knowledge and strength, motivating the woman to withdraw from her debilitating situation and find a more independent milieu in order to survive.[10]

The nurse's expertise should assist in the process of maintaining wholeness and personal, family and social structure, through a minimum expenditure of energy, supporting and promoting social rehabilitation and insertion. The core of this theory has three theoretical pillars: adaptation, conservation and integrity. In this research, the dimension of conservation of health was addressed, which encompasses four principles: (1) conservation of energy, (2) conservation of structural integrity, (3) conservation of personal integrity and (4) conservation of social integrity.[11]

The conservation of energy is characterized by activities necessary for supporting life, such as those involving growth and development. The conservation of structural integrity focuses on experiences with injuries, sickness processes and inflammatory and immunological responses. The conservation of personal integrity focuses on the sense of being – defined, protected and described by its essence – wherein each person is unique, exclusive and complete. In turn, the conservation of social integrity involves defining the person within a context that extends beyond the individual, where each one is defined through their relationships. Each person's identify is connected to family, community, culture, ethnicity, religion and education.[10]

The applicability of Levine's theory provided support to this research through the principles of conservation, which underlie the interventions of nurses when faced with the problem of violence in the care of women. It can be argued that the current care model still operates on the basis of rationality and reductionism, which reinforces the biomedical model in the care administered by health professionals.[12]

The scientific literature uncovered studies that show the consequences of violence upon women's health as problems common to physical and psycho-emotional integrity.[5,12-14] As a weakness in knowledge production, it was noted that few studies use the Levine Theory approach, from the perspective of conservation of health, in relation to energy and structural, personal and social integrity.

The objective of this study was to analyze the consequences of intimate partner violence, from the viewpoint of women, based on Levine's Theory of Nursing, as an intervention approach for nurses in the comprehensive care of women's health.

Methods

Qualitative, descriptive and exploratory research, carried out in the Centro de Referência e Atendimento à Mulher em Situação de Violência Doméstica - CR Mulher (a reference care center for women in situations of domestic violence), in the metropolitan region of Rio de Janeiro, state of Rio de Janeiro, Brazil. This center uses focus groups, frequent meetings and educational dynamics in an effort to restore the self-esteem of abused women.

The participants were women, over the age of 18, who had suffered physical, psychological or sexual violence at the hands of an intimate mate, attended focus group meetings and voluntarily signed a Free and Informed Consent Form.

Data were collected between June and September of 2012. Sixteen of the 32 women receiving care at CR Mulher were interviewed. The empirical profile was limited by the saturation of data and the diversity of this universe.

Individual interviews, with a semi-structured script, were conducted in a room reserved at this facility in order to collect data. Permission was given to record them and they lasted on average 40 minutes. There was a formal presentation with respect to the ethical criteria, the issue of confidentiality and the right to stop participating in the research, without this in any way affecting the care being received. The first step was getting to know the socio-demographic profile of the female participants.

The analysis of the results was based on the method of Collective Subject Discourse, which entailed organizing the verbal empirical data obtained

from the testimonies. To prepare the Collective Subject Discourse, it was necessary to build two methodological figures: Key Expressions and Central Ideas. The first consists of literal transcriptions of the discourse that reveal the essence of the testimonies. "Central Ideas" is a linguistic expression that describes, in a more authentic way, the meaning of each homogeneous set of Key Expressions. As a data processing technique, Collective Subject Discourse suggests a collective person speaking as though an individual subject from the discourse.[15]

In the construction of this Collective Subject Discourse, isolated parts of the testimonies were added in, to form a discursive whole, where each party could be recognized as a constituent within the whole and vice versa.[15] When a response had more than one Collective Subject Discourse, it was differentiated from the others using difference and antagonism or complementarity criteria, adhering to a consistency of ideas. Lastly, repetitions and particularities were removed from the individual discourses in order to structure the Collective Subject Discourse, which imparted naturalness and spontaneity to the collective thought.

The development of this study complied with national and international ethical guidelines for research involving human beings.

Results

People cannot be understood outside the context of time and place in which they interact and are never isolated from the influence of everything happening around them, according to Levine. Human beings are influenced by their immediate circumstances and undergo experiences throughout their entire lives, which leave marks on their minds, bodies and spirits.

Of the 16 women who participated, nine were from 25 to 44 years of age. In terms of marital status, eight were separated or divorced from their mates. Insofar as education, ten women had completed 12 years of education. Of the participants, 11 had paid activities, three were housewives and two were retired. Half of them were white, seven were brown and one was black.

Four Central Ideas emerged from the data analysis related to the consequences of violence, according to the principles of conservation of health in Levine's Nursing Theory, described in the Collective Subject Discourses, based on the testimonies of the women.

The first Central Idea shows the consequences of violence that undermine the conservation of energy of women:

My sleep is restless; I wake up several times a night. I feel worn down, I'm tired, and my body aches. When he [the mate] *beat me, I didn't eat for four days, and I had to breastfeed my son. I feel weak and without any energy. I've lost weight. I'm constipated and have a stomach ache.* (CSD 1)

The consequences of violence that undermine the conservation of structural integrity are seen in the second Central Idea, stemming from the second discourse:

The beatings make me nervous and I eat a lot. I'm overweight, but I can't stop eating. I had bruises on my arms. When he [the mate] *tried to choke me, he left marks on my neck. He kicked me and I had purple marks on my back. He left me all bloody and I had to be hospitalized for a while. I started smoking again, something I didn't want to do.* (CSD 2)

The third Central Idea shows the consequences of violence that undermine the conservation of personal integrity of women:

I was destroying myself, I hated myself. I felt I wasn't good for anything and I would say to myself, 'what good am I if I can't even make my husband like me?' The psychological scars are the worst. You feel incapable and helpless. You don't want others to know you're experiencing violence. You get very disturbed by the mean words your husband says to you. I have low self-esteem. (CSD 3)

The consequences of violence that undermine the conservation of social integrity can be seen in the fourth Central Idea:

When he [the mate] *would say he was going to do something bad to my family I'd go crazy. I'd rather he would kill me. My greatest regret is that I stopped working. I've lost my trust in men and think they're*

all going to do the same thing and I back away. I've lost interest in everything. I stopped taking care of myself and didn't leave the house. I stayed holed up in my room and didn't want to see or talk to anyone. (CSD 4)

Discussion

The limitations of these results involve the employability of the methodology of Collective Subject Discourse as a discursive methodological strategy, which enabled a relatively limited understanding of a set of representations that comprised the specific imaginary construct of a group of women who had experienced violence.

Our results enable nurses to develop intervention initiatives for the care of women in situations of intimate partner violence, based on concepts from Levine's Nursing Theory, related to the consequences of aggressive acts of violence against their health.

The characteristics of these women were similar to the profile of the female population in situations of violence in other studies.[16-20] The majority were young, white, adult women of reproductive age, who were married or in common law marriages, had completed high school and were working in the job market. The aggressors were predominantly the intimate partner.

The negative impact on the women's conservation of energy was characterized by sleep and rest disorders, physical fatigue, constant tiredness, inadequate nutrition, weakness, lack of energy and disorders of the intestinal tract. Conservation of energy is a protective factor for the integrity of the functional system of individuals, which addresses their health from a holistic angle.[10] The symptoms resulting from violent relationships were reflected in insomnia, headaches, fatigue, constipation and weight loss, among others. The effects of spousal violence occur due to its repetition, in the form of psychic traumas of moderate or severe intensity, without being tied to a medicinal approach for problems that, generally, have a political or sociocultural nature.[21]

In the care provided by nurses to women in situations of violence, as far as conservation of energy, an anamnesis and physical examination are essential for checking the following: vital signs, nutritional assessment related to frequency and availability of food, physical exercise, bowel and bladder elimination pattern and evaluation of menstrual cycles. The focus of these parameters was to identify aspects of energy conservation and expenditure related to the suffering, leading the women to seek nursing care.

In the discourse of the participants, injuries were referred to, such as bruises, abrasions, dislocations and lacerations. In regard to disease processes and inflammatory and immunological responses, they reported body pain, obesity, panic attacks, bouts of gastritis and ulcers. Conservation of structural integrity is the process of restoration and maintenance of the organism, which has defense mechanisms to protect the individual against possible tissue losses, thereby preventing the entry of microorganisms, avoiding a physical breakdown and promoting recovery.[10] Among the damages arising from violence to women's health are mutilations, fractures, sex-related problems and obstetric complications.[22] Violence also leads to a higher risk of accidents and smoking. These women generally overuse medication, especially antibiotics and anti-inflammatory drugs.[23]

In the care administered by nurses to women, in terms of conservation of structural integrity, it is essential in the physical examination to inspect and observe skin integrity, to check for the presence of skin lesions. At the time of the anamnesis and clinical background, women may reveal the disease processes experienced and inflammatory and immunological responses, and referrals should be made to support networks.

The personal consequences for the participants in the study were feelings of annihilation, sadness, discouragement, loneliness, stress, low self-esteem, inability, powerlessness, anger and worthlessness. The principle of conservation of personal integrity is the preservation of individuality and privacy.[10] A study conducted in hospitals indicated the following effects of violence upon women: irritability, decreased self-esteem, professional insecurity, sadness,

loneliness, anger , lack of motivation, relationship difficulties, desire to quit their jobs and family relationship difficulties.[24]

With respect to the conservation of personal integrity of women, nurses are responsible for ensuring their privacy and involving them in the decision-making process, providing an embracing environment, attentive listening and sensitivity toward the problem. However, women who share their life experiences with others also preserve their identity as unique beings. Human beings have a public persona and a private persona, details of which are often not divulged even to those closest to them. When these women recognize, in the nurse, a professional willing to help and guide them, this facilitates the process of strengthening their self-esteem and autonomy.

The women expressed fear that their mates could cause harm to their families, especially their children; they regretted having quit outside jobs; and they found it difficult to engage in relationships with other people due to lack of interest. The conservation of social integrity is based on the fact that all individuals live in society and their behavior is related to social groups.[10] In a state of weakened health, these women feel lonely, and think back to family and friends, with these being essential to their recovery. The nurse, within social support networks, has the role to encourage and help reinsert the women into their new context, understanding them as beings who have been dominated, exploited and suffered, and whose story is shrouded in subjectivity.[25]

In terms of conservation of social integrity, the information obtained by nurses is relevant for establishing personal possibilities and social and family resources, building alternatives and actions that strengthen bonds of care and support, and expand the support networks related to security, justice and social assistance.

Conclusion

In this study, the analysis of the consequences of intimate partner violence found links with the principles of the conservation of health in Levine's Nursing Theory, in relation to the undermining of conservation of energy and structural, personal and social integrity. The results were characterized by physical, psychological and emotional disturbances, influencing the conservation and integrity of the health of these women in a way that had a degrading, aggressive and destructive effect on their self-esteem and state of complete independence. There is a need for inclusion of nurses in the comprehensive care of women's health and in humanistic care, as well as in embracing these women, in order to strengthen their autonomy and self-esteem. Through Levine's Nursing Theory, it was possible to expand knowledge in the field of nursing care with possibilities for intervention and actions focused on reducing the impact of violence against women.

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Collaborations

Netto LA worked on the preparation of the project, concept and design of the research, literature review, data collection and analysis, interpretation of the results and drafting of the article. Moura MAV contributed with guidance and direction of the article through a critical relevant review of its intellectual content. Queiroz ABA, Tyrrell MAR and Bravo MMP collaborated on the final approval of the version to be published.

References

1. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise de Situação de Saúde. Viva: instrutivo de notificação de violência doméstica, sexual e outras violências [Internet]. Brasília DF: Ministério da Saúde; 2011[cited 2014 Abr 7]. Série F. Comunicação e Educação em Saúde. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/viva_instrutivo_notificacao_violencia_domestica.pdf.
2. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH; WHO

Multi-country Study on Women's Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet. 2006;368(9543):1260-9.

3. Kopcavar NG, Svab I, Selic P. How many Slovenian family practice attendees are victims of intimate partner violence? A re-evaluation cross-sectional study report. BMC Public Health. 2013;13:703.
4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes: norma técnica [Internet]. 3. ed. atualizada e ampliada. 1. reimpressão. Brasília, DF: Ministério da Saúde; 2012[cited 2014 Abr 7]. Série A. Normas e Manuais Técnicos. Série Direitos Sexuais e Direitos Reprodutivos; Caderno n. 6. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/prevencao_agravo_violencia_sexual_mulheres_3ed.pdf.
5. Fundação Perseu Abramo. [Brazilian women and gender in public and private spaces] [Internet]. 2010[cited 2014 Abr 7]. Available from: http://www.fpabramo.org.br/sites/default/files/pesquisaintegra.pdf. Portuguese.
6. Acosta DF, Gomes VL, Barlem EL. [Profile of police reports related to violence against women]. Acta Paul Enferm. 2013; 26(6): 547-53. Portuguese.
7. World Health Organization (WHO). Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guideline. World Health Organization; 2013.
8. Guedes RN, Fonseca RM, Egry EY. [The evaluative limits and possibilities in the family health strategy for gender-based violence]. Rev Esc Enferm USP. 2013;47(2):304-11. Portuguese.
9. Morais SC, Monteiro CF, Rocha SS. [Nursing care for sexually violated women]. Texto & Contexto Enferm. 2010; 19(1): 155-60. Portuguese.
10. Levine ME. Conservation and integrity. In: Parker ME, organizadora. Nursing theories in practice. New York: National League for Nursing; 1990. p.189-201.
11. George JB. Myra Estrin Levine. In: George JB, organizadora. Teorias de enfermagem: fundamentos para a prática profissional. Porto Alegre (RS): Artes Médicas; 2000. p. 159-68.
12. Guzmán YE, Tyrrell MA. [Building an in-commom language among women, victims of conjugal violence]. Esc Anna Nery Rev Enferm. 2008; 12(4): 679-84. Spanish.
13. Guedes RN, Silva AT, Fonseca RM. [The violence of gender and health-disease process of women]. Esc Anna Nery Rev Enferm. 2009; 13(3): 625-31. Portuguese.
14. Miranda MP, Paula CS, Bordin IA. [Life-long domestic violence against women: prevalence and immediate impact on health, work, and family]. Rev Panam Salud Publica. 2010;27(4):300-8. Portuguese.
15. Lefèvre F, Lefèvre AM. Princípios básicos e conceitos fundamentais do discurso do sujeito coletivo. In: Lefèvre F, Lefèvre AM. O discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa. Caxias do Sul (RS): Desdobramentos, Educs; 2005. p. 13-35.
16. Rodrigues CS, Malta DC, Godinho T, Mascarenhas MD, Silva MM, Silva RE. [Accidents and violence among women attended in Sentinel Emergency Services - Brazil, 2009]. Ciênc Saúde Coletiva. 2012;17(9):2319-29. Portuguese.
17. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise de Situação de Saúde. Saúde Brasil 2011: uma análise da situação de saúde e a vigilância da saúde da mulher [Internet]. Brasília, DF: Ministério da Saúde, 2012[citado 2014 Abr 7]. Disponível em: http://www.paho.org/bra/index.php?option=com_content&view=article&id=3200:saude-brasil-2011-uma-analise-da-situacao-de-saude-e-a-vigilancia-da-saude-da-mulher&catid=758:bra-principal&Itemid=347.
18. Oshikata CT, Bedone AJ, Papa MS, Santos GB, Pinheiro CD, Kalies AH. [Characteristics of women victims of sexual violence and their compliance with outpatient follow-up: time trends at a referral center in Campinas, São Paulo State, Brazil]. Cad Saúde Pública. 2011;27(4):701-13. Portuguese.
19. Griebler CN, Borges JL. [Violence against women: profiles involved in the occurrence of Maria da Penha law police reports]. Psico. 2013; 44(2):215-25. Portuguese.
20. Moura MA, Netto LA, Souza MH. [Socio-demographic profile for women who faces the violence and get the support at specialized police stations]. Esc Anna Nery Rev Enferm. 2012;16(3):435-42. Portuguese.
21. Pazo CG, Aguiar AC. [Senses of intimate violence: analysis of an anonymous telephone service database]. Physis Rev Saúde Coletiva. 2012; 22(1):253-73. Portuguese.
22. Nascimento MG, Xavier PF, Sá RD. [Pregnant teens: experiences at the family and social levels]. Adolesc Saúde. 2011; 8(4):41-7. Portuguese.
23. Sonego M, Gandarillas A, Zorrilla B, Lasheras L, Pires M, Anes A, et al. Unperceived intimate partner violence and women's health. Gac Sanit. 2013;27(5):440-6.
24. Barbosa R, Labronici LM, Sarquis LM, Mantovani MF. [Psychological violence in nurses' professional practice]. Rev Esc Enferm USP. 2011; 45(1):26-32. Portuguese.
25. Labronici LM. [Resilience in women victims of domestic violence: a phenomenological view]. Texto & Contexto Enferm. 2012; 21(3):625-32. Portuguese.