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Risk Factors Related to the Psychic Suffering in Women in Pre and Post-Natal Accompanied by an Institution of Philanthropic Pernambuco State

ORIGINAL

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Abstract

This article aims to identify the prevalence of women who present risk for psychological distress in the pre- and postnatal period. A descriptive, exploratory study was conducted with a quantitative data approach, a study carried out at the pre and postnatal health outpatient clinic of IMIP - Instituto de Medicina Integral Prof. Fernando Figueira, Recife (PE). We used instruments such as the Sociodemographic Data Survey Questionnaire, the Puerperal Pregnancy Cycle Questionnaire Questionnaire, and the Psychiatric Morbidity Questionnaire in Adults (QMPA) with 775 women, of whom 450 were pregnant and 325 were women who had given birth in the period of August/October 2014, After approval of the Ethics and Research Committee (CEP) of IMIP, under the number of CAEE: 30991314.9.0000.5201. The study showed that, in prenatal care, 48% (216) of the cases presented a risk

for psychological distress; And in the postnatal period, 47% (152). It was possible to identify psychic suffering in the majority of women, and they often go unnoticed by the professionals who assist them. The knowledge of the risk factors, triggers and symptoms during the pregnancy-puerperal cycle, makes the mental diagnosis more efficient, thus providing a safer and more peaceful pregnancy for mother-child-family.

Keywords
Women's Health; Mental Health; Stress Psychological; Rick Factors.

Introduction

Each woman lives the pregnancy in a unique way, in a complex of psychological, physical, social and emotional modifications. In most cases, you have a healthy process. However, sometimes deviations from normality can happen, and through early detection, they can be properly followed and do not have consequences for the pregnant woman and her child [1].

Since small women are created to develop love, understanding, tranquility, tenderness, balance and welcome. Such adjectives are charged for all the moments of their lives. He affirms that the model of "perfect giver", a romantic maternal stereotype developed over the last few years to support the patriarchal, capitalist and male dominated system. Fleeing from this pattern would cause women to be prejudiced and excluded [2].

The Program of Integral Assistance to Women's Health (PAISM) [3], focuses on the concept of woman as a social being, not restricted to the gravidico-puerperal clinic and the mother-child binomial. The gestation is as a stage that is part of the normal process of human development. There are great interfaces, not only in the woman's organism, but in her well-being, thus altering her psyche and her role in society and in the family life. The birth of a child, in turn, has as factors associated with stress situations in some families, usually in face of changes in daily routine developed since the pregnancy period, which often pre-dispose the occurrence of maternal depression recorded after birth of the concept [4].

The puerperal process is a stressful period of adaptation, during which physiological manifestations occur in the body of the woman, coinciding with the period in which the woman will have to reorganize her daily life, including the baby in her life dynamics. It consists of a chronologically variable period of imprecise scope and, depending on how the woman deals with it, may or may not present significant symptoms of mental process [5]. "Psychiatric disorders related to the puerperium are classified as: Postpartum Sadness Syndrome or Puerperal Dysphoria; Puerperal Depression or Postpartum and Puerperal Psychosis" [6].

Among these disorders, postpartum depressions and puerperal psychoses are psychic changes dependent on organic, familial, marital, social, cultural and personality factors that, when present, cause damage to the psychic well-being, either during the Gestation or even in the puerperium. Given the negative effects and risks that pregnancy-related disorders can bring to women and their children, this work underscores the importance of adequate follow-up, promoting quality care, which contributes to the reduction of deleterious effects on maternal and child health.

For this, the study aims to: identify the prevalence of women who are at risk for developing psychic suffering in the pre- and postnatal period; for this it

was necessary: to characterize the socio-demographic aspects of pregnant women and postpartum women interviewed; To point out obstetric aspects that may interfere with mental health in the pregnancy-puerperal cycle; And to list the risk factors that present the highest index among women interviewed.

Method

This is a descriptive, exploratory study with a quantitative data approach, carried out at IMIP - Instituto de Medicina Integral Prof. Fernando Figueira, an outpatient care service for pregnant women and puerperal women, respectively in the pre- and postnatal period.

The study population was of a non-probabilistic type, totaling an N of 960 women enrolled in said outpatient service among (560 pregnant women and 400 postpartum women), a sample of 775 women (450 pregnant women and 325 postpartum women) were included in the study. Which among the inclusion criteria, are older than 18 years of age, attended at prenatal and postnatal care services at IMIP, and excluded women with threatened abortion, high-risk pregnant women, women with some disorder Mental health and hearing-impaired women that prevented their active participation at the time of collection, those that lacked prenatal and postnatal consultations during the period of data collection; Those who refused to participate in the study, totaling 110 women in prenatal care and 75 postnatal women.

In view of this outpatient follow-up of the IMIP, the Ministry of Health (2012) recommends that the pregnant woman have at least 6 prenatal visits, 1 in the first trimester; 2 in the second quarter and 3 in the third quarter [7].

In the light of these recommendations, data were collected in 3 months, between August and October 2014, and operated through visits carried out in 03 (three) working days per week, justifying the possibility of access to interviewees approaching 100 %, However a sample n of approximately 75% was possible. The interviews were in the waiting room of the pre and post natal care clinic, always looking for a space reserved for women to be at ease with the researchers.

To collect data, the following instruments were used: first, the Questionnaire on Psychiatric Morbidity in Adults - QMPA (adapted), an instrument originally composed of 45 items, developed by Santana (1982). The QMPA version used was 45 questions, and the questions of numbers 26, 27, 31, 39, 40, 43, 44 and 45 were not part of the research because they were questions whose answers would influence the present study and/Or required the presence of a relative. The instrument consists of questions indicative of Mood Disorders, Anxious, Obsessive-Compulsive, Alcoholism, in addition to psychotic pictures. Being the depressive, anxious and alcoholic pictures those presenting consistent and satisfactory results [8].

In the second moment, a likert type instrument was applied to the Sociodemographic Data Survey - LDS containing 8 questions for the analysis of biopsychosocial factors, and in the third moment a Questionnaire of the conditions of the Puerperal Pregnancy Cycle - QCGP, composed of 20 questions developed with In order to identify measures related to obstetric aspects that may interfere with mental health in pregnancy and labor, both questionnaires were performed by the researchers themselves.

The study respected the ethical and legal precepts of Resolution 466/12 of the National Health Council/Ministry of Health - CNS/MS, which deals with research conducted with human beings, in order to guarantee their anonymity, privacy, secrecy, right of withdrawal At any time without any penalties, as well as to ensure the absence of burdens related to their participation, where all were invited to participate voluntarily, being previously informed about the objectives of the study, possible risks arising from their participation, guaranteed anonymity When the disclosure of the results, with the signing of the Informed Consent Term - TCLE.

The collection was only possible after approval by the Ethics and Research Committee (CEP) of IMIP, under the number of CAEE: 30991314.9.0000.5201. The collected data were processed in computer, in the program Microsoft Office Excel and Word 2010, through graphs and tables and analyzed with simple descriptive statistics.

Results and Discussion

Before analyzing the data collected, regarding the socio-demographic profile, it was verified that of the women interviewed in prenatal care, 35% belonged to the age group between 21 and 25 years; 38% of pregnant women were single; 26% of women had incomplete high school; the family income was equivalent to 1 and 2 minimum wages corresponding to 39% of the sample; 84% live in urban areas; 88% do not have work (occupation); The majority of them referring to 69% reside at home; And as for religion, 43% are Roman Catholic apostolic.

Regarding the postnatal period, still on the socio-demographic profile, it was seen that a significant majority of them were included in the description of young women, aged between 26 and 30 years (34%); Which are mostly single (60%); And 30% have incomplete primary education. Subsequent data are the largest numbers and percentages; are they: family income of 1 to 2 minimum wages corresponding to 54%; 89% live in urban areas; 82% have no employment relationship; 83% live at home; And 52% are Roman Catholic.

Single mothers in the prenatal 38% and postnatal 60% represent for Schardosim and Heldt (2011), a vulnerability not only to a possible rejection of the baby and the gestational process, but also can cause future psychic disorders in this. They reinforce that the unmarried woman during pregnancy experiences a sense of incapacity for not being able to offer a complete family structure to the baby; As well as, may feel unequal for not being able to share new tasks and/or responsibilities with a partner and/or spouse. They also point out that unmarried, low-educated women who are unemployed or unoccupied, smokers or who drink alcohol are very likely to develop psychological distress during or after pregnancy [9].

Being the maternity, a period of risk for the development of crisis, where there are more occurrences of hospitalizations and triggering psychiatric problems in women, it is also important to have knowledge about the care directed to women in the puerperal pregnancy cycle, Pointing to the health care service a focus on the prevention of mental illness in pregnant women [10].

In both the pre and postnatal samples, 76% and 66%, respectively, it is observed that the great majority of women did not have the right to accompany during labor. Law conferred on them by Law 11.108 of 7 April 2005, but which unfortunately is not fulfilled by a large part of the health services.

The importance of having an escort during labor is evident because women feel safer and this reduces the time of labor and the reduction of cesarean surgeries. The presence of this companion also reduces the chances of the woman developing postpartum depression [11, 12].

According to **Table 1**, regarding the Conditions of the Puerperal Pregnancy Cycle of the women, it was observed that 92% of the pregnant women reported having performed prenatal consultations; 93% had a desired pregnancy; 70% did not have previous pregnancies; 76% stated that they were not entitled to the presence of a family member or companion during delivery. Of the pregnant women interviewed, we still have 53% conceptualized care as regular; 82% claimed that they had not received information about the procedures performed; And 61% also stated that no conduct was taken in an absolute or immediate manner.

As to the postnatal data, 97% performed prenatal care; 99% wanted their gestation; 69% did not have any previous management; 66% did not have

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Table 1. Conditions of the Puerperal Pregnancy Cycle of pre and postnatal women accompanied by a philanthropic institution of the State of Pernambuco. Recife (PE), 2014.

Variables	Questionnaire on the conditions of the Puerperal Pregnancy Cycle			
	Pre-natal woman		Postnatal women	
	n	%	n	%
Prenatal (nº* 450 e 325)				
Accomplished	412	92	314	97
Unrealized	38	08	11	03
Gestation (* no. 450 and 325)				
Desired	418	93	321	99
Not Desired	32	07	04	01
Previous pregnancies (* no. 450 and 325)				
Caesarean Surgery	63	14	56	17
Normal birth	52	12	31	09
Abortion and/or dead fetus	18	04	15	05
None	317	70	223	69
Right to family during childbirth (* no. 115 and 83)				
Guaranteed	28	24	28	34
Not guaranteed	87	76	55	66
Inpatient care (nº* 115 and 83)				
Regular	61	53	33	40
Good	27	23	17	20
Bad	09	08	27	33
Great	18	16	06	07
Procedures carried out (* Nos. 115 and 83)				
Informed	21	18	14	17
Not informed	94	82	69	83
Conduct (nº* 115 and 83)				
Immediate	45	39	61	73
Late	70	61	22	27

*: Multiple answers.

the right to a family member during childbirth; 40% found regular care; 83% stated that they had not been informed about the procedures performed; 73% said they had not had absolute or immediate actions taken.

Among the measures performed by the health team, in the period of prenatal care, **Table 2** indi-

Table 2. Care developed by the health team in pre and postnatal women accompanied by a philanthropic institution in the State of Pernambuco. Recife (PE), 2014.

Variables	Questionnaire on the conditions of the Puerperal Pregnancy Cycle			
	Pre-natal woman		Postnatal women	
	n	%	n	%
Relief and comfort ducts (nº* 115 and 83)				
Fulfilled	53	46	36	43
Not performed	62	54	47	57
Privacy during labor (Nos. 115 and 83)				
Gift	33	29	17	20
Absent	82	71	66	80
Object of study by the academics (nº* 115 and 83)				
It was considered	43	37	51	61
It was not considered	72	63	32	39
Injured due to excessive vaginal manipulation (# 115 and 325)				
Felt	74	64	203	62
Did not feel	41	36	122	38
Preference for delivery (no. 450 and 325)				
Normal	258	57	134	41
Caesarean Surgery	192	43	191	59
Cesarean section surgery (no. 63 and 56)				
Chose	23	37	18	32
Did not choose	40	63	38	68
Venloclise (# 115 and 83)				
Submitted	106	92	83	100
Not submitted	09	08	--	--
Head and/or hunger during labor (Nos. 115 and 83)				
Stayed	102	89	80	96
Did not stay	13	11	03	04
Aggressive maneuvers for leaving the baby (nº * 115 and 83)				
Witnessed	24	21	64	77
Did not witness	91	79	19	23
Episiotomy (# 52 and 31)				
There was	27	52	13	42
There was no	25	48	18	58
Verbal aggression during the procession (nº * 115 and 83)				
There was	52	45	35	42
There was no	63	55	48	58
Multiprofessional reception (nº * 115 and 83)				
Has received	85	74	21	25
Did not receive	30	26	62	75

*: Multiple answers.

cates that 54% of the women reported pain, affirming that no measure of relief and comfort was taken; 71% reported having no privacy during delivery; 63% were not considered as an object of study for academics; 64% felt "injured" about the excessive amount of manual examination to check the cervical opening of the cervix; 57% have a normal delivery preference; 63% claimed that they had not had a cesarean section against their will; 92% underwent venoclysis when admitted to have their baby; 89% were long thirsty and/or hungry during labor; As for the aggressive maneuvers to remove his/her child, 79% said that there was no; 52% were submitted to the episiotomy technique; 53% claimed to have been verbally assaulted during labor; And lastly, 74% said they felt welcomed by the professionals who assisted them during labor.

Regarding the measures performed by the health team in the postpartum period, 57% were not provided with therapeutic measures to promote relief and comfort when referring pain; 80% had no privacy during childbirth; 64% felt "injured" over the excessive amount of touch; 68% did not undergo cesarean surgery against their will; 96% of the sample said they had been long thirsty and/or hungry during labor; 58% of postpartum women felt verbally assaulted during delivery; And 100% of the interviewees were submitted to venoclysis in the maternity ward.

There were data that were divergent in the postnatal period compared to prenatal care, as 73% of the women affirmed that they had taken some absolute/immediate behavior; 61% said that they were considered as object of studies towards health academics; Regarding the type of delivery, 59% opted for cesarean surgery; 77% answered that their child was withdrawn through an aggressive maneuver; 58% were not submitted to episiotomy; While 75% did not feel welcomed by the professionals who attended them [12].

It is important that the health professional understands that he needs to share the personal world of the individual with pain, of his self-realization, only then to understand that person in this world of pain. It is necessary for this professional to be prepared and conscious in regard to the human dimension, with a view to being existing in the world, focusing on pain as a moment of fear and anxiety, with the right to search for the relief of this discomfort. It is important to emphasize that non-pharmacological methods can reduce this painful perception in the relief of labor pain and are also considered as non-invasive [13].

It is worth mentioning that the majority of health professionals who work in maternity clinics observe the pain experienced by parturients, a suffering they most often have nothing to do, and to stay in these places with women complaining of pain, it becomes the experience unpleasant for such professionals. Being important to remember the lack of emotional support, over medicalization in childbirth care, are factors that may be related to the increase in pain intensity and little or nothing is offered for your relief.

During and after giving birth, it must be known that every woman has the legal right to: receive treatment free of damages and mistreatment, obtain information, informed consent with possibility of refusal and guarantee respect for her/his choices and preferences, including companion during All admission into the obstetric unit [12, 14].

Silva et al., (2014) also emphasizes the direct to: privacy and confidentiality, being treated with dignity and respect, receiving equal treatment, free of discrimination and equal care, receiving professional care and having access to the highest possible level of health With freedom, autonomy, self-determination and non-coercion. Violated these rights, the woman becomes susceptible to develop traumas and psychic disorders. With this study, it could be observed that the first fruits advocated by the Ministry of Health with regard to Humanized Delivery are still little used today [14].

The restricted use of non-pharmacological methods of pain relief and the harmful practice of restricting fluid during labor are practices observed by other authors in the care of labor [13]. The traumatic history of the period of care during childbirth enhances the probability of various interferences in the life of the assisted mother, as well as in the newborn child, and finally in the family they both make up [15]. Therefore, it is necessary to use health and humanization policies in the Institutions of Women's Health, in order to enable the effectiveness of the real objectives of the practice of care. **(Table 3)**

Table 3. Risk factors associated with Adult Psychological Morbidity - QMAP in pre and postnatal women accompanied by a philanthropic institution in the state of Pernambuco. Recife (PE), 2014.

Variables	Questionnaire on the conditions of the Puerperal Pregnancy Cycle			
	Pre-natal woman		Postnatal women	
	n	%	n	%
Lack of appetite				
Suffer	259	58	221	68
Does not suffer	191	42	104	32
Difficulty sleeping				
Has	256	57	234	72
Does not have	194	43	91	28
Ringing in the ears, agony in the head				
Complains	176	39	121	37
Do not complain	274	61	204	63
Frequent head pains or pangs				
Presents	219	49	142	44
Does not display	231	51	183	56
Weakness in the legs, pains in the nerves				
Feel	211	47	153	47
Do not feel	239	53	172	53
Aggressiveness and explosions with ease				
Stayed	124	28	62	19
Did not stay	326	72	263	81
Sad with dismay				
Gift	321	71	226	70
Absent	129	29	99	30
Feeling of a sore throat, burning or stomach cramping				
Gift	304	68	287	88
Absent	129	29	38	12
Tremors or coldness in hands				
Gift	173	38	73	22
Absent	277	62	252	78
Irritation crises				
Frequent	105	23	270	83
Absent	345	77	55	17
Difficulty in learning				
Has	98	22	78	24
Does not have	352	78	247	76
Drink				
Exaggeratedly	34	8	4	1
Socially	416	92	321	99
Cry				
Much	348	77	248	76
Little	102	23	77	26
Thoughts on ending life				
Gift	04	01	14	04
Absent	446	99	311	96
Shyness				
Gift	303	67	293	90
Absent	147	33	32	10
Nervousness or mental illness				
Prevents work	18	04	-	-
Does not prevent work	442	96	325	100
Episodes without talking or seeing				
Introduced	12	03	05	02
Did not present	438	97	320	98
Crying isolating				
Gift	320	71	26	08
Absent	130	29	299	92
Weekly drunkenness				
Gift	18	04	26	08
Absent	432	96	299	92
Daily				
Drink	14	03	02	01
Do not drink	436	97	323	99

Variables	Questionnaire on the conditions of the Puerperal Pregnancy Cycle			
	Pre-natal woman		Postnatal women	
	n	%	n	%
Tachycardia or tightness in the heart				
Complains	328	73	02	01
Do not complain	122	27	323	99
Nervousness or restlessness				
Frequent	361	80	288	89
Never	89	20	37	11
Hypochondriacal Concerns and Complaints				
Ever	341	76	64	20
Never	109	24	261	80
After fright or annoyance				
Suffer attack	39	09	64	20
Do not suffer attack	411	91	261	80
Excessive fear				
Several things, some bugs, or closed and/or dark places	343	76	242	75
Absent	107	24	83	25
I hear voices or see things				
Gift	27	05	-	-
Absent	423	95	325	100
Nonsense speech				
Frequent	99	22	51	16
Absent	351	78	274	84
Talk or laugh alone				
Frequent	311	69	211	65
Absent	139	03	114	35
Controlled by telepathy, radio or spirits				
Frequent	09	02	-	-
Absent	441	98	325	100
Spends a lot of time in a strange position				
Frequent	117	24	98	30
Absent	333	76	227	70
Joyful without knowing why				
Gift	145	32	70	22
Absent	305	68	255	78
Walk, sing or talk nonstop				
Frequent	135	30	83	26
Absent	315	70	242	74
Sleeping remedy				
Gift	16	04	--	--
Absent	434	96	325	100

Variables	Questionnaire on the conditions of the Puerperal Pregnancy Cycle			
	Pre-natal woman		Postnatal women	
	n	%	n	%
Difficulty attending school				
Gift	126	28	36	11
Absent	324	72	289	89
Excess of madness				
Suffer	56	12	08	02
Does not suffer	394	88	317	98
Attacks, falling to the ground				
Suffer	--	--	--	--
Does not suffer	450	100	325	100
Drugs				
Uses	41	09	21	06
Do not use	409	91	304	94

The study revealed as feasible the psychological suffering of women in the Pre and Postnatal stages, and thus enables the highlighting of the main characteristics of women who are prone to develop any type of mental disorder, with 12 (twelve) risk factors Distribution of QMPA referring to prenatal care were: 58% suffer from lack of appetite; 57% have difficulty sleeping; 71% are sad and dismayed; 68% feel a 'throat, burn or stomach cramp; 77% sometimes stands still, crying a lot; 67% are very shy or inhibited; 71% cry in the bedroom without wanting to see anyone; 73% complain of tachycardia or chest tightness in the heart; 80% are nervous or are always restless; 76% claimed to be very worried about diseases or to complain at all; 76% have excessive fear of certain things, of some animals, of enclosed places, or of darkness; 69% speak or laugh alone.

While in the postnatal period, 10 (ten) risk factors were observed in the sample, being: 68% suffer from a lack of appetite; 83% often have bouts of irritation; 88% 'feel a lump in the throat, burning or stomach cramping; 70% are sad and discouraged; 90% feel very shy or inhibited; 76% sometimes stand still, crying a lot; 89% are nervous or are always restless; 75% have excessive fear of certain

Figure 1: Positivity of propensity for psychic suffering in prenatal care. Recife (PE), 2014.

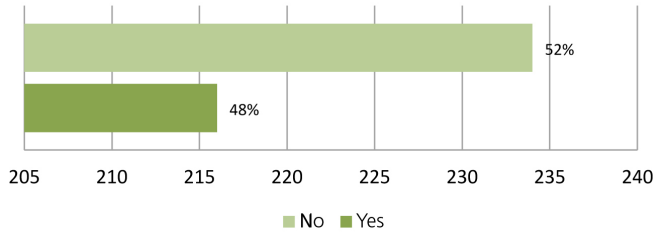
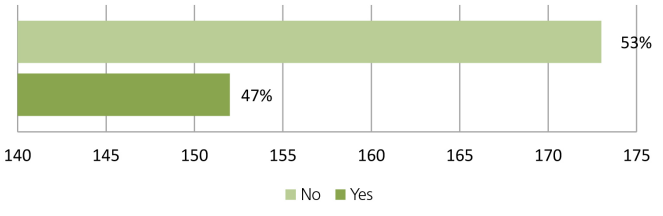


Figure 2: Positivity of propensity for psychic suffering in the postnatal period. Recife (PE), 2014.



things, of some animals, of enclosed places, or of darkness; 65% speak or laugh alone; 72% have difficulty sleeping.

It is assumed that anxious disorders are more frequent than depressive disorders and that, although the association between anxiety and depression is common, not all anxious patients are depressed and maternal anxiety has deleterious effects on galactopoiesis. Indicating that the pregnancy-puerperal period is the phase of higher prevalence of mental disorders in women, especially in the first and third trimester of gestation and in the first thirty days of puerperium, in association with external factors [16].

Figure 1, 48% of the women interviewed, which corresponds to a number of 216 pregnant women, are at risk of developing.

Figure 2 showed that 152 puerperal women who constitute 47% of the interviews are at risk of developing psychic disorders.

As mentioned above, QMPA is a tracking tool developed by Santana (1982) [8], and validated for the Brazilian population in 1998 by Andreoli et al. (2000) [17]. The same consists of 45 questions covering psychiatric symptoms characteristic of mental disorders. In Graphs 1, 2 and in relation to exposed risk factors, they show the number and percentage of pregnant and postpartum women respectively, who presented a cut-off point equal to or greater than seven, indicating the possibility of a psychiatric disorder, that is, the punctuation Equal to or greater than seven points that correspond to the QMPA's yes response [18].

Conclusion

Relating the lines of care in the prenatal and puerperium, it is fundamental that the professionals have means that guarantee a quality assistance and based on humanization, investigating the factors that may influence the health/disease process. Therefore, it is important to emphasize the social, economic, cultural and physical environment of women. The health professional must include an integral and holistic assistance, directed both to physical and mental health and to pay due attention to each particularity that may compromise the psychic well-being of the client or be indicative of possible suffering.

It is concluded that the majority of women who agreed to undergo the interview were women who had a stress or embarrassment situation in their previous pregnancies, also being able to be configured as obstetric violence in what refers to the data of the Cycle Conditions Questionnaire Pregnancy-puerperal. Therefore, becoming predisposing factors and triggering some type of mental disorder or psychic suffering, it is necessary the good analysis of the nursing team and multidisciplinary team for the perception of initial characteristics or the installation of the disease itself.

With an assessment of the socio-demographic profile and through the application of the QMPA, done with each pregnant woman and the puerpe-

rium, it is possible to identify the presence of psychic suffering in a large part of the women, and that often go unnoticed by the attending professionals. The knowledge of the triggering factors and the symptoms developed during the pregnancy-puerperal cycle, including the previously mentioned risk factors, causes the diagnosis of mental illness to become faster, and when necessary the client will be referred to a care More specific, thus providing a safer gestation for mother and fetus.

However, this study is of significant relevance regarding the need not only for professional preparation and research, but also for the awareness of not only these professionals, but also for the implementation of intervention measures to avoid future disorders at a stage that is so common in the reproductive cycle of women. Therefore, mental disorders at this stage should be of importance for Public Health Policies, both in Women's Health Programs, as well as in Mental Health Programs.

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