DOI: https://doi.org/10.36489/saudecoletiva.2020v10i56p3318-3335

High-risk pregnant women: an analysis of self-esteem and associated factors in a reference maternity in the city of Recife, PE, Brasil

Mujeres embarazadas de alto riesgo: un análisis de autoestima y factores asociados en una maternidad de referencia en la ciudad de Recife, PE, Brasil

Gestantes de alto risco: uma análise da autoestima e fatores associados em uma maternidade de referência na cidade do Recife, PE, Brasil

ABSTRACT
The research aims to correlate with self-esteem patterns and associated factors in high-risk pregnant women at a reference maternity hospital in the city of Recife, Pernambuco, Brazil. This is a descriptive, cross-sectional study with a quantitative approach. The sample population included 112 women, pregnant women, adults. For data collection, a form adapted from the Brazilian version of the Rosenberg Self-Esteem Scale (EAR) was used, plus socioeconomic, obstetric, and reproductive issues. It was observed that education was the only variable with a significant association with self-esteem ($p <0.05$) and for that variable it is highlighted that the percentage with unsatisfactory self-esteem decreased with the level of education, being 96.0% among those who had even incomplete elementary school, 75.0% among those with elementary education and 61.0% among those with secondary / higher education. It is recognized that maternity wards often function as a gateway for the identification and reception of these pregnant women, with the need to update / train health professionals to provide adequate and targeted care, since few women have access to assess their emotional state during pregnancy.
DESCRIPTORS: Pregnant; Self Esteem; Women's Health.

RESUMEN
La investigación tiene como objetivo correlacionar con patrones de autoestima y factores asociados en mujeres embarazadas de alto riesgo en un hospital de maternidad de referencia en la ciudad de Recife, Pernambuco, Brasil. Se trata de un estudio descriptivo, transversal con enfoque cuantitativo. La población de la muestra incluyó 112 mujeres, mujeres embarazadas, adultos. Para la recolección de datos se utilizó un formulario adaptado de la versión brasileña de la Escala de Autoestima de Rosenberg (EAR), además de aspectos socioeconómicos, obstétricos y reproductivos. Se observó que la educación fue la única variable con asociación significativa con la autoestima ($p <0.05$) y para esa variable se destaca que el porcentaje con autoestima insatisfactoria disminuyó con el nivel de educación, siendo 96.0% entre los que tenían incluso primaria incompleta, 75.0% entre aquellos con educación primaria y 61.0% entre aquellos con educación secundaria / superior. Se reconoce que las maternidades suelen funcionar como puerta de entrada para la identificación y recepción de estas gestantes, con la necesidad de actualizar / capacitar a los profesionales de la salud para brindar una atención adecuada y focalizada, ya que pocas mujeres tienen acceso para evaluar su estado emocional durante el embarazo.
DESCRIPTORES: Mujeres Embarazadas; Autoestima; Salud de la Mujer.

RESUMO
A pesquisa tem como objetivo correlacionar com os padrões de autoestima e fatores associados em gestantes de alto risco em uma maternidade de referência na cidade do Recife, Pernambuco, Brasil. Trata-se de um estudo descritivo, transversal, com abordagem quantitativa. A população amostral incluiu 112 mulheres, gestantes, adultas. Na coleta de dados foi utilizado um formulário adaptado da versão no Brasil da Escala de Autoestima de Rosenberg (EAR), acrescido de questões socioeconômicas, obstétricas e reprodutivas. Observou-se que escolaridade foi à única variável com associação significativa com autoestima ($p < 0,05$) e para a referida variável se destaca que o percentual com autoestima insatisfatória reduziu com o grau

de escolaridade, sendo 96,0% entre as que tinham até fundamental incompleto, 75,0% entre as que ensino fundamental e 61,0% entre as que tinham ensino médio/superior. Reconhece-se que as maternidades funcionam muitas vezes como porta de acesso para identificação e acolhimento dessas gestantes sendo necessária a atualização/capacitação dos profissionais de saúde para o atendimento adequado e direcionado, uma vez que poucas mulheres têm acesso à avaliação de seu estado emocional durante a gestação.
DESCRITORES: Gestantes; Autoestima; Saúde da Mulher.

RECEIVED ON: 05/21/2020 **APPROVED ON:** 05/22/2020

Liniker Scolfild Rodrigues da Silva
Sanitary in residence mode by the Faculty of Medical Sciences (FCM) / University of Pernambuco (UPE). Specialist in Nursing Obstetrician in the residency modality by the Faculty of Nursing Nossa Senhora das Graças (FENSG) / UPE. Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0003-3710-851X

Eliana Lessa Cordeiro
Master in Neuropsychiatry and Behavioral Sciences from the Federal University of Pernambuco (UFPE). Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0001-7305-9431

Antonio José de Vasconcelos Neto
Specialist in Oncology in the Residence modality by the Hospital de Câncer de Pernambuco (HCP) / Institute of Integral Medicine Prof. Fernando Figueira (IMIP). Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0002-9504-6778

Luana Camila Alves da Silva
Specialist in Public Health from Faculdade Alpha. Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0001-5551-7179

Ana Paula Maurício da Silva
Bachelor of Nursing from Centro Universitário Maurício de Nassau (UNINASSAU). Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0002-1827-3678

Roberta Rosas Trigueiro Gomes
Nurse, Specialist in Health Systems Auditing from the University Estácio de Sá.
ORCID: 0000-0002-4341-3441

Fernanda da Mata Vasconcelos Silva
PhD student in Nursing at the University of Pernambuco (UPE). Recife, Pernambuco (PE), Brazil.
ORCID: 0000-0001-5465-9714

INTRODUCTION

Pregnancy is a peculiar period of transition for women, due to hormonal, psychological and social adaptations, making them more susceptible to physically and mentally stressful events. These situations of wear and tear can result in physiological consequences for both mother and baby[1,2]. During the formation of the new being in the mother's womb, feelings and perceptions about her own body are recreated. The woman integrates herself in a new social context, where obligations are imputed to her according to her new rolel[3].

The mother is seen as a provider of the best feelings. However, in the vast majority of times it is neglected that this new woman / mother has needs for love, affection, care and attention. The fact of being pregnant, for many, is seen as a reason for contentment, pride and fulfillment, however, due to changes in body perception, changes in mood, change in sleep patterns, need to adapt to new social roles, losses can happen in their resourcefulness to conduct their routine and usual roles, bringing about a decline in their self-appreciation, which may arise or show psychiatric disorders[4].

The female organism, during pregnancy, despite important anatomical, endocrine, hemodynamic and immunological changes, manages to maintain balance through compensatory mechanisms and, thus, its evolution, in most cases, occurs without major disorders, being classified as a usual risk pregnancy. However, it may happen that in some cases, due to specific hereditary characteristics, or due to some complicating event, the evolution happens in an unfavorable way, being classified as a high-risk pregnancy[5].

Pregnancy is referred to as high risk when there is any maternal illness that affects the socio-biological condition and may impair its development. The need for various medical follow-ups, which may include frequent hospitalizations and invasive procedures, generates factors that trigger depressive symptoms, such as: anxiety, low concentration, fear, irritability, fatigue, lack of appetite, insomnia, among others. Making high-risk pregnant women more susceptible to the development of depression[6].

Self-esteem is the value judgment that an individual has of himself, corresponding to the set of principles that he brings with him, reflecting on what he feels and thinks. It is evidenced through the reactions that each person presents to different situations and events in life. When its manifestation is positive, the individual generally feels confident, competent and has a personal value. Self-esteem is also considered an important indicator of mental health for interfering in the affective, social and psychological conditions of individuals, thus interfering in the health, well-being and quality of life of the general population[7].

Through the concept of self-esteem, it is possible to establish distinctions in the pregnant woman's mental health assessment processes, helping to perceive an unsatisfactory self-esteem. With this objective, of evaluating self-esteem in a global sense, Rosenberg created his scale, which became known as the Rosenberg Self-Esteem Scale (EAR). The scale assesses the attitude and the positive or negative feeling for itself, where low levels of self-esteem are related to the appearance of mental disorders, such as depression, anxiety and somatic complaints, which can have negative consequences on the interaction of the mother-baby binomial, as well as in the individual development of the human being[8].

Thus, starting from the daily observation of the woman / mother, empathy for the present theme emerged, considering that the guidelines and care received, in most cases, have limited action, emphasizing only a new life to the detriment of the pregnant woman's needs. how to be individual. This reality added to the fact that in Brazil there are still few studies on self-esteem and quality of life during pregnancy, justifies the importance of this article. Therefore, this study aims to correlate with self-esteem patterns and associated factors in high-risk pregnant women at a reference maternity hospital in the city of Recife, Pernambuco, Brazil.

METHODOLOGY

This is a descriptive, cross-sectional study, with a quantitative approach, carried out at the High-Risk Maternity Ward of Hospital Agamenon Magalhães (HAM), in the city of Recife-PE.

The studied population included pregnant women users of the unit mentioned. This was followed by a non-probabilistic sampling, for convenience, with the adoption of the inclusion criteria: pregnant women who used the inpatient services of the High Risk infirmary of the HAM Maternity during the data collection period, aged over 18 years . Pregnant women who did not have the ability to understand and / or verbalize to answer the form were excluded.

Data were collected during the period from April to June 2016. For this purpose, a form adapted from the Brazilian version was used in the year 2011 of EAR by Hutz[9]. This is a one-dimensional measure consisting of ten statements related to a set of feelings of self-esteem and self-acceptance that assesses global self-esteem. Items are answered on a four-point Likert scale ranging from: strongly agree = 4, agree = 3, disagree = 2 and strongly disagree = 1. However, half of the items are stated positively, and the answer options represent the numbers described, and the other half negatively, whose answer numbers should be: strongly agree = 1; agree = 2; disagree = 3; strongly disagree = 4. Thus, each item can receive a score of at least 1 and at most 4. The sum of the responses of the 10 items provides the scale score, whose total score ranges from 10 to 40, and obtaining a high scores reflect high self-esteem. Satisfactory self-esteem is defined as a score greater than or equal to 30 on the referred Scale. Also added questionnaires on socioeconomic, obstetric, and reproductive conditions.

A database was built using the Statistics is a Powerful Statistical Software (SPSS) version 23.0. Data analysis was performed using descriptive statistics. For this, the percentage frequencies and frequency distributions of the analyzed variables were calculated. Inferential analysis was performed using Pearson's Chi-square test or Fisher's Exact Test when the use for the Chi-square test was not verified. The margin of error used in deciding the statistical tests was 5.0%. The program used for data entry and the preparation of statistical calculations was SPSS version 23. The discussion of the results was based on the assumptions of self-esteem in high-risk pregnant women.

The study followed the regulatory guidelines for research involving human beings as recommended by Resolution No. 466, of December 12, 2012, of the National Health Council - CNS[10].

The participants signed the Infor-

Tabela 1. Caracterização dos antecedentes obstétricos e reprodutivos na vida das gestantes participantes da pesquisa. Recife, PE, Brasil, 2018

Variável	n	%
TOTAL	**112**	**100,0**
Idade gestacional		
Pré-termo precoce (< 34 semanas)	60	53,6
Pré-termo tardio (34 a 36 semanas e 6 dias)	35	31,2
Termo precoce (37 a 38 semanas e 6 dias)	16	14,3
Termo (39 a 40 semanas e 6 dias)	1	0,9
Número de gestações		
Primigesta	28	25,0
Secundigesta	28	25,0
Tercigesta	33	29,5
Multigesta	23	20,5
Número de partos		
0	28	25,0
1	43	38,4
2	25	22,3
3 a 8	16	14,3
Cirurgia cesariana em gestações anteriores		
Sim	45	40,2
Não	67	59,8
Número de abortos		
0	80	71,4
1	25	22,3
2	4	3,6
> 3	3	2,7
Planejamento da gravidez atual		
Planejada	39	34,8
Não planejada	73	65,2

Tabela 2. Distribuição das pesquisadas conforme ocupação e religião. Recife, PE, Brasil, 2018

Variável	n	%
TOTAL	**112**	**100,0**
Tem ocupação		
Sim	76	67,9
Não	36	32,1
Ocupação		
Vendedor	2	1,8
Autônomo	2	1,8
Caixa de loja	2	1,8

med Consent Form (ICF), ensuring anonymity and respect for the decision not to participate or withdraw at any time from the study. It was approved by the HAM Ethics and Research Committee (CEP), according to Opinion Number: 2,299,753, and under CAAE: 5379916.2.000.5197.

It is relevant to inform that, because this article is part of the Conclusion of Residency Work (TCR) by the author Liniker Scolfild Rodrigues da Silva (2017), all cases presented in the present study remained unchanged, being used in full, as well as in original work.

RESULTS

The sample studied comprised 112 adult pregnant women. Regarding the socioeconomic indicators of the participants, there is a predominance of the age group between 21 and 25 years old (38.4%), most of them have a stable relationship with their partner, being: marriage (36.7%) and union consensual (33.95%). Regarding religious practice, evangelical (50.9%) was frequent.

As for work and income, 40.2% were domestic workers; 47.3% had a monthly family income of around 1 minimum wage. Regarding housing conditions, 82.1% lived in urban areas, 91.1% lived at home. As for years of study, 42.0% had completed high school.

Regarding obstetric and reproductive history, it is observed that more than half had been pregnant before (75.0%). Table 1 shows the characterization of obstetric and reproductive antecedents in the lives of pregnant women participating in the research. It is observed that 53.6% were during an early preterm pregnancy. Regarding the number of previous pregnancies, 29.5% were tertigravidae, 38.4% had already undergone a previous delivery, 59.8% were never submitted to cesarean delivery at any time. Among the totality, the great majority (71.4%) had no previous abortion. Finally, 65.2% did not plan their current pregnancy.

Costureira	4	3,6
Doméstica	1	0,9
Do lar	45	40,2
Lanchonete	1	0,9
Professora	1	0,9
Auxiliar de serviços gerais	1	0,9
Atendente	1	0,9
Cozinheira	2	1,8
Agricultora	3	2,7
Vigilante	1	0,9
Agente Comunitária de Saúde (ACS)	1	0,9
Cabeleireira	1	0,9
Auxiliar de contábeis	1	0,9
Call Center	1	0,9
Educadora de hotelzinho	1	0,9
Pedagoga	1	0,9
Cobradora de ônibus	1	0,9
Técnica de Enfermagem	1	0,9
Cambista	2	1,8
Não tem ocupação	36	32,1
Religião		
Católica	39	34,8
Evangélicas	57	50,9
Sem religião	16	14,3

Tabela 3. Avaliação das Escalas de Autoestima de Rosenberg. Recife, PE, Brasil, 2018

Variável	n	%
TOTAL	**112**	**100,0**
Autoestima		
Satisfatória	31	27,7
Insatisfatória	81	72,3

Table 2 shows that: the majority (67.9%) had an occupation and of this percentage the most frequent (40.2%) was at home and the other occupations had percentages that varied from 0.9% corresponding to a surveyed person. 3.6%; approximately half (50.9%) were evangelical, followed by 34.8% Catholic and the remaining 14.3% had no religion.

When asked about self-esteem and self-acceptance, according to the Rosenberg scale (EAR), which consists of ten statements (5 positive and 5 negative), related to a set of feelings, the answers being scored according to the variants between, I totally agree , agree, disagree and strongly disagree, a predominance of unsatisfactory self-esteem was obtained through the final calculation (72.3%), as shown in Table 3, which exposes the evaluation of Rosenberg's self-esteem scales.

Table 4 analyzes the association between the categorization of the self-esteem scale and the sociodemographic variables. This table shows that education was the only variable with a significant association with self-esteem ($p < 0.05$) and for that variable it is highlighted that the percentage with unsatisfactory self-esteem decreased with the level of education, with 96.0% among those who had incomplete elementary school, 75.0% among those with elementary education and 61.0% among those with secondary / higher education.

There were no significant associations ($p < 0.05$) between the results of self-esteem and the obstetric data contained in Table 5.

Tabela 4. Avaliação da autoestima segundo os dados sociodemográficos. Recife, PE, Brasil, 2018

Variável	Autoestima						Valor de p	OR (IC 95%)
	Insatisfatória		Satisfatória		Grupo total			
	n	%	n	%	n	%		
TOTAL	**81**	**72,3**	**31**	**27,7**	**112**	**100,0**		
Faixa etária							p (1) = 0,662	
18 a 20	10	58,8	7	41,2	17	100,0		1,00
21 a 25	31	72,1	12	27,9	43	100,0		1,81 (0,56 a 5,85)
26 a 30	17	81,0	4	19,0	21	100,0		2,98 (0,69 a 12,76)

31 a 35	8	72,7	3	27,3	11	100,0		1,87 (0,36 a 9,63)
36 ou mais	15	75,0	5	25,0	20	100,0		2,10 (0,52 a 8,51)
Estado civil							p (2) = 0,702	
Solteiro	23	71,9	9	28,1	32	100,0		**
Casado	26	65,0	14	35,0	40	100,0		
União estável/moram juntos	30	78,9	8	21,1	38	100,0		
Viúva	1	100,0	-	-	1	100,0		
Outros	1	100,0	-	-	1	100,0		
Escolaridade							p (1) = 0,004*	
Até fundamental incompleto	24	96,0	1	4,0	25	100,0		**
Ensino fundamental	21	75,0	7	25,0	28	100,0		
Ensino médio / superior	36	61,0	23	39,0	59	100,0		
Renda familiar (mínimos)							p (2) = 0,306	
Menos que um	13	72,2	5	27,8	18	100,0		1,00
Um	42	79,2	11	20,8	53	100,0		1,47 (0,43 a 5,00)
1 a 2	20	60,6	13	39,4	33	100,0		0,59 (0,17 a 2,06)
Mais de 2	6	75,0	2	25,0	8	100,0		1,15 (0,17 a 7,74)
Tem ocupação							p (1) = 0,068	
Sim	59	77,6	17	22,4	76	100,0		2,21 (0,93-5,22)
Não	22	61,1	14	38,9	36	100,0		1,00
Habitação							p (1) = 0,798	
Zona rural	14	70,0	6	30,0	20	100,0		1,00
Zona Urbana	67	72,8	25	27,2	92	100,0		1,15 (0,40 a 3,32)
Religião							p (1) = 0,874	
Católica	29	74,4	10	25,6	39	100,0		1,00
Evangélica	40	70,2	17	29,8	57	100,0		0,81 (0,33 a 2,03)
Sem religião	12	75,0	4	25,0	16	100,0		1,03 (0,27 a 3,95)

Nota: (*) Associação significativa a 5%; (1) Através do teste Qui-quadrado de Pearson; (2) Através do teste Exato de Fisher.

Tabela 5. Avaliação da autoestima segundo os dados obstétricos. Recife, PE, Brasil, 2018

Variável	Autoestima						Valor de p	OR (IC 95%)
	Insatisfatória		Satisfatória		Grupo total			
	n	%	n	%	n	%		
TOTAL	**81**	**72,3**	**31**	**27,7**	**112**	**100,0**		
Idade gestacional							p(1) = 0,513	
Pré-termo (Precoce)	42	70,0	18	30,0	60	100,0		**
Pré-termo (Tardio)	24	68,6	11	31,4	35	100,0		**
Termo precoce	14	85,5	2	12,5	16	100,0		**
Termo	-	-	1	100,0	1	100,0		
Número de gestações							p(2) = 0,117	
Primigesta	20	71,4	8	28,6	28	100,0		1,00
Secundigesta	16	57,1	12	42,9	28	100,0		0,53 (0,18 a 1,62)

Tercigesta	25	75,8	8	24,2	33	100,0		1,25 (0,40 a 3,92)
Multigesta	20	87,0	3	13,0	23	100,0		2,67 (0,62 a 11,53)
Número de partos							p(2) = 0,231	
0	20	71,4	8	28,6	28	100,0		1,00
1	27	62,8	16	37,2	43	100,0		0,68 (0,24 a 1,88)
2	21	84,0	4	16,0	25	100,0		2,10 (0,55 a 8,08)
3 ou mais	13	81,3	3	18,8	16	100,0		1,73 (0,39 a 7,76)
Número de abortos							p(2) = 0,385	
Nenhum	56	70,0	24	30,0	80	100,0		1,00
Um ou mais	25	78,1	7	21,9	32	100,0		1,53 (0,58 a 4,02)
Via de parto das gestações anteriores vaginais							p(2) = 0,689	
Sim	40	74,1	14	25,9	54	100,0		1,19 (0,52 a 2,72)
Não	41	70,7	17	29,3	58	100,0		1,00
Número de partos vaginais							p(2) = 0,615	
0	41	70,7	17	29,3	58	100,0		1,00
1	23	69,7	10	30,3	33	100,0		0,95 (0,38 a 2,42)
2 ou mais	17	81,0	4	19,0	21	100,0		1,76 (0,52 a 6,01)
Cirurgia cesariana							p(2) = 0,844	
Sim	33	73,3	12	26,7	45	100,0		1,09 (0,47 a 2,54)
Não	48	71,6	19	28,4	67	100,0		1,00
Número de partos cesaria-nos							p(2) = 0,190	
0	48	71,6	19	28,4	67	100,0		**
1	21	65,6	11	34,4	32	100,0		**
2 a 3	12	92,3	1	7,7	13	100,0		**
Quanto à gravidez							p(2) = 0,725	
Desejada / planejada	29	74,4	10	25,6	39	100,0		1,17 (0,49 a 2,82)
Indesejada / não planejada	52	71,2	21	28,8	73	100,0		1,00

Nota: (**) Não foi calculado devido à ocorrência de frequências nulas ou muito baixas; (1) Através do teste Exato de Fisher; (2) Através do teste Qui-quadrado de Pearson.

DISCUSSION

It is observed that the characteristics of the women participating in this study corroborated with information from other studies. Research published in 2015[1], investigated the self-esteem and quality of life of a series of pregnant women attended in units of the single health system in the municipality of Rio Branco - Acre, showed that the majority were over 21 years old, had high school complete, income less than 2 minimum wages. Similarly, authors(11) described the sociodemographic profile of high--risk pregnant women, most of whom were married, completed high school, aged 18-40 years.

The socioeconomic problems present in the life of pregnant women appear to have numerous consequences, such as: low self-esteem, depression, phobia, post-traumatic stress, among others. And they cause damage not only to the victim's life, but also to the lives of those around him and / or living with him. In this sense, health professionals, especially in primary care, should practice qualified listening and welcoming to assist the pregnant woman whenever possible, in order to minimize damage[12].

Regarding obstetric history, a study[13] pointed out that the majority of high--risk pregnant women were multigravida (65.5%), did not mention previous abortion (73.1%), already had at least one child (34.6%), cesarean delivery (59.6%), and early preterm pregnancy (71.2%). Results that corroborate with our study, differing only in relation to the number of previous pregnancies and the mode of delivery.

The results revealed high-risk pregnant women with a predominance of unsatisfactory self-esteem (72.3%), agreeing with the results of other studies in which they pointed out a high number of pregnant women who make up the high-risk group with low levels of self-esteem, they present feeling of helplessness, despair, distortion of self-este-

em. They are also concerned with the possible differentiated life condition of their premature child, marked by limitations, special care and often prejudices[14].

These results show, therefore, that a pregnancy brings with it several challenges to be felt and experienced, especially as it is a high risk, involving the mother-woman-society context. Often, they feel insecurity, shyness, frustration, and fear of the unknown. It is also noticeable distortions between the roles of woman and mother, as this relationship is currently occurring with the devaluation of being a woman, leading to a decrease in the desire to take care of appearance, to dress up, or even to be unaware of the changes of your body in the gestational process[15].

Similarly to the results found, we have a study in which more than half of the pregnant women interviewed (60.6%) showed unsatisfactory self-esteem[16]. Another comparative study between habitual and high-risk pregnancies expresses higher rates for high-risk pregnant women, at least 56.5% of high-risk pregnant women demonstrated at least minimal rates of depression. This behavioral dynamics is promoted mainly by fear of fetus malformation, risk of death and feeling of incompetence in its role as procreator[6].

It is worth noting that the decrease in self-esteem obeys a progressive scale, starting with aggressions, depreciation of oneself that passes for feelings of worthlessness, and may even lead to depression. And that is why it is essential to monitor, whenever possible, psychology. In this sense, the assistance of this professional aims to reduce psychosocial risks present in the pregnancy process[17].

When socioeconomic data are crossed with levels of self-esteem, we have to be analogous to our study, study[4] characterized pregnant women with depression as young (20 to 25 years), completed high school (37.3%), had some paid activity (49.3%), Catholic religious practice (56.9%), disagreeing with the latter topic of the results found in the present study, which presents a predominance of evangelical religion. One study found that most women with low levels of self-esteem were married or lived in a stable relationship with their partner[16].

In reference to religious practice, it is worth mentioning that, during the gestation process, women go through conflictual situations, thus, the search for ways to cope with these situations is remarkable. In this context, religious practice is integrated, acting as a form of escape, regardless of its denomination[4].

It was found that most high-risk pregnant women showed unsatisfactory self-esteem...

It was observed that the level of education presented a significant value in relation to an unsatisfactory self-esteem, similarly, a study carried out to assess the self-esteem of pregnant women using the Rosenberg self-esteem scale found a significant relationship between low education and unsatisfactory self-esteem, $p=0.04$[16]. Authors[11] also found the same results with impaired self-esteem in pregnant women with schooling up to high school.

When obstetric data were associated with levels of self-esteem, there were no significant associations, however, they were verified in other studies identical to ours. Studies that characterized in their research that poor self-esteem was significantly more common among mothers of premature births compared to mothers of full-term newborns and that the risk of depression in mothers of premature babies was twice as high as the risk in mothers of term babies[18,19]. Study[20] presented an obstetric profile where 48% of women were in the second or third pregnancy, 38.8% stated a history of abortion, and 51.4% did not wish or planned the pregnancy, data that corroborate with our study, differing only in terms of the desired pregnancy.

CONCLUSION

It was found that most high-risk pregnant women showed unsatisfactory self-esteem, showing self-deprecating symptoms about their own body and negative feelings regarding the development of pregnancy, such as: fear, insecurity, making them more susceptible to the development of disorders psychiatric.

The depreciating events of self-esteem in pregnant women is not a new phenomenon, however, it is observed that it reaches worrying numbers and has roots in the patriarchal system, causing damage to the quality of life and health of women. It is necessary to interrupt this cultural dynamic in which the woman is held responsible for the total family balance.

It is necessary, therefore, to rethink the sexual and social division of family responsibilities and denaturalize domination over women, especially pregnant women, allowing them to be considered as being in the process of transformation and adaptation, providing them with the bases for their emotional development. and physical.

In short, it is recognized that health care, provided in maternity hospitals, is sometimes the gateway to the identification and reception of women in situations of emotional and / or psychiatric disorders. In this sense, it is recommen-

ded to promote the updating / training of health professionals in maternity hospitals (especially those at high risk), especially nurses, so that they can recognize the vulnerabilities of high-risk pregnant women and intervene with quality through the approach psychosocial, educational and clinical-preventive care for women in vulnerable situations. ■

REFERENCES

1. Santos AB, et al. Autoestima e qualidade de vida de uma série de gestantes atendidas em rede pública de saúde. Revista Cogitare Enfermagem [Internet]. 2015 [acesso em 13 out 2017];20(2):392-400. Disponível em: http://revistas.ufpr.br/cogitare/article/view/38166.

2. Zanatta E, Pereira Caroline RR, Alves AP. A experiência da maternidade pela primeira vez: as mudanças vivenciadas no tornar-se mãe. Pesqui. prát. Psicossociais [Internet]. 2018 [acesso em 20 mai 2020];13(1):1-16. Disponível em http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1809-89082018000100005&lng=pt&nrm=iso.

3. Tomaschoewski-Barlem JG, et al. Promovendo A Autoestima Na Gestação: foco no acolhimento. Enfermagem em Foco. 2016;7(2):83-86. http://dx.doi.org/10.21675/2357-707x.2016.v7.n2.801.

4. Silva MMJ, et al. Ansiedade e depressão na gravidez: caracterização de gestantes que realizaram pré-natal em unidades públicas de saúde. Revista de Enfermagem UFPE on line. 2015;9(7):9027-37. Doi: 10.5205/reuol.8074-70954-1-SM0907supl201512.

5. Tostes NA, Seidl EMF. Expectativas de Gestantes sobre o Parto e suas Percepções acerca da Preparação para o Parto. Trends in Psychology [Internet]. 2016 [acesso em 20 dez 2017];24(2):681-693. Disponível em: http://pepsic.bvsalud.org/pdf/tp/v24n2/v24n2a15.pdf.

6. Zeoti FS, Petean EBL. Apego materno-fetal, ansiedade e depressão em gestantes com gravidez normal e de risco: estudo comparativo. Estudos de Psicologia, Campinas [Internet]. 2015 out. [acesso em 20 dez 2017];32(4):675-683. Disponível em: http://www.scielo.br/scielo.php?pid=S0103-166X2015000400675&script=sci_abstract&tlng=pt.

7. Cabral AMF. Avaliação da autoestima e qualidade de vida dos filhos separados pela hanseníase no Estado do Rio Grande do Norte. 2016. 86 f. Tese (Doutorado) - Curso de Enfermagem na Atenção à Saúde, Centro de Ciências da Saúde, Universidade Federal do Rio Grande do Norte, Natal, 2016.

8. Sena R, et al. Correlação entre imagem corporal e autoestima em pessoas com estomias intestinais. Psic., Saúde & Doenças [Internet]. 2018 dez. [acesso em 20 mai 2020];19(3):578-590. Disponível em: http://www.scielo.mec.pt/scielo.php?script=sci_arttext&pid=S1645-00862018000300009&lng=pt&nrm=iso.

9. Hutz CS, Zanon C. Revisão da adaptação, validação e normatização da escala de autoestima de Rosenberg. Revista Avaliação psicológica [Internet]. 2011 [acesso em 15 jan 2017];10(1):41-49. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-04712011000100005.

10. Conselho Nacional de Saúde (BR). Resolução n.º 466, 12 de dezembro de 2012 [Internet]. Diário Oficial da União, Poder Executivo, Brasília, DF, 13 jun. 2013 [acesso em 15 dez 2016]. Seção 1. p.59-62. Disponível em: http://sintse.tse.jus.br/documentos/2013/Jun/13/cns-resolucao-no-466-de-12-de-dezembro-de-2012.

11. Guerra JVV, Valete COS, Alves VH. Socio-demographic and health profile of pregnant women in a high-risk prenatal care. Braz. J. Hea. Rev [Internet]. 2019 fev. [acesso em 25 mai 2020];2(1):249-261. Disponível em: https://www.brazilianjournals.com/index.php/BJHR/article/view/911.

12. Oliveira EC, Barbosa SM, Melo SEP. The Importance Of Monitoring Prenatal Made By Nurses. Revista Científica Facmais [Internet]. 2016 jul. [acesso em 25 ago 2020];7(3):24-38. Disponível em: https://docplayer.com.br/53056080-A-importancia-do-acompanhamento-pre-natal-realizado-por-enfermeiros-the-importance-of--monitoring-prenatal-made-by-nurses.html.

13. Luz BG, et al. O perfil das gestantes de alto risco acompanhadas no pré-natal da policlínica de Divinópolis-MG, no biênio 2013/14 Journal Of Health & Biological Sciences. 2015;3(3):137-128. http://dx.doi.org/10.12662/2317-3076jhbs.v3i3.177.p137-143.2015.

14. Ulloque-Caamano L, Monterrosa-Castro A, Arteta-Acosta C. Prevalencia de baja autoestima y nivel de resiliencia bajo, en gestantes adolescentes de poblaciones del caribe colombiano. Rev. chil. obstet. Ginecol. 2015 dez.;80(6):462-474. http://dx.doi.org/10.4067/S0717-75262015000600006.

15. Silva MLFS. Gravidez de alto risco: adaptação psicológica de gestantes. Revista Saúde [Internet]. 2016 [acesso em 15 out 2017];10(1). Disponível em: http://revistas.ung.br/index.php/saude/article/view/2593.

16. Carvalho IG, et al. Ansiedade, depressão, resiliência e autoestima em indivíduos com doenças cardiovasculares. Rev. Latino-Am. Enfermagem [Internet]. 2016 [acesso em 20 mai 2020];24:e2836. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692016000100432&lng=en&nrm=iso.

17. Paiva TT, Pimentel CE, Moura GB. Violência conjugal e suas relações com autoestima, personalidade e satisfação com a vida. Gerais, Rev. Interinst. Psicol. [Internet]. 2017 dez. [acesso em 20 mai 2020];10(2):215-227. Disponível em http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1983-82202017000200007&lng=pt&nrm=iso.

18. Candido TCR, et al. O uso de bebida alcoólica entre gestantes adolescentes. SMAD, Rev. Eletrônica Saúde Mental Álcool Drog. (Ed. port.). 2019 dez.;15(4):1-8. http://dx.doi.org/10.11606/issn.1806-6976.smad.2019.151701.

19. Cordeiro EAO, Silva LMS, Silva GL. Self-esteem in pregnancy: prevention and Social Protection. Revista Cientifica do Unisalesiano. 2018 dez.;9(19):427-439.

20. Novaes ES, et al. Perfil obstétrico de usuárias do sistema único de saúde após implantação da rede mãe paranaense. Revista Ciência Cuidado e Saúde. 2015 dez.; 14(4):1436-1442. http://dx.doi.org/10.4025/cienccuidsaude.