



# Prevalence and Risk Factors of Domestic Violence in Primigravidae in Low Socio-Economic Areas of Hamedan, Iran

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Received: 02 Nov 2022  
Accepted: 27 Dec 2022  
ePublished: 19 Mar 2023



## Abstract

**Background and Objective:** Domestic violence against women is a major physical and mental health problem all across the globe. Therefore, the present study aimed to investigate the prevalence of domestic violence in pregnancy, as well as its correlation with sociodemographic and psychological characteristics.

**Materials and Methods:** This cross-sectional study was conducted on 360 pregnant women who were referred to the health care centers of Hamedan in 2022. Data were collected through a questionnaire that consisted of three parts: sociodemographic characteristics, psychological characteristics, and the questionnaire on domestic violence (Revised Conflict Tactics Scales OR CTS2). Data analysis was performed in SPSS software (version 20) using descriptive statistics, t-test, and Chi-square.

**Results:** The overall Prevalence of domestic violence during pregnancy was 58.6%. The prevalence rates of emotional, sexual, and physical violence were obtained at 46.8%, 31.6%, and 27.7%, respectively. The level of education, occupation, wealth index, as well as alcohol and drug abuse, had a significant relationship with domestic violence ( $P < 0.001$ ). Domestic violence was significantly correlated with unplanned pregnancies ( $P < 0.001$ ), self-esteem ( $P < 0.004$ ), stress ( $P < 0.001$ ), social support ( $P < 0.001$ ), and prenatal depression ( $P < 0.001$ ).

**Conclusions:** The results of this study pointed to a relatively high prevalence of domestic violence during pregnancy. Therefore, it is suggested that all prenatal care centers have a screening program to identify domestic violence. Moreover, it is recommended to educate health professionals and women at risk and implement support programs for injured women.

**Keywords:** Domestic violence, Pregnant women, Psychological characteristics

## Background

Domestic violence (DV) against women is an acute social issue that is observed all across the globe. It seriously affects not only women's health, well-being, and rights but also families, communities, and the next generation[1]. Violence, as defined by the World Health Organization, refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women [2]. The DV could be a genuine, preventable, and public health issue that influences millions of women. The term "domestic violence" depicts violence by a current or previous spouse[3].

The 9%-15% years of life lost in women aged 15-44 is another factor that highlights the need for the health sector to pay closer attention to this problem.

These factors make DV and abuse among the main risk factors for mortality, higher than cancer, motor vehicle accidents, and war[4]. As a result, DV affects about 40%-50% of women at one time or another in their lives, affecting their physical and mental health[2]. The DV occurs in different cultural, age, racial, and religious groups; moreover, it sometimes starts or worsens during pregnancy. Some studies have also reported a change in the type of violence[5]. Although the prevalence of DV during pregnancy varies from 1%-30% in different studies, it was reported to be higher than 60% in conducted studies in Iran [2,6].

The prevalence of DV is higher than many common pregnancy complications, such as preeclampsia and diabetes [7]. Pregnancy can affect

the intensity and prevalence of DV due to some reasons, such as reducing sexual relations, misconceptions about pregnancy, and the husband's abnormal feelings about pregnancy. Consequently, it is recommended to screen all pregnant women for DV at the first visit in prenatal care and then each trimester of pregnancy and postpartum[7]. The factors implicated in pregnancy violence include low educational attainment, smoking and drug abuse, unwanted pregnancy, and low income. Different types of violence include physical, sexual, and psychological that vary greatly in different cultures [5].

Although physical injuries and death are the most obvious and immediate consequences of physical DV against women, there is a wide array of psychological complications (such as chronic physical complaints, reproductive health problems, and engaging in high-risk behaviors, such as drug and alcohol abuse) and each of these issues re-exposes the individual to DV[8]. Multiple studies have pointed to the role of physical violence in the occurrence of such pregnancy complications as low birth weight, premature birth, low Apgar score, and cesarean delivery. In addition to the physical and psychological complications of DV in pregnant women, it also affects the well-being of the fetus and the future child [3,9].

Self-esteem and social support may characterize two concepts involved in DV. One of the functions of social support is to advance positive change, which has been presented to be a possible barrier against the negative effect of stress [10]. Self-esteem can be perceived as an index for the level of mental health. The DV, with its different effects, unavoidably influences women's self-esteem. Stress and low self-esteem were independent risk factors for DV. Perceived social support and self-esteem were lower in mothers who reported domestic violence. Self-esteem was significantly lower when sexual violence was inflicted [10]. Pregnant women who were involved in any level of DV by their partner suffered from more severe depression compared to others[11].

The first step to address the issue of DV is to collect data on the extent and distribution of this phenomenon. The second step is to understand the relationship of sociodemographic and psychological variables (perceived stress, self-esteem, social support, and prenatal depression) with DV in pregnant women. The studies pointed out that this problem is undeniable in all countries and cultures. There is a dearth of information on the early recognition of DV, understanding its relationship with socio-demographics and psychological variables, as well as preventive measures in

Hamedan, especially in low-income areas. Therefore, the present study aimed to assess the prevalence and factors related to DV in pregnant women referring to health care centers on the outskirts of Hamedan city.

### Objectives

Domestic violence against women is a major physical and mental health problem all across the globe. Therefore, the present study aimed to investigate the prevalence of domestic violence in pregnancy, as well as its correlation with sociodemographic and psychological characteristics.

### Materials and Methods

This cross-sectional study was conducted on pregnant women on the outskirts of Hamedan in 2022. The research population included all women who were referred to healthcare centers. The sample size was calculated at 360 primigravidas with a confidence interval of 95% and a sampling error of 05%. After obtaining permission from the health deputy of the university, five healthcare centers in low-income areas in Hamedan were randomly selected. Thereafter, primiparous women were selected using simple random sampling according to the inclusion criteria (the age range of 18-35 years, completed primary school, and gestational age of above 20 weeks) and exclusion criteria (history of abortion and infertility, obstetric complications, as well as physical and psychological disorders). The data were collected using a self-administered questionnaire which comprised of sociodemographic, psychological characteristics, and DV questionnaire. Psychological characteristics are as follows: The Perceived Stress Questionnaire (PSS) is adaptable to any cultural context since it compares participants within a sample. The reliability of PSS was in the range of 0.84-0.86[12]. The reliability of PSS-10 was assessed in Iran, rendering a Cronbach's alpha coefficient of 0.90 [13].

The Rosenberg Self-Esteem scale (RSES) is a 10-item Likert-type scale to measure self-esteem (range 0-40). It is used as a one-dimensional measure of global self-esteem (cognitive and affective components), general self-worth, and positive self-esteem [14]. The reliability and validity of the Rosenberg Self-Esteem Scale have been periodically checked and confirmed in Iran[15].

Social support was assessed by the multidimensional scale of perceived social support (MSPSS), which is a 12-item scale to assess perceptions about support from family, friends, and a significant other. It is a self-administered questionnaire, and each item is scored 1-7. The Psychometric characteristics of the MSPSS were assessed in 1990, and its reliability was calculated at 0.93 [16]. The MSPSS was translated

into Farsi and checked for reliability and validity [17]. Edinburgh Depression Scale was designed to detect depression with 10 items. The score on the Edinburgh Scale range from 0-30, with a score  $\geq 12$  being regarded as prenatal depression. The reliability of the questionnaire has been checked in other countries and Iran. Cronbach's alpha coefficient for the Edinburgh questionnaire was obtained at  $>0.70$  [18,19].

Revised Conflict Tactics Scales OR CTS2 is widely used to measure physical and psychological conflicts of couples during 12 months. This 30-item questionnaire encompasses five domains: psychological aggression (8 items), physical attack (12 items), sexual coercion (4 items), and injury (6 items). In the research by Strauss et al. (2004), the validity of the questionnaire was confirmed by examining convergent validity and construct validity. Moreover, Cronbach's alpha coefficients were reported between 0.79 and 0.95 [20]. In a similar vein, the validity and reliability of the questionnaire were confirmed in Iran [21].

This study was approved by the Research Ethics Committee of Hamedan University of Medical Sciences (code: IR.UMSHA.REC.1396.516). To observe ethical considerations, before sampling, the participants were asked to sign written informed consent forms to cooperate in the research and were informed of the purpose of the study. Moreover, the protection of the private and personal information of the volunteers was put on

the agenda. This research has no contradiction with the religious and cultural standards of the subject and society. The data were analyzed in SPSS software (version 20) using descriptive tests, chi-square, and t-test at a significance level of 0.05.

## Results

In the present study, 360 pregnant women participated. The mean age scores of pregnant women and their spouses were  $26.3 \pm 5.8$  and  $31.5 \pm 4.6$  years, respectively. The majority of women and their spouses had diplomas (43.6%) and high school education (56.4%), respectively. Most pregnant women in this study (73.9%) were housewives, and most of their husbands (52.5%) have been recently employed. Most women (46.1%) had unsuitable economic status. Most participants said that their husbands were not alcohol or drugs abuser. The majority of women (62.7%) had planned pregnancy.

Table 1 illustrates the relationship between demographic characteristics and DV. Although DV has no statistically significant relationship with respondents' age and their husbands' age, it showed a significant correlation with the education, job, and wealth of pregnant women and their husbands ( $P < 0.001$ ). In addition, DV demonstrates a statistically significant relationship with the plan of pregnancy in pregnant women, as well as drug and alcohol abuse in their spouses ( $P < 0.001$ ).

**Table 1.** Relationship between sociodemographic characteristics and DV among pregnant women (n=360)

Characteristics	Total	Experienced any form of DV N(%)		P-value
		Yes	No	
<b>Age</b>				
18-24	101(28.1)	51.6	48.4	NS
25-29	225(62.5)	41.3	58.7	
30-34	34(9.4)	52.8	47.2	
<b>Educational level</b>				
Primary	42(11.7)	56.8	43.2	<0.001
Secondary	100(27.8)	63.6	36.4	
Diploma	157(43.6)	42.6	57.4	
Higher	61(16.9)	12.8	87.2	
<b>Occupation</b>				
Employee	94(26.1)	21.8	78.2	<0.001
Housewife	266(73.9)	53.1	46.4	
<b>Husband's Age</b>				
22-24	47(13.1)	46.9	53.1	NS
25-29	139(38.6)	44.4	55.6	
30-34	174(48.3)	44.8	52.2	
<b>Husband's Educational level</b>				
Primary	52(14.4)	43.9	56.1	<0.001
Secondary	203 (56.4)	56.3	43.7	
Diploma	70(19.4)	29.4	70.6	
Higher	35(9.7)	16.6	83.4	
<b>Husband's Occupation</b>				
Employee	189(52.5)	39.7	78.3	<0.001
Self-Employed	91(25.3)	35.5	75.5	
Unemployed	80(22.2)	66.4	38.6	

Table 1 continue

<b>Wealth Index</b>				
Unsuitable	166(46.1)	64.7	35.3	<0.001
Middle	77(21.4)	35.9	64.1	
Relatively suitable	117(32.5)	22.6	77.4	
<b>Drug or Alcohol abuse of husband</b>				
No	222(61.7)	31.3	68.7	<0.001
Yes	138(38.3)	68.4	31.6	
<b>Plan of pregnancy</b>				
planned	226(62.7)			<0.001
unplanned but welcome	49(13.6)	24.3	75.7	
unplanned	85(23.6)	80	20	
		81.3	18.7	

Table 2. Relationship between psychological characteristics and DV among pregnant women (n=360)

Psychological Characteristics	Experienced any form of DV		Test-statistics	P-value
	Yes Mean ± SD	No Mean ± SD		
RSES	23.87 ± 1.75	26.47 ± 1.8	t=2.87	0.004
PSS	26.05 ± 4.64	18.36 ± 2.77	t=15.35	<0.001
MSPSS	49.56 ± 9.28	54.42 ± 9.78	t=6.34	<0.001
Prenatal depression	16.56 ± 4.28	12.43 ± 3.64	t=5.72	<0.001

Table 2 displays the relationship of self-esteem, stress, social support, and prenatal depression with DV. The mean score of self-esteem and social support in women who experienced DV was lower than that in other women ( $P < .001$ ).

Nonetheless, the mean score of stress and prenatal depression in women with DV experience was higher than that in other women ( $p < .001$ ). In general, the difference in the score of self-esteem, social support, as well as stress and prenatal depression, was significant in women who experienced DV and other women.

The prevalence of DV was 58.6%, and the data indicated that, in general, 46.8% of pregnant women experienced emotional violence. This violence was mild, moderate, and severe in 22.3%, 62.9%, and 14.8% of participants, respectively. In total, 27.7% of pregnant women experienced physical violence. This violence was mild, moderate, and severe in 34.4%, 52.7%, and 12.9% of subjects, respectively. Finally, 31.6% of pregnant women experienced sexual violence. This violence was mild, moderate, and severe in 28.3%, 47.1%, and 24.6% of cases, respectively (Table 3).

Table 3. Frequency of different types of domestic violence and their intensity among pregnant women (n=360)

Type of Violence	Total	Severity		
		Mild	Moderate	Severe
Emotional Violence	46.8	22.3	62.9	14.8
Physical Violence	21.7	34.4	52.7	12.9
Sexual Violence	31.6	28.3	47.1	24.6

## Discussion

The Prevalence of DV during pregnancy was obtained at 58.6% in the present study. According to the Ministry of Health and Medical Education, the Prevalence of DV in Iranian women was 65%. Nevertheless, the results of other studies in Iran were indicative of a higher prevalence. For instance, the prevalence rates of 82.8%, 79.94%, 72%, 67.5%, and 60.5% were reported in Tehran, West Azerbaijan, Zanjan, Charmahal Bakhtiari, and Kordestan, respectively [6,8,22,23]. This discrepancy in prevalence can be ascribed to methodological, sampling, and cultural variances, as well as respondents' willingness to share their experiences of spousal abuse during pregnancy

as part of their privacy [2].

The results of the current study pointed out that the most common type of violence was emotional violence (46.8%), sexual violence (31.6%), and physical violence (21.7%), respectively. The present findings are consistent with the results of the studies performed in Kurdistan and Ahvaz, signifying that physical violence was the least frequent form of violence [5,24]. It seems that the low prevalence of physical violence can be attributed to the fear of harming the mother and fetus during pregnancy [2]. In accordance with the present research, Shamsi and Bayati (2011) presented emotional violence as the most common type of violence (56%), followed by verbal 48%

and physical 11% violence [25]. In a study in Zanjan, the overall prevalence of DV (72%) was higher than that obtained in the present research, and the most common types of violence were emotional (64.4%), sexual (28.8%), and physical (22.7%) [23]. In the study of DV in Tehran, 81% of women had experienced violence. This violence was reported as mild (68.7%) and moderate to severe (12.0%). 18.29 of women reported emotional violence, and 13.43 reported physical violence [26]. The results of studies in different Asian countries reported different prevalence; for instance, International Center for Research on Women (ICRW) reported that the highest local rate of DV prevalence was 43% in South Asian women [3]. In a similar vein, a review analysis of 137 articles on DV in India revealed that an average of 41% of women reported DV [27]. In a study in Lebanon (2007), 68.8% of women had at least one positive answer to one of the types of violence. Physical, sexual, and emotional-verbal types of violence were reported by 68.8%, 26.2%, and 16% of women, respectively [28]. This discrepancy in the intensity of the types of violence in different countries and cities can be ascribed to different methods of investigating violence and cultural differences in various societies.

The inferential findings of this research demonstrated that although there was no significant relationship between the age of women and their spouses with DV, an elevation in the educational, occupational, and economic level of women and their partners has been a protective factor in the reduction of violence. These findings confirmed the results of previous studies [29–31]. The study by Noori et al. (1395) illustrated that 84.78% of pregnant mothers mentioned the experience of violence, and the most common type of violence was emotional violence. Violence against mothers decreased with an increase in the educational level of women and their husbands. Spouse violence was significantly high in men aged 20–29, with a prevalence of 14.38%; therefore, there was a significant relationship between the age of the husband and the types of DV [32]. The results of a study in Shiraz displayed that DV was not significantly correlated with educational, occupational, and economic levels [29].

The results of a study by Golu (2013) denoted that women's level of education and job status are important predictors of DV [33]. The results of a study by Lee et al. (2015) on 497 women who reported DV indicated that Taiwanese women who experienced violence had higher education and employment levels compared to immigrant women who experienced violence [34]. Inconsistent with the

findings of the present research, the results of a study by Bagherzade et al. showed no significant relationship between education and DV [29]. In the current study, drug abuse and alcohol consumption were significantly correlated with DV. In the same context, a study performed in Thailand indicated that alcohol consumption by spouses was associated with DV and that the committer was disposed to consume alcohol before engaging in any violence [34]. The attitude towards DV displayed a significant relationship with drug abuse and alcohol consumption by spouse and. [30]. Violence had a direct and strong relationship with drug abuse and the educational level of husbands [23]. In agreement with the findings of a study by Hassan Zadeh [24], the results of the present research pointed out that the women whose husbands had not consumed alcohol or drugs experienced less violence.

In the present study, pregnant women who experienced DV had more perceived stress, more perinatal depression, lower self-esteem, and less social support. These findings are in line with the results of a study by Etsamipour, who demonstrated that women who had lower self-esteem were more likely to be subjected to DV [35]. Abused women experience many problems, such as a lack of social support and feelings of worthlessness. Stress and depression are other common responses of injured women who continue to live with abusive husbands with low self-confidence [36,37]. Psychological violence among pregnant women is the most common type of violence, inclining them to depression, low self-esteem, and anxiety [38]. The social support system has been recognized as a protective factor against violence during pregnancy. Many women who are abused during pregnancy report that their husbands attempt to socially isolate them from family, friends, and other social support systems. Decreased social support increases the chance of DV [39].

### Conclusions

In women with DV, social support is the most important factor in accepting violence from the spouse [34]. Social support is considered a deterrent to violence. Training couples on communication skills and increasing social support, especially in the first years after marriage, are effective ways to reduce the psychological damage of violence against pregnant women in the family [7]. In addition, the prevalence of violence demonstrated a marked increase in cases where the woman did not have social support that could support her socially and economically. The incidence of prenatal depression seems to be affected by DV [40].

Trabold, in his PhD thesis entitled "the

interrelationship between DV and postpartum depression," referred to a higher prevalence of depression in pregnant and non-pregnant women who had experienced DV. In the evaluation of pregnant women who have experienced DV but no information about postpartum is available, a high prevalence of prenatal depression are observed prenatal depression is more marked in women who experience DV compared to others. The DV and prenatal depression interact; however, the presence of DV affects the severity of prenatal depression [40].

#### Compliance with ethical guidelines

All ethical principles were considered in conducting the present study.

#### Acknowledgments

We highly appreciate all personnel of health care centers in Hamedan, as well as the pregnant women who participated in this study.

#### Authors' contributions

All authors participated in drafting of the article and approved the final version.

#### Funding/Support

There were no financial supports/funds for the study.

#### Conflicts of Interest

The authors declare no conflict of interest.

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