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Intimate partner violence during the first pregnancy: A comparison between adolescents and adults in an urban area of Iran

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ABSTRACT

There is uncertain evidence that intimate partner violence (IPV) during pregnancy is more common among adolescents. We aimed to compare prevalence and chronicity of IPV during the first pregnancy between adolescents and adults. 136 women aged 15 to 19 and 272 women aged 20–29 years between 24 and 30 weeks gestation (stratified by center) were examined at all 80 public health centers/posts in Tabriz-Iran. IPV was assessed using the revised conflict tactics scales. The adolescents and adults reported roughly the same rate of overall IPV perpetration (72% vs. 71%, p = 0.816). Rate of victimization was slightly higher among the adolescents (69% vs. 62%) but the difference was not statistically significant (p = 0.144). The most common types of IPV perpetration and victimization in the both groups were psychological aggression, followed by physical assault and sexual coercion. Using only two physical assault and sexual coercion subscales, rate of IPV perpetration fell to 40% vs. 28%, p = 0.016 and victimization fell to 46% vs. 38%, p = 0.227. There were no statistically significant differences between the groups in terms of prevalence and chronicity of various types of IPV, except sexual coercion victimization which was more prevalent among the adolescents (31% vs. 21%, p = 0.034). The high rates of IPV perpetration and victimization during pregnancy among both adolescents and adults in the study area with significant higher risk of sexual coercion victimization among adolescents require health policy makers and care providers to have serious efforts for its reduction.

1. Introduction

Intimate partner violence (IPV), defined as psychological, physical, or sexual harm by a partner or spouse, is a serious public health problem. It has devastating consequences on its victims and long standing impacts on foundations of the family.[1,2]

IPV against women is very common and widespread all over the world. Worldwide almost one third of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner.[3] There are limited studies on IPV against men and the results are conflicting.[4–6] A national study in the United States (US) indicates that men are significantly less likely than women to experience physical or sexual IPV but more likely to report verbal abuse alone.[4] In another study in the US using only physical assult and sexual coercion scales it was shown that rate of IPV perpetration was higher than victimization among pregnant women.[6]

The WHO study in 10 various countries found that prevalence of physical IPV against women in pregnancy is varied and ranges between 1% in a city of Japan to 28% in a province of Peru.[7] In Iran, reported prevalence of overall IPV during pregnancy ranges from 56% to 73%, using more detailed and behaviorally specific tools like psychological aggression, physical assault and sexual coercion scales of the conflict tactics scales (CTS).[8–11]

Violence during pregnancy is a major public health concern. It is associated with many maternal health problems like reduced prenatal care in early pregnancy, poor maternal nutrition and weight gain, increased cigarette smoking, and alcohol and illicit drug use,

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anxiety, depression, vaginal bleeding, anemia and sexually transmitted diseases. It also has some risks for the fetus and infant, including increased likelihood of elective pregnancy termination, spontaneous abortion, premature childbirth, low birth weight, and fetal and neonatal death.[1,6,12–14]

Marriage and pregnancy in adolescence have been mentioned as risk factors for domestic violence.[15–17] Higher rate of overall or some types of IPV during pregnancy among adolescents compared to adults have been reported in studies conducted in the US [4,17] and Turkey.[18] However, the evidence is very limited and we found no study in this area in Iran.

About 11% of all births worldwide are to girls aged 15–19 years old.[19] Although in Iran the rate is lower than the global level (7% of the total),[20] it is expected to rise in the following years due to the recent change in population control policies in the country toward population-promoting policies and encouraging women to have three children by the age of 30.[21]

This study aimed to compare prevalence and chronicity of overall and various types of women's IPV perpetration and victimization during the first six months of first pregnancy and also their lifetime risk in adolescents with those aged 20–29 years. We also compared the proportion of various types of IPV perpetration with IPV victimization within each group.

2. Methods

This comparative cross-sectional study was conducted on 136 women aged 15–19 years and 272 women aged 20–29 years with first pregnancy between 24 and 30 weeks gestation who had prenatal care records at public health centers/posts of Tabriz-Iran in 2014.

Tabriz with about 1.7 million population is the capital city of east-Azerbaijan province. In urban area of Iran, literacy rate of women aged 15–24 is 97%; rate of women marriage before 18 years is 15%; mean women age at marriage is 22.3 years; rate of antenatal care coverage at least one visit is 97%.[22] At public centers/posts in the country, all primary care services, including prenatal care, are provided free of charge. In 2005, about half of pregnant women in the city were receiving prenatal care at these centers/posts.[23]

The inclusion criteria included duration of marriage between one and five years, living with the husband during the past 12 months, literacy of middle school level or more, and first formal marriage of both wife and husband. Women with any of following condition in their own and\or their husbands were excluded: serious known chronic diseases or mental illness, drug abuse, a history of being in prison, a history of infertility, or experience of a very stressful event (like death of first degree family members) in the past nine months.

Sampling began after obtaining ethical approval from the Ethics Committee of Tabriz University of Medical Sciences (No. 5-4-2959 dated June 26, 2014). The researcher (EBV) selected potentially eligible women (in two groups of 15–19 and 20–29 years) using the information in the registry book of pregnant women and the medical records of the women at all 80 centers/posts. All eligible women aged 15–19 years were considered as study samples in the adolescent group. From each center/post, eligible women aged 20–29 years were randomly selected twice as many as the adolescent group.

The researcher called the selected potentially eligible women, by phone numbers accessed from the registry book of pregnant women at the centers/posts, and explained them about the objectives and methods of the study, reassured them of confidentiality of information, and scheduled an appointment for eligible women to attend the determined health center/post to complete the study questionnaires. At the centers/posts, the researcher obtained informed consent, emphasized importance of honest answer to the questions and asked study participants to complete the anonymous questionnaires in a private room.

The data collection tools consisted of a socio-demographic questionnaire and the revised conflict tactics scales (CTS2). The Conflict Tactics Scales are the most widely used instrument for identifying domestic violence.[24] CTS2 assess prevalence and chronicity of intimate partner violence with five scales including negotiation (6 items, emotional and cognitive subscales), psychological aggression (8 items), physical assault (12 items), sexual coercion (7 items) and injury (6 items). Except negotiation, the other scales have minor and severe subscales. Overall, CTS2 has 39 items with 8 response categories (0–7) for each items; the category 0 corresponds with “never” and category 7 corresponds with “not in the referent period but it did happen before”, the 1 to 6 response categories correspond with “once”; “twice”; “3 to 5 times”; “6 to 10 times”; “11 to 20 times”; and “more than 20 times” in the referent period, respectively. The approximate midpoints of the frequency response categories are used for scale scoring purposes (i.e., “once” is scored as 1; “twice” as 2; “3 to 5 times” as 4; “6 to 10 times” as 8; “11 to 20 times” as 15; and “more than 20 times” as 25).[25]

CTS2 items are presented in pair questions. The first question in the pair asks respondents to indicate how often they carried out each item in the referent period. The second asks how often the partner carried out each behavior. The default referent period is the past twelve months, but it can be used for any period of time.[24,25]

In this study, a period of six months was considered as referent period to limit the assessment of violence to pregnancy period. Selecting options 1 to 6 for any item of each subscale or scale was considered as presence, and selecting options 0 or 7 for all items of the subscale or scale was considered as absence of that type of IPV. The report of violence experience at least once in any types of the psychological aggression, physical assault, sexual coercion or injury was considered as presence of overall IPV. To assess the prevalence of violence in lifetime, the option 7 was also considered as presence of violence. Chronicity of minor and severe violence in each type among women with a positive experience of that type of violence was determined by adding up the midpoint scores of their items.

CTS2 has high internal consistency. It's reported Cronbach's alpha coefficients for various scales of its English version range 0.79–0.95.[25] The scales has been translated into Persian using forward-backward method by Ardabily et al. and for cultural reasons, the word “weapon” has been excluded from items 19, 20, 47 and 48 in the Persian version. Repeatability of the Persian version has also been confirmed using test-retest method.[26]

We obtained written permission from the Persian translators. As we thought that some cultural differences in the study population may affect on validity of the scale, we asked 10 experts to give their comments on the content validity of the scales and minor modifications were done in the scale. The scale was administered twice to 20 eligible women within a 10 days interval (test-retest). In our sample, intra-class correlation coefficients (ICC) were 0.93–0.99 and Cronbach's alphas (consistency) were 0.70–0.87 for the CTS2 subscales.

Estimated sample size was 136 for the 15–19 and 272 for 20–29 years old group, considering 5% two-sided significance level, 90% power and unequal ratio of adolescents to adults group ($r = 2$) and results of the study by Hajikhani-Golchin et al.[10] on the prevalence of psychological aggression (P1 = 35%) among women aged 20–29 years and assuming a 50% increase among adolescents (P2 52.5%). Considering the results of the study on the prevalence of physical assault (P1 28%) and sexual coercion (P1 4%) among women aged 20–29 years, and assuming a 50% increase in prevalence of physical assault (P2 42%) and a three-fold increase in prevalence of sexual coercion (P2 12%) in adolescents, the estimated sample size was