

Factors and Psychosocial Profiles of Intimate Partner Violence among Pregnant Women*

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Abstract:

Purpose: To investigate factors and psychosocial profiles (e.g., stress, social support, and self esteem) of intimate partner violence (IPV) among pregnant women.

Design: Descriptive comparative design

Methods: The sample was comprised of 420 pregnant women who received their antenatal care visits at a university hospital in Bangkok. Data was collected through a set of structured questionnaires which were then analyzed by descriptive statistics, chi-square test, and independent t-test.

Main Findings: Compared to non-abused pregnant women, abused pregnant women rated significantly higher in areas of divorce, separation and remarriage, alcohol abuse, smoking, unplanned and unwanted pregnancy ($p < .05$). They also had significantly shorter length of marriage, lower levels of education, and the greater number of gravidarum and abortion ($p < .05$). Moreover, abused pregnant women had significantly higher stress, but lower social support and self-esteem than non-abused pregnant women ($p < .05$).

Conclusion and recommendations: Based on these findings, nurses should pay attention and increase awareness of IPV among pregnant women as well as perform universal screening of IPV aimed at reducing such violence experienced and negative health outcomes during pregnancy.

Keywords: factors, psychosocial profiles, intimate partner violence, pregnant women

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Introduction

Intimate partner violence (IPV) during pregnancy is a global health and social problem, resulting in negative health consequences for pregnant women and their unborn child.¹ A comprehensive review of IPV studies suggested that abuse might be initiated in the prenatal period – before, during, or after pregnancy up to one year postpartum.² However, many researchers have concluded that IPV during pregnancy might be greater in frequency and severity than violence at any other time³ and such violence can cause a myriad of devastating health outcomes.

Background

Although the body of research examining pregnancy-related violence has grown in recent years, there has been relatively little examination of the epidemiology of risks for abused pregnant women. However, one factor that has emerged as a consistent risk factor for violence is low socioeconomic status (measured with educational levels, income, and/or employment).⁴ It also appears that abused pregnant women do not have the same levels of social support as non-abused pregnant women.⁵ Each of these two factors, low socioeconomic status and low levels of social support, may also be related to elevated levels of stress and in combination may increase the risk for violence.^{4,5} To support this assumption, Thanadom⁶ examined the relationship among demographic characteristics, stressful life events, perception of sex roles, and violence from 400 pregnant Thai women attending an antenatal care unit at a hospital in Bangkok. The results indicated that both physical and emotional violence were significantly related to lower educational and income levels, single marital status, unemployment, greater number of children, being a nuclear family, and having more stressful life events.

In terms of health outcomes, previous research of IPV explicated that there are a number of consequences of pregnancy-related violence both for the pregnant mother and their unborn child, including late entry into prenatal care, low birth weight babies, premature labor, unhealthy

maternal behaviors, fetal trauma, and health issues for the mother.²⁻⁵ For example, Thananowan⁷ investigated the relationship of IPV, maternal characteristics, health practices during pregnancy, and maternal health among 475 pregnant Thai women recruited from five hospitals in Bangkok, in Thailand. The results revealed that abused pregnant women were more likely to engage in fewer health practices during pregnancy (neither eating healthy food nor sufficient sleeping during their pregnancy, etc.) and reported more pregnancy-related health problems (e.g., weight gain/loss, anemia, hypertension, etc.) and depression than non-abused pregnant women.

Relying on data collected from a few studies of IPV during pregnancy in Thailand, however, factors and psychosocial profiles related to IPV are not fully examined. Thus, the purpose of this study was to investigate factors and psychosocial profiles (e.g., stress, social support, and self-esteem) of IPV among pregnant Thai women. Such understanding is considered valuable for health care providers, particularly obstetric nurses to perform universal screening of IPV during pregnancy in order to reduce violence experienced and negative health consequences from IPV for the better health of pregnant Thai women and their unborn child.

Methodology

This study was the first phase of a longitudinal descriptive study examining the effects of IPV during antenatal and postpartum period on stress, depression, and breastfeeding satisfaction. To estimate the number of participants, a medium effect size of 0.25 with a power of .89 was used. Four hundred and twenty pregnant Thai women were eligible. Participants were recruited during their antenatal care clinic visits at a university hospital in Bangkok, Thailand. The inclusion criteria included: (a) age 18 or older, (b) singleton pregnancy, (c) gestational age between 36-42 weeks, (d) received antenatal care and delivered at site, (e) no obstetrical complications during pregnancy, and (f) ability to understand, read, and write in Thai language.

All procedures were approved by the Institutional Review Board (SiEc 361/2549). The World Health Organization's guideline⁸ on IPV was used during data collection. For example, with respect to autonomy, a clinical nurse was assigned to recruit and provide the prospective participants with the information participation sheet and consent form. The participants had the right to decide voluntarily whether to participate in the study, without the risk of incurring any penalties or prejudicial treatment. For safety and privacy, the participants were invited to stay in a private area and to fill out a set of questionnaires without time pressure and coercion. All completed questionnaires were kept in a sealed box at the nurses' station and were coded with only a serial number without participants' names. After completion, a free small card with a list of services on IPV was available in the room for the participants as wished.

Instruments consisted of the Maternal Characteristic Questionnaire (MCQ), the Abuse Assessment Screen (AAS),⁹ The Index of Spouse Abuse (ISA),¹⁰ and The Prenatal Psychosocial Profiles (PPP).¹¹ The AAS, ISA, and PPP were translated and back-translated into the Thai language following the Brislin's translation method.¹²

The MCQ, a 18-item questionnaire, consisted of socio demographic factors (e.g., pregnant women's age, marital status, remarriage, length of marriage, family structure, educational level, employment status, income, and economic status), risk factors (e.g., alcohol abuse, smoking, and gambling), and pregnancy factors (e.g., unplanned and unwanted pregnancy, the number of gravidarum, parity, and abortion, and gestational age at first entry into prenatal care).

The AAS was used to determine the victimization prevalence of (1) past-year physical IPV by asking "Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?", (2) physical violence during pregnancy by asking "Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone?", (3) past-year sexual violence by asking "Since you've been pregnant, were you hit,

slapped, kicked, or otherwise physically hurt by someone?", and (4) emotional violence during pregnancy by asking "Are you afraid of your partner or anyone you listed above?" Abuse status was determined by a "yes" response to any one of the AAS. Internal reliability was established with Kuder-Richardson 20 of 0.84.

The ISA, a 30-item with a 5-point Likert scale ranged from 1 = never to 5 = very frequently, was used to measure severity of three forms of IPV including physical, emotional, and sexual violence in the past year. The original ISA includes two scales measuring 11 items of physical violence (ISA-P, $\alpha = 0.91$) and 19 items of nonphysical violence (ISA-NP, $\alpha = 0.93$).¹³ In this study, the original ISA was modified into three subscales: physical violence (ISA-P), emotional violence (ISA-E), and sexual violence (ISA-S); therefore, each subscale was scored by averaging the responses. The possible range of scores for each scale is 0 to 5, with lower scores indicating the relative absence of abuse and higher scores representing increasing severity of violence. Alpha coefficient of total scale was 0.93, and the three modified subscales were 0.82, 0.90, and 0.81, respectively.

The PPP consists of four subscales including stress, social support from husband, social support from others, and self-esteem. The possible range of scores for each subscale is 11 to 66, with lower scores of stress but higher scores of social support and self-esteem indicating a better quality of psychosocial health during pregnancy. The PPP's validity and reliability have been supported among ethnically diverse rural and urban pregnant women.¹¹ The alpha coefficient of these four subscales in this study were 0.72, 0.95, 0.96, and 0.82, respectively.

The SPSS 11.0 software package¹⁴ was used to analyze descriptive statistics on socio demographic factors, abused status, and severity of IPV. Chi-square tests were used to analyze differences of socio demographic, risk, and pregnancy factors. Independent t-tests were used to analyze for mean differences of psychosocial profiles between non-abused pregnant women and abused pregnant women.

Findings

The mean age of participants was 27.7 ($SD=6.23$). About one-third (29%) were between 25 and 29 years old. The majority of participants were Buddhist (98.8%) and married (98.3%). Approximately 21% of these participants admitted that they had remarried due to unfaithful husbands (43%) and different perspectives (19.6%). The mean length of marriage was about 2.9 years ($SD=1.32$). Most participants (94.3%) lived with their husbands and children. About one-third of participants (30%) had attended primary education and under. Almost half (44%) had a secondary education. About 40% had low to middle income. Approximately 40% of participants had insufficient economic status and 5% of participants were in debt. Almost half of participants (41.2%) had their first time pregnancy and admitted that their pregnancy was unplanned (45.2%). About 3% of participants reported an unwanted pregnancy.

About forty-five participants reported IPV experiences including past-year physical IPV ($n=28, 6.1\%$), physical violence during pregnancy ($n=9, 1.9\%$), past-year sexual violence ($n=21, 4.5\%$), and emotional violence ($n=14, 3\%$), respectively.

The results of chi-square tests revealed that marital status, remarriage, family structure, pregnant women's alcohol abuse and smoking, husbands' alcohol abuse and gambling, and unplanned and unwanted pregnancy were significantly different between non-abused and abused pregnant women ($p < .05$). In particular, abused pregnant women had significantly higher numbers of divorce, separation, remarriage, de facto living arrangements, alcohol abuse and smoking, as well as unplanned and unwanted pregnancy ($p < .05$) (see Table 1). Abused pregnant women's husbands had significantly higher rates of alcohol abuse and gambling than non-abused pregnant women's husbands ($p < .05$) (see Table 2).

Table 1 Chi-square Test of Sociodemographic, Risk, and Pregnancy Factors between Non-abused and Abused Pregnant Women ($N = 420$)

Pregnant women's factors	Non-abused ($n=375$) n (%)	Abused ($n=45$) n (%)	χ^2	p
Marital status				
- marriage	373 (99.5)	40 (88.9)	27.43	.000*
- divorce/separate	2 (0.5)	5 (11.1)		
Remarriage				
- yes	71 (18.9)	17 (37.8)	8.61	.003*
- no	304 (81.1)	28 (62.2)		
Family structure				
- living with husband	358 (95.5)	38 (84.4)	9.06	.003*
- living with others	17 (4.5)	7 (15.6)		
Alcohol abuse				
- yes	29 (7.7)	9 (20)	7.35	.007*
- no	346 (92.3)	36 (80)		
Unplanned pregnancy				
- yes	158 (42.1)	32 (71.1)	13.62	.000*
- no	217 (57.9)	13 (28.9)		
Unwanted pregnancy				
- yes	4 (1.1)	4 (8.9)	13.16	.000*
- no	371 (98.9)	41 (91.1)		

* $p < .05$

Table 2 Chi-square Test of Alcohol abuse, Smoking, and Gambling between Husbands of Non-abused and Abused Pregnant Women (N = 420)

Husband's factors	Non-abused (n=375)		Abused (n=45)		χ^2	p
	n (%)	n (%)	n (%)	n (%)		
Alcohol abuse						
- yes	251 (66.9)	37 (82.2)	4.36	.037*		
- no	124 (33.1)	8 (17.8)				
Smoking						
- yes	112 (29.9)	18 (40)	1.93	.165		
- no	263 (70.1)	27 (60)				
Gambling						
- yes	40 (10.7)	14 (31.1)	14.99	.000*		
- no	335 (89.3)	31 (68.9)				

* $p < .05$

Although pregnant women's age, income, the number of gravidarum, parity and abortion were significantly different between non-abused and abused pregnant women, only length of marriage, level of education, the number of gravidarum and abortion, and gestational age were correlated with IPV. That is, abused pregnant women had a significantly shorter length of marriage, lower level of education, and greater number of gravidarum and abortion, and reported late entry into prenatal care ($p < .05$). More specifically, physically abused pregnant women reported significantly

lower levels of education than those who experienced emotional and sexual abuse ($p < .05$). Emotionally abused pregnant women reported a significantly shorter length of marriage ($p < .05$). Sexually abused pregnant women reported significantly greater numbers of gravidarum and abortion ($p < .05$).

The t-test's results revealed that abused pregnant women had significantly higher stress, but lower social support and self-esteem than non-abused pregnant women ($p < .001$) (see Table 3).

Table 3 Differences among Stress, Social Support, and Self-esteem between Non-abused and Abused Pregnant Women (N =420)

Psychosocial Profiles	Non-abused (n = 375)		Abused (n = 45)		t	p
	\bar{X}	SD	\bar{X}	SD		
Stress	13.33	2.04	18.38	4.42	-7.56	.000**
Social support (husband)	60.69	8.13	41.56	16.57	7.64	.000**
Social support (others)	58.72	12.56	49.87	20.26	2.87	.000**
Self-esteem	32.07	1.79	29.22	2.58	7.23	.000**

** $p < .001$

Discussion

The results of this study are consistent with previous studies of IPV in that abused pregnant Thai women have significantly higher reported incidence of separation, divorce, remarriage, de-facto living arrangements, as well as unplanned and unwanted pregnancy, alcohol abuse and smoking than non-abused pregnant women ($p < .05$). Compared to non-abused pregnant women's husbands, abused pregnant women's husbands had significantly higher rates of alcohol abuse (82.2% vs. 66.9%) and gambling (31.1% vs. 10.7%) ($p < .05$). Results also support a higher percentage of substance abuse among both abused pregnant women and their husbands.¹⁵ However; the use of self-reported data could be problematic because there is a tendency for research participants to under or over report. Therefore, in future research, there is a need to ask about the severity and frequency of substance abuse among pregnant women and their husbands separately to prevent subjective bias.

Although length of marriage, level of education, the number of gravidarum and abortion, and gestational age were not different between non-abused and abused pregnant women, these factors were associated with IPV. Possible explanation for this result could be marital discord between couples who had an abusive relationship. As a result, the couples tended to end their marriage with divorce or separation, resulting in a shortened length of relationship. Another explanation could be the stress associated with financial hardship due to unplanned and/or unwanted pregnancy. This is because couples expecting an unplanned or unwanted pregnancy may be facing a greater level of stress compared to those couples who have planned or wanted pregnancy, consequently increasing the risk for violence.^{4,5} To support this assumption, Goodwin and colleague's study found that the prevalence of abuse was greater when the male partner did not want the baby.¹⁶ As a result, it is possible that pregnant women who experienced sexual abuse in this study were more likely to have greater number of gravidarum and abortion than non-abused pregnant women. This result also supported a link between sexual coercion and an unplanned/unwanted pregnancy.

Interestingly, this study found that there was a high rate of substance abuse on both abused pregnant women and their husbands compared to the couples without IPV. First, it is possible that high rates of alcohol abuse and smoking among abused pregnant women and their partners may be in response to the stressful situations and/or financial hardship.¹⁷ Thus, future research needs to develop prevention and intervention programs regarding substance abuse for those couples with an abusive relationship.

Similar to the results reported by Bacchus and colleagues,¹⁸ this study explicated that pregnant women who reported all three forms of violence (physical, emotional, and sexual) had significantly higher stress, fewer social supports, and lower self-esteem than non-abused pregnant women. Further investigation of the correlates of IPV with socioeconomic and psychosocial health outcomes is necessary because women who are subjected to violence during pregnancy may face the risk of poor pregnancy outcomes, such as a low birth weight baby and preterm birth. Therefore, determining the relationship between violence during pregnancy and these outcomes will provide potential pathways for prevention and promotion as well.

Conclusion

This study has revealed that there are many factors, including socioeconomic, risk, and pregnancy factors, as well as psychosocial factors associated with IPV during pregnancy. However, IPV during pregnancy in Thailand remains a neglected public health issue because of social norms, cultural beliefs, and privacy issues. In fact, most health care providers accept IPV as a health care issue, but they lack fundamental knowledge of the issues surrounding IPV.¹⁹ Thus, the provision of education about IPV is the first step toward a change for Thai nursing practices. In particular, nurses should pay attention and be aware about IPV and the contribution of IPV to physical and psychosocial health.^{18,20} To prevent such risks, nurses should perform universal screening of IPV for all pregnant women aimed at reducing victimization and negative health outcomes among pregnant Thai women and their unborn child.

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ปัจจัยและผลทางจิตสังคมของความรุนแรงที่เกิดจากคู่สมรสในสตรี ตั้งครรภ์*

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บทคัดย่อ:

วัตถุประสงค์: เพื่อศึกษาปัจจัยและผลทางจิตสังคม (ได้แก่ ความเครียด การ
สนับสนุนทางสังคม และความรู้สึกมีคุณค่าในตัวเอง) ของความรุนแรงที่เกิด
จากคู่สมรสในสตรีตั้งครรภ์

รูปแบบการวิจัย: การวิจัยเชิงบรรยายเปรียบเทียบ

วิธีดำเนินการวิจัย: กลุ่มตัวอย่างเป็นสตรีตั้งครรภ์จำนวน 420 คน ที่เข้ารับ
การฝากครรภ์ ณ โรงพยาบาลมหาวิทยาลัยแห่งหนึ่งในเขตกรุงเทพมหานคร
เก็บรวบรวมข้อมูลโดยใช้แบบสอบถาม จากนั้นนำข้อมูลที่ได้มาวิเคราะห์โดยใช้
สถิติเชิงพรรณนา การทดสอบไคสแควร์ และการทดสอบค่าที

ผลการวิจัย: เมื่อเปรียบเทียบกับสตรีตั้งครรภ์ที่ไม่ได้รับความรุนแรง สตรีตั้ง
ครรภ์ที่ได้รับความรุนแรงมีประวัติหย่าร้างหรือแยกทางกับสามี การแต่งงาน
ครั้งนี้เป็นการแต่งงานครั้งที่สอง อาศัยอยู่กับบุคคลอื่นที่ไม่ใช่ญาติ ตีมีสุรา
และสูบบุหรี่ ไม่มีการวางแผนการตั้งครรภ์ และเป็นการตั้งครรภ์ที่ไม่พึง
ประสงค์อย่างมีนัยสำคัญทางสถิติ ($p < .05$) สตรีตั้งครรภ์เหล่านี้ยังมีระยะ
เวลาสมรสสั้น มีระดับการศึกษาน้อยและมีจำนวนครั้งของการตั้งครรภ์และ
การแท้งมากกว่าสตรีตั้งครรภ์ปกติอย่างมีนัยสำคัญ ($p < .05$) นอกจากนี้ยัง
พบว่า สตรีตั้งครรภ์ที่ได้รับความรุนแรงจะมีความเครียดสูง ได้รับการ
สนับสนุนทางสังคมน้อย และมีความรู้สึกมีคุณค่าในตัวเองต่ำกว่าสตรีตั้งครรภ์
ที่ไม่ได้รับความรุนแรงอย่างมีนัยสำคัญ ($p < .05$)

สรุปและข้อเสนอแนะ: จากผลการวิจัยครั้งนี้ พยาบาลควรให้ความสำคัญ
และตระหนักเกี่ยวกับความรุนแรงที่เกิดจากคู่สมรสในสตรีตั้งครรภ์และควร
ทำการคัดกรองความรุนแรงที่เกิดจากคู่สมรส และดูแลเพื่อลดอัตราการเกิด
ความรุนแรงดังกล่าว รวมทั้งผลกระทบต่อสุขภาพขณะตั้งครรภ์

คำสำคัญ: ปัจจัย ผลทางจิตสังคม ความรุนแรงที่เกิดจากคู่สมรส สตรี
ตั้งครรภ์

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