Journal of Population Therapeutics & Clinical Pharmacology

RESEARCH ARTICLE
DOI: 10.53555/jptcp.v31i4.6046

INTIMATE PARTNER VIOLENCE, PERINATAL DISTRESS, AND PSYCHOLOGICAL WELL-BEING OF THE URBAN AND RURAL FEMALES OF KHYBER PAKHTUNKHWA

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Abstract

Background:
This study aimed to examine the occurrence of intimate partner violence, perinatal distress, and psychological well-being among rural and urban females in Khyber Pakhtunkhwa and investigate the correlation between perinatal distress and psychological well-being.

Methodology:
This cross-sectional study was conducted from January to July 2023, a sample of 300 pregnant women aged 18 to 40 was obtained through purposive sampling from gynaecology and obstetrics wards in various teaching hospitals in Peshawar. Data were collected using various measures, including the Hurt, Insult, Threaten, and Scream (HITS) questionnaire, Hospital Anxiety and Depression Scale (HADS), Perceived Stress Scale (PSS), Post-traumatic stress disorder (PTSD) checklist (PCL-5), and the psychological well-being scale. The SPSS 23 version was used for analysis. The significance level was set at $p \leq 0.05$.

Results:
There were no statistically significant differences in intimate partner violence or perinatal distress between the two groups. However, the mean scores for psychological well-being subscales, "Purpose in life" were significantly higher in urban women compared to rural women ($p = 0.044$). In urban women, positive correlations were observed between autonomy and perceived stress ($r = 0.192$, $p = 0.019$) and environmental mastery and perceived stress ($r = 0.169$, $p = 0.039$). A significant positive correlation was also found between purpose in life and Hospital Anxiety and Depression Scale-Anxiety (HADS-A) scores ($r = 0.333$, $p < 0.001$). In contrast, rural women showed a significant positive correlation between autonomy and perceived stress ($r = 0.197$, $p = 0.016$) and a significant negative correlation between purpose in life and PTSD ($r = -0.194$, $p = 0.017$).

Conclusion:
No significant differences were found in intimate partner violence and perinatal distress between urban and rural women in Khyber Pakhtunkhwa. However, urban women scored higher in the psychological well-being subscale "Purpose in life," and certain psychological factors showed significant correlations with perceived stress in both settings.

Keywords: Intimate Partner Violence, Perinatal Care, Psychological Well-Being, Depression

Introduction

Intimate partner violence (IPV) is a serious public health issue affecting millions worldwide, including pregnant women. IPV can have a profound impact on the physical and mental health of pregnant women. IPV is any behaviour that "causes physical, sexual, or psychological harm within an intimate relationship, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours" (*Intimate partner violence*,2022). In intimate partner violence, sexual violence affects nearly 40% of women in the United States, while physical violence affects 20%. However, other types of IPV are underreported (Stewart & Vigod, 2017). It has a substantial impact on the physical and psychological health of women.

Perinatal distress, which refers to the distress experienced by women during pregnancy and the postpartum period, is a common issue among women who have experienced IPV. Studies have shown that women who experience IPV during pregnancy are more likely to experience perinatal distress, including symptoms of anxiety and depression (J.C. Campbell, 2002). Based on population studies, estimated rates of perinatal IPV in physical violence range from 3.7% to 9%. However, it is difficult to estimate the rates of perinatal IPV because these population-based studies have focused on physical violence without adequately assessing for other forms of perinatal IPV, such as sexual violence and psychological aggression (Coker et al., 2021). Further, the frequencies of IPV are higher in clinic-based samples compared to epidemiological samples. Among 104 rural women attending prenatal care at the beginning of their third trimester, 20.2% experienced sexual IPV, 27.9% reported physical IPV, and 79.8% endorsed psychological aggression during pregnancy (Chisholm et al., 2017). Other clinic-based studies have reported rates of perinatal IPV up to 16.4% and 73% for physical and psychological IPV, respectively. Perinatal providers are in a unique position to identify, evaluate, and facilitate services for women experiencing IPV (Stewart & Vigod, 2019).

Regarding psychological well-being, the experience of IPV during pregnancy has been linked to negative outcomes, including increased stress, anxiety, and depression. Research has also shown that women who experience IPV during pregnancy are at a higher risk for post-traumatic stress disorder (PTSD) and other mental health issues (Tai, 2020). Studies have shown that IPV significantly predicts poor psychological well-being during pregnancy. Women who experience IPV during pregnancy are more likely to experience depression, anxiety, post-traumatic stress disorder (PTSD), and other forms of psychological distress (J. Campbell et al., 2002). Pregnant women subjected to IPV also suffer from increased mental health problems (Paul et al., 2021). Using the Edinburgh Postnatal Depression Scales, nearly 50 per cent of pregnant women subjected to IPV exceeded the cutoff score for depressive symptomatology. In population-based studies, women exposed to various forms of interpersonal violence (e.g., child abuse, sexual abuse, IPV) have high rates of PTSD, depression, and substance use symptoms (Kumari, n.d).

Methodology

A cross-sectional study was conducted in January-July 2023. A sample size of 300 patients through a purposive sampling technique was obtained from the gynaecology and obstetrics wards of various teaching hospitals in Peshawar. The inclusion criteria included being pregnant women between 18 and 40, from rural or urban areas, and indoor or outdoor patients. Exclusion criteria encompass

patients with a history of psychiatric illness, major chronic physical diseases, or comorbid conditions and those who could not communicate effectively.

Several measures were used to gather data, including a demographic sheet, the Hurt, Insult, Threaten, and Scream (HITS) questionnaire, the Hospital Anxiety and Depression Scale (HADS), the Perceived Stress Scale (PSS), the Post-traumatic stress disorder (PTSD) checklist (PCL-5), and the psychological well-being scale. The data collection occurred in the gynaecology and obstetrics wards of the selected teaching hospitals in Peshawar. Prior permission was obtained from the hospital authorities, and the potential participants were informed about the study's objectives. Informed consent was obtained from the patients, emphasizing voluntary participation and the confidentiality of their data for research purposes.

To ensure the validity of the results, strict exclusion criteria will be followed to minimize bias resulting from confounding factors. The confidentiality of the patient's information will be carefully maintained. The collected data will undergo statistical analysis using SPSS 23. Descriptive statistics, such as mean and standard deviation, will present numerical data, while frequency and percentages will be used for categorical data. A significance level of $p \leq 0.05$ will be considered statistically significant.

The study employed the Mann-Whitney U test to determine differences in intimate partner violence, perinatal distress, and psychological well-being between rural and urban women. Furthermore, the relationship between perinatal distress and psychological well-being will be assessed using the Spearman rank correlation. These analyses will provide insights into the prevalence of intimate partner violence, perinatal distress, and psychological well-being among women in different settings and shed light on the association between perinatal distress and psychological well-being.

Results

Table 1 shows that perinatal distress was higher in urban women than rural women, but intimate partner violence was greater in rural women, but none of these differences were statistically significant. It was also found that a sense of autonomy, personal growth, and purpose in life was higher in urban women, but the contrary was true for environmental mastery, positive relations, and self-acceptance. These differences in the scores of psychological subscales were also not significantly different between urban and rural women, as shown in Table 1.

Table 2 shows a statistically significant weak positive correlation between autonomy and PSS but a negative correlation with PTSD. The environmental mastery scale also had a weak positive and significant correlation with PSS. Personal growth and purpose in life had a significant and weak positive correlation with Hospital Anxiety and Depression Scale-Anxiety (HADS-A) in urban women, as shown in Table 2.

Table 3 shows a statistically significant but weakly positive correlation between autonomy and PSS. A weak negative but significant correlation was seen between environmental mastery and Hospital Anxiety and Depression Scale-Depression (HADS-D). Purpose in life had a statistically significant weak positive correlation with HADS-A but a negative correlation with PTSD in rural women, as shown in Table 3.

Table 1: Intimate partner violence, Perinatal distress, and psychological well-being among urban and rural women of Khyber Pakhtunkhwa

		Urban women (Mean ± SD)	Rural women (Mean ± SD)	P value
Intimate partner violence (HITS score)		12.87±5.266	12.93±5.18	0.965
Perinatal distress	**HADS-A**	17.53±1.54	17.33±1.37	0.350
	HADS-D	17.03±1.57	16.90±1.55	0.414
	PSS	25.14±7.021	24.85±7.03	0.705
	PTSD	1.75±1.100	1.73±1.123	0.800
Psychological well being	**Autonomy**	3.31±1.854	3.29±1.992	0.797
	Environmental Mastery	2.35±1.524	2.43±1.67	0.899

	Personal growth	3.59±1.707	3.34±1.760	0.188
	Positive relations	3.55±1.633	3.61±1.670	0.701
	Purpose in life	3.59±1.730	3.20±1.738	0.044
	Self-acceptance	2.86±1.907	2.97±1.993	0.766

Table 2: Relationship between Perinatal distress and psychological well-being in Urban women of Khyber Pakhtunkhwa

Psychological well being		**Parameters of Perinatal Distress in urban women**			
		HADS-A	**HADS-D**	**PSS**	**PTSD**
Autonomy	**Correlation co-efficient (rh_0)**	0.041	-0.071	0.192	-0.164
	P value	0.620	0.390	0.019	0.045
Environmental Mastery	**Correlation co-efficient (rh_0)**	0.104	-0.153	0.169	-0.154
	P value	0.204	0.061	0.039	0.059
Personal growth	**Correlation co-efficient (rh_0)**	0.258	0.040	-0.106	0.060
	P value	0.001	0.627	0.195	0.464
Positive relations	**Correlation co-efficient (rh_0)**	0.019	0.031	-0.008	-0.155
	P value	0.819	0.702	0.922	0.057
Purpose in life	**Correlation co-efficient (rh_0)**	0.333	0.141	0.021	-0.081
	P value	≤0.001	0.086	0.800	0.323
Self-acceptance	**Correlation co-efficient (rh_0)**	-0.126	-0.103	-0.070	0.080
	P value	0.124	0.210	0.395	0.332

Table 3: Relationship between Perinatal distress and psychological well-being in rural women of Khyber Pakhtunkhwa

Psychological well being		**Parameters of Perinatal Distress in rural women**			
		HADS-A	**HADS-D**	**PSS**	**PTSD**
Autonomy	**Correlation co-efficient (rh_0)**	-.006	-.050	.197	-.140
	P value	.946	.540	.016	.087
Environmental Mastery	**Correlation co-efficient (rh_0)**	.095	-.176	.081	-.215
	P value	.248	.031	.322	.008
Personal growth	**Correlation co-efficient (rh_0)**	.135	-.094	-.115	.050
	P value	.100	.252	.162	.546
Positive relations	**Correlation co-efficient (rh_0)**	-.046	.068	.107	-.095
	P value	.580	.409	.194	.247
Purpose in life	**Correlation co-efficient (rh_0)**	.277	.050	.023	-.194
	P value	.001	.544	.784	.017
Self-acceptance	**Correlation co-efficient (rh_0)**	-.155	-.113	-.089	.079
	P value	.059	.167	.277	.340

Discussion

Intimate partner violence (IPV) reaches pandemic proportions worldwide and is a significant public health issue that unduly affects women. Estimates of the prevalence of IPV during pregnancy vary widely and are heavily influenced by sociodemographic characteristics. Data from a 2009-2010 survey in a 30-state area revealed that 3.2% of pregnant women reported being pushed, hit, slapped, kicked, choked, or physically hurt in some other way during their most recent pregnancy (Keskinbora & Guven, 2020). Nearly 7% of teen mothers reported IPV during pregnancy compared with fewer than 2% of mothers older than 30. Overall, the highest prevalence of IPV during pregnancy was reported in non-Hispanic American Indian/Alaska Native and non-Hispanic black gravidas (6.5% and 5.8%, respectively), and the lowest prevalence was seen among non-Hispanic Asian gravidas (1.5%) (Ossowska et al., 2022, Patra et al., 2018). A researcher reported even higher rates, noting physical and sexual violence in 28% and 20%, respectively, of pregnant women (Kiely et al., 2010). National Intimate Partner and Sexual Violence Survey, 5.9% of women reported

experiencing IPV in the past year. The prevalence of lifetime exposure to specific forms of IPV is alarming, ranging from 8.6% for reproductive control to 47.1% for psychological aggression (Black et al., 2011). In this study results found that perinatal distress was higher in urban women than rural women, but intimate partner violence was greater in rural women, but none of these differences were statistically significant. A UK-based cross-sectional study with 295 participants found that women in rural areas (n = 130) were at a higher risk of depression and anxiety compared to their urban counterparts (n = 165). The risk for depression and/or anxiety was significantly higher in the rural group, with an unadjusted odds ratio of 1.67 (95% CI 1.03 to 2.72, p = .038) (Ginja et al., 2020). It was also found that a sense of autonomy, personal growth, and purpose in life was higher in urban women, but the contrary was true for environmental mastery, positive relations, and self-acceptance. These differences in the scores of psychological subscales were also not significantly different between urban and rural women, as shown in Table 1. A study conclude that the prevalence of interpersonal violence and psychological distress is higher in urban compared to rural women. Demographic, household, and community factors interact differently with psychological distress in rural and urban contexts (Manyema et al., 2018). Similarly, another study's results showed that the Odds of perinatal depression risk were higher by 21% among rural versus urban women (OR = 1.21, 95% CI: 1.05-1.41) adjusted for race, ethnicity, and maternal age (Nidey et al., 2020). According to Table 2, there were statistically significant correlations between various psychological variables in urban women. Specifically, autonomy showed a weak positive correlation with the Perceived Stress Scale (PSS) but a negative correlation with Post-Traumatic Stress Disorder (PTSD). The environmental mastery scale exhibited a weak positive and significant correlation with PSS. Moreover, in urban women, both personal growth and purpose in life demonstrated a significantly weak positive correlation with the Hospital Anxiety and Depression Scale-Anxiety (HADS-A). In the analysis of a study, 288 women revealed a noteworthy link between prenatal and postnatal psychological distress. The study found that a considerable proportion of women experienced distress during both prenatal and postpartum periods, indicating a continuity of mental health challenges across these stages. the analysis of 288 women revealed a noteworthy link between prenatal and postnatal psychological distress. The study found that a considerable proportion of women experienced distress during both prenatal and postpartum periods, indicating a continuity of mental health challenges across these stages (Obrochta et al., 2020). According to the findings expectant mothers experience significant reductions in stress levels when they receive emotional and financial support from their partners (Cheng et al., 2016). The researchers also noted that active participation of partners in prenatal meetings was associated with decreased stress levels in expectant mothers. Additionally, women who perceived their spouses as supportive during pregnancy reported a greater sense of adequacy and higher relationship satisfaction during the postpartum period. Similarly, Powell and Karraker emphasized that women who sense a supportive spouse during pregnancy tend to feel more adequate in the postpartum period and experience higher levels of relationship satisfaction (Powell & Karraker, 2019). During pregnancy, the prevalence of depression varies across trimesters, with rates of 7.4% in the first trimester, 12.8% in the second trimester, and 12.0% in the third trimester. In Pakistan, studies have reported the prevalence of anxiety and depression in pregnant women to range from 18% to 39%.[22] however, there was limited literature on the urban and rural women related to the intimate partner violence, perinatal distress and psychological well-being. Therefore, the study on Intimate Partner Violence, Perinatal Distress, and Psychological Well-being of the Urban and Rural females of Khyber Pakhtunkhwa holds significant importance as it addresses the pressing issue of IPV during pregnancy, shedding light on its prevalence and impact on the psychological well-being of pregnant women in both urban and rural areas. By considering the unique socio-cultural dynamics and healthcare disparities in Khyber Pakhtunkhwa, the study recognizes the need for tailored interventions and support systems. Investigating the link between IPV and perinatal distress is crucial for understanding its implications on maternal mental health and its potential long-term consequences for both mother and child. Furthermore, the study can raise awareness about women's

rights and safety during pregnancy, empowering women and potentially leading to policy changes and protective interventions. Ultimately, the findings can inform the development of targeted strategies to address IPV and support psychological well-being, thus contributing to improved maternal health outcomes and the overall well-being of women in the region.

Conclusion

The study results indicate that there were no statistically significant differences in perinatal distress, intimate partner violence, or psychological well-being between urban and rural women in Khyber Pakhtunkhwa, suggesting similar impacts of these factors on both groups. Although urban women scored higher in autonomy, personal growth, and purpose in life, and rural women scored higher in environmental mastery, positive relations, and self-acceptance, these differences were not statistically significant. Weak positive correlations were observed between autonomy and perceived stress (PSS) in both urban and rural women, along with weak negative correlations between environmental mastery and depression (HADS-D) in rural women. Additionally, purpose in life had a weak positive correlation with anxiety (HADS-A) in both urban and rural women and a negative correlation with PTSD in rural women. The presence of significant correlations between psychological well-being and perinatal distress underscores the importance of addressing maternal mental health and support systems during the perinatal period, regardless of the urban-rural divide, providing valuable insights for future interventions and policies in the region.

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