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Prevalence of Intimate Partner Violence Against Women and Its Contributing Factors in Tehran, Iran

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Abstract

Background: Intimate partner violence (IPV) is a major public health and social concern affecting women globally. In many societies, including Iran, its high prevalence and serious consequences highlight the need for a deeper understanding. This study aimed to estimate the prevalence of intimate partner violence and examine its contributing factors among married women in Tehran, Iran.

Methods: This cross-sectional descriptive-analytical research was conducted from February 2020 to June 2020. A total of 471 individuals were chosen through the convenience sample approach. The study's questionnaire comprised 2 sections: demographic information and Haj-Yahia's (1999) Violence Against Women Scale. We used the Shapiro-Wilk, t test, Mann-Whitney U-test, or $\chi 2$ test, and multiple linear regression analysis. All statistical analyses were performed by STATA Version 14 software.

Results: The mean age was 32.7 ± 7.96 years. The prevalence of intimate partner violence was 92.14%. Additionally, the prevalence of psychological, physical, sexual, and economic violence was 91.08%, 46.71%, 41.4%, and 29.3%, respectively. The husband's education level ($\beta = 0.751$, 95% CI: 0.115 to 1.387, $P = 0.021$), husband's addiction ($\beta = 5.671$, 95% CI: 2.585 to 8.758, $P \leq 0.001$), duration of marriage ($\beta = 0.130$, 95% CI: 0.024 to 0.236, $P = 0.016$), imposed marriage ($\beta = 4.313$, 95% CI: 1.480 to 7.146, $P = 0.003$), and consanguineous marriage ($\beta = -2.651$, 95% CI: -4.327to -0.976, $P = 0.002$) were associated with intimate partner abuse.

Conclusion: Given the high prevalence of intimate partner violence, especially during the coronavirus disease 2019 pandemic, and its association with factors such as education, addiction, and marriage characteristics, these findings highlight the urgent need for increased awareness and policy interventions. The broad definition of IPV used in this study, where any "once or more" response was classified as positive, may have inflated the prevalence. Additionally, due to the pandemic's constraints, the online sampling method likely introduced bias by targeting individuals more likely to report IPV. These factors should be considered when interpreting the findings, and further research with stricter definitions and diverse sampling methods is recommended. Developing screening programs for the early identification of IPV is essential.

Keywords: Prevalence, Violence, Women, Iran, Community Health, Community Health Nursing, Midwifery

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Introduction

Domestic violence against women is common in all countries across the globe, regardless of social, economic, religious, or cultural differences, and the World Health Organization (WHO) considered it a health priority in 2000 (1). The WHO defines violence against women as any act of violence by a husband against a woman that results in emotional, psychological, physical, or sexual injuries in her or directly and indirectly impacts her health (2). Intimate

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↑What is "already known" in this topic:
Intimate partner violence (IPV) is a global issue with severe physical and psychological consequences. Factors such as low education, substance abuse, and socioeconomic issues contribute to IPV. Studies show varying prevalence rates, but comprehensive data for Tehran, Iran, is limited.

→What this article adds:
This study provides a detailed analysis of IPV in Tehran, Iran, revealing a high prevalence (92.14%). It examines all 4 types of IPV and highlights the impact of forced and consanguineous marriages. Using robust statistical methods, it identifies key risk factors and suggests policy interventions, awareness programs, and support strategies for victims.

partner violence (IPV) can negatively affect couples' lives; for example, it can lead to women's lower self-confidence and self-esteem, high anxiety, interpersonal relationship disorders, eating disorders, posttraumatic stress disorder, and female sexual dysfunctions (3). Research has it that physical comorbidities, such as headaches, abdominal syndromes, chronic pain, vaginal bleeding, irritable bowel syndrome, gynecological symptoms, and sexually transmitted diseases are highly prevalent in women experiencing domestic violence (4).

Global studies have shown that this health issue is highly prevalent worldwide. The WHO study of the prevalence of domestic violence in 10 countries on 24,000 women indicated that 15% to 71% of the women were physically or sexually abused (5). Additionally, 40% to 50% of women in North America have suffered from physical and emotional violence and rape despite the existence of an act of equality between men and women, and 25% to 30% have been beaten by their husbands once in their life (6-7). The results of a survey in the Arab and Islamic countries show that at least 1 in 3 women had experienced violence by men (8). In Iran, a large-scale study in 28 provincial capitals found that 66% of women had encountered domestic violence at least once since the beginning of their marital life (9). These statistics highlight that IPV is not confined to developing nations but remains a global crisis affecting both developed and developing societies.

As a learned behavior, violence is passed from one generation to another and disrupts family cohesion. Additionally, children, shaped by their family structures and experiences, transmit violence in society; an issue also known as the "cycle of violence." Domestic violence is the root of all social violence (10). Factors such as unwanted pregnancies, age of couples, age of marriage, addiction, poverty, socioeconomic problems, the presence of a disabled child in the family, the husband's experience of abuse in childhood, and patriarchy are known to be predictors of domestic violence against women (11). Past research has shown that age (12), education level (13), occupation (14), family relations between couples (15), and religious beliefs (16) are among the factors contributing to domestic violence.

Despite the existing body of research, significant gaps remain, particularly regarding IPV in Tehran, Iran, a metropolis with unique sociocultural and legal dynamics that influence domestic violence patterns. While previous studies have examined IPV at a national level, few have provided a localized, in-depth analysis of IPV prevalence and associated risk factors in Tehran. Additionally, research on IPV in Iran has often focused on limited forms of violence, whereas our study comprehensively investigates psychological, physical, sexual, and economic IPV simultaneously. Another novel aspect of our research is its emphasis on the influence of sociocultural variables, such as consanguineous and imposed marriages, which have been largely understudied concerning IPV.

Given the severe health and social implications of IPV and the variability of its prevalence across different sociocultural settings, therefore, we decided to conduct a study aimed at determining the prevalence of domestic violence against women and the factors influencing it in Tehran. Through this research, we seek to inform policymakers and stakeholders about the realities of IPV in this region, encouraging them to adopt targeted interventions and legal reforms to reduce violence against women.

Methods

Study Design and Participants

This cross-sectional descriptive-analytical study was conducted between February 2020 and ended in June 2020. The required sample size for the research was about 374 individuals according to Cochran's formula (z = 1.96), 41.7% prevalence of violence against women, and 5% error (17), but a total of 471 people attended the study. A convenience sample method was employed to gather the data. Owing to the coronavirus disease 2019 (COVID-19) pandemic and associated lockdowns, the study employed web-based data gathering, disseminating the survey link via Telegram channels and WhatsApp groups. Married women in Tehran were solicited for participation. The research encompassed married women residing in Tehran who had been married for a minimum of 1 year. Women who were widowed, divorced, or residing apart from their husbands at the time of the study were excluded.

Questionnaire

The questionnaire of the study consists of 2 sections: the first part included demographic information, and the second included Haj-Yahia's (1999) Violence Against Women Scale, which consists of 32 items and measures violence against women in the past year. Haj-Yahia's study was conducted in Iran, and its validity and reliability had already been confirmed. The reliability for each dimension of the original questionnaire was evaluated as follows: psychological violence: 0.90; physical violence: 0.93; sexual violence: 0.79; and economic violence: 0.78. Also, the reliability of the whole questionnaire was 0.95 (18). The questionnaire employs a dichotomous scale (never and at least once), classifying a response of "once or more" as positive for violence, as per the questionnaire developer's definition (18). This broad classification may have contributed to the high IPV prevalence observed in the study. In the present study, intimate partner violence is defined as the violence perpetrated by the husband against the woman during the past year, and a person is considered to have experienced violence if she has given at least 1 positive answer to each of the items of the Violence Against Women questionnaire.

Independent Variables

Independent variables were divided into 2 categories: First, the social and demographic characteristics of women (age, education, occupation, type and duration of marriage, kinship with the husband's family, number of children, and previous marriage). Second, the characteristics of the husband (age, education, occupation, monthly income, drug use, and previous marriage).

Dependent Variable

The outcome variable is a score obtained from the total scores of 32 questions of the questionnaire. The outcome range of the variable is 0 to 32.

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Data Analysis

Continuous variables were represented as means ± standard deviations, whereas categorical variables were expressed as frequencies and percentages. The Shapiro-Wilk test for normality determined whether to employ the independent sample t test or the Mann-Whitney U-test for comparing continuous variables. The $\chi 2$ test and the Fisher exact test were employed to compare categorical data between the 2 groups, one experiencing abuse and the other not. The outcome variable was the score of the violence questionnaire, ranging from 0 to 32. While we transformed it into a binary variable (indicating the presence or absence of violence) for descriptive purposes and to provide a simplified understanding of violence prevalence, we used the continuous outcome for modeling to avoid dilution bias. Therefore, we applied linear regression and ensured that its assumptions were met. Before using multiple linear regression, the variance inflation factor (VIF) was used to check for multicollinearity among independent variables, ensuring that all VIF values were <10. To assess the normal distribution of residuals for the dependent variable, a quantile-quantile plot was examined. Homogeneity of residual variances was tested using the Cook & Weisberg test, while heteroscedasticity was controlled with robust standard errors. Additionally, the Durbin-Watson test was conducted to check for the independence of errors (19) (Table 1). The significance level was set at $P < 0.05$, and the software used for data analysis was STATA.14.

Table 1. Assumptions of Regression Models (Predictive Models)

Tests	*P*-value
Variance Inflation Factor	1.10
Cook – Weisberg test	0.38
omitted-variable test	0.13
link test	0.99
Durbin-Watson test	1.94

Results

A total of 471 women participated in this study. The mean age was 32.7 ± 7.96 years old and the age group of 28-37 years was the most common. Of the participants, 21.44% had a master's degree or higher, 41.83% had a bachelor's degree, 9.13% had an associate's degree, 20.17% had a high school diploma, and 7.43% had less than a high school degree. Also, 42.04% of them were employed, and 57.96% were housewives (Table 2).

The mean age of marriage for the group that experienced violence was 9.7 ± 7.92 years, and for the group that did not experience violence was 7.11 ± 5.35 years. The prevalence of intimate partner violence among the 471 women studied was 92.14%. In terms of the number of children, the highest prevalence of intimate partner violence was reported among women with 3 children (100%) and those with ≥4 children (100%). When it comes to the husband's education level, the highest prevalence of intimate partner violence was reported in women whose husbands had less than a high school diploma (100%) and in husbands with a high school diploma (98.17%).

The prevalence of intimate partner violence was higher among housewives compared to working women (94.51% vs. 88.89%; $P = 0.025$). Moreover, the prevalence of intimate partner violence among women who had a forced marriage was higher than among women who had a voluntary marriage (100.% % vs 91.40%; $P = 0.050$) (Table 2).

The prevalence of intimate partner violence among the participants was 92.14% (Table 3). Additionally, 91.08% reported psychological violence, 46.71% reported physical violence, 41.4% reported sexual violence, and 29.3% reported economic violence.

Table 2. Demographic Characteristics and Other Factors Related to Wife Abuse

Characteristic	Total (n=471)	Wife abuse		*P* value
		No (n=37)	Yes (n=434)	
Age (y)	32.70 ± 7.96	31 ± 5.58	32.84 ± 8.12	0.471
Age				0.217
18-27	132 (28.03)	12 (9.09)	120 (90.91)	
28-37	227 (48.20)	21 (9.25)	206 (90.75)	
38-47	82 (17.41)	4 (4.88)	78 (95.12)	
≥48	30 (6.37)	0 (0.00)	30 (100.00)	
Husband's Age	36.99 ± 8.49	34.24 ± 7.99	37.22 ± 8.50	0.084
Duration of Marriage	9.48 ± 7.78	7.11 ± 5.35	9.69 ± 7.92	0.026
Duration of Marriage (yrs)				0.287
≤ 5	190 (40.34)	19 (10.00)	171 (90.00)	
6-10	118 (25.05)	9 (7.63)	109 (92.37)	
11-15	73 (15.50)	6 (8.22)	67 (91.78)	
≥16	90 (19.11)	3 (3.33)	87 (96.67)	
No. of Children				0.001
None	168 (35.67)	10 (5.95)	158 (94.05)	
single	157 (33.33)	24 (15.29)	133 (84.71)	
Two	111 (23.57)	3 (2.70)	108 (97.30)	
Three	26 (5.52)	0 (0.00)	26 (100.00)	
Four children and more	9 (1.91)	0 (0.00)	9 (100.00)	
Education level				0.073
Below diploma	35 (7.43)	1 (2.86)	34 (97.14)	
Diploma	95 (20.17)	1 (1.05)	94 (98.95)	
Associate's degree	43 (9.13)	3 (6.98)	40 (93.02)	
Bachelor's degree	197 (41.83)	20 (10.15)	177 (89.85)	
Master's degree and higher	101 (21.44)	12 (11.88)	89 (88.12)	

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Table 2. Continued

Characteristic	Total (n=471)	Wife abuse		*P* value
		No (n=37)	Yes (n=434)	
Husband's Educational level				0.009
Below diploma	50 (10.61)	0 (0.00)	50 (100.00)	
Diploma	109 (23.14)	2 (1.83)	107 (98.17)	
Associate's degree	40 (8.49)	7 (17.50)	33 (82.50)	
Bachelor's degree	167 (35.46)	17 (10.18)	150 (89.82)	
Master's degree and higher	105 (22.29)	11 (10.48)	94 (89.52)	
Occupation				0.025
Employed	198 (42.04)	22 (11.11)	176 (88.89)	
Housewife	273 (57.96)	15 (5.49)	258 (94.51)	
Husband's Occupation				0.590
Retired	10 (2.12)	1 (10.00)	9 (90.00)	
Employee	6 (1.27)	0 (0.00)	6 (100.00)	
manual worker	231 (49.04)	23 (9.96)	208 (90.04)	
Self-employment	215 (45.65)	13 (6.05)	202 (93.95)	
Unemployed	4 (0.85)	0 (0.00)	4 (100.00)	
Student	5 (1.06)	0 (0.00)	5 (100.00)	
Previous marriage				0.235
Yes	16 (3.40)	0 (0.00)	16 (100.00)	
No	455 (96.60)	37 (8.13)	418 (91.87)	
Husband's previous marriage				0.077
Yes	34 (7.22)	0 (0.00)	34 (100.00)	
No	437 (92.78)	37 (8.47)	400 (91.53)	
Husbands' drug use				0.098
Yes	30 (6.37)	0 (0.00)	30 (100.00)	
No	441 (93.63)	37 (8.39)	404 (91.61)	
Type of Marriage				0.050
Imposed	41 (8.70)	0 (0.00)	41 (100.00)	
Voluntary	430 (91.30)	37 (8.60)	393 (91.40)	
Consanguineous marriage				0.624
Yes	124 (26.33)	11 (8.87)	113 (91.13)	
No	347 (73.67)	26 (7.49)	321 (92.51)	

Table 3. The Prevalence of Wife Abuse and Its Types

Types of Wife Abuse	N=471			
	Yes		No	
	N	%	N	%
Psychological violence	429	91.08	42	8.92
Physical violence	20	46.71	251	53.29
Sexual violence	195	41.40	276	58.60
Economic violence	138	29.30	333	70.70
Total wife abuse	434	92.14	37	7.86

Table 4. Multiple Linear Regression Model to Determine the Factors Affecting Wife Abuse, [a,b]

Predictor	Unstandardized β	Standard Error	95%CI	*P*-value
Husband's Educational level (Ref. master's degree and higher)	0.751	0.323	0.115, 1.387	0.021
Education level (Ref. master's degree and higher)	0.463	0.331	-0.187, 1.112	0.162
Husband's Occupation (Ref. retired)	0.913	0.554	-0.176, 2.003	0.100
Husbands' drug use (Ref. no)	5.671	1.570	2.585, 8.758	< 0.001
Duration of Marriage	0.130	0.054	0.024, 0.236	0.016
Type of Marriage (Ref. voluntary)	4.313	1.442	1.480, 7.146	0.003
Consanguineous marriage (Ref. no)	-2.651	0.852	-4.327, -0.976	0.002

[a] β, regression coefficient; CI, confidence interval.
[b] Dependent Variable: Total score of sleep quality

Table 4 shows the results of linear regression output with factors contributing to intimate partner violence. In the multiple linear regression model, husband's education level (β = 0.751, 95% CI: 0.115 to 1.387, $P = 0.021$), husband's addiction (β = 5.671, 95% CI: 2.585 to 8.758, $P \leq 0.001$), duration of marriage (β = 0.130, 95% CI: 0.024 to 0.236, $P = 0.016$), type of marriage (β = 4.313, 95% CI: 1.480 to 7.146, $P = 0.003$), and consanguineous marriage (β = -2.651, 95% CI: -4.327 to 0.976, $P = 0.002$) independently and significantly were associated with intimate partner abuse.

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Discussion

Violence against women is a critical public health and human rights issue globally, affecting women across all cultures and socioeconomic backgrounds. IPV severely impacts the health and well-being of women and their children, compromising both current and future generations' health. This study aimed to estimate the prevalence of IPV and examine contributing factors among married women in Tehran, Iran.

The findings suggest that the prevalence of intimate partner violence was 92.14%. Psychological violence accounted for 91.08%, physical violence for 46.71%, sexual violence for 41.4%, and economic violence for 29.3% of the violence. Type of marriage, husband's history of addiction, family relations between the couple, husband's level of education, and marriage duration were the most important factors contributing to intimate partner violence.

Regarding the high IPV prevalence, this figure may seem disproportionately high compared to international studies. Previous systematic reviews in Iran have reported IPV prevalence ranging from 5.4% to 95%, with an overall figure of 23% (20). In comparison, global figures include 67% in Japan (21), 33% in Ghana (22), 20% to 78% in Ethiopia (23), 56% in India (24), and 2% to 70% in the United States (25). A major factor contributing to the high prevalence of IPV in our study is the inclusion of psychological violence, which is often excluded from many other studies. While IPV is typically limited to physical, sexual, and economic violence in many studies, our research also considered psychological violence, which is more difficult to identify and measure. As a result, the inclusion of psychological violence likely led to a higher observed prevalence compared to studies that do not account for this dimension. Additionally, the broad definition of IPV used in our study, where any response of "once or more" to any of the questions was classified as positive for violence, may have further inflated the prevalence rate. This approach was necessary due to the lack of clear, visible indicators for some forms of violence, particularly psychological abuse. Without physical signs, such forms of violence can often go unrecognized, and this broad classification ensured that even subtle forms of abuse were accounted for in the study's findings.

Other studies have indicated a rise in psychological violence, as cultural changes may have reduced physical violence but led to an increase in nonphysical forms (26, 27). This aligns with the present study, where psychological violence was more prevalent than physical and sexual abuse. The lack of visible symptoms in psychological violence may make it less recognized, yet it remains a significant form of abuse. In the study of Mahaparto et al, which was conducted on Indian women, the prevalence of psychological violence was more common than physical and sexual violence (28), which is consistent with the present study. Nonetheless, in Arefi's study (29), physical violence was more common than psychological and economic violence, which does not tally with the present study. The reason for the high prevalence of psychological violence can be attributed to the fact that men are not well familiar with all aspects of violence, and for them, violence is defined as something physical. On the other hand, the lack of visible symptoms and marks of psychological violence has made men carry out this type of violence recklessly. This can also probably be ascribed to the fact that it is almost impossible to prove the person had been injured, as this form of violence is physically symptomless. Therefore, it has a higher rank among all types of violence.

In addition to cultural and social factors, several global studies have reported an increase in IPV during the COVID-19 pandemic, particularly during lockdowns. This increase is attributed to factors such as heightened stress, financial insecurity, and prolonged confinement with abusive partners (30-32). Our study's findings align with this trend, suggesting that the high prevalence of IPV observed in our study may have been influenced by pandemic-related factors. The stress, financial hardships, and isolation caused by the pandemic might have exacerbated preexisting abusive behaviors, leading to an increase in violence against women.

In the present study, the relationship between the husband's level of education and domestic violence against women was significant, which is in line with the results of Bazmi et al (33) and Elsberg et al (34). Yani Karam in Turkey also mentioned that a high education level is significantly associated with low violence (35). The reason behind this is that educated people are more aware of women's rights and position in the family, compared with illiterate or low-educated people.

The relationship between the use of cigarettes, alcohol, and illicit drugs with personality is reciprocal. This means that substance abuse affects the personality of the addicted person, and people with various personality traits, such as dependent personality, are more prone to drug addiction. The mutual effect of these factors is the basis of intimate partner violence. These results can be explained by the fact that the use of alcohol and drugs impairs judgment and increases aggressive behavior in them (3). Shayan et al also found a significant and negative relationship between husband's addiction and intimate partner violence (3). In the study of Sarichello et al, there was a significant and inverse relationship between husbands' addiction and intimate partner violence (36).

In the present study, women who had forced marriage were more prone to violence and abuse by their husbands, which supports the results of Kolumgah et al (37) and Bardesiri et al. (38). A reason behind this finding is that unfortunately, there is no law in Iran to prevent forced marriage in families, and at times, children are forced into unwanted marriages, which is the basis of various future psychological disorders in them and families are more likely to experience violence.

It is often believed that marriage length reduces violence against women; however, the results of this research and other studies have revealed that marriage length did not decrease male violence against women but increased it. This is probably due to the inability to deal with and cope with the situations or the lack of conditions for women to deal with the abusive behavior of their husbands, which gradually gives rise to such behaviors in their husbands (39, 33). In Ghazizadeh's study (39), however, the prevalence of physical violence was lower in longer marriages.

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In the present study, intimate partner violence was significantly less in couples who had a consanguineous marriage. In the study of Razaghi et al, in couples who had a consanguineous marriage, sexual abuse was significantly less, while physical abuse was significantly more (27).

Limitations

Given the convenience sampling of the study, the generalization of the findings to other contexts should be done with caution. Considering the 1 year of recalling the experience of violence by women, the respondents may not have correctly remembered some experiences.

Our study focused on women who had access to online platforms and were willing to share their experiences. While this may have led to a higher representation of affected individuals, it does not necessarily invalidate the findings. Instead, it highlights the need for urgent policy interventions.

We employed rigorous data-cleaning procedures and ensured anonymity to encourage honest reporting. While self-selection bias is a recognized limitation of online surveys, our findings still provide valuable insights into IPV prevalence and its urgent implications.

In light of the findings of this paper, the health officials of Iran are advised to take preventive measures to decrease intimate partner violence and increase social support for injured women. Raising awareness throughout society concerning the issue of intimate partner violence, increasing social support for women, and teaching coping and problem-solving skills to injured women are effective measures to maintain and preserve the family foundation as well as women's health.

Conclusion

This study showed that psychological violence is the most common form of violence against women, and marriage type, husband's addiction history, kinship with the husband's family, husband's level of education, and marriage length are associated with intimate partner violence. Given the high prevalence of intimate partner violence and its relationship with some characteristics of couples, it seems necessary to raise awareness concerning this issue and its contributing factors. Developing screening programs to identify this issue promptly is also proposed. Conducting similar studies on the male population to investigate the prevalence of intimate partner violence and its associated factors is also recommended.

Authors' Contributions

S.S.G. gathered data, conducted analysis, and authored the manuscript. M.G. provided analytical guidance and revised the article. A.H. and K.F.B. authored the manuscript and conducted a review of the study. S.SH.N. served as the study supervisor, designed the research, and edited the manuscript. All writers reviewed and endorsed the final manuscript.

Ethical Considerations

This article is adapted from a master's thesis in epidemiology; the ethical approval is granted by the ethics committee of the School of Public Health and Neuroscience Research Center, Shahid-Beheshti University of Medical Sciences, Tehran, Iran (IR.SBMU.PHNS.REC.1400.013). The requirement for informed consent from participants was waived because data were collected through social media, participants participated in the study willingly, and there was no compulsion.

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Conflict of Interests

The authors declare that they have no competing interests.

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