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An Evidence-Based Glance at Domestic Violence Phenomenon in Early Marriages: A Narrative Review

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Abstract

Objectives: Teenage marriage results in social, cultural, and economic problems including domestic violence. Based on research evidence, the present study attempted to provide a documentary image of domestic violence in early marriages.

Materials and Methods: This study was conducted by searching different databases such as Web of Science, Cochrane Library, Science Direct, PubMed, Scientific Information Database, Google Scholar, Magiran, Irandoc, and Iranmedex for articles which were published during 2000-2018. To this end, MeSH keywords like "dating violence", "intimate partner violence (IPV)", "teenage marriage", and "domestic violence" were utilized and thus a total of 176 articles were obtained and selected for review. Finally, the "Grading of Recommendations, Assessment, Development, and Evaluations" (GRADE) approach was used to order the quality of evidence.

Results: Based on the findings, the general prevalence of domestic violence varies from 7% to 48% in the world and from 10.7% to 93% in Iran. IPV is more prevalent in younger women and psychological and physical violence is higher in this group. In addition, the prevalence of domestic violence in pregnancy varies from 2% to 43.5%. Women experience more violence in three months pre-pregnancy, during the first six months of pregnancy, and three months after childbirth. During pregnancy, domestic violence is related to the complications of preterm labor, low birth weight, vaginal bleeding, and hospitalization. Eventually, depression, panic attacks, excessive alcohol use, eating disorders, and suicidal thoughts are mental health disorders resulted from domestic violence.

Conclusions: Overall, young women are the sacrifice of violence in their most active years of life, which is along with the most harm in society concerning health, economics, cultural, and social issues. Considering its high rate, teenage marriage can be prevented by increasing public awareness and the cooperation of related organizations.

Keywords: Dating violence, Dating abuse, Teenage marriage, Intimate partner violence

Introduction

"And as one of His Signs, He created mates for you from your souls that you may find rest in them. And He put between you love and mercy (compassion). Most surely there are signs in this for people who reflect" (1).

Marriage is a men-women memorandum of understanding that leads to compatibility and agreement so that both parties undertake to support each other in any situation such as sadness, happiness, illness, along with wellness, poverty and wealth (2). In addition, adolescence is the transfer from childhood to adulthood and the greatest primary changes (i.e., physical, attitudinal, and behavioral) take place during this period (3). According to the World Health Organization (WHO), the age range of 10-19 is considered adolescence (4).

The average marriage age is still low in some regions despite the expansion of urbanization and the increase of the age of marriage (5). Further, teenage marriage refers to marriage under 18 (6). According to the obtained results of a study in the United States, more than 10% of women marry before 18, half of whom are 16 years or younger, and 1 per 9 (12%) marry at 14 or at younger age, however, the prevalence of this marriage is estimated at 40-50% in low and middle income countries (7). Statistical Center of Iran indicated that approximately 9.8% of women aged 10-19 have married at least once while 2.1% of them got divorced during this period (8).

Based on previous research, teenage marriage increases the chance of poverty in the future by approximately 31% (9). Similarly, the main causes of increased early-age relationships and informal marriages are known as poverty, dropout, and the lack of social and economic care (6). Moreover, the number of divorces is high in such marriages (7). In teenage marriage, adolescents face challenges such as perusing education for obtaining a diploma and early parenting (9).

Furthermore, intimate partner violence (IPV) is one of the outcomes of these marriages. Violence against women by the sexual partner is a remarkable public health problem that manifests itself with inappropriate behaviors imposed by one person on the body, spirit, and psyche, ethics, and the culture of another person. It happens during

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adolescence and early adulthood often among married or unmarried couples, including physical and sexual violence, emotional abuse, and controlling behaviors (10). IPV has its roots in evolutionary and cultural forces that explain its persistent and universal nature. Moreover, it arises by interpersonal and intrapersonal complexities that change the biological function of an individual (11).

According to the WHO, the prevalence of domestic violence in the world was 35%, the most and least of which happened in Africa and the European countries, respectively (10). Additionally, a multinational study on women's health indicated that 15%-71% of women aged 15-49 reported physical and sexual violence of their intimate partner during the past year (12). The prevalence of domestic violence in Iran has two ranges of 19.4%-46% and 59%-93.6% as well (13). In addition, Balali Meybodi and Hassani reported the prevalence of domestic violence in Kerman by 46%. The most usual types of violence were mental (78.6%), physical (55.6%), and sexual (28.6%), respectively (14). Abdollahi et al (15), in their descriptive and analytical study, showed that the prevalence of psychological violence of intimate partner in Mazandaran province was 5.5%-60.5% more than that of physical violence (14.1%).

Poverty or unemployment, housekeeping, harmful drug and drink usage such as alcohol by the husband, the interference of others in the private lives of couples, the dissatisfaction with sexual expectations (16), the lack of women's employment, women's financial dependence on their husband, low literacy, low socioeconomic status, a history of husband's mental illness, and smoking (by 6.5 times) are highlighted as several factors which affect violence (17). Likewise, there is a meaningful relationship between husband's age, marital duration, family income, female's financial dependency, the level of female occupation, female job, husband's addiction, sexual satisfaction, and IPV (18). Violence in low social classes is high and often of physical type. Apparently, religious beliefs play a deterrent role in violent acts (15). The promotion of the level of women's literacy and education and their employment prevents violence as well (19). Women with low literacy are 1.59 times more at the risk of being victimized for IPV compared to educated women (17). There is a meaningful inverse relationship between marriage age and economic status, as well as education and domestic violence (20). Further, IPV occurs within the family, though its economic costs can be wide and heavy in public areas, namely, healthcare and the judiciary system (21).

Furthermore, women living with IPV are more at the risk of physical, psychological symptoms and disease such as depression, posttraumatic stress disorder, anxiety, suicidal thoughts, self-harm, insomnia, pain, respiratory and musculoskeletal diseases, cardiovascular disorders, as well as diabetes and digestive system disorders (22). Physical violence also causes complications such as fractures, tears, head trauma, and sexually transmitted diseases (23). The experience of partner sexual violence increases the chances of developing the symptoms of depression, leading to suicide among women (24, 25).

On the other hand, teenagers' pregnancy leads to cultural, social, and health challenges in human societies. Teenage pregnancy is considered as a normal issue in some cultures and thus is followed by less negative consequences and vice versa (26). Pre-pregnancy care is lower in adolescents than adults, and the importance of this issue is unclear to these women due to young age and low literacy (27). The rate of anemia, preeclampsia, eclampsia, and the premature rupture of the membranes, as well as cesarean, because of cephalopelvic disproportion and fetal distress is high in these pregnancies. Moreover, teenager pregnancy leads to poor delivery outcomes such as preterm labor, low birth weight, and maternal mortality (28). Additionally, teenage mothers most likely experience pregnancy problems such as perinatal mortality or disability due to difficult labor, endometritis, systemic infections, and the like. The rate of unsafe abortions in unhealthy conditions also increases since the non-consumption of contraceptives, as well as unwanted pregnancy are at higher levels (29). Based on the report of WHO, Pregnancy and labor at young age account for approximately 23% of the illness burden throughout the entire woman's life. In low and middle-income countries, stillbirth and infant death in the first week and month of life are 50% higher (30). The accompaniment of violence in adolescent pregnant increases the above-mentioned problems. The overall prevalence of domestic violence in pre-pregnancy and pregnancy is 75.3% and 68%, respectively. The most frequent types of chronic violence in pregnancy are verbal abuse (56.2%), along with emotional (12.8%) and sexual (7.3%) matters. The overall prevalence of violence has a significant association with the type of marriage and unwanted pregnancy (31). According to the Ministry of Health, the prevalence of violence during pregnancy is 60% in Iran (32).

Considering the above-mentioned discussions, the present narrative review aimed to investigate the domestic violence phenomenon in early marriages based on the evidence-based review.

Materials and Methods

In the present review, articles were independently searched by two researchers without language restriction from 2000 to 2018 through several databases including PubMed, BMJ, Google Scholar, Cochrane Library, Web of Science, Science Direct, Scientific Information Database, Magiran, Irandoc, and Iranmedex. Totally, 176 articles (49 articles in Persian and 128 articles in English) were extracted using MeSH keywords including "dating violence", "intimate partner violence", "IPV, "teenage marriage", "domestic violence". The present research utilized all types of studies such as cross-sectional randomized clinical trials in addition to descriptive, analytical, cohort, and review

studies. A number of 176 articles were selected for review, analyzed, and finally, summarized after investigating the articles and based on the inclusion criteria such as being at teenage and getting married at this age and experiencing domestic violence. Then, 115 articles regarding domestic violence were excluded due to dealing with domestic violence at adulthood. Among the 61 articles on teenagers, 17 cases were excluded for the reasons mentioned in Figure 1. Eventually, 44 articles were selected, out of which 23 and 13 cases dealt with domestic violence in married teenagers and pregnant women, respectively, while eight articles investigated the psychological outcomes of domestic violence (Figure 1).

The GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) approach was used to order the quality of evidence (33). Two review authors (AFKH, THM) worked independently to evaluate the quality of evidence and resolve disagreements.

Results

The outcomes of teenage marriage can be divided into significant phenomena such as domestic violence, mental health, and high-risk pregnancies.

Domestic Violence

Most children and teenagers are unaware of the warning signs of IPV, which turns it into a major social and health problem in adolescents. The victims of IPV may not

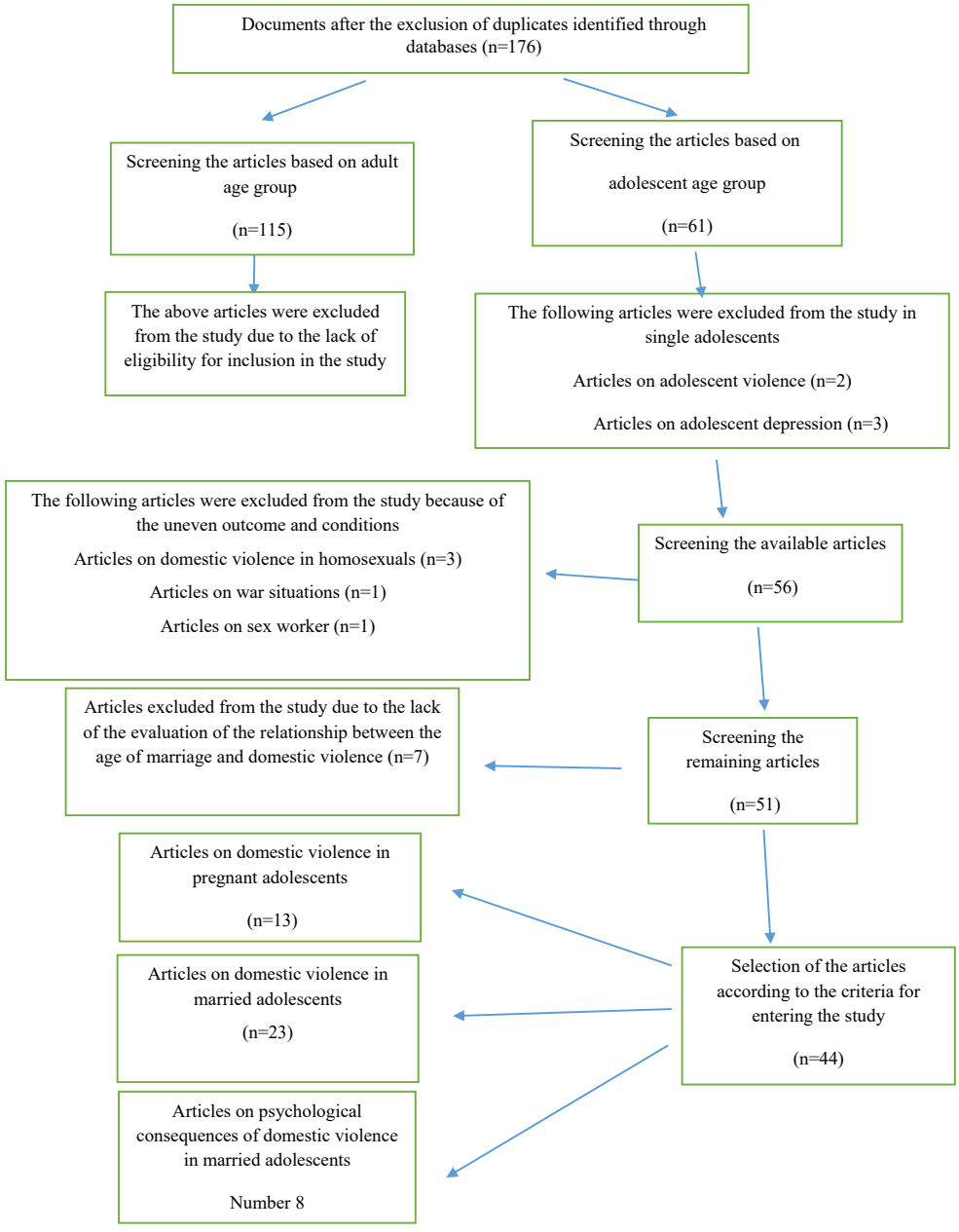

Figure 1. Flow Diagram of Investigated Articles.

identify it as a threat and avoid reporting it (34). Roman et al conducted a review study and found that the prevalence of domestic violence in African countries varies from 26.5%-93%, which has reached epidemic levels (21). According to the available evidence-based articles and based on Persian articles, the prevalence of violence in the world and Iran, in particular, varies between 7%-48% and 10.7%-93%, respectively. Considering the above-mentioned data, it is inferred that the rate of violence in Iran is higher than its global rate.

In the study by Raj et al, married teenage women reported significantly higher IPV than those married at higher ages (43% vs. 24%), of whom, 16% of teenagers indicated severe physical violence compared to 6% of adult women (35). In addition, teenager women further experience their husband's controlling behavior and are vulnerable to IPV, especially physical violence (36). Further, formerly married teenage women reported more and severe physical violence, as well as more psychological consequences of violence owing to the coercive control behaviors of their husbands in comparison with newly married women (37).

There is a meaningful and inverse correlation between women's marriage age and physical violence. In other words, more marriage at teenage and childhood causes the greater experience of physical violence (20). In fact, early marriages lead to the death of dreams and the threat of individual independence, as well as the unpleasant experience of coercive sexual and violence in teenage women (38). Women who experience mild violence in teenage are 2.5 times more likely to be the victim of physical violence compared to women who have no experience and thus are the victims of sexual violence by 1.3 times (39).

Based on the findings of the descriptive study by Raj et al, many parents and adolescents continue to maintain the norms of inhibiting the choice of the girl in marriage and the contraceptive method and supporting the acceptance of IPV, which are among the related factors in the poor health of mother and child and their survival (40).

Similarly, Nasrullah et al conducted a study on children marriage and controlling behaviors and found that one in three women aged 15-24 in Pakistan experimented IPV and reported approximately 22% physical violence and 26.3% psychological violence (36). In another study by Taherkhani, the prevalence of violence, in general, as well as physical, emotional, and sexual violence was reported 88.3%, 25.4%, 87.3%, and 39.1%, respectively (41). Furthermore, Rasoulian et al asserted that the outbreak of physical violence was 38.7% and 6.6% during lifetime and over the past year, respectively. They also indicated that women in rural areas experience a high level of physical violence while the opposite occurs in urban areas (17). Based on the findings of Asadi et al, the outbreak of mental and physical violence was estimated 93% and 12%, respectively, and there was a significant relationship between the persistent psychological, sexual, and physical domains of violence with the quality of life (42).

Investigating the retrospective studies, Evans et al reported that 20%-40% of the adults were exposed to violence during childhood and adolescence (43). Moreover, Halpern et al concluded that the rate of physical or sexual violence was 40% among teenagers of whom 8% and 25% reported IPV in adolescence and young adults, respectively and 7% were the victims of persistent violence from adolescence to youth (44). IPV perpetration, especially sexual IPV becomes stable over the period of time from adolescence to adulthood (45). Evaluating IPV among the students, O'Leary and Slep also found that IPV in the form of physical invasion often begins sooner than high school. Nearly 35% of men and women above high school reported their involvement in IPV (46). In the study by Romito and Grassi (47) on the effects of intimate partner and sexual violence, 37.6% of men and 39.6% of women mentioned psychological violence and 17.7% of women reported physical violence as the influential factors. Additionally, women significantly experienced higher domestic violence (45.2%) compared to men 34.8% (Table S1, Supplementary file 1).

Marriage Age and Violence

IPV is more prevalent in younger women, with the maximum frequency of violence against women aged 15-25 and then 25-35 (48). Regarding the marriage duration, the highest frequency pertains to the first 6-10 years of marriage while the lowest frequency is related to women married for 36-40 years (49). Likewise, Arefi indicated that a high percentage of women experiencing violence had an elementary education or were illiterate and more than 56% of harassed women aged between 17 and 32 years old. The highest rate of violence occurred among women aged 17-20 (16.5%) as well (50).

Taherkhani indicated that the level of violence decreased simultaneously with an increase in the marriage age for women and men. Women who had a spousal role at the age of 24 or younger were 2.8% more exposed to violence than women who were married after 24 years. In addition, violence among men who married before 30 was 1.8 times more those whose marriage happened at the age of 30 or older (41). It seems that the specific pattern of IPV decreases after adolescence or early 20 years (46) and the probability of committing IPV during adolescence is predicted to increase and maximize at the age of 20 and then decrease in the early third decade and its second half (51). Thus, the highest rate of violence occurs in younger years (41). Wolfe et al found that teenage education at school (e.g., concerning healthy relationships and methods of avoiding marital violence) reduces the rate of violence in the next 2.5 years (52). Lundgren and Amin (53) and De Koker (54) in separate studies also demonstrated that the implementation of interventional programs in the school (the most effective), society, and

at home by parents for primary and secondary prevention among IPV teenage victims and perpetrators was effective in preventing violence against teenagers (see Table S1).

Pregnancy and Domestic Violence

Based on investigations performed on available studies, the outbreak of domestic violence in pregnancy varies from 2% to 43.5%, and adolescent women are subject to violence before and during pregnancy and after labor.

IPV during pregnancy has a significant relationship with low education and the lack of employment of the husband, 5-9 years after marriage, and the gravidity of two (55). In addition, the outbreak of IPV in pregnancy varies from 2% in Australia, Denmark, Cambodia, and the Philippines to 13.5% in Uganda. It seems that the outbreak of IPV in Africa and Latin America is higher compared to European and Asian countries (56). According to Johri et al, the outbreak of cruelty in pregnant women aged 15-19 is 21% (57). Farrokh-Eslamlou et al conducted a study on women (48 hours postpartum) and reported a high outbreak of psychological IPV during pregnancy, chiefly verbal insults. They further showed that the prevalence of physical and sexual violence was 10.2% and 17.2%, respectively (55). Furthermore, in the study by Nojomi and Akrami, the outbreak of physical cruelty and physical violence was 10.7% and 11.9% during pregnancy and three months before pregnancy, respectively (58). In another study by Adamu and Adinew, the role of IPV in postpartum depression was established in women with a case history of a psychological problem and sexual dissatisfaction. Moreover, the rate of the experience of postpartum depression, as well as marriage dissatisfaction was 23.3% and 18.8% (59), respectively. Similarly, domestic violence had the highest (21%) and the lowest (13%) prevalence three months and 24 hours after labor. Additionally, 75% of mothers reported domestic violence during pregnancy and 24 months after labor (60). Peedicayil et al found a total outbreak of modest to intensive cruelty during pregnancy by 13%. Based on their findings, women experienced all types of physical violence during pregnancy, including slapping (16%), hitting (10%), beating (10%), kicking (9%), as well as the use of weapons (5%) and other methods (6%). Finally, 18% of women reported at least one of these behaviors while 3% of them experience all six behaviors (61). In addition, adolescent women (15.1%) had more fear of their husband because of IPV in pregnancy (55, 62).

Physical violence, which is usual in pregnancy, is related to maternal complications and adverse labor consequence (58). Further, IPV is associated with unwanted pregnancy (23), as well as maternal complications such as depression, pregnancy-related distress symptoms, inadequate antenatal care and hypertension, and preeclampsia (63). The number of women who are subjected to IPV is probably limited regarding registering for antenatal care, receiving adequate supplementation (i.e., iron and folic acid), enjoying dietary variety, as well as relaxation and sleep during the daytime, and finally, attending mothers' group meetings (64). Furthermore, maternal problems such as pyelonephritis, the premature rupture of the membranes, preterm labor, vaginal bleeding with pain, low birth weight, and hospitalization were reported in women with physical violence (58).

In their study, Mohammadi et al demonstrated that women married at the age of 16 were the victims of violence, especially during pregnancy and the violence mainly occurred in the second trimester and in the upper and lower extremities (65). Similarly, Mohammad-Alizadeh et al. found that the most common IPV in women was the psychological attack, following the physical attack and sexual harassment throughout the lifetime, especially during pregnancy. The outbreak of these conditions was higher in teenage and in the first six months of pregnancy as well (27). Silverman et al. concluded that women experiencing IPV were more susceptible to undesirable pregnancy and the loss of gestation in the form of spontaneous abortion, induced abortion, and stillbirth (66, 67). They also indicated that sexual violence in adolescent girls was related to the raised risk of sexual behavior such as the non-use of condom, multi-partner sex, unwanted pregnancy, and sexually transmitted diseases (68) (see Table S2).

Mental Health

Teenage marriage is attributed to a broad range of mental disturbance which seems to be independent of demographic and social factors. Among married women with psychiatric disorders, those with early marriages were more probable to seek health services in contrast to women who married at adulthood (7). Domestic violence is considered as a common phenomenon with adverse health and social consequences (69, 70). Lehrer et al reported that the recognition of depressive symptoms in teenage girls was related to the increased risk of bodily violence by the sexual partner at the end of adolescence and early adulthood and was related to bodily or sexual abuse, along with the experience of IPV or sexual coercion. About 28% of the girls with a great rate of baseline depressive symptoms were more susceptible to develop mood disorders. Likewise, girls with severe depressive symptoms had 1.86 times more chance of future confrontation with moderate to severe violence of their husband compared to girls with a low rate of the depressive sign. Eventually, the risk of violence victimization increased by the ever-increasing rates of depressive symptoms (70).

Based on the findings of another research, teenage IPV is related to the high rates of domestic violence in adulthood, and women who bruit IPV in adolescence and adulthood have high mean levels of depressive symptoms (71). In many cases, the pressure exerted by family members, premarital pregnancies, or religious affiliation for an under-18 marriage may be related to the consequences of

mental health in the future (7).

Moreover, the prevalence of IPV is associated with an increase in depression in both genders, as well as the substance abuse, anti-social behaviors, and suicide in girls and the high levels of high-risk behaviors in both genders (72). IPV also causes high-risk behaviors in adolescent mothers (73). According to the study by Gage, 8% of 15-year-old versus 2.5% of 24-year-old married adolescents had suicide thoughts and attempts (74). An accumulative and current IPV predict the possibility of depressive signs at adulthood and at the age of 28 years (71). The psychological health outcomes associated with IPV in adolescents include depression, panic attacks, excessive alcohol use, eating disorders, and suicidal thoughts among which, panic attacks and alcohol consumption are more usual in women and men, respectively (47). In individuals with an experience of violence, high-danger actions such as drug use, improper weight loss, pregnancy, high-risk sexual behaviors, and suicide attempts are observed further (75). Children and teenagers encountered with domestic violence are at the raised risk of experiencing emotional, somatic, and sexual misuse. Ultimately, the problems concerning emotional and behavioral development and other problems in their life increase when they face violence (76) see Table S3).

Discussion and Conclusions

Although marriage has declined in teenagers, especially under the age of 15, teenage marriage is still a serious problem in the whole world. In many countries, there is a legal age for girls' marriage, but according to Jones, the marriage of about 10% of the girls happen before their lawful age. Additionally, the marriage rate in adolescence is greater among girls than boys. Although adolescent marriage is generally related to teenage girls and boys, in some countries, young women marry older men (77). Early marriage imposes considerable costs on the households and their children and the community (78). In fact, early marriages cause the death of dreams and the threat of individual independence in adolescents, especially girls.

As previously mentioned, domestic violence, high-risk pregnancies, and mental disorders are considered as the consequences of early marriage. Several maternal problems such as preterm labor, pyelonephritis, the premature rupture of membranes, vaginal bleeding with pain, low birth weight, and hospitalization occur in women who experience physical violence. IPV is more observed in younger women, with the highest levels of violence among women within the age range of 15-25. In addition, teen marriage is related to a broad spectrum of mental disturbance. Mental health consequences associated with domestic violence in adolescents are depression, panic attacks, excessive alcohol use, eating disorders, and suicidal thoughts. Panic attacks and alcohol problems are more common in women and men, respectively.

Young women are the victims of violence in the most active and useful years of their life, which is most harmful to society in terms of health, economic, cultural, and social issues. The greater incidence of violence in young women can be due to the lack of experience, familiarity with life proficiency, and knowledge on how to deal with family problems. Therefore, due to the high level of violence in Iran, it is necessary to prevent teen marriage by increasing public awareness, especially for children, adolescents, and their parents. Women are subject to violence during all stages of life, especially pre-pregnancy, during pregnancy, and after labor. Accordingly, domestic violence screening can be used to identify and monitor these cases. Women who experience violence perhaps even follow no care and even may report abusive practices even if they have its signs. Therefore, searching for sexual violence and the other forms of abuse should be considered worthwhile, and women who have experienced violence should be identified and intervened accordingly.

This review only included 44 eligible articles including two randomized clinical trials, eight review studies, and 34 observational studies. In terms of evidence quality, articles were at a very low level (n=10), low level (n=5), medium level (n=13), and high levels (n=14). As a result, high-quality studies are recommended based on current research.

The meta-analysis of the reviewed studies was not conducted due to the selection of a variety of studies that should be considered in subsequent studies, which is considered as a limitation of the present study.

Conflict of Interests

Authors declare that they have no conflict of interests.

Ethical Issues

The study was approved by the Ethics Committee of Tabriz University of Medical Sciences under No. TBZMED. REC, 1396. 233IR and registered in Iranian Registry of Clinical Trials (identifier: IRCT2017070334052N2; https://www.irct.ir/trial/26139).

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Supplementary Materials

Supplementary file 1 contains Tables S1-S3.

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