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CORRELATES OF DOMESTIC VIOLENCE, AGE AND SEXUAL SATISFACTION IN ANTEPARTUM DEPRESSION: A STUDY OF PREGNANT WOMEN IN ANAMBRA STATE

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Abstract

This study investigated the extent to which domestic violence, age, and sexual satisfaction correlate with antepartum depression among pregnant women in Awka, Anambra State. A purposive sample of 156 women, aged 19 to 44 years (M = 31.4, SD = 7.58), participated in the study. The research adopted a correlational design and utilized three standardized instruments: Domestic Violence Scale, Sexual Satisfaction Scale, and the Depression Scale specifically adapted to measure antepartum depressive symptoms. Pearson Product Moment Correlation was employed to analyze the data. Findings revealed a significant positive correlation between psycho-physical violence—a subdimension of domestic violence—and antepartum depression ($r = 0.499$, $p < 0.05$), suggesting that physical and psychological abuse markedly elevate the risk of depressive symptoms during pregnancy. Conversely, the control-based dimension of domestic violence showed a negative but non-significant correlation with antepartum depression ($r = -0.093$, $p > 0.05$), indicating a limited or inconsistent association. Overall domestic violence was significantly and positively associated with antepartum depression ($r = 0.426$, $p < 0.05$), emphasizing the cumulative psychological toll of abusive environments. Age was not found to be a significant predictor of antepartum depression ($r = -0.032$, $p > 0.05$), suggesting that vulnerability to depressive symptoms in pregnancy may be more influenced by psychosocial than demographic variables. Notably, sexual satisfaction demonstrated a significant inverse relationship with antepartum depression ($r = -0.376$, $p < 0.05$), implying that higher levels of sexual fulfillment serve as a protective factor against maternal depressive symptomatology. These findings highlight the

urgent need for integrative maternal mental health interventions that account for intimate partner dynamics and sexual well-being. It is therefore recommended that public health initiatives should focus on screening for domestic abuse and addressing relational distress during antenatal care.

Keywords: Domestic Violence, Age, Sexual Satisfaction, Antepartum Depression, Pregnant Women

Introduction

Pregnancy is often heralded as a period of joy and anticipation; however, for many women, it is accompanied by significant psychological challenges, notably antepartum depression (APD). APD, also referred to as prenatal depression, is characterized by persistent sadness, anxiety, and a loss of interest in activities during pregnancy. Recent studies indicate that the prevalence of APD ranges from 11.3% to 19.6% globally, emphasizing its significance as a public health concern (El-Hachem et al., 2022). The ramifications of APD extend beyond maternal well-being, impacting fetal development and leading to adverse outcomes such as preterm birth, low birth weight, and developmental challenges in infancy (Hamed et al., 2022). Moreover, APD is a strong predictor of postpartum depression, highlighting the necessity for early detection and intervention during the prenatal period (Beck, 2001; Guintivano et al., 2018).

Among the various factors influencing APD, domestic violence (DV) has emerged as a particularly potent predictor. The World Health Organization (2013) reported that approximately one in three women globally experiences intimate partner violence, which may include physical, emotional, or sexual abuse. Exposure to such violence during pregnancy can intensify emotional distress and contribute to the onset or worsening of depressive symptoms (Akhtari et al., 2022; Kaufman & Jasinski, 2019). Thus, DV is not only a human rights violation but also a critical psychosocial stressor with implications for maternal mental health, including increased risk of APD.

Another key variable linked to APD is maternal age (Altendahl et al., 2022). Younger pregnant women, particularly adolescents and women in their early twenties, are often disproportionately affected by APD due to stressors such as financial instability, lack of social and emotional support, and limited access to healthcare services (Sulyman et al., 2021; Altendahl et al., 2022). On the other hand, older women may face different but equally distressing challenges, such as fertility-related anxieties, increased medical risks, and the burden of balancing family and career responsibilities. These age-related stressors can undermine psychological resilience and contribute to depressive symptoms during pregnancy.

Sexual satisfaction, often overlooked in prenatal mental health discourse, also plays

an integral role in shaping emotional well-being during pregnancy. Hormonal changes, physical discomfort, altered body image, and shifting relationship dynamics can disrupt sexual functioning and satisfaction (Öktemer & Küçükakça, 2023). Reduced sexual satisfaction has been found to correlate with increased depressive symptoms, possibly due to its impact on self-esteem, intimacy, and emotional connection with a partner (Yeh et al., 2016; Serife et al., 2022). Therefore, a decline in sexual satisfaction may further compound the psychological burden on expectant mothers, increasing susceptibility to APD.

Despite growing awareness of APD and its consequences, research examining its multifactorial predictors especially the interconnected roles of domestic violence, age, and sexual satisfaction remains sparse, particularly in developing countries such as Nigeria. This study, therefore, seeks to fill this gap by investigating how these three variables contribute to the experience of APD among pregnant women. By exploring these associations, the research aims to deepen understanding of APD's etiology in this context and provide a foundation for designing an appropriate and evidence-based interventions to support maternal mental health.

Statement of the problem

The transition into motherhood is a profound experience characterized by substantial psychological, social, and physiological changes, all of which can increase a woman's vulnerability to mental health challenges. Although pregnancy is often anticipated with joy and fulfillment, many women encounter a contrasting reality marked by emotional distress, particularly in the form of antepartum depression. This condition can be deeply overwhelming and disorienting, disrupting both the prenatal experience and maternal well-being.

Despite growing recognition of antepartum depression as a significant public health issue, scholarly attention remains disproportionately focused on postpartum depression. This imbalance may stem from enduring societal misconceptions that idealize pregnancy as an emotionally stable period, or from the absence of routine mental health screening during the prenatal phase. As a result, antepartum depression frequently goes undiagnosed, leaving many women without the necessary psychological support and treatment interventions.

This study seeks to address this critical gap by exploring the prevalence and psychological impact of antepartum depression, with a specific focus on the roles of domestic violence, maternal age, and sexual satisfaction as potential risk factors. These variables are often under-investigated in maternal mental health research, yet they may significantly contribute to the onset or intensification of depressive symptoms during pregnancy. By examining these complex and interrelated factors, the study aims to inform the development of more comprehensive screening protocols and support systems for pregnant women.

Ultimately, the findings are intended to enhance maternal mental health care and promote positive outcomes for both mothers and their infants.

Purpose of the Study

The general aim of the study is to investigate the correlation between domestic violence, age, sexual satisfaction and ante partum depression among women in Anambra State. The specific objectives of the study include:

1. To ascertain the correlation between Psycho-physical violence dimension of domestic violence and ante partum depression among women in Anambra State
2. To determine the correlation between control violence dimension of domestic violence and ante partum depression among women in Anambra State
3. To ascertain the correlation between overall domestic violence and ante partum depression among women in Anambra State
4. To examine the correlation between age and ante partum depression among women in Anambra State
5. To determine the correlation between sexual satisfaction and ante partum depression among women in Awka metropolis, Anambra State

Research Questions

The present study sought to answer the following questions.

1. Will physical dimension of domestic violence significantly correlate with ante partum depression among women in Anambra State?
2. Will control dimension of domestic violence significantly correlate with ante partum depression among women in Anambra State?
3. Will overall domestic violence significantly correlate with ante partum depression among women in Anambra State?
4. Will age significantly correlate with ante partum depression among women in Anambra State?
5. Will sexual satisfaction significantly correlate with ante partum depression among women in Anambra State?

Theoretical Framework

Hopelessness Theory of Depression (Seligman, 1972)

The hopelessness theory of depression, originally introduced by Seligman (1972), posits that individuals who are repeatedly subjected to negative life

experiences may develop a pattern of learned helplessness, ultimately giving rise to a profound sense of hopelessness. This theory emphasizes that those vulnerable to depression are likely to construct maladaptive cognitive schemas—mental frameworks that influence how they view themselves, interpret their surroundings, and anticipate the future. These pessimistic thought patterns increase susceptibility to depressive symptoms, particularly when individuals perceive their circumstances as uncontrollable or unchangeable. In the context of this study, the hopelessness theory serves as a valuable lens through which the interconnected influences of domestic violence, age, sexual satisfaction, and antepartum depression (APD) can be understood among pregnant women.

Domestic violence, involving repeated instances of physical, emotional, or psychological harm, often reinforces a state of learned helplessness. Women exposed to such trauma may internalize distorted beliefs about their self-worth and efficacy, feeling incapable of altering their situation. These perceptions reflect the core principles of hopelessness theory, whereby chronic victimization fosters feelings of powerlessness and despair. As these cognitive distortions deepen, the likelihood of developing APD increases, positioning domestic violence as a critical risk factor for mental health disturbances during pregnancy.

Age also plays a moderating role in the relationship between domestic violence, sexual satisfaction, and antepartum depression. Younger women—especially adolescents and those in early adulthood—may possess limited coping strategies and fewer life experiences, making them more prone to developing learned helplessness in response to adversity. From the perspective of hopelessness theory, these individuals may face greater difficulty in restructuring negative thought patterns, thereby heightening their risk for depressive symptoms when confronted with intimate partner violence or dissatisfaction in sexual relationships. In contrast, older women may possess more robust psychological resilience and adaptive coping skills, which could buffer against hopelessness and, by extension, reduce the likelihood of experiencing APD.

Sexual dissatisfaction during pregnancy also holds significant psychological implications. Bodily changes, shifting emotions, and altered partner dynamics can affect a woman's perception of intimacy and desirability. Drawing from the hopelessness framework, continuous dissatisfaction in this area may foster feelings of inadequacy and rejection. Women who experience declining intimacy may attribute these changes to personal deficits, reinforcing negative cognitive patterns and emotional distress. Over time, this can contribute to a sense of helplessness in their relationship, which intensifies hopelessness and elevates the risk of antepartum depression.

APD, marked by persistent sadness, anxiety, and psychological discomfort during pregnancy, often emerges from an

overarching sense of hopelessness. According to the hopelessness theory, when individuals feel incapable of escaping or modifying distressing situations—such as those involving domestic abuse or relational dissatisfaction—they are more likely to succumb to depressive symptoms. If a pregnant woman internalizes these negative experiences as inescapable and believes that her future offers no improvement, hopelessness may become entrenched, further worsening her depressive state. This reinforces the theory's proposition that learned helplessness perpetuates psychological decline.

Through the application of Seligman's (1972) hopelessness theory, it becomes evident that the dynamics of domestic violence, sexual satisfaction, and age interact in shaping the emergence of antepartum depression. These variables influence psychological outcomes by nurturing negative cognitive schemas and helplessness, thereby increasing vulnerability to depressive states during pregnancy.

Based on the broad objective of the study and comprehensive review of the literature, the hypotheses generated and tested for the purpose of the study are stated thus;

1. Psycho-physical violence dimension of domestic violence will significantly correlate with ante partum depression among women in Anambra State.
2. Control violence dimension of domestic violence will significantly correlate with ante partum depression among women in Anambra State.
3. Overall domestic violence will significantly correlate with ante partum depression among women in Anambra State.
4. Age will significantly correlate with ante partum depression among women in Anambra State.
5. Sexual satisfaction will significantly correlate with ante partum depression among women in Anambra State.

Method

Participants

The participants for this study consisted of 156 women recruited from different health centres (Apex multispecialty hospital and Teaching hospital, Awka) all in Anambra State. Recruitment were conducted in collaboration with healthcare providers in the hospital's prenatal and mental health departments. This collaboration ensured that eligible participants have received or are eligible for a clinical diagnosis of depression within the past 12 months, as assessed by qualified medical professionals like clinical psychologists. A purposive sampling

technique was employed, allowing for the selection of participants based on the study's specific criteria (i.e.,women who have been clinically assessed for depressive symptoms within the past year). This method was appropriate as it ensured that participants meet the study requirements. The sampled women were within the age range of 19 to 44 years with the mean age of 31.4 (SD = 7.58). 92 (58.4%) had primary education, 42 (26.7%) had secondary education, while 22 (13.9%) had tertiary education. 142 (90.1%) identified as Christians, 2 (1%) identified as islam and 12 (7.9%) identified to be traditionalists.

Instruments

Domestic Violence Questionnaire (Abolmaali et al., 2014)

This self-report 43 items scale, developed by Abolmaali et al., (2014) was adopted for this study. Domestic violence Questionnaire is a multi-dimensional structure and the considered dimensions of this questionnaire are including as follows: 1) Psycho-physical violence, 2) control violence. In this questionnaire the response of each option is scored on a Likert scale: Not at all true of my spouse (0); slightly true of my spouse (1); moderately true of my spouse (2);very true of my spouse (3), and extremely true of my spouse (4). The highest score of this questionnaire shows the highest level of violence. Igbolekwu et al., (2021) validated the instrument in Nigeria with Cronbach's alpha of 0.87 for the overall scale, which showed high internal consistency. The reliability scores obtained from the pilot study on this instrument which was carried out by the researcher using 45 women who were purposively sampled from government general hospital in Onitsha, reported 0.90 for psychi-physical dimension, 0.83 for control violence dimension, and 0.92 for the over all scale, with a convergent validity of (*r* .79).

Sexual satisfaction scale (Aleksander et al., 2011)

This is a 25-item scale developed by Aleksander et al. (2011), which measures the degree of satisfaction with sexual relationship was also adopted in the present study to measure sexual satisfaction among the women. Obtaining a reliability score of 0.88. Olatubi et al., (2019) validated the instrument in Nigeria with Cronbach's alpha of 0.87, which showed high internal consistency. The reliability scores obtained from the pilot study on this instrument which was carried out by the researcher using 45 women who were purposively sampled from government general hospital in Onitsha reported 0.83 for the sexual satisfaction scale with the norm at (n=45) 78.47, with a convergent validity of (*r* 0.71). The respondents were asked to answer the questions as it relates to their personal life and sexual experiences by marking (*) in the 5-point likert type interval scale starting from, 1. Strongly disagree 2. Disagree 3.Neither agree nor disagree 4. Agree 5. Strongly agree.

The Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI), originally developed by Beck and colleagues in 1961, was employed as a tool to evaluate the intensity of depressive symptoms in the pregnant women. This self-report instrument comprises 21 items, each rated on a scale from 0 to 3, resulting in a cumulative score that can range from 0 to 63. Although the BDI was not initially created as a diagnostic tool, it is widely recognized for its effectiveness in quantifying the severity of depression. Within the Nigerian context, the BDI has been extensively used in empirical studies to assess its applicability and psychometric soundness. For example, Ossai et al. (2021) utilized the BDI to examine depression among medical students in Nigeria, demonstrating its relevance in local mental health research. The instrument has consistently shown strong psychometric properties across different populations. Specifically, studies conducted in Nigeria have reported internal consistency estimates (Cronbach's alpha) between 0.82 and 0.91, signifying high reliability. Additional measures of test-retest reliability and concurrent validity have also yielded acceptable ranges, typically between 0.77 and 0.90 (Ossai et al., 2021). In the pilot phase of the current study, the BDI yielded a Cronbach's alpha of 0.80, indicating good internal consistency. This finding is consistent with previous Nigerian-based research, further validating the use of the BDI in assessing depression symptoms among women in this region. Given its established reliability and previous application within the Nigerian context, the use of the BDI in this study is both appropriate and methodologically justified.

Procedure

All measures in this study were administered through in-person interactions with participants who met the study criteria (ie pregnant women in their second and third trimesters, women age 19-45, women attending antenatal clinics at Apex Multi – Specialty hospital and Teaching hospital, women who are able to understand and complete the study questionnaires and also able to give informed consent). 156 pregnant women attending Antenatal clinics at the two hospitals where used. The recruitment process involved a pre-screening phase, during which the researcher, along with five trained research assistants, collaborated with healthcare centers in Awka metropolis which include Apex multispecialty hospital and Teaching hospital to identify eligible participants who had symptoms of depression. Once eligible participants were identified, they were approached and invited to take part in the study. Participant received a (Domestic violence scale, Sexual satisfaction scale and Beck depression Inventory), each participant first received an informed consent form, attached to the front of the survey instrument, which provided an overview of the study, including any potential risks and benefits. By proceeding to the survey, participants indicated their understanding of the form and provided their consent to participate. Following consent, participants completed the survey instrument, which was expected to take

approximately 20-30 minutes. After completing the survey, participants were debriefed, and their participation were acknowledged with appreciation from the researcher (vote of thanks, Gifts) to participant, while to Healthcare providers (Acknowledgement, formal letter and small gifts) where done. Data analysis proceeded after assumptions of normality and linearity were verified. Certain aspects of ethics were employed by the researcher before and during the administration of instruments to avoid variables that are extraneous such as label, bias. They include;

Informed consent: The researcher sought the consents of the respondents before embarking on the research. This was to encourage free choice of involvement and assert to the participants that they weren't under any obligation to join the research.

Openness: The researcher told the respondents the nature of the research and essence of the study they were about to embark on. This was done to enable the respondents to be open and sincere in their responses.

Confidentiality: The researcher assured the respondents that the result of the test and questionnaire will remain confidential. This was to give the respondents a relaxed state of mind and avoid any thought of labeling that the participants might have.

Research Design and Statistics

This study adopted a correlation design and Pearson Product Moment Correlation for analyses of the data collected using SPSS version 26.0.

Results

Table 1: Descriptive statistics of age, domestic violence, sexual satisfaction and antepartum depression

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Age	156	18	44	31.53	7.67	-.096	.194	-1.244	.386

Psycho-physical violence	156	1	67	108	7.57	7.77	-.180	.194	-.510	.386
Control violence	156	1	24	90	9.08	4.82	-.369	.194	.080	.386
Overall domestic violence	156	1	43	170	108.5	38.1	-.044	.194	-1.282	.386
Sexual satisfaction	156	1	38	142	1.33	30.6	-.040	.194	-1.267	.386
Antepartum depression	156	1	29	86	8.34	15.5	.103	.194	-1.081	.386
Valid N (listwise)	156									

Source: Researcher's primary data

Table 1 showed that Psycho-physical violence (-.180) was negatively skewed, indicating that higher levels of Psycho-physical violence were prevalent among participants. The standard deviation (SD) of 7.770 demonstrated a moderate variation in Psycho-physical violence experiences. Similarly, control violence (-.369) was negatively skewed, reflecting a higher prevalence of control-related violence, with an SD of 4.828 suggesting relatively low variability. Overall domestic violence (-.044) was also negatively skewed, signifying widespread exposure to domestic violence, with an SD of 38.191 indicating substantial variation in participants' experiences. Sexual satisfaction (-.040) exhibited a negative skewness, suggesting relatively lower levels of sexual satisfaction among participants, while the SD of 30.682 demonstrated considerable variability. Antepartum depression (.103) was positively skewed, reflecting higher levels of depressive symptoms, with an SD of 15.505 indicating moderate variation in depression scores. The kurtosis for Psycho-physical violence (-.510) and control violence (.080) suggested distributions close to normal, while overall domestic violence (-1.282), sexual satisfaction (-1.267), and antepartum depression (-1.081) exhibited a flatter distribution, indicating diverse levels of these experiences among the sampled population.

Table 2: Correlation table between domestic violence, age, sexual satisfaction and antepartum depression among women.

Correlations

	Psycho-physical violence	Control violence	Overall domestic violence	Age	Sexual satisfaction	Antepartum depression
Psycho-physical violence	1					
Control violence	-.036	1				
Overall domestic violence	.694**	.694**	1			
Age	.028	-.080	-.038			
Sexual satisfaction	.047	-.038	.006	065	1	
Antepartum depression	.499**	-.093	.426**	.032	-.376**	1

**. Correlation is significant at the 0.01 level (2-tailed).

The result from Table 2 showed several correlations between the variables in the study. Psycho-physical violence positively correlated with antepartum depression ($P < 0.05$; $r = 0.499$; $N = 156$), indicating that increased exposure to psycho-physical violence was associated with higher levels of antepartum depression among women. Overall domestic violence also showed a significant positive correlation with antepartum depression ($P < 0.05$; $r = 0.426$; $N = 156$), suggesting that women who experienced greater levels of domestic violence reported higher symptoms of antepartum depression. On the other hand, control violence showed no correlation with antepartum depression ($P > 0.05$; $r = -0.093$; $N = 156$), indicating that control-related domestic violence had no meaningful association with depressive symptoms during pregnancy. Age also did not correlate with antepartum depression ($P > 0.05$; $r = -0.032$; $N = 156$), implying that the age of the women had no significant relationship with their experience of antepartum depression. However, sexual

satisfaction showed a significant negative correlation with antepartum depression ($P < 0.05$; $r = -0.376$; $N = 156$), indicating that lower sexual satisfaction was associated with higher levels of antepartum depression among the sampled women.

Discussion

The first hypothesis, which posited that psycho-physical violence—a specific dimension of domestic abuse—would be significantly associated with antepartum depression among women in Anambra State, was empirically supported. The data revealed a significant positive correlation between psycho-physical violence and symptoms of depression during pregnancy. This finding indicates that an increase in psycho-physical violence correlates with a heightened risk of depressive symptoms in expectant mothers, thereby emphasizing the substantial psychological burden intimate partner violence imposes on maternal mental health.

This outcome aligns with an expanding body of empirical evidence linking psycho-physical abuse to mental health disturbances, particularly depression (Campbell et al., 2019; Taft et al., 2020; Bohn & Meador, 2021). Prior studies have documented that women subjected to physical violence during pregnancy are at elevated risk for mood disturbances. For instance, Bohn and Meador (2021) observed increased depressive symptomatology among physically abused pregnant women, while Campbell et al. (2019) reported elevated levels of depression and anxiety among victims of intimate partner violence during pregnancy. The present findings reinforce these conclusions, identifying psycho-physical violence as a significant risk factor for prenatal depression.

One plausible mechanism underlying this relationship involves the sustained psychological stress and physiological strain induced by repeated exposure to physical and psychological harm. Such violence often engenders chronic fear, emotional dysregulation, and trauma, which can collectively precipitate depressive states. During pregnancy, these effects may be compounded by anxieties concerning the unborn child's safety. Taft et al. (2020) highlighted that abused pregnant women frequently experience intensified vulnerability and feelings of helplessness, which are central to depressive pathology. The ongoing trauma disrupts emotional stability, thereby increasing susceptibility to antepartum depression.

Furthermore, this relationship is consistent with findings from El-Khoury et al., (2021), who reported that physical abuse undermines emotional resilience and contributes to the onset of depression in women. The physiological repercussions of such violence may also adversely impact pregnancy, elevating the risk of complications such as hypertension, preterm labour, and low birth weight. This highlights the imperative for early detection and intervention in cases of partner violence to safeguard both maternal mental health and fetal outcomes.

The Hopelessness Theory of Depression (Seligman, 1972) provides a useful explanatory framework for understanding

these dynamics. According to this model, depression is more likely when individuals believe they are unable to influence their adverse circumstances. Women trapped in violent relationships may internalize a sense of powerlessness and futility, nurturing cognitive patterns that promote depressive symptoms, particularly in the emotionally vulnerable state of pregnancy.

Conversely, the second hypothesis that controlling behavior as a form of domestic violence would significantly correlate with antepartum depression was not supported. The data indicated no statistically significant relationship between control violence and depression in this cohort. This suggests that, within this population, experiences of coercive control may not directly contribute to prenatal depressive symptomatology.

Although previous literature has identified coercive control as detrimental to psychological well-being (Johnson & Leone, 2019; Stark, 2020), the current findings suggest that its effects on mental health may be contingent upon moderating variables such as the presence of physical abuse, perceived social support, and individual coping strategies (Ali et al., 2021). Stark (2020) emphasized that coercive control, while emotionally taxing, may not independently lead to clinical depression unless accompanied by overt violence. The null findings here may indicate that affected women possess psychological or social resources that buffer the mental health consequences of controlling behaviors.

Another consideration is that control violence, though distressing, may not elicit the same immediate stress response as physical aggression. Johnson and Leone (2019) argued that cumulative exposure to multiple abuse forms rather than control violence alone is more predictive of depressive outcomes. Pregnant women in this study may not interpret controlling acts with the same severity as physical abuse, thereby experiencing less emotional disruption.

From a theoretical standpoint, while the learned helplessness paradigm (Seligman, 1972) suggests that a sense of uncontrollability fosters depression, it may not fully account for situations involving non-violent control. Women subjected to non-physical coercion may still perceive some agency in their circumstances, which might reduce the likelihood of developing depressive symptoms in response to such abuse.

The third hypothesis, which examined the relationship between overall domestic violence and antepartum depression, was substantiated by the findings. A significant positive correlation was observed, indicating that increased exposure to domestic abuse corresponds with greater levels of depression during pregnancy. This reinforces the notion that intimate partner violence is a potent determinant of poor maternal mental health.

These findings mirror existing research demonstrating a strong link between domestic abuse and psychological distress,

particularly among pregnant women (Campbell et al., 2019; Taft et al., 2020; Bohn & Meador, 2021). For example, Bohn and Meador (2021) found that prenatal exposure to intimate partner violence was significantly associated with depressive symptoms. Similarly, Campbell et al. (2019) reported that abused pregnant women exhibited higher levels of depression, anxiety, and psychological stress compared to non-abused counterparts. The present study confirms the robustness of these associations.

The underlying mechanism likely involves the cumulative psychological harm inflicted by domestic violence, which can disrupt emotional stability and promote maladaptive cognitive patterns. This is particularly concerning in pregnancy, a period already characterized by heightened emotional sensitivity. Taft et al. (2020) emphasized that domestic violence exacerbates fear, hopelessness, and low self-worth, all of which are prominent features of depression. Additionally, chronic stress stemming from abuse may negatively affect pregnancy outcomes, including increased risk for preterm birth and intrauterine growth restriction.

These findings can again be contextualized using the Hopelessness Theory of Depression. Women exposed to sustained abuse may develop pervasive negative beliefs about their capacity to alter their situations, thus fostering depressive cognitions. The perceived inescapability of the abusive environment may create a psychological trap, fueling emotional despair and depressive symptoms during the vulnerable antenatal period.

Given these results, it is critical that healthcare professionals incorporate screening for domestic violence into routine antenatal care. Early identification and intervention strategies such as trauma-informed counselling, support groups, and access to protective services may mitigate the mental health consequences of abuse and improve both maternal and fetal well-being.

The fourth hypothesis, which proposed that maternal age would significantly correlate with antepartum depression, was not supported by the data. A non-significant negative correlation was found, suggesting that age does not substantially influence depressive symptoms during pregnancy in the studied population. Although a slight inverse relationship was noted, it lacked statistical significance, implying that age is not a key predictor of antenatal depression in this context.

This finding diverges from research indicating that age may be a contributing factor to maternal mental health. For instance, Kuehner (2020) noted that younger women might be more vulnerable to depression due to limited financial stability, social support, and relationship security. Conversely, older women may face depression due to heightened concerns over pregnancy risks and health complications. However, such patterns were not replicated in the present study.

A possible explanation may lie in the socio-cultural characteristics of the Anambra metropolis, where access to emotional support and healthcare services might be relatively equitable across age groups. In such a context, age-related vulnerabilities may be less pronounced. Hohmann et al., (2021) argued that social support and healthcare accessibility are often more decisive than age in determining depression risk, which may help explain the current findings.

Moreover, antepartum depression is multifaceted and likely influenced by various interrelated factors beyond age, such as economic stress, relationship quality, prior mental health conditions, and experiences of abuse. The insignificant role of age in this study highlights the need for more investigations that incorporate broader biopsychosocial variables.

The fifth hypothesis, which predicted a significant association between sexual satisfaction and antepartum depression among women in Awka, was supported by the findings. The results revealed a significant negative correlation, indicating that higher levels of sexual satisfaction were associated with lower levels of depressive symptoms during pregnancy. This suggests that sexual satisfaction may serve as a protective factor, mitigating the emotional and psychological strain experienced by pregnant women and reducing the likelihood of antepartum depression.

This finding is consistent with previous literature emphasizing the role of sexual well-being in overall mental health, particularly during sensitive life stages such as pregnancy. For instance, Lindow et al. (2018) found that women who reported higher levels of sexual satisfaction during pregnancy also experienced fewer symptoms of anxiety and depression. Positive sexual experiences contribute not only to emotional intimacy but also to self-esteem and perceived relationship quality—factors that are closely linked to psychological stability during pregnancy.

Sexual satisfaction often reflects broader relational dynamics, including emotional closeness, communication, mutual respect, and physical affection. According to McKinley and Currie (2020), fulfilling sexual relationships enhance a sense of connectedness, reduce feelings of isolation, and nurture emotional resilience, all of which are critical in managing mood fluctuations during pregnancy. In contrast, persistent sexual dissatisfaction may lead to relational conflict, reduced self-worth, and feelings of rejection which are conditions known to increase vulnerability to depressive symptoms.

Additionally, research by Shah and Zeng (2021) highlighted the psychological dimensions of sexual satisfaction, particularly its relationship to body image and self-confidence. During pregnancy, bodily changes can affect a woman's perception of attractiveness and desirability. If sexual satisfaction remains intact, it may

reinforce a positive body image and emotional security, thereby lowering the risk of developing depressive symptoms. However, when sexual dissatisfaction is present, especially in the context of existing vulnerabilities such as low partner support or domestic conflict, the psychological strain may intensify, increasing the risk of antepartum depression.

The relationship between sexual satisfaction and depressive symptoms can also be interpreted through the lens of the Hopelessness Theory of Depression (Seligman, 1972). Within this framework, depression emerges when individuals perceive their situation as uncontrollable and unlikely to improve. For pregnant women, a decline in sexual satisfaction especially when tied to feelings of neglect or emotional disconnect may nurture a sense of relational hopelessness. This emotional detachment can evolve into negative cognitive schemas about self-worth, intimacy, and future relationship satisfaction, thereby contributing to depressive episodes.

Conclusion

This study investigated the relationship between sexual satisfaction, domestic violence, age and antepartum depression among women in Anambra State. The findings revealed that sexual satisfaction was negatively associated with antepartum depression, highlighting its protective influence on maternal mental health. Conversely, domestic violence was positively associated with antepartum depression, emphasizing the detrimental impact of abuse and relational conflict during pregnancy. In addition, sociodemographic variable such as age did not significantly influence the occurrence of depressive symptoms. These results emphasize the multifaceted nature of antepartum depression and the need for holistic approaches to maternal care. Addressing issues related to sexual well-being, intimate partner violence, and sociodemographic vulnerabilities is essential for the early identification and prevention of depression during pregnancy. Interventions that promote healthy relationships, empower women, and offer targeted psychosocial support can play a crucial role in enhancing emotional resilience and maternal well-being. Future research should further explore these associations in broader populations and consider longitudinal designs to establish causal links and inform sustainable preventive strategies.

Recommendations

Based on the findings of the study, the following recommendations are proffered.

1. Healthcare providers should routinely screen pregnant women for symptoms of depression during antenatal visits, particularly assessing for sexual dissatisfaction and domestic violence.

2. Antenatal care programs should include relationship and sexual health counselling to help improve sexual satisfaction and reduce emotional strain during pregnancy.

3. Government and NGOs should strengthen interventions against domestic violence, ensuring that pregnant women have access to safe reporting channels, legal support, and protective services.

4. Capacity-building programs should be organized to train healthcare workers on identifying and managing psychosocial risk factors, including poor sexual satisfaction and partner abuse.

5. Public health campaigns should raise awareness on the impact of domestic violence and sexual dissatisfaction on maternal mental health, encouraging supportive environments for pregnant women.

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