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Coping Mechanisms and Psychosocial Responses to Domestic Violence among Pregnant Women: A Cross-Sectional Study in Ilorin West Local Government, Kwara State, Nigeria

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Abstract: ***Background*:** Domestic violence (DV) during pregnancy confronts affected women with severe and recurring stressors that demand constant psychological and behavioural adaptation. Understanding the coping mechanisms employed by pregnant women is essential for designing psychosocial support interventions that are both effective and culturally responsive. This study examined the coping strategies adopted by pregnant women experiencing DV in Ilorin West Local Government Area (LGA), Kwara State, Nigeria. ***Methods*:** A descriptive cross-sectional study was conducted among 384 pregnant women attending antenatal clinics in seven primary health care facilities in Ilorin West LGA. The Brief COPE Inventory was used to assess 10 coping strategies. Descriptive statistics were used to characterise coping patterns. ***Results*:** Seeking emotional support was the most utilised coping strategy (53.6%), followed by taking action to improve the situation (51.6%), religious or spiritual coping (47.1%), denial (46.4%), and self-blame (44.3%). Distraction-oriented coping (31.2%), active problem-solving (33.9%), emotional venting (38.7%), and substance use (8.9%) were less prevalent. Psychological fatigue and resignation were evident in 42.7% of respondents. The findings reveal a dual pattern of adaptive resilience and maladaptive withdrawal, embedded within a sociocultural context that simultaneously encourages faith-based endurance and suppresses formal help-seeking. ***Conclusion*:** Coping with DV among pregnant women in Ilorin West is shaped by the intersection of personal, relational, and cultural forces. Strengthening adaptive coping requires integrating psychosocial counselling and empowerment programmes into antenatal services, collaborating with faith leaders to re-orient spiritual coping towards action, and reducing barriers to formal help-seeking through community education and institutional responsiveness.

Keywords: Coping Mechanisms, Domestic Violence, Pregnant Women, Brief COPE, Psychosocial Support, Resilience.

Research Paper

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INTRODUCTION

Domestic violence (DV) is a chronic stressor, requiring ongoing psychological adjustment by people who suffer it (Lazarus & Folkman, 1984). For women who are pregnant, the added stress of DV combined with the physical and emotional stress of pregnancy is a unique combination for coping. The way women cope with this stress, whether they are actively problem-solving, seeking to others for support, engaging in spiritual practices, or using more maladaptive coping strategies like denial or self-blame can have significant consequences for their mental health, use of maternal health services and their unborn children's wellbeing.

Coping is the dynamic cognitive and behavioral process that an individual uses to deal with the stressors that he or she considers to be stressful (Lazarus & Folkman, 1984). Adaptive coping strategies are active coping, seeking social and emotional support, positive reframing and acceptance, while maladaptive coping strategies are denial, behavioural disengagement and substance use (Carver *et al*., 1989). A specific strategy may or may not be effective depending on the stressor,

individual's resources, and the sociocultural environment in which coping takes place. In the case of DV, coping is often limited by concerns about retribution, financial needs, shame and stigma, and lack of institutional responsiveness.

Coping repertoire of DV victims in Nigeria is unique because of the high cultural norms on the importance of marriage stability, female endurance and religious faith in Nigeria. Research has shown that women who experience DV in Nigeria are more likely to seek help from religious coping and informal social networks, and they often express trust in these means of support while demonstrating a distrust of formal legal or health systems which often do not protect women's rights and interests (Tella & Tobin-West, 2020; Oyat *et al*., 2024). Studies in sub-Saharan Africa have shown that the use of professional psychosocial services remains limited, thus reinforcing a vicious cycle of victimisation and psychological distress with especially adverse effects during the vulnerable perinatal period.

While coping has been identified as an important factor that influences health outcomes of DV survivors, limited studies have been conducted on the coping mechanisms used by pregnant Nigerian women. Reliable studies to date have generally focused on prevalence or risk factors, and coping has not been given adequate consideration as a clinical and public health problem. This study aimed at filling this gap by extensively describing coping strategies used by DV affected pregnant women in Ilorin West LGA.

The study aimed to: (i) assess the coping strategies employed by pregnant women experiencing DV, as measured by the Brief COPE Inventory; (ii) characterise the relative prevalence of adaptive versus maladaptive coping responses; and (iii) identify implications for psychosocial support within antenatal care frameworks.

Literature Review

International studies on coping among DV survivors demonstrate varying coping styles with respect to cultural, economic and institutional factors. Oliver *et al*., (2022) identified that self-efficacy is positively correlated with the effectiveness of empowerment programmes and use of adaptive coping strategies amongst women exposed to DV. In a qualitative study of coping strategies employed by female DV survivors after separation in Malaysia, Yusof *et al*., (2022) found five main coping strategies: engaging in purposeful activity, positive thoughts, seeking formal support, religious or spiritual strategies, and disclosing problems to informal support.

Emotional support has been consistently cited as one of the most widely used and effective coping strategies used by DV survivors to buffer against distress and as a means to accessing formal help (Heise, 1998; WHO, 2016). But, social supports can also have a negative effect when the community or social supporters themselves stigmatize the situation or when disclosure is seen as a private matter, as this may increase the likelihood of being treated poorly by those disclosing the situation, which can negatively affect future disclosure (Tella & Tobin-West, 2020).

The role of religious coping in the literature is very unique and complex. Spiritually oriented coping strategies for survival and resilience are common among people with mental health issues, and positive religious coping (finding meaning, forgiveness, and spiritual support) is linked to less distress, as reported by Graça and Brandão (2024). But, in religious contexts that are patriarchal, passive forms of religious coping (e.g., believing that abuse is a test or punishment from God, or that women should endure abuse) can undermine women's ability to take protective measures, thereby promoting the endurance and submission (Tella & Tobin-West, 2020). Being able to both sustain and limit survivors highlights why it is important to involve religious communities in gender transformative DV prevention.

Denial and self-blame are common maladaptive coping mechanisms found among DV survivors worldwide. Denial is a psychological mechanism that is a first reaction and allows the person not to feel the impact of the recognition of abuse yet can prevent them from seeking assistance and continues to be a mechanism of victimisation when it persists for a longer duration (Heise, 1998). Self-blame is especially common in cultures where women are expected to be responsible for the harmony of their marriage and wellbeing of their children. In Nigeria, there are social narratives that present DV as a problem that women cause themselves through their actions – perhaps through refusing to engage in sexual activities or perhaps because they acted subversively – which actively promote self-blame, making victims hesitant to disclose and ask for help (Ezelote *et al*., 2021; Adekola *et al*., 2022).

Learned helplessness, a state of psychological resignation and the absence of active coping has been documented as a result of chronic exposure to DV (Heise, 1998). After multiple attempts to leave or resist the abusive partner with none of them succeeding, women may give up proactive strategies and develop the belief that ‘there is no way out of this situation'. In pregnant women, this resignation is especially damaging, because it adds to the physical helplessness of pregnancy, the psychological helplessness. It is a clinical priority to identify and remedy learned helplessness through empowerment based counselling and survivor mentorship programmes (Ejioye & Gbenga-Epebinu 2021).

The research specifically on coping among DV affected women in Nigeria reveals that extended family, friends and religious communities are largely the

informal support networks preferred over formal services like police, legal aid and/or professional counselling (Oyat *et al*., 2024; Tella & Tobin-West, 2020). This is due to the influence of the strong social capital within extended families, and the distrust of formal institutions that often ignore DV as a private issue (Ezelote *et al*., 2021). FBOs are especially active, providing informal counselling centres, refuge and mediation in DV disputes, although this is not always done with good quality and is often based on the preference of the marriage to be saved rather than victim safety.

METHODOLOGY

This study employed a descriptive cross-sectional design. Data were collected from 384 pregnant women attending antenatal clinics in seven primary health care facilities in Ilorin West LGA, Kwara State, Nigeria, over a six-week period. Multistage sampling was used, combining proportional allocation across facilities with systematic random sampling of individual participants. Inclusion criteria required current pregnancy and willingness to participate; women in acute crisis were excluded and immediately referred to support services.

Coping was assessed using the Brief COPE Inventory (Carver, 1997), a validated 10-item measure adapted for contextual use in this study. The instrument evaluates the following coping dimensions: self-distraction, active coping, emotional venting, seeking emotional support, substance use, behavioural disengagement, taking action, denial, religious/spiritual coping, and self-blame. Each item is scored on a four-point Likert scale (1 = Not at all to 4 = A lot), with higher scores indicating greater use of the respective strategy.

The Brief COPE has demonstrated robust reliability and validity across diverse populations, including sub-Saharan African settings. In this study, Cronbach's alpha for the overall coping scale was 0.83, with sub-scale alphas ranging from 0.71 (self-distraction) to 0.88 (seeking emotional support), all meeting acceptable thresholds. Coping strategies were classified as adaptive (active coping, seeking emotional support, taking action, positive religious coping) or maladaptive (denial, self-blame, substance use, behavioural disengagement) based on extant theoretical and empirical literature (Compas *et al*., 2017).

Questionnaires were administered by trained research assistants in the clinic waiting areas under conditions of privacy. Completed questionnaires were reviewed for completeness before analysis. IBM SPSS Statistics Version 25 was used for all analyses. Descriptive statistics, frequencies and percentages were computed for each coping strategy. Proportions of women predominantly using adaptive versus maladaptive strategies were calculated. Ethical approval, informed consent, and confidentiality procedures were consistent with those described in the companion studies from this research programme.

RESULTS

Table 1 presents the distribution of coping strategies among the 128 women who reported DV exposure. Seeking emotional support (53.6%) was the most widely utilised adaptive coping strategy, indicating that more than half of DV-affected pregnant women sought comfort and understanding from family, friends, or community members. Taking action to improve the situation was employed by 51.6% of respondents, representing a positive finding of proactive engagement. Religious or spiritual coping was utilised by 47.1% of participants, reflecting the deep faith orientation characteristic of the study community.

Among maladaptive strategies, denial was the most prevalent (46.4%), with nearly half of respondents expressing disbelief or minimisation of the abusive experiences. Self-blame was adopted by 44.3%, reflecting the internalisation of social narratives that attribute marital conflict to women's behaviour. Emotional venting (38.7%) and active problem-solving (33.9%) were employed at moderate rates, suggesting some degree of proactive emotional processing. Self-distraction (31.2%) and psychological resignation (42.7%) indicated that many women alternated between purposeful engagement and disengagement. Substance use was the least prevalent strategy (8.9%), consistent with cultural and religious prohibitions against alcohol and drug consumption in the predominantly Muslim study community.

Table 1: Coping Strategies Utilised by DV-Affected Pregnant Women (n = 128)

Coping Strategy	n	%	Type
Seeking emotional support	69	53.6	Adaptive
Taking action to improve situation	66	51.6	Adaptive
Religious/spiritual coping	60	47.1	Adaptive/Mixed
Denial	59	46.4	Maladaptive
Self-blame	57	44.3	Maladaptive
Psychological resignation	55	42.7	Maladaptive
Emotional venting	50	38.7	Mixed
Active problem-solving	43	33.9	Adaptive
Self-distraction	40	31.2	Mixed
Substance use	11	8.9	Maladaptive

Overall, 56.3% of the DV-affected women in this study primarily employed adaptive coping strategies, while 43.7% predominantly relied on maladaptive or avoidant strategies. This near-even split reflects the concurrent existence of resilience and resignation within the study population, shaped by a complex interplay of personal capacity, relational support, and sociocultural context. Women who employed adaptive coping tended to have higher educational attainment, stronger social support networks, and greater awareness of available resources.

DISCUSSION

The highest prevalence adaptive coping strategy reported was seeking emotional support (53.6%), which aligns with the global literature, indicating that social support is one of the most effective coping mechanisms to reduce psychological distress related to DV (Heise, 1998; Oliver *et al*., 2022). Social support among pregnant women in Ilorin West is likely to be influenced by the network of extended family, neighbourhood and faith community associations which are important aspects of social life in the Nigerian context. But social support is also dependent on the quality of the response that it generates. Advice from family members and friends to remain silent, for the sake of the marriage or that domestic violence is normal, can have the opposite effect of reducing victimisation, and can increase it. Building informal support networks' capacity to respond with empathy, non-judgemental approach and empowerment is thus a key element of community-level DV prevention.

A key finding that is encouraging and challenges monolithic stories of women as passive victims of DV is the prevalence of proactive coping (51.6%) – that is, women took proactive steps to improve their situation. This proactive approach may be direct contact with the partner, mediation by religious or community leaders or availed formal support services. The empowering counselling, safety planning and awareness of legal rights can transform this nascent agency into more effective and enduring protective action. WHO (2016) proposes the implementation of structured safety planning which is an important operational approach towards implementing women's agency within a clinical context and is an essential part of antenatal DV management.

The results show that religious coping (47.1%) is the most important dimension among the study participants. Spirituality is a coping strategy for making sense of suffering in Nigeria and is a source of communal support in the face of suffering (Graça & Brandão, 2024). The relationship between religious coping and outcome of DV, however, is complex as described by Tella & Tobin-West (2020). Positive religious coping (using it as a source of courage, meaning, and social support) can be a factor increasing resilience and encouraging protective action. Passive religious coping (accepting mistreatment as God's will or sacrificing personal safety for marital fidelity, out of religious obligation) can help to reinforce victimisation by discouraging disclosure and by preventing help seeking. Approaches involving religious communities to support theologically informed, but gender transformative, understandings of faith that uphold the dignity, bodily autonomy and safety of women, are thus a culturally appropriate and strategic way to intervene in the issue of DV.

Denial was found to be high (46.4%) which is in line with findings in literature from Nigeria and Africa. Denial can also be adaptive in the sense that it helps women to buffer themselves from the emotional impact of acknowledging abuse, especially when it occurs during pregnancy and can have a negative impact on the wellbeing of the foetus. Sustained denial, however, over time serves to ensure that abuse is not acknowledged, help-seeking is delayed, and the conditions that allow violence to endure. Denial can be supported by environmental factors that make it "expensive" to acknowledge: In societies where divorce is extremely stigmatizing and has significant economic repercussions, denial may be reinforced. There is a need, therefore, for clinical interventions to be sensitive and patient towards denial, and to also create space for it without provoking retreat in denial. Evidence-based approaches to this process are motivational interviewing and trauma-informed counselling (WHO, 2016).

Self-blame (44.3%) is a successful internalisation of the cultural narratives that blame many women for provoking or perpetuating abuse because of their behaviour – failing to have sex, not doing enough in the home, or giving birth to a female child. This internalised attribution has been documented to have links with depression, low self-esteem, poor mother–infant bonding and delayed access to healthcare seeking (Heise, 1998; Tella & Tobin-West, 2020). A major therapeutic intervention to combat self-blame is the cognitive restructuring of perceiving DV as an infraction of human rights, instead of a personal failing. Antenatal nurses and midwives, who have frequent and trusted access to pregnant women, are ideally suited to provide short-term counselling in an empathetic manner, to challenge thoughts of self-blame and to empower women to see themselves as intrinsically valuable and with rights.

Psychological resignation (42.7%) reflects a considerable number of women being in a state of learned helplessness, that is, an absence of psychological functioning resulting from repeated failures to resist or escape abuse. Learned helplessness has been linked to social disengagement, lack of prenatal adherence and heightened risk for perinatal depression (Heise, 1998). But to overcome the phenomenon of learned helplessness, addressing it on an individual level through counselling is not enough; they must also be offered a viable, believable and available avenue for protection, in

the form of enforceable protective orders, women's shelters and a supportive police and justice system. Empowerment focused counselling without these structural supports would risk to overestimate the women's choices, and to leave them frustrated when they realize that they are very limited.

The prevalence of substance use (8.9%) is low and is probably a consequence of the religious and cultural taboos on alcohol and drug use that existed in the majority Muslim population studied. This differs from the Western literature where substance use is more often reported as a coping mechanism for DV victims, with culturally specific factors influencing the coping options at their disposal or socially acceptable (Aboagye *et al*., 2022). Nevertheless, health workers should be alert to substance use in this group as it can have significant clinical implications even if in small numbers.

Nearly equal numbers of adaptive and maladaptive coping (56.3% vs. 43.7%) reflect the basic ambivalence of the coping landscape of the DV-affected pregnant woman. Intervention is a process that can start with adaptive strategies as they are a sign of resiliency and a basis for intervention, while maladaptive strategies represent the constraining influence of fear, stigma, economic dependence and institutional failure. Good psychosocial support needs to build on what is going right, and must be systematic in breaking down individual, relational and structural barriers to maladaptive responses.

Conclusion and Recommendations

This study was to show the extent of the coping mechanism adopted by pregnant women of Ilorin west LGA, Kwara state who are victims of domestic violence. The most prevalent adaptive strategies were emotional support-seeking, taking proactive action, and religious coping; and the most frequent maladaptive coping strategies included denial, self-blame, and resignation. Resilience and resignation co-occurrence highlights the complexity of the social/cultural and structural context in which DV coping takes place in this context. This must be a multilevel response and include psychosocial counselling and empowerment programming, as part of antenatal care, as well as involvement of faith communities in gender-transformative DV prevention, while minimizing structural barriers to formal help-seeking. Informed by the transactional model of stress and coping along with the ecological systems framework, these interventions provide a route for better support for the large number of pregnant women in Ilorin West who are coping with domestic violence while pregnant.

The results have immediate implications for nursing practice, antenatal care policy and health systems design. The Brief COPE Inventory should be added to the routine assessment of women receiving antenatal care to screen those who have tended to cope in a predominantly maladaptive way and may therefore benefit from early psychosocial intervention. The early identification allows for timely referral, and a progressive psychological deterioration can be avoided.

Second, nurses and midwives need special training about the utilization of trauma-informed care, motivational interviewing and cognitive restructuring techniques to provide effective support to the DV survivors in the antenatal setting. Training should include recognising indicators of DV, and councelling in an empathetic manner, avoiding judgement, and helping them to feel safe, to come forward with information and to take control. The integration of DV and psychosocial support should be included as key skills for maternal health workers in Kwara State professional development curricula.

Thirdly, there should be linkages between antenatal services and community mental health providers, women's rights groups, faith-based counselling services, and legal aid clinics, thus establishing a multi-agency system of referral, ensuring comprehensive and ongoing support to DV survivors. Training programmes should be organised for religious leaders involved in the provision of pastoral counselling for affected women, so that the spiritual support they provide will be victim-centred and rights-based, supporting and affirming women's safety and dignity, rather than unconditional marital endurance.

Structured psychosocial support can be incorporated into maternal health guidelines at national policy level, with adequate funding and trained staff, for system-level change to happen. The Violence Against Persons (Prohibition) Act (VAPA) should be used to ensure that DV screening and psychosocial response are part of the package of services in antenatal care, and to ensure there are monitoring and evaluation systems to monitor implementation fidelity and outcomes.

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