

## Effect of Bullying on Reproductive Health and Psychological Well-being among Pregnant Women

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### Abstract

**Background:** Bullying is a form of violence that endangers the well-being of children, youth, and adults. It results from the interaction of multiple factors related to individual characteristics, relationships with peers and adults, and community expectations. Bullying is widely recognized as a serious problem in elementary and secondary schools, but it is also prevalent among adults, as evidenced by bullying on university and workplace campuses. It causes the victim mental anguish as well as physical pain. **Aim:** Assess the impacts of bullying on psychological well-being and reproductive health among pregnant women. **Subjects and Methods:** A descriptive design was used with a convenient sample of 66 pregnant women attending antenatal inpatient and outpatient units at Mansoura University Hospital, Egypt. Ryff's Psychological Well-Being Scales (PWB), the reproductive health scale, and the Illinois bullying scale were used for data collection. **Result:** About 42.0% were in 17–28 weeks of pregnancy; 54.5% of the wives in the study did not work, and 83.3% of the husbands were working. Highly statistically significant relationships between reproductive health and the wife's work, income, wife's educational level, husband's educational level, and residence were found ( $p < 0.01$ ). In addition, a statistical relationship was discovered between the Illinois Bully Scale fight subscale and the reproductive health scale ( $p < 0.05$ ). **Conclusion:** lower levels of bullying, a higher level of reproductive health, and higher psychological well-being among the studied pregnant women Women's reproductive health can be affected by personal characteristics. Reproductive health is negatively affected by bullying and poor psychological well-being. However, the relationship between reproductive health, bullying, and psychological well-being is not statistically significant. **Recommendations:** Design booklets, brochures, and posters, publish the results of the study, and disseminate them via antenatal clinics to reach every pregnant woman and inform her of the effects of psychological status and bullying on reproductive health.

**Key word:** Bullying, Psychological Wellbeing, Reproductive Health, Pregnant Women

### Introduction

Bullying is defined as any deliberate, repeated aggressive behavior that lacks empathy and social behavior in order to assert power over a weak individual (Baumer & Goldstein, 2011). However, it is important to point out that not all aggressive behavior is bullying and not all bullying behavior is aggressive. But what remains constant is the repetitive, intentional aggressive behavior that is directed to hurt the other individual (Rodkin, et al., 2015).

Bullying is defined as any unwanted hostile behavior(s) directed at another young person or group of young people who are not siblings or romantically involved with the victim and are repeated frequently or are very likely to be repeated (Hill & Kearn, 2011).

Luxenberg et al., (2015) stated that the types of bullying and victimization include: verbal, e.g., name calling, verbal abuses, threats of violence, making jokes, offensive remarks, and teasing as

racist, sexist or homophobic; physical bullying such as beating, kicking, punching, spitting, other types of physical violence and damaging others property or taking someone's belongings; Relational/Social such as starting false stories about someone, excluding someone from social groups and use of electronic devices to text messaging, call, take pictures and videos and posting them on social networks (Luxenberg et al., 2015).

The most common forms of aggression are direct aggression as physical, verbal and indirect as social isolation, rumors, and relational aggression, and they often require humiliating elements (Arsenio, et al., 2004).

The term "psychological well-being" refers to inter- and intra-individual levels of positive functioning, including interpersonal relationships and self-referential attitudes such as a sense of control and personal development. According to one definition, psychological well-being is a combination of cognitive and emotional responses to life experiences (Burns, 2017).

Ryff (2014) defined the Psychological well-being as; it comes from life-span developmental perspectives, which emphasize the differing challenges confronted at various phases of the life cycles. Positive criteria of mental health, generated to replace definitions of well-being as the absence of illness, also offer extensive descriptions of what it means to be in good psychological health. The foundation of psychological well-being development is positive psychology function of individual, which is characterized by self-acceptance, positive relationship, autonomy, environmental mastery, purpose in life, and personal growth (Ryff, 2014) Psychological well-being is the primary goal of human characterized by the necessity to psychologically feel better and is related to individual's feeling about their daily activities and personal feeling disclosure (Duan, et al., 2016).

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Therefore, reproductive health means that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do

so. It also includes access to information and services on safe, effective, affordable and acceptable contraceptive methods (Fathalla and Fathalla, 2017).

Reproductive health refers to overall, lifelong health, not just the health of women in the reproductive age ranges of 15 to 49. It also emphasizes how crucial it is for women to be able to manage their health throughout the course of human life rather than only being cautious when they are pregnant. Reproductive health targets a comprehensive approach which encompasses family planning, maternal and child health and other health issues related to reproduction including sexually transmitted infections including HIV/AIDS that had been treated in isolation in conventional vertically separated administration systems [10].

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Reproductive and sexual health is an important component of women's health that is related to both a woman's physical and psychological well-being. The concept of reproductive health is one of the health concepts that have received great attention at the global and local level in the recent period due to its importance in the life of the individual, the family and the society as a whole. At the level of community and population health, reproductive health includes social, personal and biological preparations for bearing responsibilities of pregnancy, parenthood and at the level of individual health (Abdel-Mohsen & Abdel-Star, 2006).

Victimization to bullying has many negative emotional consequences ranging from anger, fear, lack of concentration, sorrow, emotional distress, loneliness, poor academic achievement, education compromised, and absenteeism up to somatic disorders such as depression and suicidal

ideation and commit suicide. It undermines the lifestyle, affects the work life, and disturbs the social relationships (Patchin, 2006; Shariff, 2008; Gradinger, et al., 2009; Houle, et al., 2011).

Consequences of bullying victimization tend to be serious, negative, and long-lasting regardless of type of bullying. Bullying victimizations have commonly been associated with psychological and behavioral problems (Espelage & Swearer, 2010; Finkelhor, 2008). Copeland et al., (2013) stated that the effects of bullying during adolescence are acute and may in some cases also persist into later adolescence and adulthood<sup>[18]</sup>. Recent studies suggest that victims of school bullying are at increased risk of poor health, as well as lower wealth and social-relationship outcomes in adulthood even after controlling for family hardship and childhood psychiatric disorders.

There is previous evidence to suggest that traditional bullying has a significant adverse impact on victimized youths, particularly in relation to their mental health. Traditional bullying victimization has been found to be a significant risk factor for later depression, which persists even decades after bullying occurred (Ttofi, et al., 2011).

Negative effects of bullying are affect any age. Bullying creates risks for antisocial behaviors as substance abuse, criminal tendency, and psychiatric diseases in adolescence and adulthood (Sourander, et al., 2000). There are also effects into adult life. Adults are likely to experience long-term effects in terms of their general health and wellbeing. Systemic inflammation, a higher risk of diabetes and heart disease, and other effects on adult health are caused by this unpleasant childhood experience (Copeland, et al, 2014).

In a study Espelage et al., (2016) of almost three thousand Australian adults, poorer physical and mental health was found for those in their sample who were bullied as children (Espelage, et al., 2016). Other research has found comorbid mental health concerns such as generalized anxiety, social anxiety, agoraphobia, depression, panic disorder, antisocial personality disorder, substance abuse, post-traumatic stress, and suicidality (DeLara, 2016).

Bowes et al., (2009) stated that Bullying is a world-wide phenomenon where family, and

social-ecological factors all play a role in children's bullying involvement, it is for this reason that an eco-systemic perspective is useful in investigating this public health issue. Family systems, school systems, neighborhoods, and workplace systems either support or discourage bullying behaviors have adopted a definition in an attempt to standardize how researchers conceive of this phenomenon: Bullying is any unwelcome hostile action that is repeated frequently or is very likely to be repeated by another adolescent or group of youths who are not siblings or romantically involved with them (Bowes et al., (2009). Youth who are the targets of bullying may suffer from physical, psychological, social, or educational injuries (Gladden, et al., 2014).

Bullying not only has severe negative effects on the victims involved, but also has serious implications on much broader levels, including family life, education and health. It is important for both the victim as well as the bully to share their experience so that the root causes of such aggressive nature and volatile behavior can be determined. They should be helped, and counseling as well as confidence building programs should be introduced in both schools and colleges (Robers, et al., 2014).

Finally, bullying or harassment is one of the most common problems between international and Arab communities. But it is religiously and ethically forbidden. Therefore, it is a crime punishable by international and domestic law. It is the necessary to start raising awareness of the Arab society and Egypt, with respect to the articles of the Egyptian Penal Code that help the women and family to preserve their rights and the right of all family members to these crime States. Article number 306 bis (a) provides that, the accused shall be punished by imprisonment for a period of  $\geq 6$  months and with a financial fine of 3000-5000 pounds. One of these two penalties shall be punished together for anyone who exposed to others in a public/private place or stunned by making things/suggestions or sexual or pornographic remarks, by any means, and In the case of return, the penalty shall be doubled with imprisonment and financial fine in their lower and maximum limits. Additionally, Article number 306 bis (b) states; The penalty shall be imprisonment for a period of  $\geq 1$  year and a fine of 5000-1000 pounds or one of these penalties if repeated act of the perpetrator through the

prosecution and tracking of the offender. Moreover, in the case of repetition, the sentences of imprisonment and fines shall be doubled in their lower and maximum limits (The Egyptian Penal Code promulgated by Law No. 58 of 1937, 2018).

### Significance of the Study

On searching and learning about psychosocial well-being among pregnant women, we found that mood disorders are common during their childbearing years. The gestational period is considered to be a relatively high-risk time for women with a number of pre-existing psychological health problems that arise during or soon after pregnancy. In addition, a relevant recent study reported that women with an absence of psychological well-being were at the highest risk of low birth weight (LBW), as compared with those with good psychological well-being. Some studies indicate that the developing foetus may be adversely affected by maternal depression itself (Hassan, 2016; Nasr, et al., 2016).

Bullying victimization has garnered more attention in recent years because of the change in the perception of bullying from a "rite of passage" to a serious social problem that has lasting, negative consequences for its victims (Espelage & Swearer, 2010; Hong & Espelage, 2012; Peguero, 2012). The World Health Organization (WHO) stated that "the frequency of bullying was estimated to be 8–30% and may reach 50% in many studies" (Espelage, 2011). According to Tang et al. (2020), the global prevalence of bullying victimization is 35.3%, with wide variation and gender differences (Tang, et al., 2020)

Previous research has found that gender influences the type of bullying victimization. Girls are more likely to experience indirect forms of bullying, whereas boys are more likely to experience direct forms of bullying (Finkelhor, 2008; Dukes, 2010; Popp, 2-11). As there have been so few studies exploring any association between bullying and pregnancy, the studies previously cited are the only known studies exploring this phenomenon. Those studies did associate either victimization or perpetration of bullying with pregnancy among teens, both planned and unplanned, in other countries (Marshall, et al., 3018).

Pregnancy research has primarily focused on

diagnosable physiological and psychological disorders, as well as, to a lesser extent, posttraumatic disorder following childbearing experiences. No research studies have been done before about the prevalence of bullying among pregnant women and its effects on reproductive health and psychological wellbeing. The psychological issue of bullying and its treatment is often neglected. Health is not only about physical well-being, but it also involves both social and psychological well-being. This study addresses the need for reproductive health, psychological wellbeing, and bullying to be studied together in the same research project. Specifically, we addressed "How much?" and "With what impact?" Questions using survey items that had the same format for both bullying and reproductive health, psychological wellbeing, and emotional impacts of this experience.

### Operational Definitions

**"Bullying victimization"** refers to the process by which a person is repeatedly and over time exposed to intentional negative actions by their peers.

**Cyber-bullying** is a type of bullying victimization that occurs through the use of electronic devices (such as instant messaging, websites, and chat rooms) (Sánchez et al., 2017).

**Self-acceptance:** The capacity for accepting and acknowledging one's strengths and virtues as well as recognizing one's weaknesses

**Positive relations with others:** the sense that one has warm, satisfying, and trusting relationships and is socially concerned

**Autonomy:** Is the degree to which one regards oneself as self-determining and independent, resisting social pressure to conform?

**Environmental mastery** Feelings of competence and capacity to manage and meet the responsibilities of everyday life

**Purpose of life:** feelings of purpose and having a sense of life direction, as well as past and present experiences, are meaningful.

**Personal development:** the ability to continue developing, potential, and openness (Abbott, et al., 2006).

### Aim of the study:

Currently, no known studies have examined the occurrence of bullying either as victimization or perpetration among pregnant women in Egypt. The purpose of this exploratory study was to

assess the effects of bullying on psychological well-being and reproductive health among pregnant women in the Assiut government using a standardized assessment scale.

### Research Questions

- [1]. Is bullying prevalent among pregnant women?
- [2]. Are psychological well-being and reproductive health affected by bullying among pregnant women?
- [3]. There is an association between psychological wellbeing, reproductive health, bullying, and the socio-demographics of pregnant women?

## Subject and Methods

### Research Design

A descriptive study of 66 pregnant women was conducted to assess the relationship between bullying and reproductive health and psychological well-being.

### Research Setting

The antenatal inpatient and outpatient units at Mansoura University Hospital, Egypt

### Subjects

The sample for this study was comprised of 66 convenient pregnant women receiving obstetrical care at a maternal health unit in Assiut, Egypt, during six months from January 2023 to June 2023, who were pregnant from the first semester to the third semester and were coming to follow up on the pregnancy. For this study, participants had to be 20-45 years old, have written and verbal fluency in English, and provide verbal consent or assent to participate.

### Exclusion Criteria

- Unwillingness or refusal to participate in the study.
- Diagnosed with any other psychological or psychiatric disorder (had prior psychiatric morbidity).

### Tools of Data Collection

In order to obtain the necessary information from the following parts was designed by the researchers after reviewing the related literature:

**The first part:** personal, socio-demographic characteristics, and reproductive health. It is divided into two sections, as stated below:

**Section I:** personal data such as age, educational level, marital status (age at marriage and duration of marriage), job, residence, income adequacy, number of marriage years, and breastfeeding.

**Section II:** Obstetrical history for the studied pregnant women (gestational age, miscarriage, fertility, etc). It presented the reproductive health scale designed by Abdel Moneim et al. (2011). It was measured through nine items comprising questions, represented by the following:

1. **Number of children:** It was measured by asking the respondents about the number of children. The answers were given for 1-2 children, 3 children, or 4 children or more, with scores of 3, 2, and 1, respectively.
2. **The number of miscarriages:** It was measured through two questions about the number of children's deaths and the number of abortions. The answers were given: No, 1-2 times, 3 times, or more, with scores of 3, 2, and 1, respectively.
3. **Fertility period of the respondent:** It was measured through two questions about the respondents' age at the first pregnancy and the respondents' age at the last pregnancy, and then giving the answers 20–35 years, more than 35 years, and less than 20 years, scores of 3, 2.1, respectively.
4. **The period between the last two births:** It was measured by asking the respondents about the time between the last two births and then giving the answers of more than 2 years and less than 2 years scores of 2, respectively.
5. **The place of the last birth:** It was measured by asking the respondents about the place of the last delivery. The answers were given as general hospital, private hospital, and home, with scores of 3, 2, and 1, respectively.
6. **Type of delivery:** It was measured by asking the respondents about the type of delivery. Caesarean sections were classified as "normal," "dried," or "aspirated," with scores of 3, 2, and 1, respectively.
7. **The obstetrician:** It was measured by asking the respondent about the person who delivered the obstetrician, and the answers were given to a doctor, nurse, midwife, or one of the family, relatives, or friends (grades 3, 2.1, respectively).
8. **Use of family planning methods:** It was measured by asking the respondent about the extent to which she used any method of family planning. The answers were yes and no, with

scores of 3, 2, and 1 indicating that they did not apply.

9. **The health problems that the respondent was exposed to:** They were measured through questions about the health problems that the respondent was exposed to before pregnancy, during pregnancy, after childbirth, between births, and during the use of family planning methods. The answers were given: there is no problem, there is a problem, and the respondent took action. True, there is a problem, and the respondent displayed incorrect behavior, earning scores of 2 and 1, respectively.

**The scoring of the reproductive health scale is briefly summarized as follows:**

The total point scale ranged from 16 to 48. It was subdivided into three categories as follows:

- ❖ 16-24 (<25) point is considered Low reproductive health
- ❖ 25-34 (25 to <35) point is considered Moderate reproductive health
- ❖ 35-48 (35 ≤ to >45) point is considered High reproductive health

**The second part is Psychological well-being.**

Ryff's Psychological Well-Being Scales (PWB) was developed by Burns & Machin (2009). It consists of 42 items. This scale demonstrates that life experiences and how they are interpreted provide useful avenues for understanding human variations in well-being. This scale contains six dimensions: a positive attitude toward the self and one's past life (self-acceptance); a close, trusting, and open relationship with others (positive relations with others); self-regulation and independence (autonomy); the competence to manage the environment and external. This scale contains six dimensions: a positive attitude toward the self and one's past life (self-acceptance); a close, trusting, and open relationship with others (positive relations with others); self-regulation and independence (autonomy); the competence to manage the environment and external activities (environmental (Environmental Mastery); a belief in the meaning of one's present and past lives (purpose in life); a sense of improvement or expansion over time (personal growth). Please indicate your level of agreement (on a scale of 1-6) with the following sentences.

Scoring Instruction:

- 1) Recode the negative phrases #3, 5, 10, 13, 14,

15, 16, 17, 18, 19, 23, 26, 27, 30, 31, 32, 34, 36, 39, and 41. (i.e., if the score is 6 in one of these items, the adjusted score is 1; if it is 5, the adjusted score is 2, and so on.)

2) Add together the final degree of agreement in the 6 dimensions:

1. Autonomy: items 1, 7, 13, 19, 25, 31, and 37
2. Environmental mastery: items 2, 8, 14, 20, 26, 32, and 38
3. Personal Growth: Items 3, 9, 15, 21, 27, 33, and 39
4. Positive Relations: Items: 4, 10, 16, 22, 28, 34, and 40
5. Purpose in life: items: 5, 11, 17, 23, 29, 35, and 41
6. Self-acceptance: items 6, 12, 18, 24, 30, 36, and 42

**The third part: Illinois Bully Scale**

It was developed by Espelage & Holt (2001), and is an 18-item self-report scale that includes three subscales for measuring the frequency of fighting, peer victimization, and bullying behaviors. The scale presents a Cronbach's alpha of 0.75. For each of the following questions, choose how many times you did this activity or how many times these things happened to you.

**Scoring Instructions**

**Point values are assigned as follows:**

Never = 0 1 or 2 times = 1 3 or 4 times = 2 5 or 6 times equals 3 7 or more times = 4.

Victim subscale: Items 4, 5, 6, and 7.

Bully subscale: Items 1, 2, 8, 9, 14, 15, 16, 17, and 18.

Fight subscale: Items 3, 10, 11, 12, and 13.

**The rating scale is briefly summarized as the follows:**

- "0" was never used to mean "didn't apply at all."
- "1": Sometimes "applied to some degree or some of the time."
- "2": Often "applied to a considerable degree, or a good part of the time."
- "3" Almost Always "Applied very much, or most of the time"

**Administrative Considerations**

Before beginning the research, the Assiut maternal health unit directors gave their approval. Written letters describing the purpose of the study were issued by the respondents to obtain the permit to gather the research sample from clinics under their

directorate.

### Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee at the Faculty of Nursing – Mansoura University. Approval issued on May 28th 2023 under Ref. No. o485). All ethical considerations were considered for privacy and confidentiality. Consents were obtained from the women participating in the study after a brief explanation of the study's aim and they were reassured that the information obtained would be private and used only for the study with their right to withdraw at any time without any consequence. The subject of this study will not address religious, ethical, moral, or cultural issues among women

### Pilot Study

The pilot study included about 10% of the study sample (6 participants) and excluded some participants.

### Statistical Design

Proper statistical tests were applied to decide whether there was a significant difference or not, using the statistical package for social science (SPSS), version 21 (SPSS). The following statistical measures were used:

- Descriptive measures included count (N), percentage (%), and arithmetic mean and standard deviation (Mean±SD).
- Relations between different numerical variables were tested using Pearson correlation.
- The following degrees of significance of results were considered:
  - ❖ P-values greater than 0.05 are not significant.
  - ❖ P-value  $\leq$  0.05 indicates significance.
  - ❖ P-value  $\leq$  0.01 is considered highly significant.

### Results

**Table 1** presents that 42.4% were 17-28 weeks of pregnancy, while 30.3% of them were from 29-40 weeks of pregnancy. More than half (54.5%) of the wives in the study did not work. The majority (83.3%) of the husbands in the study were at work. About half (48.5%) of the wives were aged from 24 to 29 years old, whereas 66.7 percent of the husbands were aged

30 years and older. The same table shows that 42.4% of the wives in the study had secondary education, while 42.4% of the husbands in the study had university education. More than half (56.1%) of the respondents lived in rural areas, and the bulk (69.7%) of the wives in the study were breastfeeding.

**Table (2)** illustrates that more than half (62.1%) of pregnant women had 1-2 children. 78.8% of respondents were between the ages of 20 and 35 during their first pregnancy. Approximately half of the respondents (47%) had worked for 2 to 4 years between their previous two jobs. More than half (54.5%) of the respondents labored in private clinics, and 63.6% underwent a caesarean section. More than half (68.2%) were used for family planning. Regarding the health problems that the respondents were exposed to, 66.7% of the respondents did not have health problems before pregnancy; 39.4% of the respondents had health problems during pregnancy, and she behaved correctly; more than half (51.5%) of the respondents did not have health problems after labors; 89.4% did not have health problems between labors; and 84.8% did not have health problems while using family planning methods.

**Figure (1)** shows the reproductive health among studied pregnant women: three-quarters (71.2%) of the studied sample have high reproductive health, while 28.7% have moderate reproductive health, whereas no one has had reproductive health in the current study.

**Figure (2)** presents that about the majority (98.48%) of the studied pregnant women have lower total scores on the Illinois Bully scales, and only 1.52% of respondents have higher total scores on the Illinois Bully scales. Regarding the Illinois bullying subscales, 28.79% were victims of bullying, 16.67% were fighting, and only 3.03 percent were bullied.

**Figure (3)** shows that the majority (74.24%) of pregnant women studied have poor psychological well-being, while only 25.76% have a good total score of psychological well-being. Regarding psychological well-being subscales, the highest percent (75.76%) of subscales had poor environmental mastery, 72.73% had poor personal growth, 68.18% had a poor purpose of life, 66.67% had poor positive relations, 63.64% had

poor self-acceptance, and finally 62.12% had poor autonomy.

**Table (3)** presents the relationship between pregnant women's Illinois Bully Subscales' scores. The Pearson correlation coefficient test ( $r$ ) revealed a highly statistically significant relationship between pregnant women's total Illinois Bully Subscales scores and their respective Illinois Bully victim Subscales, Illinois fight Subscales, and Illinois Bully Subscales ( $p \leq 0.001$ ).

**Table (4)** presents the relationship between pregnant women's Ryff's Psychological Well-Being Scales (PWB) subscale scores. The Pearson correlation coefficient test ( $r$ ) revealed that there were highly statistically significant relationships between the pregnant women's total Ryff's Psychological Well-Being Scales scores (PWB) and the autonomy, environmental mastery, personal growth, relationships with others, purpose, and acceptance subscale scores ( $p \leq 0.001$ ).

**Table (5)** presents Correlation between Reproductive Health and Illinois Bully Scale and Ryff's Psychological Well-Being Scales Scores among Studied Subjects; there was no statistically significant relationship between reproductive health and total Illinois Bully Scale except Fight; it was a statistically relationship between Illinois Bully Scale fight subscale and reproductive health scale ( $p < 0.05$ ). However, reproductive health was affected negatively by total and all items (Victim, Bully, and Fight) of Illinois Bully Scale. Moreover, reproductive health was affected negatively by total and all items (Victim, Bully, and Fight) of Psychological Well-Being Scales. However, there is no statistically significant relationship between reproductive health and total and all item (Autonomy, Environmental Mastery, Growth, Relations, Purpose, and Acceptance) of Psychological Well-Being Scales

**Table (6)** shows that there is no statistically significant relationship between the personal data of the pregnant women studied and bullying. Only a positive and statistically significant relationship ( $p \leq 0.01$ ) was discovered between breastfeeding and the bullying victim subscale. However, the total Illinois bullying

scale is negatively affected by pregnant women's income, age, education, residence, breastfeeding, and husbands' education.

**Table (7)** shows no statistically significant relationship between personal data of the studied pregnant women and total psychological well-being scale scores; it was also discovered that there was a negative significant relationship between wife's educational level and total psychological well-being scale scores ( $p < 0.05$ ). There was a significant relationship between husband age and autonomy on the psychological well-being subscale ( $p < 0.05$ ). Also, it was found that there was a highly statistically significant relationship between educational level and the personal growth and psychological well-being subscale ( $p < 0.01$ ). Moreover, the total psychological wellbeing scale was negatively affected by pregnant women's education, residence, work, marriage years, breastfeeding, and pregnancy weeks, as well as their husbands' education and work.

**Table (8)** A highly statistically significant relationship ( $p < 0.01$ ) was discovered between reproductive health and women's work, income, educational level, residence, and husband's educational level. Pregnant women's age, work, marriage years, and husbands' age and work all have a negative impact on reproductive health.

Table (1): Distribution of the studied pregnant women according to their personal data (N = 66)

<b>Socio-demographic data</b>	<b>No.</b>	<b>%</b>
<b>Gestational age</b>		
1-16 weeks	18	27.3
17-28 weeks	28	42.4
29-40 weeks	20	30.3
<b>Wife Work</b>		
Work	30	45.5
Not work	36	54.5
<b>Husband Work</b>		
Work	55	83.3
Not work	11	16.7
<b>Income</b>		
Not enough	7	10.6
Just enough	18	27.3
More than enough and can save	41	62.1
<b>Wife Age</b>		
18-23 years	11	16.7
24-29 years	32	48.5
30 years and more	23	34.8
<b>Husband Age</b>		
18-23 years	1	1.5
24-29 years	21	31.8
30 years and more	44	66.7
<b>Marriage Years</b>		
1-5 years	16	24.3
6-10 years	22	33.3
11 years and more	28	42.4
<b>Wife education</b>		
Illiterate	3	4.5
Primary education	2	3
Secondary school and equivalent	28	42.4
University	25	37.9
Postgraduate	8	12.2
<b>Husband education</b>		
Illiterate	3	4.5
Primary education	8	12.2
Secondary school and equivalent	26	39.4
University	28	42.4
Postgraduate	1	1.5
<b>Residence</b>		
Rural	37	56.1
Urban	29	43.9
<b>Breastfeeding</b>		
Yes	46	69.7
No	20	30.3

Table (2): distribution the studied pregnant women according to their Obstetric History (N=66)

Item	No.	%
1. Number of live children		
There is not	2	3.1
1-2 child	41	62.1
3 children	13	19.7
4 children or more	9	13.6
2. The number of miscarriages		
a. The number of dead children		
There is not	2	3
1-2	58	87.9
3 or more	8	12.1
b. The number of abortions		
There is not	43	65.2
1-2 times	21	31.8
3 or more times	2	3
3. Fertility period		
a. The age at the first pregnancy		
Less than 20 years	14	21.2
20-35 years	52	78.8
35years and more	7	10.6
b. The age at the last pregnancy		
Less than 20 years	7	10.6
20-35 years	45	68.2
35years and more	14	21.2
4. The period between the last two births		
Less than 2 years	19	28.8
2-4 years	31	47
More than 4 years	16	24.2
5. Place of last birth		
A general hospital or health unit	18	27.3
Private hospital	36	54.5
The house	12	18.2
6. Type of delivery		
Normal	22	33.3
Dryer or suction	2	3.1
Cesarean section	42	63.6
7. The one who performs the birth		
Doctor	53	80.3
Nurse	10	15.2
Midwife or one of the relatives	3	4.5
8. Use a family planning method		
Yes	45	68.2
No	20	30.3
Do not apply	1	1.5
9. The health problems that the respondent was exposed to		
a. Health problems experienced by the respondent before pregnancy		
There is not a problem	44	66.7

Item	No.	%
There is a problem (physical or psychological problems) and the respondent has acted correctly	13	19.7
There is a problem and the respondent has acted incorrectly	9	13.6
<b>b. Health problems experienced by the respondent during pregnancy</b>		
There is not a problem	14	21.2
There is a problem (physical or psychological problems) and the respondent has acted correctly	26	39.4
There is a problem and the respondent has acted incorrectly	26	39.4
<b>c. Health problems experienced by the respondent after delivery</b>		
There is not a problem	34	51.5
There is a problem (physical or psychological problems) and the respondent has acted correctly	13	19.7
There is a problem and the respondent has acted incorrectly	19	28.8
<b>d. Health problems experienced by the respondent between deliveries</b>		
There is not a problem	59	89.4
There is a problem (physical or psychological problems) and the respondent has acted correctly	4	6.1
There is a problem and the respondent has acted incorrectly	3	4.5
<b>e. Health problems experienced by the respondent during use a family planning method</b>	f.	g.
There is not a problem	56	84.8
There is a problem (physical or psychological problems) and the respondent has acted correctly	5	7.6
There is a problem and the respondent has acted incorrectly	5	7.6

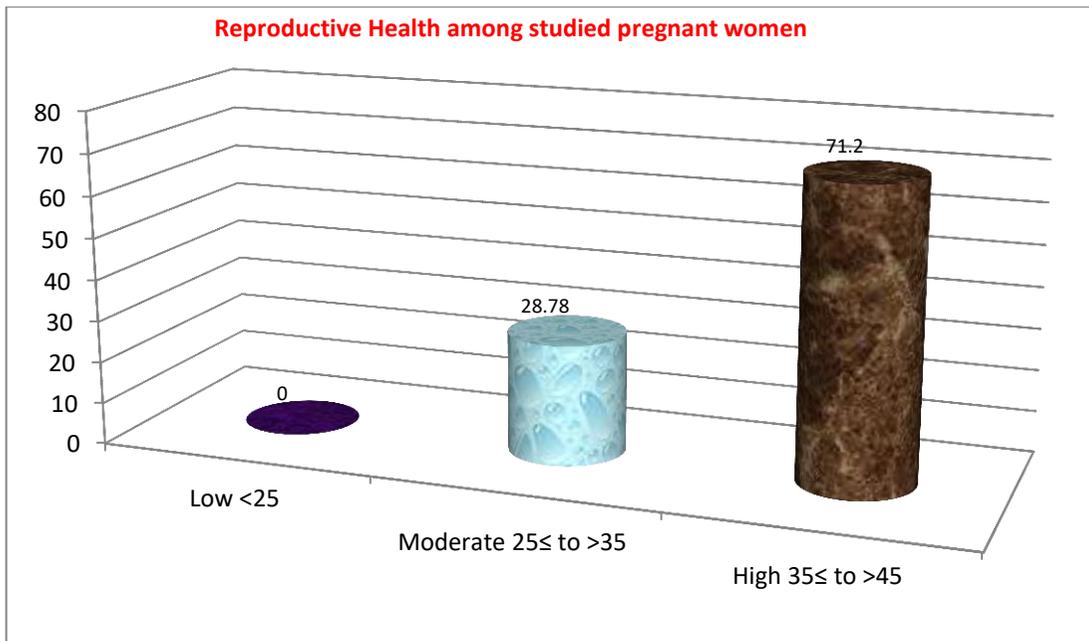
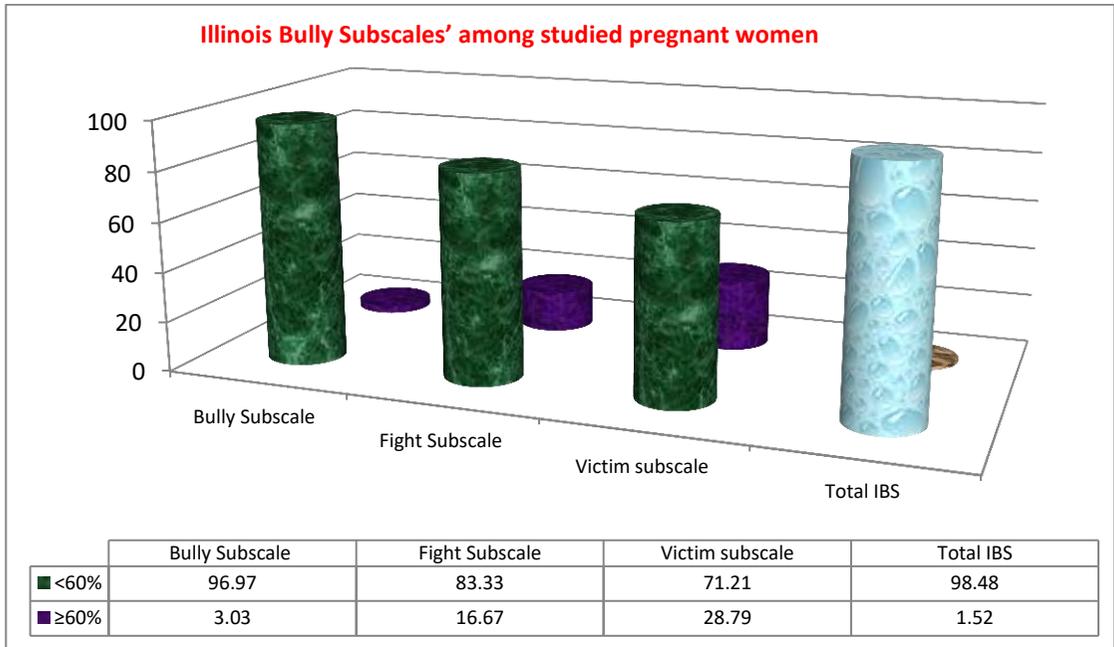
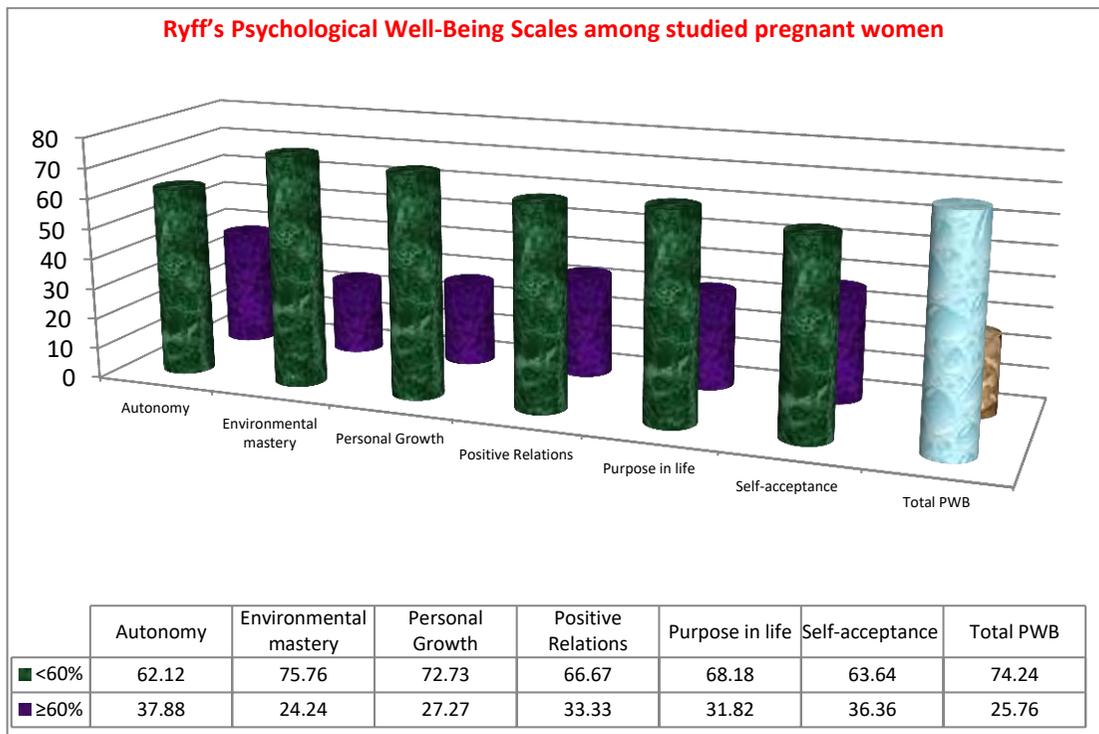


Figure (1): Reproductive Health among studied pregnant women (n=66)



**Figure (2): Illinois Bully Subscales' (IBS) among studied pregnant women**



**Figure (3): Ryff's Psychological Well-Being Scales (PWB) among studied pregnant women (n=66)**

**Table (3): Relationship between Illinois Bully Subscales' Scores among studied pregnant women**

Items	IBS-Victim		IBS-Bully		IBS-Fight		IBS-Total	
	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>p</i>
IBS-Victim	1	0						
IBS-Bully	0.674	0.00**						
IBS-Fight	0.523	0.00**	0.606	0.00**				
<b>IBS-Total</b>	<b>0.828</b>	<b>0.00**</b>	<b>0.917</b>	<b>0.00**</b>	<b>0.817</b>	<b>0.00**</b>	<b>1</b>	<b>0</b>
Mean	7.11		12.29		7.35		26.74	
Std. Deviation	3.70		5.88		4.27		11.94	
Range	15		27		17		59	

*r* = Pearson Correlation IBS = Illinois Bully Scale \*\* Highly statistical significant at  $p < 0.01$

**Table (4): Relationship Ryff's Psychological Well-Being Scales (PWB) subscales Scores among Studied pregnant women.**

Items	Autonomy		Env.Mastry		Growth		Relations		Purpose		Acceptance		Total	
	<i>r</i>	<i>P</i>	<i>r</i>	<i>p</i>										
Autonomy	1	0												
Env.Mastery	0.437	0.000**												
Growth	0.326	0.008**	0.481	0.000**										
Relations	0.213	0.085	0.408	0.001**	0.325	0.008**								
Purpose	0.364	0.003**	0.446	0.000**	0.730	0.000**	0.215	0.083						
Acceptance	0.503	0.000**	0.467	0.000**	0.491	0.000**	0.591	0.000**	0.420	0.000**				
<b>Total</b>	<b>0.631</b>	<b>0.000**</b>	<b>0.727</b>	<b>0.000**</b>	<b>0.797</b>	<b>0.000**</b>	<b>0.629</b>	<b>0.000**</b>	<b>0.742</b>	<b>0.000**</b>	<b>0.808</b>	<b>0.000**</b>	<b>1</b>	<b>0</b>
Mean	22.79		21.85		20.06		22.52		22.33		21.64		131.18	
SD	5.00		5.16		7.04		5.51		5.84		6.66		25.70	
Range	22		22		29		24		22		25		94	

*r* = Pearson Correlation \*\* Highly statistical significant at  $p < 0.01$

**Table (5): Correlation between Reproductive Health and Illinois Bully Scale (IBS) and Ryff's Psychological Well-Being Scales (PWB) Scores among Studied Subjects**

Items	Reproductive Health	
	<i>r</i>	<i>P</i>
<b>Illinois Bully Scale</b>		
IBS-Victim	-0.128	0.308
IBS-Bully	-0.221	0.074
IBS-Fight	-0.246	0.046*
<b>IBS-Total</b>	<b>-0.131</b>	<b>0.294</b>
<b>Psychological Well-Being Scales</b>		
PWS-Autonomy	-0.062	0.622
PWS-Environmental Mastery	-0.091	0.466
PWS-Growth	-0.202	0.104
PWS-Relations	-0.121	0.333
PWS-Purpose	-0.140	0.261
PWS-Acceptance	-0.198	0.111
<b>PWS-Total</b>	<b>-0.212</b>	<b>0.088</b>

*r* = Pearson Correlation PWB= Psychological Well-Being Scales

\* Statistically significant at  $p < 0.05$  IBS= Illinois Bully Scale

**Table (6): Correlation between personal data and Illinois Bully Scale among studied pregnant women**

Items	IBS-Fight		IBS-Bully		IBS-Victim		IBS-Total	
	r	P	r	P	r	p	r	P
Pregnancy Weeks	0.034	0.783	0.159	0.202	-0.007	0.958	0.155	0.214
Women's Work	0.09	0.475	0.035	0.781	-0.065	0.605	0.116	0.356
Husbands' Work	0.059	0.637	0.235	0.057	0.209	0.093	0.121	0.332
Income	-0.089	0.479	-0.121	0.332	0.008	0.946	-0.157	0.207
Women's Age	-0.037	0.768	0.028	0.823	0.046	0.714	-0.023	0.857
Husband Age	0.0	0.999	0.121	0.332	0.085	0.498	0.056	0.657
Marriage Years	-0.149	0.232	0.064	0.612	-0.079	0.527	0.004	0.972
women's education	-0.081	0.519	-0.039	0.758	0.029	0.815	-0.095	0.447
Husbands' education	-0.124	0.321	-0.047	0.706	-0.066	0.596	-0.079	0.529
Residence	-0.044	0.726	-0.007	0.955	0.033	0.795	-0.049	0.696
Breastfeeding	-0.008	0.952	0.16	0.201	0.268	0.029**	-0.012	0.923

r = Pearson Correlation IBS= Illinois Bully Scale \*\* Statistically significant at p<0.01

**Table (7): Correlation between personal data and Psychological Well-Being Scales**

Items	PWB.- Autonomy		PWB. Env.Mastery		PWB. Growth		PWB. Relations		PWB. Purpose		PWB. Acceptance		Total PWB.	
	r	p	r	p	r	p	r	p	r	p	r	p	r	p
Pregnancy Weeks	0.199	0.108	-0.093	0.46	0.051	0.683	-0.223	0.072	0.056	0.653	-0.206	0.097	-0.07	0.577
Women's Work	0.147	0.239	-0.158	0.206	0.043	0.731	-0.014	0.91	-0.116	0.356	-0.092	0.465	-0.057	0.65
Husbands' Work	0.089	0.48	-0.114	0.363	-0.118	0.347	0.054	0.664	-0.005	0.97	-0.006	0.961	-0.029	0.819
Income	-0.004	0.973	0.097	0.441	0.002	0.99	0.083	0.505	0.026	0.838	0.059	0.641	0.067	0.595
Women's Age	0.009	0.943	0.042	0.739	0.082	0.511	-0.144	0.248	0.136	0.278	0.14	0.263	0.074	0.553
Husbands' Age	-0.299	0.015*	0.015	0.907	-0.068	0.589	0.076	0.546	0.112	0.372	0.156	0.21	0.02	0.871
Marriage Years	-0.112	0.369	-0.097	0.437	0.045	0.718	-0.195	0.116	0.076	0.547	-0.025	0.843	-0.069	0.581
women's education	-0.131	0.293	-0.062	0.621	-0.336	0.006**	-0.143	0.251	-0.118	0.346	-0.174	0.162	-0.246	0.046*
Husbands' education	-0.038	0.76	-0.019	0.878	-0.239	0.053	0.019	0.882	-0.127	0.311	-0.068	0.59	-0.123	0.325
Residence	-0.1	0.422	-0.081	0.517	-0.236	0.056	-0.106	0.398	-0.172	0.167	-0.057	0.647	-0.189	0.129
Breastfeeding	0.186	0.135	0.02	0.876	-0.184	0.14	0.089	0.48	-0.015	0.904	-0.053	0.67	-0.004	0.974

r = Pearson Correlation PWB= Psychological Well-Being Scales

\* Statistically significant at p<0.05 \*\* Highly statistical significant at p<0.01

**Table (8): Correlation between personal data and Reproductive Health Scale among Studied women**

Socio-demographic Characteristics	Reproductive Health	
	r	P
Pregnancy Weeks	0.044	0.724
Women's Work	-0.362	0.003**
Husbands' Work	-0.150	0.230
Income	0.491	0.000**
Women's Age	-0.153	0.221
Husbands' Age	-0.077	0.539
Marriage Years	-0.168	0.178
women's education	0.531	0.000**
Husbands' education	0.480	0.000**
Residence	0.377	0.002**
Breastfeeding	0.070	0.577

r = Pearson Correlation \*\* Highly statistical significant at p<0.01

**Discussion:**

Research on pregnancy focuses mostly on diagnosable psychological disorders and somewhat on posttraumatic stress disorder following adverse life events or childbirth experiences. As a prelude to discussing, despite pregnancy has traditionally been considered a time of emotional well-being for protecting women against disorders (hormonal changes during pregnancy, such as increased prolactin, cortisol, and oxytocin may contribute to the suppression of the stress response that occurs during this period). Moreover, if pregnancy is associated with medical disorders, it will have an impact on psychological wellbeing and increase the risk of negative psychological symptoms (Hassan, 2016; Gamel, et al., 2019).

Bullying victimization refers to the process by which a person is repeatedly and over time exposed to intentional negative actions by their peers. There is evidence suggesting bullying victimization in children and adolescents has enduring effects which may persist into adulthood. Experts in the field classified bullying victimization into traditional forms (face to face) and electronic bullying (cyber-bullying) (deLara, 2018).

Bullying not only has severe negative effects on the victims involved, but also has serious implications on much broader levels, including family life, education and health. It is important for both the victim as well as the bully to share their experience. So that the root causes of such aggressive nature and volatile behavior can be determined. They should be helped and counseling as well as confidence building programs should be introduced in both schools and colleges (Sesar, et al., 2013).

As bullying can affect psychological status and wellbeing; In turn psychological wellbeing will affect reproductive health, generally, and pregnant women, specially. In Egypt, no known studies have examined either occurrence of bullying-either or its effect on reproductive health among pregnant women. So, the current study conducted to assess the impacts of bullying on psychological well-being and reproductive health among pregnant women in Assiut government using a standardized assessment scale and its effect on psychological well-being and reproductive health.

Regarding to reproductive health among studied pregnant women, the results of the current

revealed that three-quarters of the studied sample were having high reproductive health. This was expected as the majority of studied women were well educated, so they have awareness regarding the importance of follow-up their pregnancy. This also reflects the expansion and availability of reproductive health clinics everywhere in Egypt. This is similar to the results of a study done to by Abdel Moneim et al., (2011) to assess variables associated with the level of rural women on reproductive health in some villages of Alexandria Governorate, Egypt. They found that there was more than three quarters of the studied sample were have high reproductive health (76%).

Regarding Illions Bullying scale among studied pregnant women, findings of the present study revealed that the majority of the studied pregnant have lower scores on Illinois Bully scales' and only 1.52% of them have higher scores on Illinois Bully scales. However, total Illinois Bully Scale affected negatively by pregnant women's income, age, education, residence, breastfeeding, and husbands' education; no statistically significant relationship between personal data of the studied pregnant women and bullying. This may attributed to most of the studied women were from rural areas which had cultural and traditions. Bulling is not common at villages as people in rural areas deals together as one family.

Results of current study were in line with results of a result of researcher who concluded that the prevalence of involvement in cyber-bullying was very low according to self-report of the young adolescents in this study. This is of course a positive sign since it indicates low levels of victimization and perpetration of cyber-bullying. In comparison to other studies, our results are in line with others who show relative low levels of prevalence's of involvement in cyber-bullying, but not with those who report much higher numbers (Karin, 2020; Hassan, et al., 2019; Slonje, et al., 2017). The use of several measures to measure cyber-bullying makes comparisons across studies hard.

The results of study Cosma et al., (2017) were similar to the results of the present study that for most of the countries there was a constant decline in being bullied by others between ages 11 and 15. Significant declines in prevalence were observed in most countries and regions among both boys and girls, yet with the change usually being less than 10% was in line with current

study. However, results of current study were in contrast with findings of a study result conducted by Budden et al., (2017) that revealed a high frequency of being bullied. About 76.41% of participants in another study conducted by Ren et al., (2017) reported that they had experienced bullying in clinical settings and 91% of nursing students in Korea.

Regarding to subscales of bullying scale, types of victimization behavior among pregnant women, the high percentages of victims reported in this study indicate that there are more victims than bullies. This finding is consistent with finding around the world for example, indicating that victimization is a prevalent issue among adolescents; Based on common types of victimization among adolescents in Maldives revealed that boys and girls reported being victims of bullying (Denny, et al., 2014; Malhi, et al., 2015).

The results of the current study was consistent with the results of study Craig et al., (2009) that the incidence of victimization is 13% within the peer groups of these respondents was quite low, whilst these previous studies were generally conducted among younger respondents, it is known that experience of victimization normally reduces with age, as maturity brings with it increased ability to resolve conflict in more peaceful ways (Craig, et al., 2009)..

Regarding to Ryff's Psychological Well-Being Scales among studied pregnant women, findings of the current study revealed that three-quarters of the studied sample have poor psychological well-being, while the minorities have good psychological well-being. There was no statistically significant relationship between personal data of the studied pregnant women and total psychological wellbeing scale. However, total psychological wellbeing scale affected negatively by pregnant women's education, residence, work, marriage years, breastfeeding, pregnancy weeks and husbands' education and work as well. This may due to hormonal changes which women exposed during pregnancy, such as increased prolactin, cortisol, and oxytocin which impact on psychological wellbeing and increase the risk of negative psychological symptoms (Hassan, 2016; Gamel, et al., 2019). This result was in line with the results a study that showed lower levels of psychological well-being among participants. Specifically, 64.8% of participants reported

experiencing a serious level of depressed mood with higher scores than that in a study with Korean college students. A plausible explanation could be derived from socially accepted values connected to the language of pain, which represents cultural meanings of suffering, even if this study did not address why the subjects demonstrated low levels of psychological well-being (Ren, et al., 2015).

Moreover, a study conducted at the University Putra Malaysia (UPM) by Zulkefly et al. (2010) also found that 47.1% of UPM participants scored low level of psychological well-being indicating that a considerable number are at risk for psychological problems. Results of Zaid et al., (2007) was in line with current study Studies conducted in Malaysia have also shown decreased level of psychological wellbeing among university students in Malaysia.

In addition, regarding to Ryff's Psychological Well-Being subscales, The results of current study was in line with results of Sagone & De Caroli (2014) who comparing the six dimensions of PWB, descriptive analyses showed that sample scored more highly in personal growth, positive relations with others and environmental mastery, whereas less highly in autonomy, self-acceptance, and purpose in life.

The descriptive analyses of study of Ludban (2015) indicated that subject involved in the study possess rather high levels of overall psychological well-being. These results were in contrast with the current study, nevertheless, the dimension with the highest mean score was personal growth, followed by purpose in life, positive relations with others, self-acceptance, environmental mastery, and autonomy. In this study context, as postgraduate studies require subject to constantly deal with challenges, subject are able to experience a higher level of personal growth. In support of this claim, reported that subject personal growth increased during the first years of their academic life and also stated that growth is attained by retaining constant adaptability when encountering life crises or traumatic events, as individuals who have encountered traumatic events are also able to be self-governing in difficult situations.

The results of study conducted by Ryff, Singer (2008) were in line with the current study mentioned that the overall score for autonomy dimension was the lowest among other

dimensions. Even though the responses with high scores were related to confidence and the ability to self-govern one's judgments of their opinions, the responses pertaining to their opinions and decision making that correspond with those of other people were also quite high. This could be due to the fact that postgraduate students are mostly on their own in their academic endeavors; however, they are also aware of the importance of the people in their academic surround-40, demonstrated that individuals in some cultures (particularly the Eastern cultures) were inclined to prefer decisions that are made for them by their significant others. As the respondents of this study were from an Eastern culture, this explains the low level of autonomy and high level of positive relations with others.

Regarding to Ryff's Psychological Well-Being Scales (PWB) subscales Scores among Studied pregnant women The findings of study by Roslan et al., (2017) were agreed with results of the current study indicated high score on the dimension of personal growth, followed by Purpose in Life, Positive Relations with others, Self-acceptance, Environmental Mastery, and autonomy. However, De-Juanas et al.'s (2020) results were in line with the results of the current study. However, the results of the student's t-test show statistically significant differences in five of the six dimensions of psychological well-being and for the scale's total score. No statistically significant differences were found in positive relationships with others.

Regarding the relationship between personal characteristics and psychological well-being scales among studied pregnant women, the results of the current study revealed that the total psychological well-being scale was negatively affected by pregnant women's personal and demographic characteristics. This is not surprising, as of course residence, education, and so on all have an effect on psychological wellbeing. This negative effect may be due to hormonal changes in pregnant women. However, the results of the study by Creed et al. (2003) were in contrast with the current study results regarding the age factor; the results of past research have shown some discrepancies and found no difference in psychological well-being across age groups (young, middle-aged, and mature-aged). The inconsistency in the findings regarding personal variables and well-

being is possibly due to the way constructs are defined, the measuring instruments used, the study population, socio-economic conditions, and socio-cultural context, as well as methods of analysis. Therefore, a key component of comprehending healthy human functioning knows the nature, structure, and measurement of psychological well-being.

The results of the present study were in line with a study conducted by Panahi et al. (2013) among postgraduate students at the UPM that revealed a significant relationship between age and psychological well-being, denoting that the level of students' psychological well-being increases with age. The authors also confirmed the link between age and psychological well-being in terms of autonomy, personal growth, and life purpose. In turn, Mayordomo et al. (2016) found a positive correlation between age and level of psychological well-being, which might be the result of successful adaptation to the social environment. Bucchianeri et al.'s (2016) study results were in line with the results of a current study that found a significant positive correlation between level of education and psychological well-being in reference to personal growth and purpose in life.

The present study results were in line with the study of Khumalo et al. (2011), who found that the level of education and employment status were significantly associated with positive psychological well-being and mental health for people living in a rural or urban setting, and that level of education, marital status, and employment status all significantly influenced well-being. Education, employment, and being married were also found to be beneficial in contributing towards psychological well-being. On the other hand, living in a rural area, having a lower education, being unemployed, and being single were found to have a detrimental effect on psychological well-being (Tsuno & Yamazaki, 2007).

Regarding reproductive health among the studied pregnant women, the results of the current study highlighted many variables that affected it. To begin, it was discovered that reproductive health was significantly affected by women's personal characteristics (work, income, educational level, residence, and husband's educational level) when the relationship between personal data and the Reproductive Health Scale was examined among studied women. Pregnant women's age, work,

marriage years, and husbands' age and work all have a negative impact on reproductive health. This contradicted the findings of Khán and Zaheer (2017), who surveyed and interviewed 10,023 women, aged 12-49 in order to collect data on a variety of demographic and reproductive health topics. Personal variables include the studied pregnant women's current age, place and region of residence, education level, household wealth index, age at marriage, and parity. Reproductive health indicators consist of child size at birth, the number of antenatal visits, the place of delivery, delivery by caesarean section, reported labour duration, and reported complications during pregnancy between these two groups. It was found that no significant differences were observed between the two groups for all the variables except the variable complications during pregnancy, so the exclusion of missing information could not have an impact on the main findings.

Second, when the relationship between the Reproductive Health Scale and the Illinois Bully Scale, as well as Ryff's Psychological Well-Being Scales, was examined, it was discovered that bullying did not affect reproductive health as presented in the total Illinois Bully Scale. However, reproductive health was negatively affected by the total and all items (victim, bully, and fight) of the Illinois Bully Scale; there was no statistically significant relationship between reproductive health and the total Illinois Bully Scale. Furthermore, the total and all items of the Psychological Well-Being Scales had a negative impact on reproductive health. However, no statistically significant relationship exists between reproductive health and the total and individual items of the Psychological Well-Being Scales.

In terms of bullying and victimization, the findings of Frieden et al. (2012) and Butler-Barnes et al. (2017) were consistent with the findings of the current study. Previous research has established links between mental health and conditions such as poor psychological well-being, anxiety, and depression. Furthermore, previous studies by Nixon (2015) and Heiman et al. (2018) found similar results to the current study, demonstrating how bullying involvement is related to both depressive and anxiety symptoms, as well as lower levels of subjective well-being.

Thirdly, regarding the relationship between pregnant women, Ryff's Psychological Well-Being Scales (PWB) subscale scores Results of the current study revealed a highly statistically significant relationship between the pregnant women's total Ryff's Psychological Well-Being Scales (PWB) scores. This was consistent with the results of Bokhari et al. (2020), who suggested that youths involved in cyber-bullying, as victims, bullies, and bully-victims, are at increased risk for anxiety and depressive symptoms, as well as less well-being in general. The current study results were consistent with the finding that a significant relationship was found between the measures of victimization, psychological well-being, and stress, with victims reporting a poorer level of psychological well-being and greater levels of stress. Thus, involvement in bully/victim problems as a victim is associated with impaired health and well-being.

Additionally, McGuckin et al.'s (2012) results were consistent with the results of the current study, which revealed that bullying experience is strongly correlated with reduced psychological well-being. Bullying is regarded as a stressor with potentially serious consequences for psychological well-being, which is critical to improving nursing students' abilities to successfully complete clinical training and continue their careers as registered nurses.

Musharraf & nis-ul-Haque's (2018) studies with university students have suggested that bullying and cyber-bullying have a negative impact on victims' subjective well-being. This result is in agreement with the current study results, which found that cyber-bullying victims reported the lowest levels of mental well-being in comparison to cyber-bullying perpetrators, victims, and not-involved students. Verbal experiences of bullying victimization during both periods (before and at university) were significantly associated with a lower perceived quality of life in psychological and social relationship domains. There was a positive relationship between bullying victimization and well-being dimensions. This finding could be explained in part by the fact that victims of cyber dating abuse do not perceive their actions as serious and harmful as they do other forms of aggression.

The findings of Drennan et al. (2007) and Vllora et al. (2020) studies contradicted the findings of the current study, which found that neither the frequency of bullying experienced through mobile

phones nor the distress experienced had a direct impact on well-being. The findings of Mossige and Huag (2017) contradicted the findings of the current study, which concluded that there was no significant relationship between being a victim of cyber dating abuse and any of the examined well-being dimensions.

### **Limitation of the Study:**

The study has two main limitations that might have influenced the results we have reached. The first was that it is a descriptive cross-sectional study involving a small sample size. So, the small sample size may have provided inadequate statistical power to detect some significant differences and doesn't allow us to establish causal inferences between study variables. The second one was that many of our measures are self-reported. However, we used well-validated self-report instruments that have been found to be valid and reliable measures in a number of health surveys; using questionnaires and self-rating, although useful for assessing the severity of symptoms, isn't the best way of identifying the existence of bullying, reproductive health, and psychological wellbeing.

### **Conclusion:**

Based on the results of the current research, it can be concluded that there were lower levels of bullying, a higher level of reproductive health, and higher psychological well-being among the studied pregnant women. There is no statistically significant relationship between personal data and bullying or psychological well-being. Women's reproductive health can be affected by their work, income, educational level, residence, and husband's educational level. There was no statistically significant relationship between reproductive health and bullying. However, reproductive health was affected negatively by bullying. Furthermore, psychological well-being had a negative impact on reproductive health. However, no statistically significant relationship exists between reproductive health and the total and individual items of the Psychological Well-Being Scales.

### **Recommendations**

Based on the findings of this study the following are recommended:

1. Designing a booklet, brochure, and poster, publishing the study's findings, and disseminating them through antenatal clinics in order to reach every pregnant woman and inform her about the effects of psychological status on reproductive health.
2. Educational programme to improve the reproductive health and psychological wellbeing of pregnant women.
3. It may be interesting to do experimental research on the effectiveness of intervention programmes such as health and life skills programmes for preventing bullying behavior

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