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Depression in Women Experiencing Intimate Partner Violence

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1. Introduction

Intimate partner violence (IPV) is a well recognized public health issue. According to the U.S. Centers for Disease Control and Prevention, IPV is defined as:

“physical and/or sexual violence, or threats of such violence, or psychological/ emotional abuse including coercive tactics; between persons who are current or former spouses, marital or non-marital partners, same or opposite sex partners and boyfriend/girlfriends or dating partners. They may be co-habiting, but need not be.” (Saltzman, 1999)

In the past two decades, there has been a rapid increase in the awareness of IPV and the incidents of IPV reported in different countries. In 2002, the issue was raised at the international level by the World Health Organization (WHO) in its first report on health and violence against women (Krug, 2002). According to the report, the lifetime prevalence of physical assaults by intimate partners against women was between 10 and 69 percent among 48 population-based surveys worldwide (Krug, 2002).

IPV is known to be strongly associated with depression (Golding, 1999), which is often found in abused women staying with abusive partners. Also, depression has persistently been found in abused women after they have separated from abusive partners (Anderson, Saunders, Yoshihama, Bybee, & Sullivan, 2003; Amy E. Bonomi et al., 2009; J. C. Campbell, 2002; J. C. Campbell, Kub, & Rose, 1996; Dienemann et al., 2000; Hegarty, Gunn, Chondros, & Small, 2004; O'Campo et al., 2006). In a meta-analysis of 18 studies, the pooled prevalence of depression among abused women was 47.6 percent, which is much higher than the lifetime rate of 18.6 percent in the general population (Golding, 1999). Also, as shown in a 2009 study, the relative risk of depression in abused women is three times higher than that of non-abused women (Amy E. Bonomi, et al., 2009).

Depression has been predicted to be the leading cause of disability and the second leading contributor to the global burden of disease by the year of 2020 (Pollock, Manaseki-Holland, & Patel, 2006). Also, numerous studies have revealed that depression is associated with higher rates of physical and mental illness, such as headaches, back pain, sexually transmitted diseases, appetite loss, digestive problems, and gynaecological problems (Amy E. Bonomi, et al., 2009; J. Campbell et al., 2002), chronic pain (Humphreys, Cooper, &

Miaskowski, 2010; Wuest et al., 2008), loss of consciousness, diminished cognitive abilities, memorization and concentration problems (Valera & Berenbaum, 2003), greater functional disability and higher healthcare resource utilization (D. S. Brown, Finkelstein, & Mercy, 2008; Jones et al., 2006; Ulrich et al., 2003). There is, therefore, an urgent need to address this common and persistent adverse consequence of IPV.

2. Organization

In this chapter, we aim to enhance the understanding of depression in abused women. It includes the following sections:

- a. An examination of the definition of depression and how it is different from depressive symptoms.
- b. An introduction to the different ways of measuring depression and depressive symptoms according to current knowledge.
- c. An illustration of the possible etiology of depression in women, in particular, related to IPV given that there are a variety of causes of depression.
- d. Finally, an identification of the risk factors that have contributed to depressive symptoms in women experiencing IPV based on empirical evidence from literature. Both consistent and inconsistent findings are discussed.

3. Depression versus depressive symptoms

Most, if not all, individuals occasionally feel emotionally sad or blue. These symptoms may develop into a medical illness or disorder, termed as depression in psychopathology. According to the *Diagnostic and Statistical Manual IV* (DSM IV) (Association, 2000), depression consists of a major depressive episode that must include at least five out of nine symptoms for two weeks or more. The nine depressive symptoms are:

- a. depressed mood
- b. significant reduced level of interest in most activities
- c. loss or gain weight
- d. insomnia
- e. agitated or slowed down behaviour
- f. guilt
- g. inability to concentrate
- h. feeling fatigue
- i. thoughts of death

The symptoms should be intense, prolonged and interfere with the person's daily functioning. This distinct definition can clearly differentiate depression from unhappiness and sadness. An individual may possess depressive symptoms but may not necessarily have depression if there are fewer than five depressive symptoms or the symptoms are not intense, prolonged or interfere with daily functioning.

Unfortunately, many abused women suffer from depression without being diagnosed or receiving any treatment. They simply are not willing or are not aware of the need to seek medical advice (WHO, 1990).

4. Diagnosis and assessment of depression

The medical diagnosis of depression is conventionally conducted using the Structural Clinical Interview (SCID), which is a clinical assessment administered by a licensed clinician or clinical psychologist. In order to allow researchers and clinicians to assess for mental disorders, WHO (1990) developed the first Composite International Diagnostic Interview (CIDI), which is a structured interview designed to assess for mental disorders according to the International Classification of Disease (ICD) and DSM-IV that can be administered by trained lay interviewers. The CIDI is now widely used in research and clinical practice to diagnose depression.

Although SCID and CIDI are gold standard tools used to diagnose depression, their administration requires professional or trained personnel which can be costly and time consuming. Therefore, self-report questionnaires have been developed to assess depressive symptoms without the need for trained personnel. A valid and reliable depression questionnaire can facilitate the self-assessment of depression. This allows not only individuals to assess their level of depression on their own but also clinicians to identify individuals with potential depression problems in a busy clinical setting. It also facilitates assessment of depression in research studies, especially in large-scale epidemiologic studies where self-report measurement tools are very functional.

Self-report assessment tools for depression require rigorous evaluation of their psychometric performance before they are used in practice. An evaluation often includes the checking of reliability, validity, sensitivity and responsiveness (Fong, in press). There are depression assessment tools with evidence supporting satisfactory psychometric performance in measuring depression for clinical settings (Maercker, Michael, Fehm, Becker, & Margraf, 2004; Pokorski & Siwiec, 2006; Rohde et al., 2008). The common tools are described in the next section.

5. Common self-report measurements of depression

Beck Depression Inventory

The Beck Depression Inventory (BDI) was developed in 1961 by A.T. Beck, a remarkable scholar in the study of depression (Maraste, Brandt, Olsson, & Ryde-Brandt, 1992). He defined depression as the self-conception of worthless, outer world meaninglessness, and future hopelessness (Beck, 1971). These self-concepts are what can be observed in a person experiencing depression because of an irreversible loss or disappointment which is very significant in their life (Beck, 1971; G. W. Brown, & Harris, T.O., 1978). In 1996, the BDI was revised as BDI-II to reflect changes in the DSM-IV. The BDI-II is a 21-item questionnaire addressing the severity of depressive symptoms in the past week. The symptoms include:

- a. sadness
- b. pessimism
- c. past failure
- d. loss of pleasure
- e. guilt feelings
- f. punishment feelings
- g. self-dislike

- h. self-criticalness
- i. suicidal thoughts
- j. crying
- k. agitation
- l. loss of interest
- m. indecisiveness
- n. worthlessness
- o. loss of energy
- p. changes in sleeping patterns
- q. irritability
- r. changes in appetites
- s. difficulty in concentrating
- t. tiredness
- u. loss of interest in sex

Each item scores in the range 0 (symptom not presents) to 3 (symptom strongly presents), giving a total score from 0 to 63. The higher the total score, the more severe the depression is. It can be further categorized to define the level of depression. An individual is considered to be at a minimal depression level when their total score is between 0 and 13, mildly depressed with a score between 14 and 19, moderately depressed with a total score between 20 and 28, and severely depressed with a total score between 29 and 63.

Center for Epidemiologic Studies of Depression Scale

The Center for Epidemiologic Studies of Depression Scale (CES-D) is a questionnaire that comprises 20 items covering the most common depressive symptoms in the general population (Newcomb & Carmona, 2004). The items were selected based on previously validated depression scales. It includes the components of

- a. depressed mood
- b. feelings of worthlessness
- c. feelings of helplessness and hopelessness
- d. loss of appetite
- e. sleep disturbance

Similar to the BDI, the recall period is also one week. However, CES-D does not include some of the items the BDI does, including feelings of guilt, psychomotor retardation and suicidal thoughts. Each CES-D item is rated on a 4-point Likert scale, ranging from 0 (rarely or none of the time) to 3 (most all of the time). The plausible range of score is 0 to 60, with higher scores indicating higher depression severity. A CES-D score ≥ 16 indicates the presence of depression but no further categorization by severity is available. The CES-D has been widely used in all age groups and in both health care and community settings. It has been developed and translated into many different languages and is free for non-profit use.

Patient Health Questionnaire

The Patient Health Questionnaire (PHQ-9) is a multi-purpose questionnaire for both diagnosing and measuring the severity of depression. It incorporates the DSM-IV depression diagnostic criteria (Rohde, et al., 2008). It consists of 9 items, covering nine depressive symptoms. They are:

- a. depressed mood
- b. significant reduced level of interest in most activities
- c. loss of appetite
- d. insomnia
- e. agitated or slowed down behaviour
- f. guilt
- g. poor concentration
- h. feeling fatigue
- i. thoughts of death

For each item, both the frequency of the symptoms experienced, and how difficult the problem makes the person's life are rated on a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day). The scoring system allows the classification of depression severity where 1 – 4 = minimal depression, 5 – 9 = mild depression, 10 – 14 = moderate depression, 15 – 19 = moderately severe depression and 20 – 27 = severe depression.

Although the PHQ-9 is a short questionnaire, there is a briefer version, named PHQ-2 (Eisenman et al., 2009), which consists of only two case-finding questions:

1. "During the past month, have you often been bothered by feeling down, depressed, or hopeless?"
2. "During the past month, have you often been bothered by little interest or pleasure in doing things?"

The PHQ-2 is a very useful and feasible measure for screening depression in community and primary care settings.

6. Etiology of depression in abused women

Lenore Walker (1984) was among the first to explore the etiology of depression in IPV victims. She developed what she termed a Cycle of Abuse to describe the behavioural pattern of abusers and the responses of abused women to the violence (A. E. Bonomi, Anderson, Cannon, Slesnick, & Rodriguez, 2009). Figure 1 shows the three phases in Walker's Cycle of Abuse:

- a. Tension building phase: In this phase interpersonal tension builds up between the abuser and the abused woman. The abuser may become increasingly jealous and short tempered. The abuser's anger is always irrational. However, the abused woman usually uses placating coping strategies to avoid triggering the abuser's outburst.
- b. Acting out phase: This phase is characterized by violent incidents. The abused woman is in a very dangerous situation as she may be injured or even killed by the abuser. In this phase, the abused woman is often too frightened to seek help.
- c. Honeymoon phase: Following a violent incident, the abuser becomes apologetic. He promises that it will not happen again and becomes loving, caring and affectionate. As the abuser's behaviours are usually convincing, the abused woman is often very eager to forgive him and believes that the abuser will change. This phase is often short lived and the interpersonal tension starts to build again and even involves mildly violent behaviours. The cycle continues.

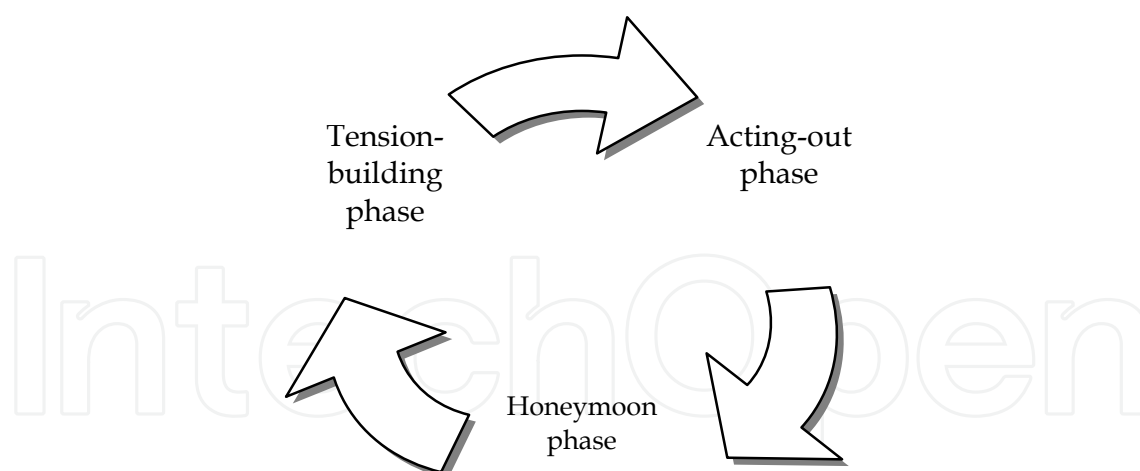


Fig. 1. *Cycle of Abuse*.

Under the Cycle of Abuse, woman may develop Battered Women Syndrome, a term also introduced by Lenore Walker (Walker, 1979). Battered Women Syndrome explains why abused women are often reluctant to leave abusive relationships where they experience physical and psychological suffering. Battered Women Syndrome is a subcategory of posttraumatic stress disorder (PTSD), which comprises symptoms of:

- a. re-experiencing the battering even though it is not re-occurring,
- b. avoiding the psychological impact of abuse by avoiding personal emotions, family and friends, and social activities,
- c. hyperarousal or hypervigilance,
- d. disrupted interpersonal relationships,
- e. body image distortion or other somatic problems, and
- f. sexuality and intimacy issues.

All these symptoms may become manifest after a traumatic experience. They can be very distressing and lead to depression. In the book, *Social Origin of Depression*, a strong causal link between stressful life events and depression was found, especially when a stressful event was severe or threatening events were of remarkably long duration (G. W. Brown, & Harris, T.O., 1978); an example of which would be IPV.

Battered Women Syndrome was developed after Martin Seligman's (1975) classical Learned Helplessness Theory, which describes the phenomenon where a person has learned to behave helplessly even though there is an opportunity to escape from an unpleasant situation. However, this does not imply abused women are helpless at all. Rather, abused women may choose to stay in abusive relationships but give up the belief that they are able to escape from their abusers because of chronic suffering. As a result, they develop sophisticated coping strategies to minimize their physical and psychological suffering. Unfortunately, the more pessimistic they become, the less likely they will be able to escape from the relationship; and even worse, the more likely it is they will develop a sense of guilt and self-blame leading to depression. Depression can pull abused women down, and normally, they will try to get rid of the painful feelings. However, as long as the cyclical pattern of abuse persists, abused women will feel increasingly discouraged and may eventually feel there is nothing that they can do.

There is no unique cause of depression in abused women. In fact, the causes may vary largely across different women. Public health approaches, instead of understanding the causes of depression in individuals, may understand what factors tend to affect some groups of individuals more than others. Risk group identification is essential for addressing public health problems because actions can be taken to alleviate IPV and ameliorate its adverse impact on women's mental health. Risk factors associated with depression in abused women are discussed in the next section and are listed in Table 1.

7. Risk factors associated with depression in abused women

- a. **Young age.** Studies have demonstrated that younger abused women are more likely to report depression (Hazen, Connelly, Soriano, & Landsverk, 2008; Wrangle, Fisher, & Paranjape, 2008). This is consistent with other epidemiology studies conducted in women with no history of abuse (Scarinci et al., 2002). However, in most of the studies conducted on abused women, the mean age of participants was between 30 and 50 years. In some other studies that investigated the relationship between depression and age in participants covering full adulthood, a U-shaped relationship was found (Kasen, Cohen, Chen, & Castille, 2003; Mirowsky & Ross, 1992). In other words, levels of depression decreased with age among young and middle-aged adults but increased among older adults.
- b. **Low socioeconomic status.** Socioeconomic status is associated with depression. Economic deprivation due to low income or unemployment has been shown to be one of the most significant risk factors for depression in abused women (J. C. Campbell, Kub, Belknap, & Templin, 1997; Deyessa et al., 2009; Hazen, et al., 2008; Mburia-Mwalili, Clements-Nolle, Lee, Shadley, & Yang, 2010) because it limits abused women's access to community resources and medical care, thus making them much more vulnerable and economically dependent on their abusers. Economic dependency amongst women of low socio-economic status reduces their ability to leave their abusers, which may cause feelings of hopelessness resulting in the development of depression.

Education attainment is another socioeconomic factor associated with depression. Numerous studies have reported that lower education is a risk factor for depression in abused women (Carlson, McNutt, Choi, & Rose, 2002; Mburia-Mwalili, et al., 2010; Newcomb & Carmona, 2004; Wong, Tiwari, Fong, Humphreys, & Bullock, 2011; Wrangle, et al., 2008). Women with lower educational attainment may have fewer chances of employment or acquiring sufficient resources to free themselves from economic deprivation and/or abusive relationships. It also appears that poorly educated women may have less knowledge about IPV and have less information about ways to protect themselves from it. These result in abused women perceiving that they are unable to control abusive situations and may result in depression.

- c. **History of child abuse.** A number of studies have found that child abuse underpins adult depression in abused women (J. C. Campbell, et al., 1997; Koopman et al., 2007; Rohde, et al., 2008; Shan A, 1995; Widom, DuMont, & Czaja, 2007). In particular, severe forms of child sexual abuse with penetration or attempted penetration is strongly associated with adult depression (Cheasty, Clare, & Collins, 1998). Child abuse and neglect acts are traumatic past experiences that may make abused women much more

sensitized to the stress response from current abuse and lead them down the path of depression. In addition, fear, increased arousal and low self-esteem developed over the years since the trauma may also contribute to depression in adulthood. At the same time, the child abuse experience may be linked to PTSD which follows the women into adulthood (Pederson et al., 2004), leading again to depression. Recently, there has been emerging evidence of an interaction in the genome of abused child that relates to adult depression (Bradley et al., 2008; Nikulina, Widom, & Brzustowicz, 2011). This new finding improves our understanding of why some children with a history of abuse develop depression in adulthood while others do not.

- d. **Abuse experience.** Although there is a strong link between depression and IPV, evidence on the relative influence of the different types of IPV as risk factors for depression has been inconclusive. Some studies suggest that physical or sexual abuse is a stronger predictor of depression (Ali, Israr, Ali, & Janjua, 2009; J. C. Campbell, et al., 1997), while others suggest that psychological abuse is a stronger predictor of depression in abused women (Follingstad, 2007; Pico-Alfonso et al., 2006; Wong, et al., 2011). Hazen and her colleagues (2008) also examined the impact of different types of psychological abuse on the mental health of abused women. They found that dominance-isolation was significantly associated with depression in abused women but emotional-verbal abuse was not.

Nevertheless, caution should be taken when examining the findings of these studies in terms of their methods of assessing the frequency and severity of IPV. In our previous study (Wong, et al., 2011), we found that different types of abuse made no significant difference to depression in abused women. However, once the frequency of abuse was considered, the findings revealed that psychological abuse was significantly associated with depression but not physical or sexual abuse. A consistent finding of other studies has been that the longer abuse endures in an abusive relationship the more it is significantly associated with depression (Lindhorst & Beadnell, 2011; Rodriguez et al., 2008).

- e. **Little or no social support.** There is much evidence that abused women are particularly vulnerable to depression if they lack social support (J. C. Campbell, et al., 1997; Mburia-Mwalili, et al., 2010; Rodriguez, et al., 2008; Wong, et al., 2011). Social support includes various forms of support including tangible resources, a support network and perceived support, which are extremely important as they act as buffers, especially after a person has experienced a stressful life event (Cohen & Hoberman, 1983). In some cases, perceived support is much more important than tangible support for abused women. When a woman suffers an abusive experience, she may consider that the threat and fear begin with her perceived ability to cope with the abuse; therefore, perceived availability of support will have an important buffering effect for women coping with abuse. Hence, social support always serves as a protective factor against depression in abused women. Moreover, some abusers use social isolation to control and assault women, which makes it more difficult for abused women to reach out for help from others. Without social support, abused women will be psychologically entrapped in abusive relationships and thus prone to developing depression.
- f. **Coping styles.** Coping has a direct influence on psychological adaptation to stress in women who experience abuse. Thus, coping is also strongly associated with depression. There have been no conclusions reached in the current literature as to which coping

styles are most prominently associated with the development of depression in abused women. From a historical perspective, active coping styles are always adaptive and problem-focused while passive coping styles are always maladaptive and avoiding. A study conducted to investigate the relationship among IPV, depression and coping styles (Haden & Scarpa, 2008) found that an avoidant coping style is a risk factor for depression in abused women. However, an inconsistent result was found in a study conducted in Japan (Yoshihama, 2002) where passive coping styles were perceived as more effective and resulted in less psychological distress for abused Japanese women. Conversely, more active coping strategies adopted by Japanese abused women, resulted in less reduction in their psychological distress. Therefore, evidence shows that effective coping styles may be culture dependent. In other words, strategies adopted by abused women may be culturally consistent and may not necessarily lead to maladaptive coping.

<p>Risk Factors for depression in abused women:</p> <ul style="list-style-type: none">• Young age• Low socioeconomic status (low education, low income and unemployment)• History of child abuse• Abuse experience (type, frequency and severity)• Lack of social support• Coping styles

Table 1. Risk factors for depression in abused women.

8. Conclusion

No woman expects that she will be hurt by a loved one. Depression, being one of the most prevalent mental health problems, is strongly associated with IPV. Some abused women have been found to be more vulnerable to developing depression than others; therefore, it is important to understand the risk factors associated with depression in abused women. It is expected that these findings may encourage health professionals to identify groups of women at high risk of developing depression, and devise appropriate and effective measures or behavioural interventions to help abused women reduce their depression.

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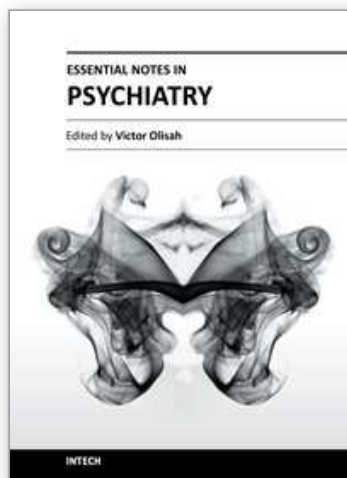
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Psychiatry is one of the major specialties of medicine, and is concerned with the study and treatment of mental disorders. In recent times the field is growing with the discovery of effective therapies and interventions that alleviate suffering in people with mental disorders. This book of psychiatry is concise and clearly written so that it is usable for doctors in training, students and clinicians dealing with psychiatric illness in everyday practice. The book is a primer for those beginning to learn about emotional disorders and psychosocial consequences of severe physical and psychological trauma; and violence. Emphasis is placed on effective therapies and interventions for selected conditions such as dementia and suicide among others and the consequences of stress in the workplace. The book also highlights important causes of mental disorders in children.

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