
Detecting Intimate Partner Violence and Postpartum Depression

Neglected Issues in Pregnancy and Women's Health

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Abstract

Postpartum depression (PPD) is a pressing public health concern because of the negative effects on women's psychological well-being and infant-mother attachment, yet few health providers screen for the condition or have protocols in place for its management. Intimate partner violence (IPV) during pregnancy is strongly associated with PPD, as well as other health conditions, yet it also is generally undetected in perinatal care visits. Early screenings for IPV during pregnancy and PPD after delivery by healthcare providers are important strategies for ensuring these health issues are detected and awareness is raised about their importance to the health of women and children. Action is needed to ensure the inclusion of training for IPV and PPD screenings during health professional training and professional association involvement, as well as the support of healthcare policies directed at prioritizing IPV and PPD screenings throughout the perinatal period.

Introduction

During pregnancy and up to one year postpartum, many women experience brief emotional lability as they adjust to new roles and routines. The persistence and severity of these distressing feelings raise concern and characterize a host of perinatal mood disorders, with symptoms spanning sadness, confusion, frustration, obsessions and panic (Postpartum Support International [PSI], 2006). Experts from the World Health Organization (WHO) and the United Nations Population Fund (UNFPA) acknowledge perinatal mood disorders as under-identified and under-treated mental health conditions, especially in low and middle income countries (WHO, 2008). Postpartum depression (PPD), in particular, is one of the most common and severe complications of childbirth worldwide, with an estimated 13% of women giving birth experiencing the disorder (WHO, 2009; O'Hara & Swain, 1996). The depressive episode generally arises within four weeks after delivery, induces feelings of worthlessness, agitation, anxiety or despondency, and often results in the

disruption of a woman's ability to bond with or care for her baby (WHO, 2009).

Intimate partner violence (IPV) is the physical, sexual or emotional abuse or threats of abuse perpetrated by a current or former partner (Centers for Disease Control [CDC], 2011). PPD is associated with a number of risk factors, including IPV, during pregnancy. Like PPD, IPV during pregnancy affects women throughout the world. The WHO estimates the incidence of women physically abused during at least one pregnancy exceeded 5% in 11 of 15 settings studied (WHO, 2005).

Early identification of IPV during pregnancy and of depression after delivery is a gateway to detecting, preventing and ameliorating negative health conditions (Antoniou, Vivilaki, and Daglas, 2008), but both IPV during pregnancy and PPD remain issues marked by stigma, silence and dismissal. To leverage perinatal healthcare's preventive power, policy makers, healthcare providers and patients should resist treating women in a vacuum and recognize the dynamic interactions between physical and mental health.

Intimate Partner Violence during Pregnancy and Postpartum Depression: An Opportunity to Intervene

Given assertions that a strong, trusting partner relationship may be vital for a woman's psychological health during the perinatal period (Mezey, Bacchus, Bewley, & White, 2005; Dennis & Ross, 2006), it makes sense that IPV during pregnancy may have a strong detrimental effect on women's mental health (Antoniou et al., 2008). Until recently, IPV had not specifically been assessed in investigations as a risk factor for the development of PPD (WHO, 2009). However, recent studies indicate that IPV during pregnancy may be a top predictor of PPD (Valentine, Rodriguez, Lapeyrouse, & Zhang, 2011; Bacchus, 2004; Antoniou et al., 2008; Ludermir, Lewis, Valongueiro, Barreto, and Araya, 2010), among other psychosocial variables such as prenatal depression, social support, childcare stress and socioeconomic status that contribute to high rates of mental health problems after giving birth (Beck,

2001). In a report on maternal mental health published in 2009, the WHO stated that the assessment of risk factors for PPD, including current exposure to IPV, should be routine in perinatal health care (WHO, 2009).

Many health care providers are aware of the corollary risk factors of PPD. Lloyd & Hawe (2003) conducted interviews with health professionals familiar with PPD to evaluate how possible solutions are viewed. One health professional viewed the screening of risk factors for PPD as a preventive approach: “[I]f you’re going to have a depressive illness the chances are that you’ve got other things happening in your life which make you vulnerable. So we should be able to pick out the people who are going to have the illness, if we’re very careful” (Lloyd & Hawe, 2003, p. 1786). However, evidence suggests screening for PPD is rare in health systems throughout the world (Gjerdingen & Yawn, 2007). In addition, although the prevalence of IPV during pregnancy may be higher than the prevalence of commonly screened conditions such as gestational diabetes and preeclampsia (Gazmararian et al., 2000), rates of screening for IPV remain low (Waalén, Goodwin, Spitz, Petersen, & Saltzman, 2000). Both IPV during pregnancy and PPD are associated with a host of other health issues, including increased substance abuse, preterm delivery, low birth weight infants and maternal suicide (Campbell, 1998; Shadigian & Bauer, 2005; Sharps, Laughon, & Giangrande, 2007). Unfortunately, screenings for IPV during pregnancy and for depression after delivery are infrequent, jeopardizing the physical and mental health of the woman and child decades into the future (O’Reilly, Beale, & Gillies, 2010).

Building a Case for the Association between IPV and PPD

Burgeoning evidence supports the case for the association between IPV during pregnancy and an increased risk for PPD (Bacchus, 2004; Ludermir et al., 2010; Tiwari et al., 2008; Gomez-Beloz, Williams, Sanchez, & Lam, 2009; Valentine et al., 2011). Although the relationship between IPV during pregnancy and PPD is not yet proven to be causal, studies conducted in various countries, including Brazil, Peru, Hong Kong and the United States, support the association (Ludermir et al., 2010; Tiwari et al., 2008; Gomez-Beloz et al., 2009; Valentine et al., 2011).

Ludermir et al. (2010) found that over half of women in a Brazilian study who experienced physical or sexual violence plus psychological violence from an intimate partner during pregnancy experienced elevated rates of PPD. Similar results were found in a study conducted in Hong Kong, in which exposure to psychological violence during pregnancy was associated with a greater risk of PPD (Tiwari et al., 2008). A sample of Peruvian women who recently gave birth and were exposed to IPV during pregnancy had higher levels of severity of depression than women not exposed to violence during pregnancy. Women experiencing IPV during pregnancy were 1.4 times more likely to experience mild depression (95% confidence interval (CI) 1.9-2.3), 2.9 times more likely to experience moderate depression (CI 1.8-4.5), 5.5 times more likely to experience moderately severe depression (CI 3.4-9.2) and 9.9 times more likely to experience severe depression (CI 5.1-19.9) (Gomez-Beloz et al., 2009). Among a sample of Latina women in the United States, exposure to IPV in the 12 months

prior to delivery was shown to be a stronger prenatal predictor than prenatal depression of PPD, and prenatal depression has been implicated as a strong prenatal predictor of PPD (Beck, 2001; O’Hara & Swain, 1996). Thus, results suggesting that the likelihood of developing PPD is greater with recent exposure to IPV than with a history of prenatal depression among a sample of Latina women are especially significant (Valentine et al., 2011).

Working Toward Prevention of Postpartum Depression

Prevention efforts are aimed at assessing women for risk factors and intervening early to reduce the threat of PPD and other negative health outcomes (Miller & LaRusso, 2011). The American Congress of Obstetricians and Gynecologists (ACOG) recommends screening for IPV as part of routine care, and ACOG’s Committee on Health Care for Underserved Women issued a statement in 2006 endorsing screening of IPV as part of comprehensive prenatal care because of the high prevalence and adverse health outcomes of violence (ACOG, 2006). The ACOG also suggests the use of validated screening tools for PPD in perinatal health care visits, and the American Academy of Pediatrics (AAP) recommends universal screening of PPD after delivery.

Screenings in perinatal care visits for IPV during pregnancy and PPD can be simple, convenient, rapid, effective and performed by primary care providers. Several instruments exist to assess risk. For example, the Abuse Assessment Screen (AAS) is a brief validated screening instrument for use among diverse populations that assesses exposure to lifetime abuse, recent abuse, abuse during pregnancy and fear of partner. The Edinburgh Perinatal Depression Scale (EPDS) can be self-administered, is available without a fee, takes less than 10 minutes, is validated for use in many countries and is a reliable means to detect clinically significant depressive symptoms while avoiding the detection of somatic complaints that are routine in the normal postpartum period (Seehusen, Baldwin, Runkle, & Clark, 2005).

Neither screening for IPV during pregnancy nor screening for PPD is a panacea. They are, however, starting points, especially for women whose profiles indicate a need for increased support. Highlighting the importance of engaging in PPD screenings, one health professional said, “One of the things that we’ve found out by taking the [PPD] screening approach was that there [are] higher levels of domestic violence than expected” (Lloyd & Hawe, 2003, p. 1788). Thus, screening women for PPD could be the “prelude to the provision of strategies” (O’Reilly et al., 2010, p. 200) to prevent and protect women from additional mental health difficulties, violence or other harmful situations.

The Role and Reservations of Screenings

Evidence suggests that providers are not routinely screening for PPD or IPV. Although studies indicate that over 80% of women surveyed are comfortable with the idea of being screened for PPD and 96% of another sample of women are comfortable with being screened for IPV, rates of screenings remain paradoxically low (Buist et al., 2006; Genmill, Leigh, Ericksen, & Milgrom, 2006; Eiseman et al., 2009). In a meta-analysis of the literature based on research conducted in high income countries, Gjerdingen & Yawn (2007) reported that the

rate of current screening for PPD in primary care practices varies but in general is low. One U.S.-based study of 508 pediatricians indicates that only 4% used formal diagnostic criteria to detect depression based on their last recalled case of maternal depression or PPD and none used a validated screening questionnaire (Olson, 2002). In another study among a sample of 298 family physicians in the northwest United States, only 18% reported using a screening instrument specifically designed to detect PPD, such as the EPDS, in postpartum gynecologic or well-child visits (Seehusen, et al., 2005). Likewise, results from several studies showed only 22-39% of pregnant women were screened for violence in prenatal care visits (Anderson et al., 2002; Johnson et al., 2003). Among a sample of pregnant Latina women recruited from two perinatal clinics in Los Angeles, California, 68% had not been screened for IPV (Rodriguez, Shoultz, & Richardson, 2009) even though there is evidence suggesting that low-income minority populations are high risk groups (Tjaden & Thoennes, 2000). The use of formal screening instruments is crucial because reliance on observation or informal questions alone to assess symptoms has not been shown to effectively identify women with PPD or exposure to IPV (Klinkman, Schwenk, & Coyne, 1997; Gjerdingen & Yawn, 2007; O'Reilly et al., 2010).

Both IPV during pregnancy and PPD remain issues marked by stigma, silence and dismissal.

Among a nationwide sample of pediatricians in the US, the most significant barriers to screening for PPD were inadequate time to provide patient education, insufficient appointment time to collect patient history and incomplete training to diagnosis maternal depression or PPD (Olson et al., 2002). Likewise, providers cited the lack of time, inexperience and the uncertainty of what to do once a woman had disclosed violence, as reasons for inattention to IPV screening (Bacchus, Mezey, & Bewley, 2002; O'Reilly et al., 2010).

These concerns are not unfounded. Screenings without appropriate follow-up and referral have little effect (Moracco & Cole, 2009; Gjerdingen & Yawn, 2007). Studies suggest that a sense of apathy among providers about PPD and IPV is not the problem, but rather that providers harbor concerns that the screening and referral process is cumbersome and requires too much effort (Seehusen, Baldwin, Runkle, & Clark, 2005; Borowsky & Ireland, 2002). Having an office protocol that promotes and prioritizes screenings and establishing a referral system has been shown to increase the chances that a given provider will screen for IPV (Holtrop et al., 2004; Waalen et al., 2000). Results are similar for PPD (Gjerdingen & Yawn, 2007; Pignone et al., 2002). One pilot program enhanced provider abilities to effectively utilize the EPDS and link women to services for PPD in a timely manner; 98% of women reported being satisfied with the program assistance (Baker-Ericzen, Mueggenborg, Hartigan, Howard, and Wilke, 2008). In order to increase screenings for IPV during pregnancy and depression in the postpartum, office protocols that facilitate

screenings and support a coordinated system of referrals to appropriate service providers are recommended (Eiseman et al., 2009; Waalen et al., 2000). Clinics that include screenings plus enhanced follow-up care show more positive patient outcomes (Gjerdingen & Yawn, 2007; Pignone et al., 2002; Baker-Ericzen et al., 2008).

Admittedly, formal agencies with appropriate service providers for women exposed to IPV or experiencing mental health problems are limited in low- and middle-income countries. Even in sites where services are available, cost, shame, self-blame, fear, dismissal, stigmatizing attitudes on the part of service providers and other barriers may prevent women from accessing follow-up care (WHO, 2005). The WHO recommends a comprehensive approach to service provision by training healthcare providers in non-stigmatizing responses and coordinating cooperation between the healthcare setting and other service sectors (WHO, 2005). In resource-poor settings, the WHO recommends strengthening women's ability to access informal sources of support, such as religious leaders, relatives, neighbors and friends. Findings from Coker et al. (2002) indicate that the risk of negative mental health outcomes declines significantly among abused women who report receiving social support. These informal sources may be a starting point for interventions seeking to reduce stigma and offer substantive support to women (WHO, 2005). The goal of the community mental health model, relevant in low- and middle-income countries, is to mobilize community resources so individuals can seek and receive help within the community and among its members (Mehryar & Khajavi, 1975). Utilizing community health workers, otherwise known as *promotores* or paraprofessional caregivers, is a cost-effective means to engage community members in awareness-raising activities, link women to services and strengthen social networks (Mehryar & Khajavi, 1975).

Perspectives on Steps Forward

Addressing the intersections between physical and mental health in the perinatal period requires a multisectoral approach in countries around the world. Because IPV during pregnancy and PPD are so highly correlated, screenings for IPV during pregnancy can and should occur in conjunction with screenings for depression after delivery. A system of referrals to appropriate service providers, if problems are detected, can be integrated into office protocol (Logsdon, Wisner, Billings, & Shanahan, 2006). Health professional education programs and professional credentialing bodies play key roles in ensuring that PPD and IPV screening are included in training curriculum (Sharps et al., 2007; Seehusen, et al., 2005; Logsdon et al., 2006). Professional associations can focus on calls for health care institutions to develop policies that promote screening and sanctions against those providers who fail to do so (Sharps et al., 2007; Seehusen, et al., 2005; Logsdon et al., 2004), particularly in low- and middle-income countries where perinatal mood disorders are under-diagnosed and IPV during pregnancy is especially prevalent (WHO, 2008; WHO, 2005).

As Antoniou et al. states, "A good clinical practice, confirmed by international data, is to ask pregnant women the necessary questions regarding abuse and postnatal depression, during pregnancy and also after birth. In this way, the documented and effective care for the women in need is secured,

prior to and after birth” (2008). As the case is built for the association between IPV during pregnancy and PPD, it is important and timely to develop strategies at various levels in the health system to address these issues. Early screenings for IPV during pregnancy and PPD after delivery by healthcare providers are strategies to detect and address these issues. To accomplish systematized screenings for IPV and PPD in perinatal healthcare settings, training for screenings needs to be included in health professional educational curricula. Professional associations need to advocate for healthcare policies directed at prioritizing IPV and PPD screenings throughout the perinatal period. Ancillary efforts to support women who are identified as experiencing IPV or at-risk for PPD include development of a coordinated and comprehensive system of referrals and helping women to activate informal support systems. These activities are not only feasible but also lay the groundwork for integrating physical and mental health more effectively in perinatal care.

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