

# Depression in Battered Women

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**Sex differences in rates of depression and of battering by intimate partners are substantial: 3:1 and 10:1, respectively. The relationship between battering and depression has been documented for more than two decades, but has rarely been noted in the depression literature. This paper presents a brief summary of the major etiological theories of depression with a discussion of the evidence that links these theories with research on battered women. It seems clear that battering can be an important component of depression in battered women. Understanding the mechanisms involved in the relationship between depression and battering can result in a better approach to the diagnosis and treatment of depression in battered women. This discussion has particular ramifications for the primary health care system as well as the mental health care system.**

Recent epidemiological studies show that depression is not only a common disorder, but also one that is increasing with each birth cohort.<sup>1,3</sup> This is evident from studies of nationally representative samples, community epidemiological studies, and research in specific settings such as primary care. Higher rates of depression in women—three depressed women for every depressed man—have been consistently found and never totally explained.<sup>4,7</sup>

For close to two decades, the relationship between battering and depression has also been documented. Battering is defined in this paper as repeated physical and/or sexual assault by a partner or

ex-partner within a context of coercive control.<sup>8</sup> At least 1.8 million women are battered in the United States each year, and almost all experts estimate the actual figure at closer to 3 to 4 million.<sup>9,10</sup> Saunders and colleagues recently demonstrated that in a sample of 394 adult women seeking care at a family practice medical center, depression was the strongest indicator of adult relationship abuse.<sup>11</sup> Gleason found a significantly higher prevalence of major depression in 62 battered women than in an age and sex matched sample drawn from the National Institutes of Mental Health (NIMH) Epidemiological Catchment Area study.<sup>12</sup> In controlled studies from a variety of settings, battered women are consistently found to be depressed on a variety of instruments.<sup>10,13,14</sup>

Although the strong association between battering and depression has been reported in the battering literature, it has rarely been noted in the depression literature. This paper will present a brief summary of the major etiological theories of depression with a discussion of how these theories apply to battered women. Discussion of the diagnostic and treatment issues related to battered women and their ramifications for the primary care and mental health care systems will also be addressed.

## **Prevalence of Depression**

Caution must be employed in any discussion of the prevalence of depression because of the methodologic problems inherent in interpreting, analyzing, and comparing research findings. One major source of discrepancy is that of case definition.<sup>5,15</sup> In the past, the term depression has been applied to moods, symptoms, and syndromes. Current clinical approaches emphasize the two distinct entities of major depressive disorder and dysthymic disorder. Major depressive disorder is defined by a constellation of symptoms in a two-week period and includes the presence of depressed mood and negative physical symptoms such as psychomotor retardation, sleep distur-

bance, and appetite changes. Cognitive impairments in the form of slowed thought processes may also be present. Depressive episodes may be single or recur over time. In contrast, a dysthymic disorder is characterized by a depressed mood that is more persistent—lasting more than two years—and less episodic and with fewer other symptoms of major depressive disorder. Finally, “depressive symptoms” refers to transient emotional states of sadness or depressed mood that do not interfere with functioning; they are less severe and not considered a clinical entity.

Unless otherwise stipulated, when this paper refers to depression, major depressive disorder as defined by the *Diagnostic and Statistical Manual IV* is meant. All of the research involving battered women has used self-report depression instruments rather than the more precise diagnostic interview.

After an extensive literature search, the US Department of Health and Human Services Clinical Practice Depression Guidelines Panel (AHCPR) concluded that the point prevalence for major depressive disorders is 2.3% to 3.2% for men and 9.3% for women, with a lifetime risk of 7% to 12% for men and 20% to 25% for women.<sup>7</sup> Using the more stringent Diagnostic Interview Schedule (DIS), the NIMH Eastern Catchment Area female sample documented a lifetime prevalence of 10.6%. Prevalence rates for depression as noted on charts in primary care sites vary from 1.5% to 4.5%, perhaps reflecting a tendency of nonpsychiatric physicians to underdiagnose the problem. With structured interviews, however, a point prevalence ranging from 4.8% to 8.6% has been found in different studies in primary care sites, closer to the point prevalence found by the AHCPR panel report.<sup>7</sup>

Self-report questionnaires have also been used for screening in primary care settings. A recent study using the Zung Depression Scale found an overall prevalence of clinically significant symptoms of 20.9%.<sup>16</sup> The significant risk factors

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for depression in that study were perceptions of poor health, gender, older age, and lower levels of education. Domestic violence was not assessed.

Significant progress in understanding depression has been made in the past 20 years, but we still cannot state the cause with certainty.<sup>17</sup> The two major theories of depression are the biological/genetic and the psychological/psychodynamic models.<sup>18,19</sup> The relationship between stress and biology is emerging as a promising area of investigation, recognizing that the etiology of depression is complex and multifactorial.<sup>18,19</sup> An examination of these two major theories in relationship to battering may lend some understanding of the relationship of depressive symptoms to battering.

### **Biological Theories of Depression**

While a single genetic marker for depression has not been identified, there is evidence that biological changes are present in the depressed individual. Indeed, the cluster of symptoms that characterize depression includes significant physiological changes: anorexia, constipation, insomnia, fatigue, and impairment in concentration among others. Depressed individuals may complain of chronic pain, gastrointestinal upset, dizziness or other vague body aches resulting in significant impairment in functioning and physical health status.

Support for a genetic or familial component in depression has emerged over the past 30 years through studies of genetics, twin cohorts, and neurotransmitters. Three different approaches have been used in studying neurotransmitters: 1) a deficiency model, 2) an imbalance model, and 3) the systems dysregulation model.<sup>20</sup> Early theories ascribed the cause of depression to a deficiency of a neurotransmitter such as norepinephrine (NE), while more recent theories have recognized the complexity and interaction of many systems.<sup>21</sup> The imbalance theory (of NE and acetylcholine) emerged from observations of drug effects on levels of NE. Most recently, the dysregulation theory (both neurochemical and neuroendocrine) has gained additional attention as has the role of cortisol as a stress-response hormone.

Earlier attempts to classify biologically based depression as "endogenous" in contrast to stress-based depression as

"exogenous" are viewed by many as overly simplistic. It is more likely, as Barlow and Durand suggest, that an integrative model accounting for these and other factors is more accurate.<sup>22</sup> While the primary trigger of a depressive episode may be an external stressor, genetic/familial contributions must be recognized since rates of depression are higher among first-degree biological relatives than in the general population.<sup>7</sup> The role of other factors, such as socialization in the family, may also contribute to the degree of depression experienced by a genetically predisposed individual. Research using twin cohorts has shown that many individuals may have a genetic and/or physiological predisposition to major depression that results in depressive episodes when stressful life events occur.<sup>23</sup> Other individuals may have no such disposition but when faced with stressors, exhibit the symptoms and biological markers of depressive disorder. Kendler, for example, found important, direct effects of stressful life events on depression.<sup>18</sup> The relationship of genetic makeup to risk for being in a stressful situation is less clear however. Kendler and associates found modest support for indirect effects of genetics on the risk of experiencing stressful life events, suggesting that the extent to which women genetically predisposed to depression are at increased risk of experiencing high-risk environments, such as battering relationships, needs further research.<sup>23</sup> No studies of depression in battered women have specifically investigated the role of biology in either the origin or intensity of the depression.

### **Stress Theory**

Stress theory was originally used to explain depression based on the assumption that disturbances in mood are responses to stress. Depressed patients, for example, report almost three times as many life events during the previous six months before the onset of depression as those in control groups.<sup>20</sup> Battering is one such stressful event.

Evidence from both longitudinal and cross-sectional studies supports the role of battering as a stressor related to depression. No studies measuring depression before battering have been reported, but longitudinal studies such as Campbell's follow-up of 114 abused and not-abused women are useful.<sup>24</sup> The majority (91%)

of the 34 women in that study who had been but were no longer battered (measured by the Conflict Tactics Scale) had decreased depression and a significantly ( $p < .05$ ) lower mean score on the Beck Depression Inventory (BDI). The BDI was chosen because it has been shown to be relatively stable over time, capturing chronic or recurrent depression rather than transitory mood states.<sup>25</sup> Three women in the no longer abused group had a basically stable or slightly increasing growth curve on depression, suggesting chronic, recurrent depression. In contrast, those still abused (N=13) had no significant mean differences in depression between Time 1 and Time 2.<sup>24</sup>

Another study found women (N=146) to be significantly less depressed ten weeks after a shelter stay than they were immediately post-exit, and the improvement was maintained over the subsequent six months.<sup>26</sup> The prevalence of severe depression (considered equivalent to major depression) as measured by the CES-D decreased from 36% to 16% after the shelter stay. Women who were still being abused at ten weeks and six months post-shelter were significantly more depressed than those whose lives were violence free.

Similarly, Follingstad and associates found a return to pre-relationship levels of emotional stability after the abuse ended for 234 abused women, the majority of whom used some source of assistance in escaping the violence.<sup>27</sup> However, only one item on the retrospective questionnaire measured depressive symptoms. Gelles and Harrop found that a significantly greater proportion of severely battered than mildly or not-battered women endorsed five items reflecting depressive symptoms.<sup>28</sup> Cascardi and O'Leary also found that depression was significantly correlated with severity of violence, although not with frequency.<sup>29</sup>

These studies did not explore the role of biology in relationship to stress, but suggest the importance of abuse as a trigger for depression (at least for those with a genetic predisposition). Taken cumulatively, the results argue for environmental stress as a major contributor to depression in battered women, with abuse acting as both a stressor in itself and a contributor to other stressors. In another sample of battered women (N=164), Campbell and Kub found everyday stres-

sors as measured by the Daily Hassles Scale to be the strongest predictor of depression, stronger than childhood physical abuse, self-care agency, and relationship physical abuse, the other significant predictors of depression.<sup>30</sup> They also found daily hassles and physical abuse to be significantly correlated (.36).

The role of moderators such as social support in the relationship between stress and depression is less clear.<sup>31</sup> Some researchers assume that support constitutes a strain in itself and that it increases the risk of mental problems, while others claim that support modifies stress effects. Brown and Harris have proposed a "resource deficit" argument that low support generates a sense of failure and low self-esteem.<sup>32</sup>

In examining the role of stress and social support in explaining depression in battered women, one confounder is that abusive men often isolate their partners, thereby decreasing levels of subsequently measured social support. Few investigators have taken these issues of coercive control into account. The evidence we do have on these issues is mixed. In Sato and Helby's multivariate analysis of battered women, social support was not a significant predictor of depression.<sup>33</sup> In contrast, Campbell, Sullivan, and Davidson's hierarchical regression analysis found social support to be one of the two strongest predictors of depression at six months post-shelter stay (along with fear and anxiety), stronger than the other significant predictors, physical and psychological abuse and locus of control.<sup>26</sup> Mitchell and Hodson also found perceived social support to be negatively correlated with depression.<sup>34</sup>

### **Cognitive Theories of Depression**

Seligman suggested that depression is analogous to learned helplessness in animals.<sup>35</sup> For humans, learned helplessness is a response to inescapable events that teach an individual that he or she lacks control and is therefore discouraged from adaptive responses.<sup>19</sup> This theory was adapted to incorporate hopelessness, reflecting the victim's belief that negative events will persist or recur.<sup>36</sup> Also part of the theory is the premise that those who blame themselves for uncontrollable events are more likely to be chronically and severely depressed than those who blame external causes.

The concept of learned helplessness was first applied to battered women by Lenore Walker who postulated that the lack of control inherent in abusive relationships created the noncontingency situation basic to learned helplessness.<sup>37</sup> The deficits of learned helplessness include depression, low self-esteem, apathy, and difficulties in problem solving, attributes frequently noted in early descriptive studies of battered women.<sup>35,38</sup> Walker found support for a model that childhood learned helplessness predicts adult learned helplessness in battered women from a large community sample.<sup>37</sup> However, her predictions that women who had left abusive relationships would be less depressed were not supported. Other studies have also found ambiguous results. Campbell found some overall support for a model of learned helplessness in a predictive correlational comparison study of 97 battered and 96 non-battered women,<sup>39</sup> but specific relationships predicted by the model (control in the relationship and duration of abuse with depression) were not supported. The greatest amount of variance in depression was explained by self-esteem rather than more independent constructs. Also contrary to the learned helplessness formulation, self-blame was equally prevalent in the nonbattered and battered groups (20%) and was unrelated to depression. In the follow-up of that sample, the majority of the battered women were able to leave the abusive relationship or otherwise end the violence, reasserting control rather than becoming more helpless.<sup>24</sup> In two other studies, more help seeking rather than less was found over time, opposite from learned helplessness predictions.<sup>40,41</sup>

Wilson et al<sup>42</sup> found a significant relationship between level of abuse as measured by the Index of Spouse Abuse and a scale of learned helplessness in their sample of 159 women (39 non-help seeking). Thus, evidence has supported certain constructs of the learned helplessness model, but it has not been sustained in research with battered women overall.

Other cognitive theorists believe the critical variable in depression is a negative self-schema, the manner in which people think about themselves.<sup>19</sup> The tendency to see oneself as a "loser" is the fundamental cause of depression in this model.<sup>25,43</sup> Other research suggests split-

ting the negative schema into one centered on dependency and another on self-criticism.<sup>44</sup> For those with dependency self-schemas, stressful social events in which their dependency would be most keenly felt lead to depression, while failure tends to trigger depression for those with self-criticism schemas.<sup>19</sup> In a recent multivariate analysis of depression in 136 ethnically diverse Hawaiian battered women from shelters, negative self-schema was the strongest predictor of depressive symptoms, and abuse (measured by the Conflict Tactics Scale) was not significantly related to depression.

### **Psychodynamic Perspectives**

The psychodynamic perspective argues that depression is not a symptom of organic dysfunction, but a defense by the ego against intrapsychic conflict.<sup>19</sup> The core assumptions of this theory include: 1) depression is rooted in some early defect, such as the loss of a parent; 2) a wound is reactivated by an event such as divorce or loss of a job; 3) major consequences of this are helplessness and hopelessness; 4) an ambivalence toward love objects is fundamental to the emotional issues at hand; 5) loss of self-esteem is an important feature of depression.<sup>19</sup>

*Grief.* One of the psychodynamic perspectives is grief theory of depression. Silverman postulated that abused women experience a grief reaction from the loss of the ideal relationship and the threat of loss of marriage, security, home, and children.<sup>45</sup> The higher levels of depression in Walker's sample of women no longer in abusive relationships could be explained by a grief model. Loss-related variables also explained a significant portion (46%) of variance in depression in the Campbell study;<sup>37,38</sup> she found no significant differences in mean levels of depression between battered women and others with serious problems in intimate relationships. Battered women, however, were significantly more likely to be seriously depressed than nonbattered women.

*Prior Trauma.* Childhood trauma as a cause of depression is thought to be related to insecure attachment and loss of self-esteem. Analysis of childhood physical abuse in relationship to depression has been limited. More interest has been shown in whether or not childhood experience of family violence is related to adult relationship violence for women,

for which the evidence is mixed.<sup>46</sup> Evidence that both childhood sexual abuse and childhood witnessing of father abusing mother are related to adult battering victimization is also mixed. There is ample evidence that childhood sexual assault survivors have a higher risk for depression as adults than woman not so victimized.<sup>47</sup> Many researchers in the sexual assault field now see this depression as part of or secondary to post-traumatic stress disorder (PTSD), although depressed mood is not the hallmark sign of PTSD according to the DSMIV.<sup>48</sup>

Herman has addressed this by calling for a diagnostic category of complex PTSD that would describe a response to chronic trauma, including persistent dysphoria, as one of the major alterations.<sup>49</sup> As Herman notes, this approach may be better for diagnosing depression in battered women, where the PTSD is different from that caused by a more time-circumscribed trauma. The only researcher who has measured both PTSD and depression in battered women found a higher prevalence for major depression using the DIS (63%) than for PTSD (40%), but did not report comorbidity.<sup>12</sup>

**Through Sense of Self.** One of the more recent areas of inquiry related to depression from a psychodynamic perspective is the "self-in-relation" theory formulated by the Stone Center researchers at Wellesley College and inspired by Carol Gilligan's formulations.<sup>50,51</sup> Surrey postulated that women's sense of self and identity is developed through relationships rather than through separation and individuation.<sup>52</sup> Because of this, abused women may feel they have to maintain the relationship in order to maintain their sense of self.<sup>53</sup> This formulation has been supported by several qualitative studies that have reported a strong theme of a loss of sense of self in abusive relationships.<sup>54,55</sup> Follingstad et al found stronger correlations between depression and psychological than physical abuse, supporting a link between sense of self and depression in abusive relationships.

Using qualitative interviews, Jack and Dill also observed that depressed women described "a loss of self" whether they were abused or not.<sup>56</sup>

## Conclusions

This review of research on the etiology of depression in battered women has not

reached any definitive conclusions about causative factors, partly due to the failure of battering research to specifically include biophysiological models of depression and of general depression research to measure abuse. We do know that depression eased as battering ceased in three different studies, and that severity and frequency of abuse were significantly correlated with depression in the majority of investigations. While depressions may result from a complex interaction of biological and other factors, battering appears to be a significant risk factor. Abuse acts as a significant stressor and contributes to related stressors and fits with cognitive and psychodynamic models of depression, such as self-blame, grief, and loss of sense of self.

The most promising route of inquiry is thus an integrative model of depression in battered women incorporating genetics, the stress of battering, and these other factors. There may be complex interrelationships between abuse and resultant biophysiological changes, similar to the physiological effects that have been found in those with PTSD. These issues need to be investigated further, specifically in relationship to abused women. Women with PTSD from prior trauma, for instance childhood sexual assault, may be particularly vulnerable to depression in an abusive relationship.

**Diagnostic Issues.** The AHCPHPR guidelines regarding depression in primary care emphasize the recognition of risk factors and the need to make differential diagnoses rather than focusing on in-depth assessment of etiologic factors.<sup>7</sup> For battered women, depressed affect is most likely to be recognized first in primary health care settings and should be evaluated as a potential sign of abuse as well as of the need to diagnose and treat depression.<sup>10</sup> All women should be assessed for both, since both are prevalent. Care providers need to assess depressed women for psychological as well as physical abuse from intimate partners. It is equally important that abused women receive careful assessments of general mental health status. Closer working relationships between the shelter and mental health care systems will help to ensure that women are provided appropriate assessment.

Several other diagnostic issues warrant consideration. Symptoms of PTSD need

to be carefully assessed. Another possibly confounded diagnosis is postpartum depression. Between 8% and 16% of pregnant women are battered, yet the relationship between postpartum depression and abuse has never been explored.<sup>8</sup> Again, there may be complex etiological interactions between postpartum hormonal changes and battering, but the possibility of abuse during pregnancy needs to be assessed as part of the diagnostic process.

As important as it is for abused women to get appropriate care for depression, such a diagnosis may pose problems for women in future custody decisions and/or in maintaining health insurance. These issues need to be discussed with women, and confidentiality of records is critical, especially in primary care settings.

**Treatment Issues.** Better referral mechanisms are needed between domestic violence programs and mental health providers to ensure that battered women who are depressed receive appropriate treatment. In addition, treatment plans for depressed battered women in primary care and mental health settings need to include strategies for ending the violence. Simply advising the woman to end the abusive relationship is not sufficient to address the issue. As described in many other publications, strategizing with the woman, safety planning, referral to local domestic violence resources, and advocacy is often a long-term process.<sup>8</sup> Providers also need to remember that many women continue to be harassed and/or battered after they have left abusive partners, a possibility that needs to be continually assessed and addressed.

The treatment for depression recommended most highly in the AHCPHPR guidelines is medication.<sup>7</sup> Although pharmacological treatment should not be the only intervention for depressed battered women, it can be very important in empowering them to take action to address the violence. Depression-related immobilization, impaired concentration, sleeping problems, apathy, and feelings of worthlessness all interfere with the battered woman's ability to seek the help she needs with abuse, follow through on obtaining protection from the criminal justice system, and understand she is not to blame for the battering. Medication can be useful for all of these symptoms, but the best protocol of depression med-

ication use with abused women has never been explored. Although group or individual therapy directed toward changing negative cognitions and correcting the damage to self-esteem in battered women has not been investigated, but it has been useful with depression in rape victims.<sup>48</sup>

While the exact nature of the relationship of biological, psychological, and social contributions to depression remains unknown, it is reasonable to assume that the severity of battering contributes to the intensity of the depression experienced in abused women. The biological model has greatly improved our understanding of major depression in general and when combined with the concept of stress, is extremely helpful for comprehending the interplay of environment and physiology in the etiology of depression.

All of the etiologic models reviewed provide possible explanations for the strong association between depression and battering. None, however, are definitive. More research is needed to examine: 1) the temporal relationship between depression and battering, 2) the role of biological/genetic factors in predisposing women to either the stressful event of battering or to depression and battering, and 3) a careful study of the interrelationships of biology and psychological/psychodynamic models with a particular emphasis on the role of battering as a stressor. From a practical perspective, what is even more important is the need for assessments of battering as well as of depression in primary care and mental health sites and depression assessments in domestic violence programs. Once identified, women who are depressed and battered need to have a plan of care that addresses both problems. ■

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