



High-frequency intimate partner violence during pregnancy, postnatal depression and suicidal tendencies in Harare, Zimbabwe



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ABSTRACT

Introduction: Intimate partner violence (IPV) is a common form of violence experienced by pregnant women and is believed to have adverse mental health effects postnatally. This study investigated the association of postnatal depression (PND) and suicidal ideation with emotional, physical and sexual IPV experienced by women during pregnancy.

Methods: Data were collected from 842 women interviewed postnatally in six postnatal clinics in Harare, Zimbabwe. We used the World Health Organization versions of IPV and Centre for Epidemiological Studies – Depression Scale measures to assess IPV and PND respectively. We derived a violence severity variable and combined forms of IPV variables from IPV questions. Logistic regression was used to analyse data whilst controlling for past mental health and IPV experiences.

Results: One in five women [21.4% (95% CI 18.6–24.2)] met the diagnostic criteria for PND symptomatology whilst 21.6% (95% CI 18.8–24.4) reported postpartum suicide thoughts and 4% (95% CI 2.7–5.4) reported suicide attempts. Two thirds (65.4%) reported any form of IPV. Although individual forms of severe IPV were associated with PND, stronger associations were found between PND and severe emotional IPV or severe combined forms of IPV. Suicidal ideation was associated with emotional IPV. Other forms of IPV, except when combined with emotional IPV, were not individually associated with suicidal ideation.

Conclusion: Emotional IPV during pregnancy negatively affects women's mental health in the postnatal period. Clinicians and researchers should include it in their conceptualisation of violence and health. Further research must look at possible indirect relationships between sexual and physical IPV on mental health.

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1. Introduction

Intimate partner violence (IPV) is a common form of violence amongst pregnant women and is a risk factor for postpartum mental health problems [1,2]. A global review of the prevalence of IPV found that African countries reported amongst the highest levels [3]. In a systematic review of IPV during pregnancy in Africa [4], as many as one in two pregnant women reported such violence. Studies have highlighted postnatal depression (PND) as a common maternal health problem globally and have shown that it is exacerbated in resource-limited settings such as many African countries [5,6] including Zimbabwe [7–9]. PND affects between 8% and 20% of women and impacts negatively on mother child bonding and care giving [10].

Biological explanations for PND include the rapid hormonal withdrawal within 4 weeks postpartum leading to vulnerability of women and activation of a biological system underlying mother–child attachment behaviour regulated by hormones [11]. It is crucial to understand the association of IPV during pregnancy and PND, including the serious dimensions of suicidal ideation, to develop prevention interventions. Prevention and early identification is important to plan treatment and further prevention [12].

There is increasing attention on the association between IPV and PND but few studies [1,13,14] focussed on IPV experienced during pregnancy, even though research shows that IPV during pregnancy is more likely to lead to PND compared to IPV outside of pregnancy [1]. Other current research limitations include recall bias when women are asked retrospectively about their pregnancies, whilst other studies did not adjust for confounding variables [10]. PND has been assessed at different times from a day after giving birth to as long as 2 years after giving birth with most studies using 6 weeks postpartum as the

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crucial time for measuring PND [10,15]. This study considers PND at 6 weeks postpartum.

In a systematic review of the associations between PND and violence in Africa, it was noted that data were only available from 8 countries with 58 PND prevalence estimates ranging between 3.2% and 48% with the majority lying between 10% and 19% and a weighted mean of 18% (95% CI 17.6–19.1%) [15]. The wide range (3.2–48%) reported is mostly due to the studies using various time periods after which PND was measured such as between 5 days and 18 months after delivery although prevalence is known to decrease after 6 months as reported in cohort studies [16,17]. In Zimbabwe, in particular, the prevalence of PND was reported at 16% in 1998 at 6–8 months postpartum using the Edinburgh PND scale [8]. Validation of PND measures in Zimbabwe has been done extensively with different tools such as the Edinburgh PND scale [18] offering adequate literature on PND with which to compare our results.

Suicide is a leading cause of perinatal maternal deaths in developed countries [19] but it has not been given adequate attention in developing countries. Suicidal ideation requires more attention in women in developing countries where it has traditionally been regarded as a male health problem [20]. The World Health Organization (WHO) Multi Country Study on women's health [3] reported that up to 12% women have attempted suicide and an even higher proportion have at one time thought about taking their lives [21]. Although measurement differences exist, a study that used the same WHO violence questions and the Centre for Epidemiological Studies – Depression Scale (CES-D) tool for measuring suicide found that 14% of women attempted suicide in their lifetime, and abused women were three times more likely to develop suicide thoughts [21]. These studies addressed the general population. Little evidence exists on suicide attempts and thoughts in the postpartum period and on IPV experienced during the time of pregnancy. Understanding the association between IPV and PND and suicidality is crucial as it affects not only the health of the mother but also that of the new born with both short and long health sequelae. A broader study on IPV during pregnancy provides an opportunity to explore PND and suicide. Women were interviewed at their sixth week after birth, minimising recall bias. This study also measured past IPV and past suicidal ideation and we were able to control for this in the analysis. The paper assesses the relationship between IPV during pregnancy and both PND and suicidal ideation.

2. Methods

2.1. Design and data collection

A cross-sectional survey was conducted amongst 2042 postnatal women who attended postpartum clinics in Harare, Zimbabwe. The study was conducted in six public postnatal clinics in low-income urban areas between May and September 2011. The study recruited 1156 women at the 10-day postnatal clinic (56.6%) and 886 women at the 6-week postnatal clinic (43.4%). This paper is based on an analysis of data from 886 women recruited at the 6-week postnatal clinic to ensure adequate measurement of PND symptomatology. We felt that measuring PND at the 10th postnatal day would not yield reliable data on PND that is normally measured from 6 weeks postpartum [8] and up to 2 years. Women aged 15–49 years were consecutively recruited from the postnatal clinic queues. Trained female interviewers invited women and conducted face-to-face interviews in a private space in vernacular.

IPV during the recent pregnancy was measured using an adapted version of the WHO questionnaire for measuring violence against women and girls [3]. In the questionnaire, partners were defined as current or past husbands, boyfriends or fiancés regardless of the legal status of the relationship. IPV was measured using four, three and six questions for emotional, sexual and physical violence respectively. For example, physical violence was measured by asking a woman if, during

the time she was pregnant, her partner ever slapped, kicked, hit, choked, shoved or threatened her with a weapon. Any positive response was coded yes for that type of violence. An additional question measuring violence frequency asked how many times each act happened during pregnancy with once, twice or thrice/more as the responses.

PND symptomatology was measured using the WHO [3] version of the CES-D that is also commonly used to measure PND. This scale has been validated and used extensively in many African settings [3] and has 20 questions that assess whether a woman experienced or felt a range of problems and emotions during the past 4 weeks including the following: sadness, bad sleep, loss of interest in things, poor appetite, often having headaches, excessive thinking, feelings of guilt, tiredness, movement/motion problems and thoughts of ending their life. For example, whilst referring to the past 4 weeks, respondents were asked, "Do you often have headaches?" Each question was dichotomously coded "yes" if the respondent reported having felt or experienced the problem and "no" if they did not.

Suicide thoughts were assessed by asking whether a participant ever had thoughts of killing themselves in their lifetime and this was dichotomised as No=0 and Yes=1. The same question was also asked with reference to the last 4 weeks. Respondents who reported "yes" to suicide thoughts were asked if they ever tried to end their lives and similarly coded as "yes" or "no". A participant was regarded as having had past suicidal ideation if they reported ever having suicidal thoughts or ever attempted to end own life.

We also collected participants' sociodemographic information in the interview such as woman's and partner's age and education, their age differences and marital status. Women's HIV status data were collected from clinic records after receiving women's written consent. Relationship quality was assessed by asking how often the couple quarrelled and this was coded on a Likert scale (often, sometimes or rarely). History of child abuse was measured by asking if a participant ever experienced physical or sexual violence before age 16 years. The questionnaire was tested with 60 postnatal women at one of the clinics in the study area and few adaptations were made. Detailed methodology and overall findings have been reported elsewhere [22].

The study followed the WHO [23] guidelines for researching violence against women and girls. Written informed assent and consent were provided before beginning each interview. Women who reported violence, depressive symptoms and suicide thoughts and attempts were given information about professional counsellors and were encouraged to consult services. Ethical clearance was received from the Medical Research Council of Zimbabwe and the University of the Western Cape research ethics committees.

3. Data analysis

Data were processed using Stata version 12. The depression cutoff point of 7 was used following studies conducted in Zimbabwe [6,8,9] and the WHO Multi Country Study [3] version of the questionnaire. We therefore classified women reporting at least 8 of the 20 items as having PND symptomatology. The WHO self-reporting questionnaire has been reported to classify depression the same way with higher degree of agreement with the local 14-item questionnaire that measures depression [6,24–26]. The reliability coefficient for the PND symptomatology scale used was 0.80, demonstrating a high degree of agreement amongst the individual items used.

A composite violence severity measure was derived from the violence frequency measures used in the study (once, twice, thrice/more). This frequency was then added to the number of types of each category of violence. The composite violence variable based on frequency and multiple types of violence were used to assess chi-square associations with mental health effects as follows: physical and/or sexual IPV and, physical, sexual and/or emotional IPV.

For each violence type or combination, we further constructed a three-level violence variable with no violence experienced during

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