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IMPACT OF PHYSICAL ABUSE ON ADULTHOOD DEPRESSIVE SYMPTOMS AMONG WOMEN

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This manuscript provides a systematic review of the literature to examine the relationship between childhood physical abuse and intimate partner physical abuse with adulthood depressive symptoms among women. Thirty-five studies that targeted women, measured depressive symptoms, childhood physical abuse, and intimate partner physical abuse were reviewed. Findings indicated an association between physical abuse experiences and depressive symptoms. However, the association of other risk factors, including other types of abuse, with depressive symptoms confounded this relationship. Recommendations, including control for other types of abuse, use of valid and reliable measures, and provision of a clear definition of physical abuse, are provided.

Domestic violence is one of the most devastating public health problems facing families throughout the world. Physical abuse directed at women, both as girls and as adults, is one of the most common types of domestic violence. Physical abuse is physically hurting a person with the intention of causing injury. Based on the National Violence Against Women Survey (NVAWS), 1,309,061 women in the United States experienced physical abuse in the year prior to the survey. The average number of physical assaults on each woman who was abused was approximately 3.4 per woman (Tjaden & Thoennes, 2000). Childhood experiences of
physical abuse are prevalent in women’s lives as well. As part of a geographically stratified sample of 1,442 men and women from the United States, 471 women were randomly selected and surveyed for childhood abuse history. Of the surveyed women, 19.5% reported a positive childhood history of physical abuse including being hit, kicked, having something thrown at them, and having bruises or scars as a result of physical abuse (Briere & Elliott, 2003).

Physical abuse impacts women’s lives in the form of both short-term and long-term sequelae. Short-term sequelae include physical injury (Forte, Cohen, Du Mont, Hyman, & Romans, 2005), fatigue, headache, and eating problems (Dienemann et al., 2000). Long-term sequelae include depression, anxiety, somatization, and substance abuse (Diaz-Olavarrieta, Ellertson, Paz, Ponce de Leon, & Alarcon-Segovia, 2002). Depression, a focus of this paper, also impacts women’s physical health (Hegarty, Gunn, Chondros, & Small, 2004), increases their use of psychiatric mental health services (Rayburn et al., 2005), and places them at risk for suicidal attempts (Thompson, Kaslow, & Kingree, 2002). Numerous studies have been conducted that examined the relationship of various types of lifetime abuse, including physical, sexual, and psychological abuse, with depressive symptoms. However, the relationship between physical abuse and depressive symptoms is not fully described. It is confounded by other risk factors associated with various demographics of the samples and other abuse experiences. Therefore, the purpose of this literature review is to examine the relationship of childhood physical abuse (CPA) and adulthood physical abuse (APA) with depressive symptoms. In this paper, CPA refers to physical abuse demonstrated by a parent, grandparent, or guardian. APA refers to physical abuse demonstrated by a male intimate partner.

METHOD

Many studies have been published in the last two decades targeting various types of abuse, including physical abuse. To get the most relevant and recent studies in this field, three databases, CINAHL, Medline, and PsycINFO, were searched. The search was limited to studies published between 2000 through 2006. Due to the variety of terms used to address domestic violence, the following terms were used for this particular search: “spouse abuse,” “spousal abuse,” “partner abuse,” “victimization,” “revictimization,” “domestic violence,” “physical abuse,” “battered women,” “child abuse,” “childhood abuse,” “child maltreatment,” “child physical abuse,” “childhood physical abuse,” “depression,” “depressive symptoms,” and “women.” In addition, a combination search
of childhood and adulthood physical abuse, and reference lists of some key articles also yielded related studies.

A total of 508 studies were found. All abstracts were reviewed. In addition, studies that did not have an abstract also were reviewed. To be selected, the studies had to meet the following criteria: (1) women were part of the study sample; (2) the relationship between physical abuse, either CPA or APA, and depression or depressive symptoms, was identified; (3) the violence in childhood was perpetrated by a parent, family caregiver, or guardian; and (4) the violence in adulthood was perpetrated by an intimate male partner. Official reports and studies that discussed types of violence other than domestic violence, homosexual relationships, and duplicate studies were not included in the review. Studies that were directed at pregnant or postpartum women also were excluded since the focus of this paper was not abuse during pregnancy. In addition, depressive symptoms among pregnant and postpartum women may be related to the physiological and hormonal changes they experience. Thirty-five studies were finally selected for this review.

RESULTS

Overview

The 35 studies surveyed women from a variety of settings. Studies used convenience samples from the settings where participants were recruited. The majority of the women were recruited from non-clinical settings. In 22 of the studies (62.9%), data were collected using surveys of community dwellers, random digit dialing, and college students recruited from the classrooms. In 13 studies (37.1%) women were recruited from clinical settings such as prenatal clinics, health departments, primary care settings, and general practice surgeries. Most of the studies included sample sizes of 100 women or more. The women represented a variety of demographic characteristics including different ethnicities, age groups, educational status, and family conditions.

Relationship Between Physical Abuse and Depressive Symptom

The researchers in 34 of the 35 reviewed studies concluded that physical abuse, even early experiences of CPA, was positively associated with depressive symptoms in adulthood. Only one study indicated a negative relationship between APA and depressive symptoms ($\beta = -0.82$) (Lang, Stein, Kennedy, & Foy, 2004). However, these researchers indicated that their results could be related to women’s withdrawal and dissociation in
response to abuse, which would have decreased their reporting of the effects of abusive episodes. Only one study (Lutenbacher, 2002) indicated that APA affects depressive symptoms indirectly. The researcher found that APA increased everyday stressors, which were negatively associated with the woman’s self-esteem. Low self-esteem in turn impacted women’s health in the form of depressive symptoms (Lutenbacher, 2002). The relationship between physical abuse and depressive symptoms was presented using odd ratios (OR) in 11 of the studies. The chance of experiencing depressive symptoms as a result of physical abuse ranged from 0.63 (Evans-Campbell, Lindhorst, Huang, & Walters, 2006) to 3.6 (Wenzel, Hambarsoomian, D’Amico, Ellison, & Tucker, 2006). In nine studies the relationship between physical abuse and depressive symptoms was presented in percentages ranging from 2.5% (Wilke & Vinton, 2005) to 76% (Kramer, Lorenzon, & Mueller, 2004). Regression coefficients were used in three studies and the values ranged from .13 (Briere & Elliott, 2003) to −.82 (Lang et al., 2004), and correlation was used in four studies with values ranging from .11 (Weaver & Etzel, 2003) to .372 (Martsolf, 2004).

Among the studies that investigated the effect of both CPA and APA on depressive symptoms, one contrary finding was found. Some investigators found that the effect of CPA on depressive symptoms was reported to be greater than the effect of APA on level of depressive symptoms (Libby, Orton, Novins, Beals, & Manson, 2005; Poleshuck, Giles, & Tu, 2006). However, the opposite finding was found as well with some researchers reporting that APA had a greater impact than CPA (Evans-Campbell et al., 2006; Nicolaidis, Curry, McFarland, & Gerrity, 2004). Only two studies targeted currently depressed women (Dienemann et al., 2000; Wise, Zierler, Krieger, & Harlow, 2001), and one of them was a case-control study (Wise et al., 2001), supporting the positive relationship between physical abuse and depressive symptoms. The rest of the studies were cross-sectional and survey studies targeting women from different settings.

Dose-Response Relationship

A dose-response relationship between physical abuse and depressive symptoms was found in 13 of the studies (37.1%). Dose, or exposure, to physical abuse is considered in terms of severity and frequency. Studies varied in the way they presented the dose of physical abuse, using a range from mild to severe levels or a numerical classification. Examples of severity of APA included being pushed, grabbed, or shoved; slapped, hit, or punched; hit with an object; or choked or attempted to be drowned...
Alternately, severity of APA was classified into three levels. These included no abuse, less severe physical abuse, and severe physical abuse (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004). Less severe physical abuse was defined as being pushed, grabbed, shoved, or slapped while severe physical abuse was defined as being choked, beaten up, and threatened with a knife or gun. Regarding frequency of CPA, while Coid and colleagues (2003) classified it as either being beaten once or beaten more than once, another study classified it on a four-point scale from 1 (never) to 4 (often) (Shaw & Krause, 2002). This lack of clarity in defining abuse makes it difficult to identify equally abused victims in terms of the frequency or severity of abuse they have had experienced.

Of the 13 studies that indicated a dose-response relationship, 12 indicated a positive dose-response relationship. Only two studies focused on the effect of physical abuse, as a unique exposure, on depressive symptoms in explaining the dose-response relationship (Coid et al., 2003; Hazen et al., 2004). Severity of physical abuse was addressed by Hazen and colleagues who identified the relationship of different levels of severity of APA, including no abuse, less severe abuse, and severe abuse, with adulthood depressive symptoms. Results indicated that as the severity of physical abuse increased, the percentage of depressed women in that group increased as well (Hazen et al., 2004). With regard to the effects of frequency of physical abuse on depressive symptoms, Coid and colleagues (2003) found that increased frequency of CPA experience was associated with increased risk of depressive symptoms in adulthood.

In the other 11 studies, dose or exposure was defined as various types of lifetime abuse including childhood and adulthood physical, psychological, and sexual abuse (Carlson, McNutt, & Choi, 2003; Coker et al., 2002; Diaz-Olavarrieta et al., 2002; Evans-Campbell et al., 2006; Houry, Kemball, Rhodes, & Kaslow, 2006; McGuigan & Middlemiss, 2005; Nicolaidis et al., 2004; Ramos & Carlson, 2004; Ramos, Carlson, & McNutt, 2004; Wise et al., 2001; Yang, Yang, Chang, Chen, & Ko, 2006). However, these studies did not limit the dose-response relationship to physical abuse and depressive symptoms.

Factors Affecting the Relationship between Physical Abuse and Depressive Symptoms

Demographic Factors

Nine studies (25.7%) examined the relationship between the physical abuse experience and the woman’s age. In five studies, investigators
reported a positive association between physical abuse and age, and in four studies a negative association was found. Prevalence of APA was found to increase accordingly as women’s age increased (Diaz-Olavarrieta et al., 2002; Wilke & Vinton, 2005). Duration of abuse was positively related to women’s age as well (Wilke & Vinton, 2005). However, a woman’s age also was a protective factor against her exposure to APA; the older the woman, the less likelihood she would experience APA (Carlson et al., 2003; Hathaway et al., 2000; Hazen et al., 2004; Kramer et al., 2004).

Nine studies (25.7%) examined the variation of the physical abuse experience and its relationship to woman’s educational level. Five studies indicated that the higher the woman’s educational level, the less likely the experience of physical abuse. Researchers varied in the way they presented this relationship depending on the way they defined educational levels in their sample. Sometimes high school level was considered a high educational level (Hazen et al., 2004) especially when researchers targeted women younger than 18 years old. In other studies, high school level was considered the lower educational level (Diaz-Olavarrieta et al., 2002; Zink et al., 2005) when researchers targeted women above the age of 18. Overall, a woman’s educational level greater than high school is generally considered a protective factor against exposure to physical abuse.

Depressive symptom variation across a woman’s age cohort was examined in seven studies (20%). Four studies indicated a negative association, with older women reporting fewer depressive symptoms (Briere & Elliott, 2003; Hegarty et al., 2004; McGuigan & Middlemiss, 2005; Yang et al., 2006), and two indicated a positive association (Hobfoll et al., 2002; Wilke & Vinton, 2005). Shaw and Krause (2002) indicated that the association between CPA and depressive symptoms is consistent across the life span without indicating whether depressive symptoms increased or decreased as a woman ages. One issue needs to be addressed with regard to this study. Although the study was a national survey of 2,788 participants aged 25 to 74, no specific instruments were used to assess for CPA or depressive symptoms. Instead, general questions were asked to address women’s experiences of these issues. Examples of physical abuse questions included “during your childhood, how often did your mother/father do any of the following: kicked, bit, or hit you with a fist; hit or tried to hit you with something; beat you up?” To determine depressive symptoms, subjects were asked to rate if during the last 30 days they had felt sad, nervous, restless, fidgety, or hopeless (Shaw & Krause, 2002).
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Research Methodology Factors

Only one qualitative study (Lutenbacher, Cohen, & Conner, 2004) was found that focused on the relationship between physical abuse and depressive symptoms. The findings supported the general quantitative studies in this field in that exposure to physical abuse is associated with a higher level of depressive symptoms in adulthood. Two case-control studies also were identified as (Lang et al., 2004; Wise et al., 2001). The findings in terms of the relationship between physical abuse and depressive symptoms were congruent with all of the surveillance studies despite the selection criteria of the cases and the controls. In the study by Lang et al. the criterion for inclusion as a case was having the experience of victimization or abuse; it was depressive status in the other study (Wise et al., 2001).

Definition and Assessment Tools

Thirteen studies (37.1%) provided an explicit definition of physical abuse. Valid and reliable instruments assessing both physical abuse and depressive symptoms were used in the majority of the studies. Twenty-six of the studies (74.3%) identified the measure of physical abuse used in the study. The Conflict Tactics Scale (CTS; Straus, 1979) and Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994) are examples of measures used to identify physical abuse experience. The other nine studies used a set of investigator-developed questions to measure the physical abuse experience (Coid et al., 2003; Hegarty et al., 2004; Libby et al., 2005; Pico-Alfonso et al., 2006; Shaw & Krause, 2002; Wilke & Vinton, 2005). Thirty studies (85.7%) measured depressive symptoms using measures such as the Profile of Mood States (POMS; Malouff, Schutte, & Ramerth, 1985) and the Center for Epidemiologic Studies-Depression (CES-D) scale (Radloff, 1977). The other five studies used a set of investigator-developed questions to assess women’s depressive symptoms (Hathaway et al., 2000; Kramer et al., 2004; Shaw & Krause, 2002; Wilke & Vinton, 2005; Zink et al., 2005).

Assessment of Multiple Types of Abuse

Thirty-four studies (97.1%) examined the impact of different types of abuse, including childhood and adulthood psychological and sexual abuse, child neglect, and intimate partner control, on depressive symptoms. Only one study was found addressing adult physical abuse as the main risk factor for depressive symptoms (Hazen et al., 2004). Control
for other types of abuse was established by restricting abuse to APA. Although Hazen and colleagues assessed for history of prior childhood maltreatment, they did not focus on its relationship with adulthood depressive symptoms. Besides, they limited their definition of abuse to APA. In other words, the relationship between physical abuse and depressive symptoms was controlled for in the analysis of the study. In the remaining 34 of the 35 studies, abuse was broadly defined and included various types of childhood and adulthood abuse. As a result, all the 34 studies found a relationship between multiple risk factors including physical abuse and depressive symptoms, depending on the focus of the studies.

DISCUSSION

Basically, a positive relationship between physical abuse and depressive symptoms was demonstrated by the majority of studies. Results support the claim that even early childhood experiences of physical abuse persist with victims and predict depressive symptoms in adulthood. There are certain issues that need to be addressed regarding the validity of this relationship. Most of the studies discussed the relationship of the women’s characteristics, such as age and educational level, and their association with either physical abuse or women’s depressive symptoms. Most studies found significant effects of those factors. Overall, studies did not discuss how such factors, specifically age and education impacted the relationship between physical abuse and depressive symptoms. This is despite the fact that the majority of studies did find a relationship between physical abuse and depressive symptoms.

The dose-response relationship between physical abuse and depressive symptoms is hard to establish for two reasons. First, the impact of physical abuse on depressive symptoms was not examined separately from other kinds of abuse in 84.6% of the studies that discussed dose-response relationship between abuse and depressive symptoms. For instance, the effect of physical and sexual partner abuse on women’s depressive symptoms were examined together (Coker et al., 2002). Second, there was a variation in the way severity or frequency of abuse was presented. Sometimes, they were presented in terms of levels like “mild,” “moderate,” and “severe” (Wise et al., 2001) or in categories such as “no victimization,” “child sexual abuse only,” “adult violence only,” and “child sexual abuse and adult violence” (McGuigan & Middlemiss, 2005). Other times, they were presented in terms of number of episodes like 1, 2–4, 5–9, and ≥10 (Nicolaidis et al., 2004). Unfortunately, these
different classifications make it difficult to determine equal levels in terms of severity or frequency of abuse. If women are not identified as equally exposed to physical abuse, in terms of type, severity, and frequency, it becomes hard to identify them as either victims or non-victims of abuse and relate their condition to the outcome of interest. For those two reasons, it becomes hard to identify a clear relationship between physical abuse and depressive symptoms and to identify how frequency and severity of physical abuse affect that relationship.

Some studies recruited women who were as young as 15 (Csoboth, Birkas, & Purebl, 2005; Diaz-Olavarrieta et al., 2002; Hazen et al., 2004; Libby et al., 2005; MacMillan et al., 2001). Younger women are more likely to engage in more intimate relationships than older women. In addition, this could imply that a significant proportion of younger women may be at risk for involvement in an abusive relationship at the time of the study compared to older women. On the other hand, depressive symptoms experienced by women younger than 18 years of age may be due to their developmental status or other psychological reasons. Their depressive symptoms may or may not be related to physical abuse.

Studies did not provide a clear indication that women who were experiencing physical abuse also were the ones exhibiting depressive symptoms. Results of most of the studies were presented as a general proportion of abused women experiencing depressive symptoms. Other times, results were presented in terms of measures of association. Cohort effect in this case obscures the real relationship. Consequently, using this literature, it becomes difficult to establish a relationship between physical abuse and depressive symptoms.

Although studies provided a positive association between physical abuse and depressive symptoms, the question remains as to whether physical abuse, more specifically APA, occurred prior to or after the occurrence of depressive symptoms. Studies did not provide evidence of temporality for the causal direction of this relationship. Because of the lack of prospective studies in this field, this question is still unanswered.

Over 60% of the investigators did not provide a conceptual definition for physical abuse (Houry et al., 2006; Kramer et al., 2004; Martsolf, 2004; Nurius et al., 2003; Poleshuck et al., 2006; Weingourt, Maruyama, Sawada, & Yoshino, 2001; Wenzel et al., 2006). One of the reasons for not defining physical abuse could be related to the physical abuse measurements used in the studies. For instance, although Nurius and colleagues did not define physical abuse, the questions used to assess for APA described various kinds of physical abuse tactics like being hit, slapped, and shoved (Nurius et al., 2003). There was no standardized definition among the studies of what represents physical abuse.
Definitions were mainly dependent on the researchers’ preferences of developing their own items or using a certain measure or part of the measure to assess for physical abuse. When physical abuse is not clearly defined, certainty about the results becomes questionable.

Some researchers developed their own items to assess for physical abuse (Coid et al., 2003; Hegarty et al., 2004; Libby et al., 2005; Shaw & Krause, 2002; Wilke & Vinton, 2005) and depressive symptoms (Hathaway et al., 2000; Kramer et al., 2004; Shaw & Krause, 2002; Wilke & Vinton, 2005). Others used standardized instruments to assess for physical abuse and depressive symptoms. Examples of instruments used to assess for physical abuse included the Conflict Tactics Scale (CTS; Straus, 1979), Abuse Assessment Screen (AAS; Soeken, McFarlane, Parker, & Lominack, 1998), and Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994). Examples of instruments used to assess for depressive symptoms include the Primary Care Evaluation of Mental Disorders (PRIME-MD; Spitzer et al., 1994), Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), and Center for Epidemiologic Studies-Depression (CES-D) scale (Radloff, 1977). Sometimes, researchers used the complete instrument and at other times, they used selected items of the instrument. This difference may represent the researchers’ personal and professional preferences and interpretations of what constitutes physical abuse and what constitutes depressive symptoms. This variation alters the relationship between study variables, if any, due to either the superficiality or depth of the measure used.

Researchers tended to study multiple types of lifetime abuse rather than limiting the study to one type of abuse. Because other types of abuse were not controlled for either in the design or in the analysis, overlap of the effect of risk factors becomes possible. In fact, this overlap between physical abuse and other types of abuse makes it possible for interaction among risk factors under study. Identifying specific linkages between physical abuse and depressive symptoms becomes difficult to determine because depressive symptoms are confounded by the overlap of other types of abuse exposure. Adulthood depressive symptoms thought to be associated with physical abuse, for example, might be related to a cumulative impact of multiple types of abuse. Severity of depressive symptoms thought to be related to the effect of physical abuse could be related to the interaction among the physical abuse experience and other risk factors, or to the cumulative impact of several risk factors; a result that obscures clearly identifying association between physical abuse and depressive symptoms.

Results of the majority of studies revealed that many other risk factors, other than physical abuse, also were associated with depressive
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symptoms. Therefore, based on the literature, we can not conclude that there is an association between physical abuse and depressive symptoms as this association is obscured by the positive association among other risk factors and depressive symptoms. In other words, it is difficult to determine whether a woman’s depressive symptoms are related to physical abuse or to other risk factors.

RECOMMENDATIONS FOR FUTURE RESEARCH

The major commonality in these studies is that they were retrospective in nature. Participants were expected to recall their abuse history. To reduce the likelihood of recall bias and to improve the reliability of the relationship between physical abuse and depressive symptoms, standardized assessment tools need to be used. These tools should have reported validity and reliability psychometrics. Those measures include items that specifically identify a variety of physical abuse events. For example, the Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) includes 12 separate items to determine physical abuse, while Abuse Assessment Screen (AAS; Soeken, McFarlane, Parker, & Lominack, 1998) groups several tactics of physical abuse into one item. Therefore, using measures, such as the CTS2, that are more comprehensive in measuring physical abuse and include one tactic per item, may decrease recall bias.

When physical abuse was defined, definitions varied in terms of severity and extent of abuse tactics. For example, Shaw and Krause (2002) defined CPA as a type of potentially chronic and micro-level trauma where the individual may have been exposed to acts of physical violence demonstrated by a parent. CPA also was defined as being pushed, grabbed, or shoved; having something thrown at them; being kicked, bitten, or punched; getting hit with something, being choked, burned, or scalded; or being physically attacked in some other way. Spanking and slapping were not included in the definition of CPA (MacMillan et al., 2001). With regard to APA, it was defined as threatened, attempted, or actual infliction of physical harm (Tjaden & Thoennes, 2000; Wilke & Vinton, 2005). On the other hand, a more detailed definition was provided by Weaver and Etzel (2003) as APA was defined as experiencing four minor incidents of violence (e.g., being pushed, shoved or grabbed; being slapped, or hit; having things thrown at them that could hurt; having their arm twisted or hair pulled) or experiencing at least two severe violence incidents (e.g., being hit or punched with a fist; exhibiting physical injury, or being choked; being slammed against the
wall or thrown down the stairs; being kicked or being beaten up; or being threatened with a weapon). Due to problems associated with lack of an agreed-upon definition of physical abuse, standardized definitions for research purposes need to be established and used in future studies. Also, standardized instruments used in their whole or complete format that measure physical abuse and depressive symptoms must be used in order to limit researcher bias.

Very few studies included conceptual models or frameworks to describe the proper attribution of physical abuse as a primary etiology of depressive symptoms. Frameworks in this area are important for two main reasons. First, the literature revealed that women experience various types of abuse (Briere & Elliott, 2003; Carlson et al., 2003; Csoboth et al., 2005; Hobfoll et al., 2002). Second, depressive symptoms were not specifically recognized as a primary or unique outcome in the majority of the studies. Usually depressive symptoms were included among a series of other psychological outcomes including anxiety, PTSD, and drug problems. Frameworks can help to clearly describe how physical abuse can contribute to the development of adulthood depressive symptoms. Future research needs to take this into consideration.

The cumulative impact of physical abuse encountered by women during childhood and adulthood was not well-supported in the literature. There is some evidence suggesting that CPA has a greater impact on adulthood depressive symptoms. Conversely, other studies suggest that APA has the greatest impact. It is important to know how the cumulative impact of both CPA and APA encountered by the same woman affects the development of depressive symptoms in adulthood. Future studies need to focus on this area.

Results of the studies were based on discovered cases. Although study samples were representative population-based samples, results can not be generalized to other populations for two main reasons. First, because of the sensitivity of the issue of physical abuse, women may report biased information. Second, there exists the possibility that discovered cases differ from undiscovered cases in certain characteristics, such as rural or urban settings, family situations, or ability to support self without the partner.

CONCLUSION

Although the majority of the studies demonstrated a positive association between physical abuse and depressive symptoms, a clear association is not well-established as other types of abuse were not controlled for in these studies. Whether this association is real or an artifact of
other factors, the association between physical abuse and depressive symptoms in adulthood demands further study.

Future studies need to control for all possible confounding variables as well as for other types of abuse in order to clearly identify the relationship between physical abuse and depressive symptoms. Identifying these most vulnerable women will help health care professionals intervene to prevent further victimization and future negative physical and psychological consequences. It also may assist in implementing certain mental health interventions to treat victims of physical abuse who might also be at risk for depression.

REFERENCES


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