Community Violence and Postpartum Depression: 
Associations and Potential Intervention Strategies
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Executive Summary

Many new mothers living in urban communities with high violent crime rates suffer from the debilitating perinatal mood disorder of Postpartum Depression (PPD) silently. This vulnerable segment of the American birthing population is often forgotten among policymakers and behavioral health professionals due to their marginalization within larger cities. As these women’s psychosocial state worsens over time without intervention, there are severe negative consequences for their individual health overall, their immediate family, and society at large, which can include the deterioration of kin networks and suicide.

To address the urgency and relevance of this maternal health issue, my thesis explores the questions: Does exposure to community violence during pregnancy increase the likelihood of being diagnosed with PPD a year after giving birth? If so, what intervention strategies can be implemented to further support those exposed to violent crime through perinatal mental health services? I answer these critical questions by utilizing a mixed-methods approach.

By completing multivariate logistic regressions based on data from the Futures of Families and Child Wellbeing Study and completing semi-structured interviews with key informants, I gauged the relationship between exposure to violent crime during pregnancy and the risk of developing PPD and how stakeholders work toward increasing access to perinatal mental health services for women living in at-risk communities.

My analyses confirm that greater exposure to community violence in large cities is associated with an increased risk of being diagnosed with PPD. Additionally, it is evident that the primary barriers preventing women in these communities from accessing perinatal mental health care include desensitization to violence due to its normalization, limited trust in care providers, and a lack of organizational capacity to support clients. I propose several recommendations that draw upon existing policies and funding opportunities to increase the efficacy of crime prevention efforts, expand housing choices, and increase access to comprehensive perinatal mental health care services.

“Women are the pillars of so many families and so many communities, and when women then receive the care they need, by extension it makes families and communities stronger… and it makes our nation stronger.”

Kamala Harris 
Vice President of the United States of America
Background and Motivations

In the United States, approximately one-eighth of all women with live births are diagnosed with Postpartum Depression (PPD) (CDC, 2022). Even this significant amount is likely an underestimation as many women fail to report their symptoms or seek professional support for an official clinical evaluation. Women of low socioeconomic status and with low educational attainment are even more vulnerable to developing PPD. Notably, it is much more common for these women to live in the urban communities of major cities, which are plagued with the highest rates of violent crime compared to other residential areas across the U.S. (Blau and Blau, 1982). Because these communities are also often poverty-stricken, the continuous cycle of violence introduces an added layer to the concentrated disadvantage and environmental stressors pregnant women are likely to encounter daily (Smith et al., 2022). With low-income and poorly educated mothers in these communities already being more likely to face logistical and cultural barriers to consistently accessing perinatal mental health care, it is critical to determine if this vulnerable group should be targeted for screening and mental health interventions (Kozhimannil et al., 2011).

Although maternal mental health has recently received increased attention from legislators and healthcare providers in light of the COVID-19 pandemic, there is still a dearth of research on the role of community violence during the postpartum period. Most previous studies have evaluated the impact of community violence on postpartum mothers strictly focusing on an individual city instead of using a national lens representative of the American birthing population. Moreover, no study has yet been conducted in which the focal point of analysis is on community violence during pregnancy rather than childhood trauma or domestic violence. Although these forms of trauma are pivotal to consider when examining risk factors for PPD, greater attention should also be placed on community violence due to the fact that a significant amount of the population, particularly in urban settings, is exposed to and suffers the consequences of it.

My thesis aims to fill these gaps through a mixed-methods analysis of large cities across the United States. Specifically, through this research, my goals are to 1) determine if a relationship indeed exists between exposure to community violence and diagnosis of PPD and 2) identify feasible strategies to increase access to comprehensive perinatal mental health care among this marginalized group.

Methods

To understand the full extent of the impact of community violence on pregnant women’s psychosocial status while considering the perspectives of individuals that work directly with this demographic, I engaged in both a qualitative and quantitative analysis. Specifically, I utilized a mixed-methods approach to investigate whether exposure to community violence during pregnancy increases the likelihood of a woman developing PPD, along with potential intervention strategies. These methods included:

- **Sample of participants from the Futures of Family Study**, to quantify the association between community violence and being diagnosed with PPD up to a year after giving birth.
  - **Year 1 Core Maternal Health Survey**, to gauge whether a new mother met the criteria for diagnosis of maternal depression during the postpartum stage.
  - **Baseline Year Uniform Crime Reports**, to assess county-level violent crime rates, which were employed as a proxy for community violence.
• **Geographic identifiers, census tract data, and medical records**, to account for and control for several demographic and neighborhood-based factors.

• **Interviews with professionals at maternal health CBOs and victim services agencies**, to evaluate the efficacy of current perinatal mental health services for pregnant women and new mothers living in violent urban communities.

  o **Framework Analysis**, to deduce key perspectives from employees working directly with women in disadvantaged urban communities.

  o Examining professional insights on **policy interventions that may increase accessibility to perinatal mental health services** in neighborhoods with high violent crime rates.

**Findings**

**Key Observation #1:** After holding all demographic and neighborhood-level characteristics constant, an increase in exposure to **community violence** during pregnancy is associated with an **increase in the likelihood of being diagnosed with PPD**.

  • Compared to a woman living in the county with the lowest violent crime rate, a woman living in the county with the **highest violent crime rate** has an **86.7% and 23.1% significant increase in odds of being diagnosed with PPD** using a liberal and conservative indicator, respectively. This aligns with the findings of another study which showed that repeated exposure to violence can lead to persistent depression, psychological withdrawal, social disengagement, and powerlessness among community members, all of which can be precursors to postpartum maternal depression (Anakwenze and Zuberi, 2013).

  • Increased **exposure to total crime** is associated with a **60.5% and 12.7% increase in the probability of diagnosis** considering the same indicators among women in the Future of Families study.

  • Having **histories of depression and intimate partner violence** were identified as the variables **most associated with increased risk of meeting the criteria for PPD diagnosis**. These controls appeared to be the most relevant when considering factors contributing to this diagnosis.

**Key Observation #2:** Each maternal mental health CBO and violent crime services agency intervened through the provision of **trauma and community-informed mental health services**.

  • Participants confirmed that utilizing a **trauma-informed approach guarantees the acknowledgment of structural violence and discrimination** embedded within their respective communities. Women who are victims of intimate partner violence and receive trauma-informed mental health care have been found to feel a greater sense of **empowerment and consider their providers more compassionate and non-judgmental** than pregnant women who did not (Drexler et al., 2022).

  • Incorporating this framework enabled women seeking care to become more trusting of the professionals providing mental health services and allowed them to actively engage by making their sessions more interactive. These women could also **better verbalize the postpartum depressive symptoms** they were experiencing.
As a part of the trauma-informed approach, the issue of stigma is explicitly and implicitly addressed while providing care. Although women seeking psychosocial support for their exposure to violence have often overcome the initial roadblock of stigma, there can still be hesitance in being fully invested in the process. Another study concludes that pregnant women with greater lifetime exposure to trauma perceive trauma-informed care to be more meaningful and beneficial than traditional care practices (Schwerdtfeger and Goff, 2008).

Key Observation #3: The primary barriers to accessing and utilizing perinatal mental health services for women in violent neighborhoods included (1) desensitization to violence, (2) faltering trust, and (3) lack of organizational capacity.

- **Desensitization** can cause some women to hesitate in pursuing or continuously utilizing perinatal mental health services. The amalgamation of stressors rooted in structural violence, state abandonment, and exposure to community violence can be debilitating for women in the perinatal period. Because these women are just managing to survive in an environment where violence is viewed as the norm, they cannot fully commit to acknowledging their mental health and seeking support for their trauma and perinatal mood disorder.

- The lack of trust among pregnant women and new mothers is largely due to historical wrongdoings in their respective communities. Lower-income women, who invariably live in violent neighborhoods, have been found to be wary of seeking treatment due to fear of being stigmatized by their care providers (Hansotte et al., 2017). Part of the issue is centered around how many organizations only provide traditional forms of mental health care to clients. When organizations refuse to institute unorthodox treatments, community members perceive those entities as not having their best interests in mind, which may confirm their concerns that those providing the services are not trustworthy.

- Many victim services agencies have an overwhelming demand for mental health services, resulting in many pregnant women and new mothers being placed on a waitlist to receive care. For a woman attempting to seek immediate psychosocial support, a waitlist could diminish her interest or enable her to de-prioritize her mental health. Moreover, a significant number of workers are not technically trained to address the mental health concerns of their patients effectively nor maximize the number of people they can support. Another critical factor identified as a contributor to organizations being under capacity is the fragmentation present in the health care system.

Key Observation #4: Community engagement and multiorganizational partnerships are key to increasing accessibility to perinatal psychosocial support services in communities with high crime rates.

- Community engagement mechanisms can increase awareness and utilization of mental health services provided. Different strategies employed by organizations include weekly community walks, bi-weekly community meetings, accepting word-of-mouth referrals from community members, and hosting block parties.

- Intentional efforts have been made to involve community members in the delivery of mental health services to clients of non-profits that support victims of violence. Their roles can range from simply volunteering, to serving as an ambassador for programming, and even becoming a staff member. Although residents may interact with clients infrequently, having these individuals has been critical to placing the organizations on community members’ radar while also increasing willingness to learn about their provided services.
• Multi-organizational partnerships with other maternal health agencies and victim services nonprofits typically include more promotion to increase familiarity with available perinatal mental health services. **Increased coordination between organizations in the same field and different sectors makes programming more accessible** by increasing exposure to services provided and channeling women into psychological support networks from which they may have previously been excluded.

**Key Observation #5:** Several multi-sectoral policy areas in need of improvement include (1) increasing affordable housing, (2) the dedication of grants to a greater proportion of perinatal mental health services, (3) improved workforce development, and (4) increasing multi-organizational collaborations through public-private partnerships.

• There is near unanimous agreement that the federal government should provide some form of housing subsidies to pregnant women and new mothers exposed to high levels of community violence. Addressing the issue of affordable housing would enable many more women in these neighborhoods to prioritize their mental health. Poor housing facilitates isolation and a lack of familial connections. This lack of a support system, coupled with constant exposure to environmental stressors in the new neighborhood, can exacerbate depressive symptoms.

• **Augmenting grants to increase organizational capacity** is another method to overcome the previously identified barriers. Moreover, these grants should be made available for non-traditional therapies to provide women with a larger selection of treatment options that would fit their needs. Because many of the non-profits in violent neighborhoods primarily serve communities of color, alternative approaches to providing psychosocial services that avoid Eurocentric models of care may be more beneficial.

• **Incentivization** can play a key role in expanding workforce development among behavioral health workers. Additionally, government agencies should make **significant adjustments to the pay scale** to gain a more committed and educated workforce. Improvements to the pay scale would not only increase the amount of qualified mental health care workers but also allow organizations to restructure their staffing hierarchy so supervisory staff isn’t overwhelmed with providing mental health care resources while constantly having to retrain other staff members.

• There should be more multi-organizational collaborations instituted to account for current funding woes and under-capacity in staffing. Public-private partnerships could work to sustain depleted nonprofits by relieving pressures related to demand among clients. Increased collaboration would **reduce fragmentation of care** by allowing for a more fluid referral system from state-funded and privatized healthcare systems, where at-risk women showing signs of having PPD can be connected to an organization that provides psychosocial support immediately.

**Additional Conclusions**

**It is critical to note that city and state-level variations in maternal health policies and access to quality care** can also influence postpartum psychosocial outcomes. Each city and state differ when considering several characteristics concerning accessibility to healthcare and social services. Specifically, the overall quality of the healthcare systems available to residents may deviate substantially. Also, Medicaid policies vary dramatically between certain states. Each state maintains differing policies towards maternal mental health, which also impacts a woman’s experience within the healthcare landscape during the perinatal stage. Moving forward, these factors should be accounted for, and policymakers should
consider how to **minimize such variations**, so all women are on an **equal playing field** in terms of accessing perinatal mental health services.

Additionally, since the data utilized was not disaggregated beyond the county level due to participant confidentiality concerns, the **findings cannot be extrapolated to the micro-level**, which represents immediate proximity to the mother’s residential location. Even more, direct exposure to violent crime, which can include either being a victim of or physically witnessing a violent act, was not recorded in this dataset. Despite these limitations, the **crime rates are still robust proxies** for determining the general level of community violence may face during their pregnancies. As the perinatal mental health crisis in violent urban communities continues to garner more attention among key stakeholders and policymakers, researchers should further **explore community violence’s impact on the neighborhood level by examining household clusters**.

**Policy Recommendations**

Several strategies should be considered to increase the efficacy of crime prevention efforts, provide better housing possibilities, and expand access to screenings and treatment through perinatal mental health care to support women residing in neighborhoods with high levels of community violence. The following policy recommendations draw upon existing policies and funding opportunities to increase access to comprehensive perinatal mental health care services for this group.

**Violence Prevention Through Collaboration**

*Increasing violence prevention tactics through collaborations with maternal health CBOs.*

Although crime prevention organizations have been successful in making their communities safer for residents, partnering with maternal health CBOs could potentially be the key to reducing both the effects of violence and violence itself. Community-based crime prevention efforts can be ineffective when they occur in isolation; collaborations with organizations focused on other vital issues, like maternal health, play a key role in increasing community participation and awareness of prevention tactics that residents can employ to protect their families and the community at large.

Since mothers are perceived as vulnerable, yet respected individuals by those affiliated with gangs, pregnant women and new mothers involved with maternal health CBOs can help crime prevention agencies through activism efforts (Mohr et al., 2001). An increase in partnerships between crime prevention organizations and maternal health CBOs can positively impact women's postpartum mental health directly and indirectly, despite their seemingly disparate natures.

**Perinatal Mental Health Assessments**

*Implementing universal screenings for depression and perinatal mental health assessments.*

A national legislative mandate for universal screenings related to PPD should be passed and enforced to become a part of the routine prenatal and postpartum care process most women of childbearing age undergo. Within these screening programs, the Edinburgh Postnatal Depression Scale (EPDS) can be used to assess whether a mother is at risk for PPD or meets the criteria for this condition. In implementing mandated universal screenings, at least one screening should be required before a woman gives birth.

Along with the implementation of screenings, states should also consider mandating perinatal mental health assessments provided right after a live birth occurs. By providing this assessment right after a woman delivers, care providers can better identify women needing additional support or brief intervention. In addition to items concerning drug use, psychiatric history, and history of intimate partner
violence, questions should be added to measure direct and indirect exposure to community violence. Although this assessment would not gauge if the woman taking it has PPD, it could help identify women at higher risk for mood disorders.

**Housing Vouchers**

*Expanding access to housing subsidies for pregnant women and new mothers in communities with high rates of violence.*

Vulnerable women living in urban neighborhoods plagued with a continuous cycle of violence should be entitled to housing vouchers that allow them to enter the private rental market in safer neighborhoods, especially during pregnancy. In addition to income-based criteria, HUD should prioritize pregnant women and new mothers who live in neighborhoods with violent crime rates above a specified threshold due to the vulnerability of this group.

Housing vouchers can have a positive effect on the mental health of mothers. Specifically, parents who were recipients of these subsidies were found to have between 8-33% improvement in their mental health, as they reported fewer depressive symptoms and less distress, compared to parents who remained in high-poverty neighborhoods (Leventhal and Brooks-Gunn, 2003). Therefore, prioritization of women in the perinatal period for housing vouchers would not only reduce the socio-economic disadvantage these women face that increases stress but also provide these women with an environment that supports their mental health, limiting their risk for PPD.

**Multi-organizational Programming & Public-Private Partnerships**

*Reducing the fragmentation of perinatal mental health care through public-private partnerships and multi-organizational collaborations.*

An increase in multi-organizational collaborations, particularly among state governments, maternal-infant healthcare organizations, and victim services agencies can ease the process of receiving perinatal mental health services for pregnant women and new mothers in violent communities by reducing confusion and increasing immediate access to services. As agencies increasingly partner to provide services, they should ensure organizations that reflect the community are involved in the collaboration.

CBOs can play a key role in addressing disparities by mediating conversations between the parties involved, allowing for shared decision-making between patients and providers. Because these nonprofits tend to be well-established in their respective communities, this vulnerable group of women may be more open to engaging with mental health services provided at these organizations as there is increased trust and access. Additionally, these collaborations can play a key role in increasing workforce capacity, reducing the burden on perinatal mental health care providers, and widening awareness of available services.

**Reallocation of Funding to Perinatal Mental Health**

*Allotting grants and other forms of funding toward the expansion of perinatal mental health care services.*

There must be an expansion in the availability of grants that enable nonprofits and agencies to provide perinatal mental health services to allow for the implementation of screening programs, encourage multi-organizational efforts, and increase workforce capacity. To ensure quality care, continuity of care, and that mental health care professionals receive high-quality training to increase their competency, adequate funding through grants is critical, especially for smaller organizations. With more avenues of financial support, it will be much less likely that healthcare facilities and external organizations become overwhelmed with patients from communities with high rates of violence.
References


