

VIOLENCE AGAINST WOMEN AND THE PERINATAL PERIOD

The Impact of Lifetime Violence and Abuse on Pregnancy, Postpartum, and Breastfeeding

KATHLEEN A. KENDALL-TACKETT

Family Research Laboratory, University of New Hampshire

Violence against women affects millions of women, including women who are pregnant or have recently given birth. During pregnancy, a woman's history of past abuse increases her risk of depression and posttraumatic stress disorder. And these increase the risk of pregnancy and neonatal complications. Women who have experienced past or current abuse are also at high risk for postpartum depression, which can affect their relationships with other adults and their babies. Violence against women can also affect women's ability to breastfeed, although abuse survivors often express an intention to breastfeed and are more likely to initiate breastfeeding than their nonabused counterparts. Current abuse, depression, posttraumatic stress disorder, social isolation, lack of social support, and cessation of breastfeeding all have negative health effects for mothers and babies.

Key words: *breastfeeding; child sexual abuse; intimate partner violence; postpartum depression*

VIOLENCE AGAINST WOMEN (VAW) is an unfortunate fact of life for millions of women around the world. And mothers are not immune. In a study of 248 married, pregnant women in Kuwait, 17% reported a lifetime history of assault. Assault history was related to depressive symptoms during pregnancy, even after controlling for family stress (Nayak & Al-Yattama, 1999). A recent study of 332 postpartum women in Toronto, Canada, found that 14% reported a history of child sexual abuse, 7% reported child physical abuse, 13% reported adult sexual abuse, 7% reported adult physical

abuse, and 30% reported adult emotional abuse (Ansara et al., 2005).

Abusive experiences, past and present, can influence women throughout the childbearing cycle. Although an important topic, research is still preliminary. However, even with a relatively limited literature, researchers have begun to document how VAW influences women's health throughout the childbearing year. And when abuse-focused research is limited, it is often possible to draw guidance from research on related topics to inform clinical decisions and future studies. Below is a summary of what we know

KEY POINTS OF THE RESEARCH REVIEW

- Pregnancy and postpartum are times when women are vulnerable to intimate partner violence.
- Past abuse can also affect women's health during pregnancy and postpartum.
- Depression and posttraumatic stress disorder increases the risk of pregnancy complications and complications during birth.
- Women with a history of child sexual abuse are more likely to express a desire to breastfeed and to initiate breastfeeding than their nonabused counterparts.

so far on how VAW influences women during pregnancy, postpartum, and breastfeeding.

PREGNANCY

VAW influences women's health during pregnancy. Because another article in this volume focuses on current intimate partner violence (IPV) during pregnancy (Sharps, this issue), I will not cover this topic here. Rather, this section focuses on the impact of past abuse on the health of mother and baby during pregnancy. The samples in the majority of these studies are survivors of childhood sexual abuse.

Several recent studies have found that high-risk sexual activity is substantially more common among sexual abuse survivors than their nonabused peers (Hulme, 2000; Kendall-Tackett, 2003; Raj, Silverman, & Amaro, 2000; Springs & Friedrich, 1992). Women who have been sexually abused often engage in consensual sexual activity at an earlier age, have more lifetime sexual partners, and are more likely to participate in high-risk sexual activity including not using condoms or contraceptives (Raj et al., 2000; Stock, Bell, Boyer, & Connell, 1997). High-risk sexual activity increases the risk for unplanned pregnancies among teens (Raj et al., 2000; Springs & Friedrich, 1992) and adults (Prentice, Lu, Lange, & Halfon, 2002). In a nationally representative U.S. sample of mothers of children younger than age 3 years ($N = 1220$), women with a history of child sexual abuse were more likely to have an unwanted pregnancy and late prenatal care (Prentice et al., 2002).

Although sexual abuse increases the risk of teen pregnancy, we cannot assume that all teen mothers have a history of abuse. A recent study of 252 pregnant teens from Montreal, Canada, found that 79% had no reported history of sexual or physical abuse. However, 21% reported multiple forms of past abuse. Only sexual abuse was related to depression during pregnancy (Romano, Zoccolillo, & Paquette, 2006).

The Effects of Poor Health Behaviors, Depression, and Posttraumatic Stress Disorder (PTSD) on Pregnancy

A history of abuse also affects women's antenatal health through their behaviors and through the effects of depression and PTSD. In a study from Norway of women with low-birth-weight ($n = 82$) and term babies ($n = 91$), 56% of women who reported childhood sexual abuse smoked during pregnancy compared to 31% of nonabused women. Abuse survivors also reported more health problems during pregnancy and used more health care services than their nonabused counterparts (Grimstad & Schei, 1999).

Depression and PTSD are common sequelae of childhood abuse and current IPV. As two recent studies found, women suffering from either of these conditions have an increased risk of pregnancy and neonatal complications, and interventions during labor. A prospective study of 959 women in Hong Kong found that depression in the third trimester was associated with increased use of epidural anesthesia, higher rates of cesarean sections and instrumental vaginal deliveries, and more infant admissions to neonatal intensive care units (NICUs). These effects were still present even after controlling for pregnancy complications, showing an independent effect of depression (Chung, Lau, Yip, Chiu, & Lee, 2001). And in a study that compared 455 women with PTSD to 638 without PTSD, Seng et al. (2001) found that women with PTSD had significantly higher odds ratios (ORs) for ectopic pregnancy, spontaneous abortion, hyperemesis, preterm contractions, and excessive fetal growth. Although not specifically addressing childhood abuse, these studies nevertheless provide us with a glimpse of some

possible health problems abuse survivors may encounter antenatally.

Summary

A history of childhood abuse can increase women's health problems during pregnancy. Common sequelae of past abuse can lead to pregnancy complications and an increased number of interventions during labor, demonstrating that the effects of abuse can last long after the abuse ends. These complications can also increase women's risk of difficulties during the postpartum period: the focus of the next section.

POSTPARTUM

Women with a history of childhood abuse or current partner abuse are at risk for postpartum mental health problems (Kendall-Tackett, 2005). And neither pregnancy nor the postpartum period offers protection from abuse, as the studies below indicate.

Risk of Current IPV

Three recent large, population-based studies found that many women are beaten during pregnancy and the postpartum period. In a Chinese study that included 32 communities, 8.5% of women were beaten before pregnancy, 3.6% during pregnancy, and 7.4% after pregnancy (Guo, Wu, Qu, & Yan, 2004). In North Carolina, 6.9% were beaten before pregnancy, 6.1% during pregnancy, and 3.2% postpartum ($N = 2648$; Martin, Mackie, Kupper, Buescher, & Moracco, 2001). Finally, in Bristol Avon, U.K. ($N = 7591$), 5% were beaten during pregnancy and 11% postpartum (Bowen, Heron, Waylen, Wolke, & ALSPAC Study Team, 2005). At this point, it is difficult to know whether pregnancy versus postpartum puts women more at risk, as these studies offer conflicting findings. The differences in these results may be due to different subgroups of abusers within the samples. Abuse during pregnancy is especially dangerous and is a risk factor for lethal abuse (Campbell & Kendall-Tackett, 2005). Samples with a higher percentage of women abused

during pregnancy may have had a higher proportion of these more dangerous perpetrators.

A study of 570 teen mothers showed the continuity between antenatal and postpartum violence. The prevalence of IPV was highest at 3 months postpartum (21%) and lowest at 24 months (13%). Seventy-five percent of mothers beaten during pregnancy were also beaten during their first 2 years postpartum. And 78% who experienced IPV at 3 months postpartum had not reported IPV during their pregnancy (Harrykisson, Rickert, & Wiemann, 2002).

Lutz (2005) also described the continuity between past and present violence in her qualitative study of 12 women who were survivors of IPV during at least one childbearing cycle. Among these women, depression, PTSD, and anxiety were common. The study participants reported many types of violence during their lives: child physical, emotional, and sexual abuse; neglect; parental IPV and substance abuse; current IPV; adult sexual assault; and community violence. The women experienced each exposure to violence as influencing and flowing into the next. They viewed IPV during childbearing as just part of the continuum of abusive experiences in their lives.

Impact of Past or Current Abuse on Postpartum Depression

A study of 200 Canadian women at 8 to 10 weeks postpartum found that women with a history of abuse are more likely to experience depression and physical health symptoms in the postpartum period (Ansara et al., 2005). A 3-year follow-up of 45 Australian mothers with postpartum major depressive disorder found that half had a history of child sexual abuse. The sexually abused women had significantly higher depression and anxiety scores and greater life stresses compared to the nonabused depressed women. Moreover, the sexually abused women had less improvement in their symptoms over time (Buist & Janson, 2001).

In another sample of 53 low-income single mothers, childhood abuse and low self-esteem predicted depressive symptoms, and these symptoms influenced women's reactions to their babies (Lutenbacher, 2002). Everyday stressors,

when combined with depression, predicted higher levels of anger in the mothers. However, current partner abuse was the best predictor of the mothers' overall abusive parenting attitudes (measured by the Adult-Adolescent Parenting Inventory), and more parent-child role reversal.

The effects of poor partner support. Women who have experienced previous abuse can have difficult relationships with their partners (Kendall-Tackett, 2003). In a longitudinal study from Avon, UK ($N = 8292$; Roberts, O'Connor, Dunn, Golding, & ALSPAC Study Team, 2004), women who had been sexually abused were more likely than nonabused women to be single parents, cohabitating in their current relationships, or stepparents. They also reported less satisfaction with their current partners. Although the study authors were not explicit about this, it seems reasonable to hypothesize that women who report low satisfaction in their relationships do not consider these relationships to be good sources of support. And lack of partner support puts them at risk for depression and health problems.

Even among nonabused women, lack of partner support increases the risk of postpartum depression. In a study of married women at 2 months postpartum, spouses' lack of help with child care and household tasks predicted depression severity (Campbell, Cohn, Flanagan, Popper, & Meyers, 1992). Furthermore, spousal support interacted with pregnancy and delivery complications so that women with more complications and lower levels of support were more likely to be severely depressed. In this same study, women with less spousal support were also more likely to be chronically depressed, even up to 2 years later.

Another study examined the importance of social support with three samples of postpartum women: 105 middle-class White women, 37 middle-class mothers of premature babies, and 57 low-income African American mothers (Logsdon & Usui, 2001). The authors tested a causal model, using structural equation modeling, and found that the women's perceptions of the support they received and their closeness to their partners significantly predicted self-esteem and depression. These predictors were the same for all three groups of mothers.

VAW and women's social networks. Women in ongoing abusive relationships, or who have a history of abuse, may also have difficulties forming other types of social bonds. The relationship between social support and depression appears to be bidirectional. Lack of social support increases the likelihood of depression, and depression seems to impair people's abilities to make social connections. A recent study (Hammen & Brennan, 2002) sought to explore this relationship in a sample of 812 community women. The women in this study were divided into three groups: formerly depressed, currently depressed, and never depressed. (They were not identified by abuse history.) Data were collected from spouses, adolescent children, and independent raters. Their findings demonstrated that interpersonal difficulties were not simply consequences of depressive symptoms. Women who were not currently depressed, but formerly had been, were more impaired on every measure of interpersonal behavior and beliefs than women who were never depressed. The formerly depressed women's marriages were less stable, and they had lower levels of marital satisfaction. There was more spousal coercion and injury. The formerly depressed women had more problems in their relationships with their children, friends, and extended families, and they experienced more stressful life events. Finally, they were more insecure in their beliefs about others. The authors concluded that interpersonal difficulties were a stable component of depression, and that these difficulties were not only difficult to treat but also may make sufferers more vulnerable to future episodes of depression (Hammen & Brennan, 2002).

A similar pattern of problems in social relationships was found in families who were maltreating their children. Gaudin, Polansky, Kilpatrick, and Shilton (1993) compared neglectful, low-income mothers with those who were low income but not neglectful. There were striking differences between the groups. The neglectful mothers were significantly lonelier and more socially isolated; they reported more depression and averaged more than twice the number of stressful life events in the previous year. Mothers in the neglect group reported fewer social ties and had more people critical of them in their social networks. The authors recommended that

case workers address loneliness and isolation in these families to help them cope with significant life stresses related to poverty, lack of access to health care, housing, and other support services.

The health effects of lack of support. Lack of support not only increases the risk for depression, it also causes its own set of health problems. Although the studies below did not specifically examine abuse history, the findings are relevant in that lack of support can be another way that past or present abuse affects women's health postpartum.

In a review, Salovey, Rothman, Detweiler, and Steward (2000) noted that social support is related to lower mortality and greater resistance to communicable diseases. Among people with good support, there is a lower prevalence of coronary heart disease, and they recover faster following surgery. When faced with stress, those with few social resources are more vulnerable to illness and mood disorders than are people with good support.

A study of high-risk teens admitted to a psychiatric hospital indicated that social support was an effective buffer in some circumstances. The teens in this study had experienced or witnessed high levels of violence in their families and communities. Social support shielded these teens from some of the effects of family violence. It did not appear to ameliorate the negative impact of community violence, however (Muller, Goebel-Fabbri, Diamond, & Dinklage, 2000).

The health effects of social support appear to be especially important to people with lower incomes. Low-income individuals with social support had better cardiovascular health and immune function than low-income people without support. These findings did not occur for those with higher incomes (Vitaliano et al., 2001).

Abuse History and Parenting Difficulties

Women who have been abused as children or adults may also have problematic relationships with their children, which can add to their life stress and compromise the health of mother and child. In one study, women with a

history of childhood sexual abuse were more anxious about the intimate aspects of caring for their own babies including activities such as diapering. These mothers were more worried that their normal parenting behaviors were inappropriate—or that others would see them that way. Finally, they reported more parenting stress than their nonabused counterparts (Douglas, 2000). This lack of confidence can have an erosive effect on their mental health, also increasing their risk for depression.

Dubowitz et al. (2001) found that when mothers have experienced multiple types of abuse, they were more likely to be depressed. They also used harsher discipline and had more problems with their children ($N = 419$). Mothers abused as children and as adults, or who were physically and sexually abused as children, had worse outcomes than those who suffered only one type of abuse. Mothers' depression and harsh parenting were associated with internalizing and externalizing behavior problems in their children. The authors speculated that mothers who have been victimized may be less attentive to their children, and less emotionally available. These mothers may also have less tolerance for the day-to-day stresses of parenting and may be more inclined to view their children's behaviors as problematic. The authors concluded that a mother's history of victimization appears to be highly prevalent in high-risk samples. More than one half of the mothers in their sample had been physically or sexually victimized at some time, and one half of the mothers victimized during childhood or adolescence were revictimized as adults.

A study comparing 670 nonabusing families with 166 abusive families found similar results (Gracia & Musitu, 2003). The families in this sample were Colombian and Spanish. The authors found that in both cultures abusive parents showed lower levels of community integration, participation in social activities, and use of formal and informal organizations than parents who were providing adequate care for their children. The abusive parents tended to be more socially isolated and negative in their attitudes toward their community and neighborhood.

Summary

Women with a history of childhood abuse or current partner violence are at increased risk for depression and parenting problems postpartum. Even if their current relationships are not abusive, they may not provide mothers with the necessary amount of support. This lack of support has implications for mothers' physical and mental health, and how they care for their babies. Current or past abuse can also affect another important part of the postpartum period: breastfeeding.

BREASTFEEDING

Breastfeeding is a major facet of the postpartum experience. At the present time, there are few studies on how abuse influences women's breastfeeding experiences. However, based on the studies we do have, and drawing from the larger breastfeeding literature, we can draw some reasonable conclusions. These studies, and their possible implications, are described below.

Breastfeeding and the Sexual Abuse Survivor

We currently have two studies that consider the impact of sexual abuse on breastfeeding. Benedict, Paine, and Paine (1994) studied 360 primiparous women in Baltimore, Maryland. The sample was predominantly African American and low income. Of these women, 12% were sexual abuse survivors. A higher percentage of sexual abuse survivors (54%) indicated an intention to breastfeed than their nonabused counterparts (41%).

Prentice and colleagues (Prentice et al., 2002) had similar findings with a very different population of mothers. This study included a national sample of 1,220 mothers with children younger than age 3 years. Of these women, 7% indicated that they were survivors of sexual abuse. As with the previous study, women who had been sexually abused were twice as likely to initiate breastfeeding (OR = 2.58) than their nonabused counterparts.

As hopeful as these findings are, there are significant gaps in what we know about survivors' breastfeeding experiences. For example, we do

not know how many of these mothers are able to breastfeed, or even what barriers they might face. From clinical observation, we know that some of these women encounter problems. And these problems may be at least partially because of the way their bodies have been primed to respond to stress—specifically, the impact of their abuse experiences on their cortisol levels when faced with current stressors. Cortisol levels can affect breastfeeding in the early days after birth. A recent study from Guatemala indicated that women who had abnormally high levels of cortisol after birth had a delayed onset of Lactogenesis II, the time when women's milk "comes in" at 3 to 4 days postpartum (Grajeda & Perez-Escamilla, 2002). Women who are abuse survivors often have disturbed cortisol levels, either being too high (in the case of depression) or too low (in the case of PTSD; Kendall-Tackett, 2000). A delayed milk supply at this critical time can cause women to falsely conclude that they cannot produce enough, and they may quit breastfeeding. Without proactive lactation management, these women may find it difficult to establish successful breastfeeding.

Current IPV and Breastfeeding

A recent review of 94 studies on the impact of childhood exposure to parental IPV asked whether women abused by their partners are less likely to breastfeed (Bair-Merritt, Blackstone, & Feudtner, 2006). The authors concluded that there was insufficient evidence to draw a conclusion; only one study addressed this issue and found no difference between abused and nonabused women in initiation or duration of breastfeeding. This study included a sample of 212 women recruited from a WIC (U.S. Women, Infants and Children supplemental feeding program) population (Bullock, Libbus, & Sable, 2001). Approximately 52% of the women had a history of abuse, and 13% had been hit in the past year. Among the women currently being abused, the number of women who breastfed ($n = 11$) was almost identical to the number of women who bottle fed ($n = 10$). The authors found no relationship between past or current abuse and feeding choice. The same proportion of abused and nonabused women breastfed their infants.

Current Abuse and Barriers to Breastfeeding

Although these are hopeful findings, they have not been replicated. From the broader breastfeeding literature, we can surmise that women involved in currently abusive relationships are likely to face significant barriers to breastfeeding. Research has identified several barriers to breastfeeding that are all more common in women in currently abusive relationships (Kendall-Tackett & Giacomoni, in press). For example, women who smoke, either in general or during pregnancy, are more likely to stop breastfeeding (Amir & Donath, 2002; Heck et al., 2003). And women who are being abused may smoke as a way to relieve stress (Kendall-Tackett, 2003). Similarly, women with short postpartum hospital stays are also more likely to stop breastfeeding (Heck, Schoendorf, Chavez, & Braveman, 2003). And it is likely that women with abusive partners are more likely to have short stays because their partners probably do not want them to remain in the hospital where someone could possibly detect abuse (Phelan, Hamberger, Ambuel, & Wolff, in press).

Women who have low-birth-weight babies (Heck et al., 2003) or babies admitted to the Special Care Nursery or NICU are also likely to stop breastfeeding. And premature delivery or other complications may come about as a result of abuse to the mother (Scott, Binns, Graham, & Oddy, 2006). Finally, women whose husbands or partners do not support breastfeeding are more likely to stop. And an abusive husband or partner may be more likely to consider his partner's breasts to be "his" and not for the baby (Kong & Lee, 2004; Scott et al., 2006).

Health Effects of Not Breastfeeding

Although cessation of breastfeeding is understandable in abuse survivors, there are health consequences of breastfeeding cessation for mother and baby. According the American Academy of Pediatrics (AAP; 2005), babies fed formula during the 1st year of life have a higher incidence of a number of diseases including pneumonia and bronchitis, diarrhea and other

digestive illnesses, ear infections, urinary tract infections, meningitis, and sudden infant death syndrome. Examining research worldwide, Jones and colleagues concluded that exclusive breastfeeding for 6 months could prevent 13% of child deaths—or prevent the deaths of 1.3 million children annually (Jones et al., 2003). And these findings are not confined to the developing world. A study in the United States concluded that many infant deaths between 1 month and 1 year of age could be prevented if all U.S. babies did any amount of breastfeeding (Chen & Rogan, 2004).

Breastfeeding also protects babies whose mothers are depressed from the harmful effects of maternal depression. Because VAW survivors are at high risk for depression, this study is of special interest. Jones, McFall, and Diego (2004) compared the infants of four groups of women: depressed mothers who were either breast- or bottle feeding, and nondepressed mothers who were either breast- or bottle feeding. The outcome measure was the babies' electroencephalogram (EEG) patterns. This measure is used to determine if infants have physiological symptoms of depression—in this case, a pattern of right frontal asymmetry. Right frontal asymmetry is a pattern that is also found in chronically depressed adults. When the researchers compared the babies of the depressed and nondepressed mothers, they found that babies of depressed/nonbreastfeeding mothers had the abnormal pattern of right-frontal asymmetry.

In contrast, the infants of the depressed/breastfeeding mothers had patterns that were indistinguishable from the babies of nondepressed women. In other words, breastfeeding protected these babies from the effects of maternal depression. The authors explained these findings by noting that the depressed/breastfeeding mothers did not disengage from their babies but continued to look at, touch, and stroke their babies because these behaviors are built-in to the breastfeeding relationship. In contrast, when mothers use a bottle to feed their babies, they do not have to even hold their babies, making it easier for them to disengage. This disengagement can lead to the symptoms that babies typically exhibit when their mothers are depressed (Jones et al., 2004).

Summary

Past or current abuse can lead to breastfeeding cessation, which increases the risk of illness in babies and makes them more vulnerable to the potentially harmful effects of maternal depression. However, even though women often face significant obstacles to breastfeeding, some still manage to breastfeed their babies, which has a positive effect on both infant and maternal health.

CONCLUSIONS

Although data are limited on the impact of VAW on women's perinatal health, we do know that women experiencing past or current VAW are at increased risk for depression, PTSD, and

physical health consequences antenatally and postpartum. There can be significant barriers to breastfeeding for VAW survivors, and this has health implications for women and their babies. However, there are some hopeful signs. Not all women who have experienced past abuse become depressed, end up in unsupportive or abusive relationships, or have difficult relationships with their children. And even in the face of significant barriers, women who have experienced violence are breastfeeding their babies. These hopeful signs offer us at least a glimpse of what the perinatal experiences of all abuse survivors could be like. And improving the antenatal and postpartum experiences of women with a history of violence is a goal worth pursuing.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Women are at risk for violence throughout the perinatal period.
- There are significant gaps in the research literature about women's experiences as abuse survivors in the perinatal period. This includes their experiences of pregnancy, labor and delivery, and breastfeeding.
- Even if not in a currently abusive relationship, women's health may be affected by depression and posttraumatic stress disorder.
- Depression and breastfeeding cessation are two factors that can have a major impact on women's health and the health of their babies.

CRITICAL FINDINGS

- Past or current abuse can have a significant impact on women's relationships and how much support they receive from them.
- Lack of support and social isolation increase the risk of depression and can have a negative impact on women's relationships with their babies.
- Women in currently abusive relationships may want to breastfeed but face significant barriers.
- The types of barriers that survivors of childhood abuse face when breastfeeding are still largely unknown.
- There are major health implications for mothers and babies when women are prevented from breastfeeding.

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Kathleen A. Kendall-Tackett, PhD, IBCLC, is a health psychologist, international board-certified lactation consultant, and research associate professor of psychology at the Family Research Lab, University of New Hampshire. She is a fellow of the American Psychological Association for the Divisions of Health Psychology and Trauma Psychology. She is author or editor of 15 books including Treating the Lifetime Health Effects of Childhood Victimization (2003), Health Consequences of Abuse in the Family (2004), Handbook of Women, Stress and Trauma (2005), Depression in New Mothers (2005), and Intimate Partner Violence (2007).