



Unit 10 Lactation Consultant Series Two

Breastfeeding and the Sexual Abuse Survivor

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As the time of my son's birth approached, my worries about breastfeeding came into sharp focus. I knew the benefits of breastfeeding and had plenty of book knowledge on the subject. I knew I wanted to breastfeed. I had been sexually abused when I was a child, however, and I was concerned. I worried that I would not be able to maintain the constant physical closeness breastfeeding would require and that breastfeeding might trigger memories of the abuse. I was especially distraught because I believed that I would be failing my child and myself if I were not able to breastfeed (Beth Dubois).

Introduction

Child sexual abuse can have a major impact on women throughout their lives. It can impact their physical and emotional health and their relationships with others—including their babies. Many women who have been abused want to breastfeed their babies. But they come to new motherhood with issues and concerns that are unique to them and their experiences, as Beth describes above.

In this presentation, the author provides an overview of the lifetime effects of childhood sexual abuse. The framework is modified from the one presented previously (Kendall-Tackett

1998), and reflects the newest work in the field. The literature on the long-term effects of sexual abuse is rich and can provide insight into how to best work with these mothers. While sexual abuse can be a devastating experience, it need not become the blueprint for the rest of one's life. Women can, and do, recover from it. By breastfeeding their babies, women can move their lives in a healing and life-affirming direction.

Do Abuse Survivors Want to Breastfeed?

The answer to that question depends on whom you ask. I have spoken with some abuse survivors who are adamant about not breastfeeding. We must respect that decision. However, other mothers are interested and want to try it. As two recent studies with very different populations have found, mothers who want to try may be the larger group. These are the women we want to reach.

In the first study, the sample was 360 primiparous women (Benedict, Paine, & Paine 1994); 74 percent were African American, and 77 percent were low-income. Twelve percent of these women were sexual abuse survivors. There were no differences between the women who had been sexually abused and the non-abused women on rates of cesarean births, induction or augmentation of labor, use of anesthesia, or failure to progress during labor. But a higher percentage of sexual abuse survivors (54 percent) indicated an intention to breastfeed than did their non-abused counterparts (41 percent).

A more recent study surveyed a nationally representative sample of 1,220 mothers with children younger than age three. Seven percent of this sample reported past sexual abuse. Women who were sexually abused were twice as likely to initiate breastfeeding (OR=2.58)¹ as the non-abused women. The abuse survivors were also more likely to be divorced, separated, or never married, to have lower incomes, an unwanted pregnancy, and late prenatal care than their non-abused counterparts (Prentice et al. 2002).

¹ OR=Odds Ratio

Abuse Survivors in the Health Care System

If you are a health care provider, you are in a unique position to work with sexual abuse survivors because they tend to be high utilizers of health care services. Generally speaking, they see more doctors, make more trips to the emergency department, and see more specialists than their non-abused counterparts. They report more symptoms on a review of systems (Kendall-Tackett 2003; Kendall-Tackett, Marshall, & Ness 2000). Their surgery rate is twice that of their non-abused counterparts (Kendall-Tackett et al. 2000). They report more chronic pain including fibromyalgia, headache, pelvic pain, and irritable bowel syndrome (Kendall-Tackett 2003; Kendall-Tackett, Marshall, & Ness 2003). Not surprisingly, they report less satisfaction with their health.

Another pattern you might observe is avoidance of all health care, which can cause them to wait until their symptoms are severe before seeking help (Haven & Pearlman 2004). This group may delay seeking care until late in their pregnancies (Prentice et al. 2002). But even this group of women can be high utilizers of health care once they do come for care. In a study from Norway, women with a history of sexual abuse reported more health complaints during pregnancy and used more health care services than their non-abused counterparts (Grimstad & Schei 1999). In a second study, sexual abuse survivors reported more depression during pregnancy, negative life events, and physical and verbal abuse before and during pregnancy than their non-abused counterparts (Benedict et al. 1999). In both studies, however, abuse survivors did not have higher rates of obstetric complications, low birth weight babies, or difficulties with newborn outcomes.

Another study examined the impact of a common sequela of past abuse—posttraumatic stress disorder (PTSD)—on pregnancy. The sample was a large group of women either with or without PTSD. Women with PTSD had significantly higher odds ratios for ectopic pregnancy, spontaneous abortion, hyperemesis, preterm contractions, and excessive fetal growth (Seng et al. 2001). Each of these complications can also increase mothers' risk of depression, which will be described in a subsequent section. PTSD will also be defined in more detail in a subsequent section.

Prevalence of Sexual Abuse

Unfortunately, sexual abuse is not a rare phenomenon. It may be something you encounter in the mothers you work with on a regular basis. In the United States, current estimates are that one in five women have been sexually abused before the age of 18 (Kendall-Tackett 2001). This is a crime that differentially impacts girls. According to the Third National Incidence Study (NIS-3), girls' risk of abuse in general was 33 percent higher than that of boys. That difference was due largely to sexual abuse: girls were sexually abused at three times the rate of boys (Sedlak & Broadhurst 1996). Girls may also become victims of rape and dating violence as teens. Current estimates are that one in 10 to one in five teens reports being hit, slapped, or forced to have sex by a dating partner (Centers for Disease Control 2000; Scott & Eliav, in press). A study of college-age women found that one in five in a nationally representative sample reported a rape (forced sexual intercourse) at some point in their lives (Brener et al. 1999). The National Violence against Women Survey indicated that one in six women have experienced rape or attempted rape in their lifetimes (Basile, in press; Tjaden & Thoennes 2000). And most rapes (approximately 71 percent) occur before the age of 18 (Basile, in press).

According to the World Health Organization (Jewkes et al. 2002), sexual violence against women is not just a problem in the US or North America; it is a problem for women and girls all over the world. Rates of sexual abuse in other countries, particularly in the developing world, are often difficult to determine due to war, poverty, and/or lack of appropriate infrastructure. But preliminary findings indicate that it occurs in every region of the world.

The peak age of vulnerability is seven to 13 years, but children much younger or older have also been victimized. Older children can also have increased vulnerability due to peer abuse (Finkelhor 1994).

The overwhelming majority of the perpetrators are male, and almost all are known to the victim. For female victims, 33 percent to 50 percent of perpetrators are family members (Finkelhor 1994).

Assumptions about Sexual Abuse

Before describing the long-term effects of sexual abuse, and how they relate to breastfeeding, I want to provide a framework for interpreting what these symptoms mean.

There Is No Uniform Response to Sexual Abuse

In a meta-analysis on the effects of sexual abuse on children, there was no single symptom that every child experienced. Some symptoms were more common in abused children than in non-abused children (e.g., sexual acting out). But there was no one symptom that all, or even, most children exhibited (Kendall-Tackett, Williams, & Finkelhor 1993). If this is true for children, who are much closer to the traumatic event, it is more strongly true for adults. There are many intervening events—good or bad—that can influence women who have experienced sexual abuse. If the events are healing, such as positive relationships with friends and/or a spouse, the effects of abuse will be attenuated. However, if women experience other noxious events (such as peer victimization and/or domestic violence), the effects of their childhood experience are likely to be exacerbated.

Other Traumatic Events during Childhood Can Cause Similar Responses

Unfortunately, sexual abuse is not the only bad thing that can happen to children. Sometimes, mothers present with symptoms that seem as though they could be caused by past sexual abuse, but they are not. Other traumatic events, such as physical abuse, dating violence, peer victimization (particularly if severe), motor vehicle accidents, and even death of or separation from a parent can cause some very similar reactions. The presence of the symptoms described in the next section means that sexual abuse is a possibility—not a certainty.

Where a Woman Is in Her Own Healing Can Influence Her Reactions

Not all sexual abuse survivors are the same in terms of how they have progressed through their healing process. Some will deal with their past abuse for the first time during the postpartum period. Others are well along in their healing and may simply need some reassurance to get through this new phase of their lives. Also, some women have experienced less severe abuse than others. They may be further along in their healing because they were less severely affected in the first place.

The Long-Term Effects of Child Sexual Abuse

In reviewing the possible long-term effects of child sexual abuse, keep in mind that there are a range of responses. Most women will not experience all or even most of these. But these reactions can happen, and you may encounter them.

Sexual abuse can affect women in five distinct areas of functioning. Each of these can influence breastfeeding, and these areas overlap with each other. The five domains of functioning are:

- Physiological
- Behavioral
- Cognitive
- Social
- Emotional

Physiological Changes

Traumatic events, such as sexual abuse, lead to tremendous fear in children. And this fear response can change children's brains and nervous systems and organize how their neural systems respond to the world. Indeed, traumatic experience can become the filter through which all new information is processed.

In reviewing the literature, Lovallo (1997) described how traumatic stress has the largest impact on the central nervous system. The changes appear to be related to long-term alterations in frontal-limbic connections in the brain and alterations in feedback to the central nervous system from the brainstem aminergic nuclei, which produce the neurotransmitters serotonin and norepinephrine. Experience may alter behavior in an adult, but it literally provides the orga-

nizing framework for a child. Because the brain is most malleable during these first five years, the child is most vulnerable to traumatic experiences during that time.

While it is adaptive for a child growing up in an abusive environment to become hypersensitive to external cues, this constant exposure to traumatic stress actually organizes their neural systems to adapt to a violent or chaotic environment. Adults exposed to traumatic events become sensitized and reactive to cues specifically related to their trauma. Children exposed to consistent trauma, in contrast, develop a generalized physiological hyperarousal, and all cues activate this system (Perry 2001). This can carry on into adulthood.

Chronic stress has been shown to alter components of the hypothalamic-pituitary-adrenal (HPA) axis (Yehuda et al. 1996). These alterations manifest themselves in many ways including abnormal levels of stress hormones such as norepinephrine and cortisol, specific changes in the number or sensitivity of receptors to these substances, and changes in certain brain structures such as the hippocampus (Lovallo 1997; Southwick et al. 1994; Weiss, Longhurst, & Mazure 1999). These changes can also mediate the association between early-life stress and the development of mood and anxiety disorders and may also account for symptoms of depression in response to current stress (Heim et al. 2000).

Bremner (in press), in a recent review of the literature, including several studies from his own lab, recounts some of the physiological changes that can accompany past sexual abuse. He noted that abused women with PTSD had physiologic differences in their brains compared to non-abused women. First, they had changes in the HPA system, such that they had abnormal levels and diurnal variations in circulating stress hormones. This makes them more responsive to subsequent stressful events.

Second, several brain structures were smaller in children who were abused and also had posttraumatic stress disorder (PTSD). These structures include the hippocampus (involved in learning and memory), and corpus callosum (the fibrous band that joins the two brain hemispheres and allows communication between the “right brain” and “left brain”). Overall brain volume was also lower in children with PTSD. There were other abnormalities in the anterior frontal cortex and temporal lobes. The constant bath of stress hormones appears to be highly toxic for developing brain tissues, and the experience of severe stress and early trauma

appears to harm brain structures and rewire neural circuitry (Bremner in press).

Finally, the neural circuitry of women with abuse-related PTSD was also significantly different from that of non-abused controls. This was manifested on various tasks asking women to respond to emotionally laden words, and tracking their brain function via PET Scans.² Women with abuse-related PTSD showed distinct differences in how they processed these words, showing a sensitization to words related to victimization (Bremner, in press).

Implications for Breastfeeding

These studies reveal three areas that are relevant to breastfeeding mothers: vulnerability to depression, vulnerability to infection, and sensitivity to pain.

The results of these studies indicate that abuse survivors are often more vulnerable to stress because their brains are sensitized to respond in this way. These physiological findings support what clinical studies have demonstrated for 20 years: that abuse survivors are more prone to depression. It is therefore important to be diligent in working with these mothers to screen for depression, which is described in a subsequent section.

Abnormalities in the HPA system can lead to a suppression of the immune system due to abnormally high levels of cortisol. This means that mothers may be especially susceptible to infections. It is especially important for these mothers to take good care of themselves and to get help so that they do not get overly fatigued. If they are highly stressed and/or fatigued, they may also take longer to recover from birth.

Abuse survivors may also report pain that seems out of proportion with clinical findings. Women who have been abused, particularly if the abuse was severe, long-lasting, and occurred early in life, can be more sensitive to sensations that they perceive as painful. Their bodies may register a sensation as “painful” even when it would not necessarily be so for non-abused women. Pain can also trigger either depression or a PTSD response and needs to be dealt with promptly (Kendall-Tackett 2000).

2 PET=Positron Emission Tomography

Behavioral

Harmful Behavior

The second area where abuse survivors can be affected is in their behavior. Adult survivors of childhood abuse are more likely to behave in harmful ways, and the health implications are staggering. Behavior and lifestyle play a major role in heart disease, cancer, HIV, and injuries, and they can also have an impact on breastfeeding. Several of these harmful behaviors will be considered separately below. But as Dallam (2001) rightly observes, these harmful activities tend to occur together, thereby multiplying their harmful effects.

Substance Abuse

Adult survivors are at increased risk for abusing alcohol and drugs. A number of studies have found a high percentage of substance abusers have a history of childhood abuse. The results are remarkably consistent across study type and population. Below are a few examples of these studies.

In a national survey of 1,099 American women, women who had been sexually abused were significantly more likely to report recent intoxication, drinking-related problems, symptoms of alcohol dependence, and lifetime abuse of prescription and illicit drugs compared to women with no abuse history (Wilsnack et al. 1997).

In a sample from a rural family practice (Springs & Friedrich 1992), women with a history of sexual abuse were more likely to abuse drugs and to report that they needed to decrease the amount of alcohol they consumed. In two other primary-care samples, men and women with a history of victimization were more likely to use recreational and IV drugs (Kendall-Tackett et al. 2000) and report heavy drinking than patients without an abuse history (Hulme 2000).

Implications for Breastfeeding

Active substance abuse can complicate any breastfeeding or parenting experience. Mothers actively abusing substances may need to wean because of potential harm to their babies. Although you may not encounter this often, it is

a genuine concern. You may encounter this even in populations that seem, on the surface, to be low risk. Substance abuse can also put mothers at risk for other problems that can seriously compromise their health.

Smoking

While not all smokers are abuse survivors, smoking is more likely among those with a history of abuse (DeWit, MacDonald, & Offord 1999; Kendall-Tackett et al. 2000). In a family-practice sample (Springs & Friedrich 1992), sexual abuse predicted smoking. Women whose abuse started at an early age began smoking at an early age, too. Indeed, the women who had been sexually abused started smoking 1.6 years earlier than their non-abused counterparts. Sexual abuse, but not current age, predicted heavier smoking.

The presence of PTSD may be more predictive of smoking than abuse history alone. In a sample of women who had been sexually abused, 45 percent of abused women with PTSD smoked. In contrast, abused women without PTSD and non-abused women did not smoke at all (Lemieux & Coe 1995). In a study of chronic pain, subjects who were abused as children or adults were significantly more likely to smoke (46 percent vs. 18 percent: Scarinci et al. 1994). Norwegian women with a history of sexual abuse were more likely to smoke during pregnancy (Grimstad & Schei 1999).

Anda et al. (1999) raised the question of how abuse survivors might benefit from the use of nicotine. They speculated that abuse survivors might use nicotine as a psychoactive substance to help regulate their emotional state and boost their mood. These authors did also find a strong, graded relationship in their data between depression in the past year and abuse severity. Current smokers were always more likely to have been depressed.

Ironically, although most smokers feel that cigarettes help them relieve stress, the reality is that stress levels of smokers are generally higher than those of non-smokers. In reviewing a number of past studies, Parrott (1999) concludes that nicotine dependence seems to cause stress. In general, smokers report being under more stress and have repeated negative moods throughout the day between cigarettes. The apparent mood benefits of smoking only reflect the relief of withdrawal symptoms. Not surprisingly, quitting smoking decreased stress.

Implications for Breastfeeding

While it is considered better for a mother who smokes to continue to breastfeed, any reduction in the number of cigarettes she smokes will have health benefits for herself and her baby. Smoking can also have an impact on breastfeeding. THE BREASTFEEDING ANSWER BOOK lists several possible effects of smoking on breastfeeding including earlier weaning, fussiness, suppressed prolactin levels, lower milk production, and interference with milk let-down (Mohrbacher & Stock 2003). Smoking can also reduce any protection that breastfeeding confers for the prevention of SIDS (Sudden Infant Death Syndrome). Encouraging mothers to either quit or cut down is a good idea both for mothers in general and for mothers who are abuse survivors.

Eating Disorders

Although the results of research studies finding a connection between sexual abuse and eating disorders are mixed, past abuse does seem to increase the likelihood of eating disorders for some women. In a primary-care sample, women with a history of sexual abuse were more likely to report eating too little, eating too much, and making themselves vomit than women with no reported history (Hulme 2000). In a large community sample, men and women who had been sexually assaulted were more likely to think they were too fat and to report one or more symptoms of anorexia (Laws & Golding 1996).

Miller, McClusky-Fawcett, and Irving (1993) found that significantly more young women diagnosed with bulimia reported sexual abuse after age 12 than did a group of matched controls. However, the relationship between sexual abuse prior to age 12 was nonsignificant. There were also high rates of dissociation and unusual mealtime experiences among the bulimic women. The authors conservatively suggest that sexual abuse may be related to the onset of bulimia for some women. Others have not found a relationship (Kinzl et al. 1994; Rorty, Yaeger, & Rossotto 1994).

Implications for Breastfeeding

Eating disorders can also put mothers at risk for breastfeeding difficulties. Mothers who restrict calories to less than 1800/day still produce adequate milk, but deplete their own reserves. Mothers who are chronically malnourished may produce milk that is deficient in vitamins A, D, B6, and B12 (Mohrbacher & Stock 2003). Moreover, mothers with past or current eating disorders are at higher risk for preterm delivery. These

mothers may also perceive that their babies are “too fat,” and attempt to restrict the baby’s caloric intake. Conversely, mothers who have experienced eating disorders may worry that their babies are not gaining enough weight because of their concerns about their own nutritional status. Or they may project their own behaviors onto their babies and constantly describe them as “bad eaters” even when they are gaining well and normally.

High-Risk Sexual Behavior

Sexual abuse is related to a number of high-risk sexual behaviors. The most commonly occurring includes early initiation into consensual sexual activity, many sexual partners, and risky sexual practices (e.g., no condom, no contraception). Other consequences include abortion, sexually transmitted diseases (STDs), and teen pregnancy (Kendall-Tackett 2003).

A question that is often raised is “Why do abuse survivors engage in high-risk sexual activity?” Many of the mediators of sexual behavior are cognitive. These processes include such thoughts as the need for social acceptance. Shame and guilt can also mediate high-risk sex (Parillo et al. 2001). In a retrospective study, self-blame resulting from early childhood abuse predicted later vulnerability to exploitation as adults (Liem & Boudweyn 1999). Early sexual abuse may set up and perpetuate a lifetime pattern of revictimization (Parillo et al. 2001).

Depression is another possible link. Someone who is depressed or angry may engage in self-gratifying behaviors including unsafe sexual practices or substance abuse in order to distract themselves from these negative states. Distorted thinking may also reduce the sense of self-care and motivation to protect themselves (Crepaz & Marks 2001).

Sexual risk behaviors may also be due to impulsivity, low self-esteem, and powerlessness (Brown et al. 1997). This may manifest as failure to set limits in sexual encounters, such as when participants fail to discuss safe-sex activities or cannot resist pressures to engage in high-risk sexual behaviors.

Implications for Breastfeeding

Early consensual sex and high-risk sexual practices often lead to teen pregnancy. Perhaps not surprisingly, teen mothers often have a history of sexual abuse or assault. But high-risk sexual activity can occur with older mothers as well. Women who have many unplanned pregnancies and/or have closely spaced babies may be abuse survivors and may have a current history of intimate partner violence as well (Campbell, in press). These women are also at substantially increased risk of HIV/AIDS, Hepatitis B, and other sexually transmitted diseases. These diseases may lead to a cessation of breastfeeding.

Sleep Difficulties

Sleep difficulties are also more common in abuse survivors. While not strictly a behavior, sleep has a strong behavioral component and is therefore included in this section. Several recent studies have found that abuse survivors may have impaired sleep. None of these studies was conducted on postpartum women, however, who are generally sleep deprived due to infant care. Abuse-related sleep problems may compound the problem of postpartum fatigue and may be due to the physiologic alterations described in the previous section.

In one study, 68 percent of sexual abuse survivors reported having sleep difficulties, with 45 percent having repetitive nightmares (Teegen 1999). In another study, subjects who had experienced at least one type of trauma (physical abuse, emotional abuse, sexual abuse, neglect, medical trauma, or a combination) reported significantly more sleep difficulties (including nightmares, sleep apnea, and narcolepsy) than the group with no trauma (Chambers & Belicki 1998).

Hulme (2000) found that sleep problems among sexual abuse survivors were common in a primary-care sample. Fifty-two percent of sexual abuse survivors reported that they could not sleep at night (compared with 24 percent of the non-abused group), and 36 percent reported nightmares (compared with 13 percent). Intrusive symptoms were also common with 53 percent of sexual abuse survivors reporting sudden thoughts or images of past events compared with 18 percent of the non-abused group.

Implications for Breastfeeding

Sleep problems have several potential effects on breastfeeding. Mothers who are overly fatigued may find their milk supply is affected, or that they are more vulnerable to plugged ducts and/or mastitis. Fatigue can also affect their desire to breastfeed; very tired mothers may decide to give up breastfeeding in order to conserve their energy. However, they may discover that weaning does not solve their problem with fatigue.

Sleep problems are also of concern because of their relationship to depression. Sleep-deprived mothers are more prone to depression, which can lead to breastfeeding cessation as well (Kendall-Tackett, in press).

Cognitive Influences: Beliefs about Self and Others

Abuse can also influence women's beliefs about themselves and others. Some of the more common types of beliefs related to past abuse are described below.

Shame and Self-Blame

Shame and self-blame are two overlapping emotional reactions that have to do with the amount of responsibility a survivor takes for the abuse. They are related to symptoms that women experience. In one study, women who blamed themselves for their sexual abuse had more severe psychopathology than abuse survivors who did not blame themselves. Self-blame was more likely when abuse was incestuous (Lange et al. 1999). McMillen and Zuravin (1997) had similar findings. Self-blame for sexual abuse was related to poor self-esteem, anxiety over relationships, and reduced comfort with closeness. If women blamed the perpetrator, they were less likely to have adjustment problems.

Wyatt, Newcomb, and Notgrass (1991) noted that 55 percent of female rape survivors blamed themselves for their experiences. Women who blamed themselves made poorer subsequent adjustments, and had more symptoms of PTSD. In a qualitative study of 40 sexual abuse survivors, women were more likely to self-blame if their abuse was chronic or they were younger when it started (Perrott et al. 1998).

Implications for Breastfeeding

Shame and self-blame are particularly toxic emotions, and both can be activated by the nudity and exposure that are inherent parts of childbirth and breastfeeding. These mothers may express shame about their birth experiences, or about their breasts and the physical

sensations of breastfeeding. It's particularly important for these mothers to be given a choice in terms of how much they are covered and who is around when they need to expose their breasts. It is also important to be sensitive to the fact that educational materials with a lot of breast exposure may cause some mothers to be concerned about their comfort level with the idea of breastfeeding.

Self-Esteem/Self-Efficacy

Child sexual abuse can also undermine women's sense of who they are. Two overlapping characteristics are self-esteem and self-efficacy. Self-esteem includes both self-liking and self-efficacy. Self-efficacy refers to beliefs about how competent people feel they are. Efficacy beliefs influence the course of action chosen, how much effort is put into the action, how long they persevere, and how much they accomplish (Bandura 1999).

In a primary-care sample, 65 percent of women with a history of child sexual abuse indicated that they had low self-esteem and did not feel good about themselves compared with 31 percent of the non-abused group. Guilt was also common, with 60 percent of the abused group reporting guilt compared with 21 percent of the non-abused group (Hulme 2000). Another study (Schuck & Widom 2001) found that abuse survivors had significantly lower self-esteem than their non-abused counterparts, and they were significantly more likely to report that they felt worthless.

Self-efficacy is grounded in the attachment relationship with the primary caregiver. According to attachment theory, the quality of this attachment provides the "safe-base" from which the child gains mastery experience. It has been hypothesized as the primary source of efficacy beliefs (Ryan, Solberg, & Brown 1996; Weinfield, Sroufe, Egeland, & Carlson 1999). Children with secure attachments learn that they can get their needs met through their own efforts. In contrast, when children are abused or neglected, and their attachments are insecure, they grow up believing that their efforts are ineffective, and that they must rely on others who may or may not meet their needs (Weinberg et al. 1999).

Implications for Breastfeeding

For many women, self-efficacy may turn out to be the most important predictor of whether they will continue to breastfeed. It predicts many different types of health behavior, such as compliance with diabetes or HIV treatment regimens (Kendall-Tackett 2003). It

even predicts the health of their children, i.e., children of mothers with low self-efficacy are often sicker than those with high self-efficacy (Grus et al. 2001). Mothers who are low in self-efficacy are likely to quit breastfeeding when they encounter any type of difficulty. Helping mothers feel that they can breastfeed, and that they can solve any breastfeeding problems, will be especially helpful.

Mistrust and Hostility

Adult survivors are often mistrustful of others. Given their experiences, their reaction is quite understandable. But it can have a negative effect on their lives now. In a sample from primary care, 52 percent of sexual abuse survivors indicated that they could not trust others compared with 17 percent of the non-abused women (Hulme 2000). Teegeen (1999) found that approximately half of the sexually abused women in her sample described their current views toward life, themselves, and others as very negative.

The health effects of hostility are well documented. Hostility has garnered a great deal of attention because of its link to cardiovascular disease. Hostility is associated with heightened cardiovascular and neuroendocrine reactivity when the hostile person is confronted with stressful situations. Hostility increases physiological arousal because of the way hostile people interpret the world; they are more likely to perceive even neutral events as negative, responding strongly because they perceive interpersonal threat (Kiecolt-Glaser & Newton 2001). Hostile people are also more prone to ischemia, and they may also be more prone to constriction of the coronary arteries during mental stress (Boltwood et al. 1993). These findings are intriguing because of the possible relationship of hostility to Raynaud's phenomenon; a condition of involuntary vasospasm that can cause sharp nipple pain.

Negativity and hostility can have a major impact on relationships as well, and may lead to problems with a woman's partner, her perceptions of her baby and her baby's needs, and even her relationship with health care providers.

Implications for Breastfeeding

Hostility and mistrust can influence breastfeeding in a number of ways. Physiologically, it can increase a mother's stress level and make her more prone to vasoconstriction. This has a possible link to difficulties in letting down and also Raynaud's. Hostility can also cause a misinterpretation of the baby's needs (e.g., "he's just getting what he wants, just like any man"), and can influence relationships with adults. Hostile mothers may find that they are socially isolated, and this can also influence their ability to breastfeed.

Social Factors

Since abuse survivors often have negative beliefs about themselves and others, it should not be surprising to learn that social relationships are also often difficult to sustain. Lack of social support can influence a woman's ability to breastfeed.

Quality of Current Relationships

Adult survivors can have difficulties in their adult partnerships. In an Australian study, sexual abuse survivors were more likely to be involved with alcoholic partners and to report dissatisfaction with their relationships. They were significantly more likely to be divorced or separated than their non-abused counterparts (Fleming et al. 1999).

Social isolation is also more common for abuse survivors. In a sample of university women, those who were sexually abused were lonelier and less likely to use social support than the women who had not been sexually abused. Of the sexually abused women, half were in treatment, half were not. The women in treatment were lonelier than those women not in treatment. However, those in treatment also had experienced more severe abuse overall (Gibson & Hartshorne 1996).

Another study found that relationship problems were common in a sample of sexual abuse survivors recruited from a primary-care practice. For example, 24 percent of abuse survivors indicated that they had problems keeping friends and partners compared with seven per-

cent of the non-abused group (Hulme 2000). And approximately half the women in a European community sample of child sexual abuse survivors described themselves as socially isolated (Teegen 1999).

Revictimization

In a cruel twist of fate, abused children are at increased risk for re-abuse by others. And this vulnerability can continue throughout their lives. In a community sample of sexual abuse survivors, an astonishing 41 percent had experienced sexual violence one or more times in relationships, at work, or in therapy (Teegen 1999). A recent review indicates that anywhere from 32 percent to 82 percent of people who are sexually victimized as children are sexually revictimized as adults (Grauerholz 2000). Studies of college students have also consistently found that sexual victimization early in life was a risk factor for adult victimization (Gidycz et al. 1993). In a national sample of college women (Koss & Dinero 1989), 66 percent of women who had experienced rape or attempted rape had been sexually abused as children.

Australian women whose abuse included intercourse were four times more likely to have been battered and raped since age 16 than the non-abused comparison group (Fleming et al. 1999). Similarly, in a study of young women from New Zealand, those with a history of child sexual abuse had higher rates of sexual assault after age 16 (Fergusson et al. 1997). In another community sample, 49 percent of women whose abuse included penetration had also been raped as adults (Parillo et al. 2001). Parillo and colleagues speculated that childhood sexual abuse changes women's perceptions of sexuality and themselves as sexual beings. They may feel that they don't deserve pleasure, do not cherish and respect their bodies, and therefore do not expect respect from others.

Implications for Breastfeeding

Mothers who are socially isolated, and who have difficulties in relationships, can be some of the more challenging mothers to work with. While this is not always true, mothers who are abuse survivors can be difficult, and may have real difficulty connecting with others in healthy, reciprocal relationships. Relational difficulties are also related to revictimization. Ongoing abuse can have an obvious negative impact on breastfeeding. On the other hand, relationships can be vehicles for healing for mothers. Mothers can learn to make more healthy connections, and this can aid in their relationships with their babies and their overall wellness.

Emotional Disturbances

Abuse survivors often have psychiatric difficulties as adults. The two most common are depression and posttraumatic stress disorder (PTSD). These are described below.

Depression

Depression is a common reaction to past sexual abuse. Felitti (1991) found that 83 percent of sexually abused patients were depressed compared with 32 percent of the comparison group in a primary-care sample. The depressed women's symptoms included sleep disturbances, chronic fatigue, despondency, and frequent crying spells. The majority of the depressed patients had never been treated. In another primary-care sample, women who had been sexually abused were significantly more likely to report feeling blue or depressed. Indeed, 65 percent were depressed compared with 35 percent of the non-abused group. An even higher percentage (68 percent) reported mood swings, compared with 29 percent of non-abused women. These same women were also more likely to report extreme anger and rage, fear of being alone, and spells of panic or terror, but a smaller percentage of women had these symptoms (Hulme 2000).

Another study considered whether sexual abuse survivors were a distinct sub-group among depression patients (Gladstone et al. 1999). Those with a sexual abuse history had more self-reported depression, personality dysfunctions, and more overall adversity in childhood. Zuravin and Fontanella (1999) compared the effects of sexual abuse to other types of maltreatment and family dysfunction. They found that women who had experienced child sexual abuse were three times more likely to be depressed than non-abused women in their sample. Child sexual abuse made an independent contribution to the variance in depression that was over and above that of other adverse events in childhood.

Abuse survivors are also more prone to postpartum depression. Buist and Janson (2001) conducted a three-year follow-up study of mothers who were hospitalized for major depressive disorder during the postpartum period. They discovered that half of these depressed women were sexual abuse survivors. When compared with other depressed women, those who had been abused had higher scores on depression and anxiety measures, and their symptoms showed less improvement over time. The women's partners were also more likely to describe their children as "dis-

turbed." In addition, sexually abused women reported more life stress, and they had significantly higher scores on the Parenting Stress Index.

Suicide

Postpartum suicide is, fortunately, a rare occurrence (Kendall-Tackett, in press). But the risk of suicide increases for abuse survivors. A study of US college women found a link between sexual victimization and suicide risk. Women had the highest risk for suicide when their abuse experiences included force and penetration, both indices of greater severity (Stepakoff 1998). A French study of teens (Choquet et al. 1997) found that those who had been raped were significantly more likely to report suicidal thoughts (OR=6.1) than those who had not.

In a study of women patients in a primary-care practice (Hulme 2000), women with a history of sexual abuse were significantly more likely to report hurting their bodies and thinking about killing themselves. There was no significant difference in actual suicide attempts. In the Adverse Childhood Experiences study (Felitti 2001), those who experienced four or more adverse childhood events were 460 percent more likely to be suffering from depression, and 1,220 percent more likely to have attempted suicide. In a European community sample, 43 percent of sexual abuse survivors had suicidal ideation, and 14 percent had made suicide attempts (Teegen 1999).

Implications for Breastfeeding

As described in a previous unit (Kendall-Tackett 2004), depression can have a devastating effect on breastfeeding. Researchers from several countries (Barbados, Pakistan, England, and Canada) have examined the role of depression in breastfeeding cessation. In each of these studies, depression preceded weaning (Bick, MacArthur, & Lancashire 1998; Galler et al. 1999; Misri, Sinclair, & Kuan 1997; Taj & Sikander 2003). In order for breastfeeding to continue, these mothers may need help with depression.

Posttraumatic Stress Disorder (PTSD)

People who experience psychological trauma, either as children or adults, often manifest symptoms of PTSD. PTSD is a common, but not universal, response to stress (Yehuda 1998). According to diagnostic criteria for PTSD, survivors must manifest symptoms in three clusters—avoidance, intrusion, and hyperarousal—in order to receive a diagnosis of PTSD. However, even if a woman does not meet full criteria, she can have symptoms of PTSD that can be troublesome.

PTSD was originally formulated to describe reactions of men who had been in combat. But now it is applied to trauma associated with childhood abuse and other life experiences. A study of hospitalized teens found that 93 percent had experienced at least one traumatic event, and 32 percent met the criteria for PTSD. Of the patients with PTSD, 69 percent had been sexually abused, and 28 percent had been physically abused (Lipschitz et al. 1999).

Implications for Breastfeeding

PTSD can also influence breastfeeding. Birth and breastfeeding can act as triggers for PTSD. The triggers can be tactile (e.g., pain, skin to skin contact, squirting sticky milk), olfactory, auditory, or visual. Mothers may have traumatic flashbacks to their abuse experiences during labor or during breastfeeding. Flashbacks are very memorable, but they are relatively rare in my experience.

A more common way that PTSD can influence breastfeeding is through co-morbid reactions. For example, in a study of 801 mothers of low birth weight infants, Breslau and colleagues (1997) found that PTSD dramatically increased the risk for alcohol abuse and first-time major depressive disorder. In addition, pre-existing major depression increased the risk for PTSD in the wake of trauma-producing events and even increased risk of exposure to traumatic events. PTSD can increase vulnerability to other stressors, all of which can lead to a cessation of breastfeeding.

Intervention

There are a number of specific steps health care providers can take to help sexual abuse survivors have positive breastfeeding experiences. It is not the health care provider's role to investigate whether sexual abuse occurred in a woman's life. Rather, mothers can be helped to deal with breastfeeding problems related to their abuse experiences—even if they never reveal that they have been abused.

Should You Ask?

Whether you should ask mothers directly about sexual abuse depends on a number of factors. Always remember that you do not have a right to this information. Mothers are free to tell you—or not. There was a trend a few years ago for health care providers to confront mothers with their suspicions of past sexual abuse. I cannot state too strongly what a bad idea this is. Mothers will reveal this information to you if they feel they can trust you, and if they feel safe revealing it. In addition, mothers may not tell you because they cannot remember. Amnesia for abuse-related experiences has been documented in the literature (Williams 1994).

You may decide to gently ask, either separately or as part of a standard intake interview. But let mothers know what you are going to do with the information, and take steps to protect her confidentiality. Be sure to allow mothers to set boundaries in terms of how much they tell you. And even if you suspect, but don't know for sure, you can still proceed as if you did know.

What You Can Do

Offer Suggestions That Will Make Breastfeeding More Comfortable

With any mother who is having trouble, find out which situations make her uncomfortable, physically, psychologically, or emotionally. These can vary from woman to woman, but if you can anticipate times and situations where mothers might be particularly vulnerable, you enhance your ability to intervene. Three particularly difficult situations mothers have described to me include early postpartum, nighttime feeding, and playful older infants.

Early postpartum can be a difficult time. The sudden life changes, the lack of sleep, and the sometimes overwhelming demands of caring for a newborn may be too much. This situation is exacerbated if the mother had a difficult birth, where she either felt psychologi-

cally traumatized by the experience or where it reminded her of her abusive past. As I described earlier, these mothers may be particularly prone to depression. It is important to know of mental health resources in the community that can help mothers cope during this stressful time.

Nighttime breastfeeding may be difficult for the entire period of lactation, especially if the woman was typically abused at night. The association of nighttime feedings with her earlier abuse may be too strong to allow her to breastfeed comfortably. Some mothers can comfortably breastfeed if they allow someone else to handle night feedings.

Other mothers may find that they are more comfortable with expressing milk and using a bottle all the time. But some may find that using a pump is also uncomfortable in that it involves an outside object manipulating their breasts. Some mothers learn to use distraction (such as watching TV) to help them cope with the uncomfortable feelings they may be having while breastfeeding.

Many survivors are comfortable breastfeeding an infant, but have trouble with older infants who pull back and smile, or who play with the breast while breastfeeding. Some mothers may even feel enraged by this normal infant behavior, or they are just too uncomfortable to allow it to continue. One helpful strategy is to help mothers to reinterpret the behavior of playful infants, explaining that this is part of normal social development. If a baby is touching the mother during breastfeeding in a way that she finds annoying, show her how to re-direct the baby's behavior. The fact that she does not have to just "take it" can also be a revelation for mothers who are not used to being able to set boundaries on other people touching their bodies.

Toddlers can trigger "out-of-control" feelings when they are insistent on breastfeeding. They are bigger, and their behavior may seem more "adult" to the mother. Acrobatics while nursing may particularly upset the mother and trigger unpleasant memories of abuse. Remind the mother that she can set appropriate limits gently with her breastfeeding toddler as well including where and how often she nurses.

Be Careful in Your Examinations

In this same regard, be careful in your examination of mothers. Empower her to set limits in terms of how undressed she needs to be when you examine her. Allow her to cover up as soon as possible, rather than

leaving her exposed. When possible, examine her sitting up rather than lying supine as this can be one of the aspects of medical care that is difficult for trauma survivors (American Medical Association 1995). And always ask permission before you touch a mother.

Help Mothers Learn What Is Normal

Mothers who have been sexually abused may have difficulty knowing what is normal within their own bodies. Many mothers derive at least some sensual pleasure from breastfeeding. But mothers who have been sexually abused may be concerned about whether these feelings are appropriate. You can reassure mothers about this or perhaps even bring up some of the pleasurable aspects of breastfeeding. Further, by emphasizing the biological function of breasts, you can de-emphasize the view of breasts as primarily sexual organs.

In addition, help mothers be realistic about what they can expect from breastfeeding. For women with trauma histories, it isn't always a wonderful experience. But it can become a tolerable experience. And that may be a more realistic goal for mothers who are struggling.

Make a Referral

If a mother reveals that she has been sexually abused, talk with her about the importance of seeing a mental health professional who can help (if she is not already doing so). She may need specific treatment for depression, PTSD or substance abuse. The best situation would be for you to work in conjunction with mental health providers. Ask mothers for permission to contact their mental health providers. And be sure to set some boundaries for yourself. While you want to be sympathetic and supportive, be cautious about becoming the main source of emotional support for issues that are only tangentially related to breastfeeding. For a mother experiencing serious difficulties, or difficulties outside the realm of breastfeeding, you must refer the mothers to a qualified care provider. (See Kendall-Tackett, in press, for a complete description of treatment protocols, including medications, for depression, PTSD, and other co-morbid conditions.)

Educate Care Providers about the Normal Course of Breastfeeding, including Breastfeeding on Demand, Co-Sleeping, and Late Weaning

This is an area where you, as an expert in lactation, can make a significant difference. Many in the sexual abuse field feel that attachment-parenting practices, such as those listed above, are negative results of the sexual abuse experience. You can educate mental health providers, either directly or via the mother, about the normality of these practices, especially from a global perspective.

Clinician Self-Care

Self-care is critical when you work with women who have been abused as children. The needs of these clients can become overwhelming, and burnout rates are high. Generally speaking, there are two potential difficulties you might encounter in working with abuse survivors: vicarious traumatization and countertransference. These are described below.

Vicarious Traumatization

It is possible for you to be traumatized by hearing about the experiences of others. This is known as vicarious traumatization, and has been well-documented in children of Holocaust survivors (Levav et al.1998; Yehuda et al. 1998) and children of American Indians (Brave Heart & DeBruyn 1998).

Not surprisingly, vicarious traumatization can also happen to clinicians who work with adult survivors. You may feel guilt that you have not been through the horrifying events your clients describe (Friedman 2001), or powerlessness because you were unable to protect your client, even when you rationally know that you could never have done that (e.g., the event took place long before you knew your client).

While it is natural to feel anguish for what your clients have gone through, the problem arises when you begin to have symptoms of PTSD yourself. For example, you might start experiencing intrusive thoughts, you might have nightmares about their experiences, or you might experience emotional numbing. All of

these experiences can cloud your professional judgment to such an extent that you try to “rescue” your clients, or you try to avoid the patients’ references to their traumas. This can lead to severe personal distress (DeAngelis 2002; Friedman 2001).

Vicarious traumatization appears to be relatively common among those who work with abuse survivors. In a national study of 1,000 women psychotherapists, those with the highest levels of exposure to sexual abuse material had the highest levels of trauma symptoms. However, spirituality was protective. When the psychotherapists had a regular spiritual practice, they seemed to do well even when exposed to abuse histories of their clients (Brady et al.1999).

Countertransference

Countertransference also has relevance to trauma work. It happens when a client’s story triggers memories of abuse in you. Countertransference is more likely to occur when patients reveal histories that are similar to the clinician’s own story (Friedman 2001).

Abuse histories are fairly common in both mental health and medical providers. For example, in a survey of 645 mental health professionals, 17 percent reported a history of sexual abuse, and 7 percent reported a history of physical abuse (Nuttal & Jackson 1994). In another study, Little and Hamby (1996) found that 32 percent of clinicians in their sample (N=501) reported a history of child sexual abuse. Therapists who had been sexually abused reported more difficulties with countertransference and boundary issues.

A study of 323 nurses revealed that 13 percent had a history of child sexual abuse. Most of the nurses in the study thought that nurses should screen for past abuse. Approximately half thought that these questions would upset patients. There was no difference between the abused and non-abused nurses. Past history did seem to influence the nurses’ level of comfort in talking about abuse with patients. Twenty-three percent of the abused nurses and 34 percent of the non-abused nurses felt “extremely comfortable” listening to patients’ stories of abuse. On the other end, 9.5 percent of abused nurses and 3.6 percent of non-abused nurses reported that they would be “extremely uncomfortable” talking to patients about abuse. For the nurses who were moderately comfortable, there were no differences between the abused and non-abused groups. The nurses who thought that all patients should be screened offered the following caveats: The nurse needs to be skilled in knowing how to ask, and

he or she must have the resources in place to respond to any needs that should arise (Gallop et al.1995).

Professional Self-Care

Given some of the challenges involved in working with abuse survivors, taking care of yourself is essential. Without self-care, you, your clients, and your family may all suffer. Vicarious traumatization and countertransference can impair both your professional judgment and your personal mental health (Friedman 2001).

Recognize the Occupational Hazards

The first step is to recognize that there are unique hazards associated with working with adult survivors of abuse. This may also involve recognizing your own vulnerability and acknowledging, perhaps for the first time, your own history of childhood abuse. This history can eventually make you more effective in your work. But it also brings with it an increased vulnerability.

Take Steps to Counter Vicarious Traumatization and Countertransference

Once you recognize your vulnerability, the next step is to take specific steps to counter it. Here are some specific ideas to help (DeAngelis 2002; Friedman 2001).

Don't Go It Alone. Clinical work is often a solitary activity, even when you share office space with others. Recognize that some clients will require a team approach. Peer support or support by a supervisor is important as you work with challenging clients. In addition, make relationships with family and friends a priority, and nurture these relationships. And if a client's story is stirring up some memories in you, don't be afraid to seek counseling yourself.

Limit Your Involvement. An important type of self-care is learning not to carry your clients' concerns once you leave the office. Keep firm boundaries between your work and home life. This way you can continue to be connected and caring in the office, while minimizing the emotional toll of this type of caring. Another strategy is to limit the number of trauma cases that you see. Try to balance out your

caseload with clients who have more mundane breastfeeding issues.

Take Care of Your Body. This final strategy applies to anyone doing stressful work, but it is especially important for you—take care of your body. This means getting enough sleep, eating nutritious foods, exercising, connecting with others, and maintaining a spiritual life. Taking care of your body might mean taking a walk in the middle of the day, getting a massage, or making a date with a friend.

Summary of Self-Care

There are some unique aspects to working with traumatized patients that make it easy to get overwhelmed. It is important that you don't isolate yourself, connect with others, and make time for activities away from work. If you are going to be available to your clients, you must take time to refresh, refuel, and restore your balance. In this way, you can continue to be a healthy helper.

Conclusion

Women vary in their reactions to past sexual abuse, and not everyone who has been sexually abused will have all the problems described in this module. Sexual abuse survivors will also have a wide range of reactions to breastfeeding. Some women who have been sexually abused cannot tolerate even the thought of breastfeeding. Others find that breastfeeding is enormously healing. Still others have mixed feelings or more neutral feelings, and breastfeed because they want the best for their babies. With awareness of possible difficulties, and perhaps in conjunction with a mental health provider, you can help mothers who have survived sexual abuse have a positive breastfeeding experience.

Beth's story continues: *I now see that not only has breastfeeding been possible for me, a survivor of childhood sexual abuse, it has been immensely healing. My desire to have a fulfilling breastfeeding relationship forced me to face emotional territory I would probably have otherwise avoided. One wound left by the abuse is an underlying sense of "I can't do it. It's not even worth trying." Birthing and breastfeeding Theodore have helped to replace this with a very real sense of capability and confidence. Also, the heightened sensitivity to both myself and my son, which I gained through our breastfeeding relationship, serves us in other ways, especially now that Theodore is in the "terrific twos" (Dubois 2003).*

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About the author

Dr. Kendall-Tackett is a Health Psychologist, International Board Certified Lactation Consultant, Research Associate Professor of Psychology at the Family Research Lab and Crimes against Children Research Center, University of New Hampshire, and a Fellow of the American Psychological Association. She is widely published in the fields of family violence, maternal depression, perinatal health, and disability. Dr. Kendall-Tackett has been involved in family violence and sexual abuse research since 1983, and is on the editorial boards of *Child Abuse & Neglect: The International Journal* and *Journal of Child Sexual Abuse*. She is a La Leche League Leader, Area Professional Liaison for Maine and New Hampshire, and chair of the New Hampshire Breastfeeding Taskforce. Dr. Kendall-Tackett is author or editor of 10 books including *Treating the Lifetime Health Effects of Childhood Victimization* (2003, Civic Research Institute), *The Health Consequences of Abuse in the Family* (2004, American Psychological Association), *Child Victimization* (2005, Civic Research Institute, with Sarah Giacomoni), *The Handbook of Women, Stress and Trauma* (in press, Taylor & Francis), and *Depression in New Mothers* (2005, Haworth). Her Web site (www.GraniteScientific.com) has additional materials related to past abuse, depression, and family violence.

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