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Breastfeeding and the Sexual Abuse Survivor

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In this paper, the possible effects of child sexual abuse on a mother's breastfeeding experience are described. The long-term effects of sexual abuse are divided into seven domains that may impact breastfeeding behavior: post-traumatic stress disorder, cognitive distortions, emotional distress, impaired sense of self, avoidance, interpersonal difficulties, and health problems. In each section, the potential impact of past sexual abuse on current breastfeeding behavior and the mother-infant relationship is described. Finally, specific suggestions and strategies for lactation consultants are offered.

Key Words: child sexual abuse, breastfeeding

One out of every five American women has been sexually abused during childhood. [1-3] Working with women who are sexual abuse survivors requires specialized knowledge. Lactation consultants cannot assume that a sexual abuse survivor will not want to breastfeed. The results of one recent study indicated that a *higher* percentage of mothers who had been sexually abused expressed their intention to breastfeed than did their non-abused counterparts. [4]

Research that specifically examines the effects of sexual abuse on breastfeeding is sparse, however. Fortunately, a large body of literature exists that describes the long-term effects of sexual abuse on many other domains of functioning that may impact breastfeeding. These include effects on emotional and physical health, coping skills and ability to handle stress. More recently, the effects of past sexual abuse on birth have been examined. The purpose of this paper is to provide an overview of this literature, and describe how sexual abuse can influence a woman's breastfeeding experience.

Overview of Sexual Abuse

What is sexual abuse? By definition, sexual abuse is sexual activity involving a child and an adult. A more sophisticated definition involves the *ability to consent* to the sexual activity. Sexual abuse is *a child's inability to consent* to sexual activity because of an unequal power relationship that can be due to: 1) age or maturational advantage, 2) position of authority or caretaking, or 3) use of force or trickery (2). The definition of child sexual abuse does not include abuse of an adult by an adult (even if the victim is developmentally delayed), or other types of child maltreatment. The peak age of

vulnerability is between 7 to 13 years of age. However, children of all ages have also been abused. [5] Ninety-percent of the perpetrators are male, 70-90% are known to their victims. For girls, 33-50% of perpetrators are family members. [2]

The Long-term Effects of Sexual Abuse

In this section, an overview of the sequelae of sexual abuse is provided. This is the *range* of possible symptoms. Women might exhibit any number of these symptoms, or may have no symptoms at all. Not everyone who has been sexually abused is severely affected. Briere and Runtz [6] estimate that 20% of adult survivors (or 5% of the total population) will experience major long-term effects and show significant symptoms. The symptoms adult survivors manifest are "logical extensions" of coping mechanisms developed during childhood. They are a combination of initial reactions to the abuse and the accommodation that children had to make in their personality formation in order to cope with the abuse on an ongoing basis. [7]

As stated earlier, sexual abuse can negatively affect a wide range of functioning. Some symptoms relate directly to breastfeeding and others to a more general style of coping and interacting with others. The long-term effects of sexual abuse can be divided into seven domains of functioning. [7] The impact of sexual abuse on these seven domains are listed below.

Post-traumatic Stress Disorder (PTSD)

Many adult survivors manifest symptoms of PTSD. To receive a formal diagnosis of PTSD, there must be a discernible traumatic event, such as past sexual abuse. In addition, there must be the following symptoms: 1) frequent re-experiencing of the event via nightmares or intrusive thoughts, 2) numbing or lack of responsiveness to or avoidance of current events, and 3) persistent symptoms of increased arousal including jumpiness, sleep disturbance or poor concentration [7]. Briere and Elliot [7] note: "although most child sexual abuse victims do not meet full diagnostic criteria for PTSD, more than 80% are reported to have some "post-traumatic" symptoms" (p. 56). These symptoms include hyper-vigilance, intrusive thoughts, and sudden intrusive flashbacks of the abuse experience. [7-9]

Intrusive thoughts can be experienced as flashbacks that can be triggered by a variety of stimuli including current abuse by another adult, talking to someone else about their abusive experiences, or learning of the abusive experiences of others. Flashbacks can also be triggered by tactile or sensory stimuli associated with the abuse such as smells (e.g., the scent of a particular cologne), tastes, textures or sounds. [7]

For some adult survivors, birth experiences can trigger flashbacks. Possible triggers related to birth include physical pain, callused treatment by caregivers, loss of control, or the perineal pressure of second-stage labor. [10] As noted in a qualitative study of the effects of child sexual abuse on birth, these experiences can suddenly revive memories of sexual abuse as if it was happening right then. The re-experiencing of the abuse can be compounded by caregivers who are insensitive to the woman's past. For

breastfeeding mothers, possible triggers include skin-to-skin contact with their babies, the milk-ejection reflex and squirting milk (which may remind them of ejaculation), or the physical sensation of milk on their breasts or hands.

Cognitive Distortions

When a woman has been sexually abused, she may develop a mental framework, or an "internal working model," where she sees the world as a dangerous place. Because she has been powerless in the past, she overestimates danger and adversity in her current environment. [11] Mothers with these cognitive distortions will underestimate their own sense of self-efficacy and self-worth in dealing with both real and perceived danger. They feel that there is nothing they can do and that they are powerless to protect and provide for their babies. These distortions can contribute to their emotional distress and increase the risk of depression. [7] They can also make mothers who experience breastfeeding difficulties feel that there is little they can do to change the situation because of their perceived lack of self-efficacy.

In describing these cognitive distortions, it's important to balance this information with the fact that mothers may be describing *real* danger. For example, a mother may be afraid for her baby because of her currently abusive spouse. While some mothers may misperceive danger, it's important not to dismiss all concerns as being unreal or distorted.

Emotional Distress

Another category of symptoms is emotional distress, including depression, anxiety, and anger. Depression is the most commonly reported symptom of sexual abuse. The *DSM IV* criteria for a major depressive episode are as follows:

Five (or more) symptoms present during the same two-week period:

1) depressed mood most of the day, nearly every day,

2) anhedonia—loss of interest in or pleasure from almost all activities

3) significant weight loss or gain

4) insomnia or hypersomnia

5) psychomotor agitation or retardation

6) fatigue nearly every day

7) feelings of worthlessness; excessive guilt

8) diminished ability to think or concentrate

9) recurrent thoughts of death; suicidal ideation. [12]

Adult survivors have a four-time greater lifetime risk for a major depressive episode compared with adults who have not been sexually abused. These women may also be at heightened risk for depression during the postpartum period. [7,13-14]

Adult survivors of sexual abuse are also more at-risk to experience anxiety disorders, panic disorders, phobias, and obsessive-compulsive disorder (OCD). [7] These anxiety-related symptoms are frequently associated with PTSD responses and cognitive distortions. Anxiety can be exacerbated by a negative birth experience, or by having a baby who is premature, ill or disabled. These birth-related experiences may heighten fearful responses and may make the mother feel that she is unable to protect herself or her baby.

Anger, another symptom of emotional distress, includes chronic irritability, rage, and difficulties in expressing anger in a constructive way. Survivors may feel that they have no right to be angry with their partner, co-workers, friends or children, and may even suppress their feelings until anger either explodes or is vented on a safer choice. Either suppressed anger or the explosion of anger has obvious implications for parenting and other relationships, and could become a problem. [6-7]

Impaired Sense of Self

Women with an impaired sense of self awareness often use the reactions of others to gauge how they are feeling about a particular situation. Because of this, they may be gullible and easily manipulated by others. They may be unable to protect themselves, or establish appropriate boundaries, even with their children. Women in this situation often become the caretaker of others within their network of friends and family, and receive little care in return. [15] They also have difficulty asking others for help or taking advantage of support that is available. Their impaired sense of self can have the serious consequence of increased risk of revictimization, including rape or domestic abuse. [6, 16] More typically, mothers with an impaired sense of self may have difficulty gathering a supportive network during the postpartum period, which can have direct implications for both their emotional well-being and their success at breastfeeding.

Avoidance

Avoidance is another long-term effect—one that is at the heart of many of the more serious sequelae. Avoidance symptoms occur because they help women cope by reducing or circumventing the emotional pain associated with abuse-related experiences or recollections. These symptoms may also make it difficult for lactation consultants to work effectively with mothers without the involvement of mental health professionals.

The first type of avoidance is dissociation, which is hypothesized as being a result of the accommodation a child had to make to "escape" the abuse or manage the pain she was experiencing. [7] Adult survivors often describe how they were able to numb body parts at will or how they would seem to "watching" the abuse from above their body.

This numbing of body parts, and other types of dissociative reactions, can also take place during birth. In a qualitative analysis of survivors during labor, Rhoades and Hutchinson [10] describe how some of the women they studied would remove themselves mentally and emotionally from labor. Some of these women appeared to have "easy" labors in that they did not cry out or indicate that they were experiencing a great deal of pain. However, the nurses and midwives who attended them were concerned because the mothers appeared to be "absent" from their bodies. These types of dissociative responses may also be present when a mother breastfeeds. A mother may appear to be absent from her body whenever the baby is brought to breast.

Amnesia for abuse-related events is another type of avoidance response. Not everyone experiences amnesia, but neither is it a rare occurrence. Williams conducted a prospective study of adult survivors who had been treated for sexual assault in an emergency room of a large urban hospital during the 1970's. When she recontacted these women 20 years later, she found that 38% of the women she interviewed—all of whom had confirmed and documented sexual abuse experiences--had experienced total or partial amnesia regarding their abuse experiences. [17]

Periodically, lactation consultants have had the experience of a mother remembering her abusive experiences for the first time in the early postpartum period, triggered by either birth or breastfeeding. These sudden memories may lead to a significant (but usually temporary) decline in mental functioning. A referral to a mental health professional is essential in this situation.

Interpersonal Difficulties

Adult survivors of sexual abuse may also experience some difficulties in interpersonal relationships, which can influence their relationships with partners, friends, members of their family of origin, and their children. [7] Becker-Lausen and Mallon-Kraft [18] describe two dysfunctional interpersonal styles that they characterize as "pandemic" outcomes of child sexual abuse. Adult survivors may adopt an *avoidant* style, which includes low interdependency, self-disclosure and warmth, leading to few interpersonal ties. Or they may adopt an *intrusive* style, which includes extremely high needs for closeness, excessive self-disclosure and being smotheringly warm. The intrusive style is overly demanding and controlling. Both styles may result in loneliness. [6, 19] Child sexual abuse also influences adult attachment relationships. In a sample of incest survivors, those classified as having "insecure" attachment relationships as adults were more likely to be depressed and have personality disorders, above and beyond any effects of abuse severity.[20] Briere and Elliot [7] summarized the results of several studies by stating that adult survivors may have fewer friends, less interpersonal trust, less satisfaction in their relationships, more maladaptive interpersonal patterns, isolation, and interpersonal sensitivity. Adult survivors may find it difficult to develop an adequate support network to help them cope with the stresses of early parenting.

Past abuse can also specifically impact parenting. In one study,[21] child sexual abuse negatively affected survivors' feelings about themselves as mothers. Mothers reported that they were also more likely to use physical strategies in conflicts with their children than were their non-abused counterparts. These results held true even after controlling for negative family-of-origin experiences such as physical abuse, neglect and negative relationships with care- givers.

Lactation consultants, and mothers themselves, may share the concern that mothers who have been abused will abuse their own children. This is a real risk, but it is far from inevitable. For example, in two longitudinal studies of high-risk mothers ("high-risk" due to low-socioeconomic status, single status, young age at first birth, and a history of abuse), the rate of intergenerational transmission ranged from 45% (22) to 63%. [23] These mothers either physically abused or neglected their own children. These rates are high, but it is important to point out that these mothers were at risk for reasons other than their abuse histories. Even with multiple risk factors present, a significant proportion of mothers *did not* abuse their own children. Both of these studies found that mothers who received emotional support from at least one non-abusive adult during childhood, had participated in therapy at some point in their lives, and were in a stable, satisfying relationship as an adult were much less likely to abuse their own children, thus breaking the cycle of abuse.[22-23]

Physical Health and Susceptibility to Illness

The symptoms discussed so far have been related to emotional and mental health. Child sexual abuse can have a fairly dramatic effect on physical health as well. Mothers who are in poor health may be more susceptible to problems like mastitis, and may find that they have little energy left to cope with the demands of the postpartum period.

Women who reported a history of abuse were more likely to report the following symptoms: chronic pelvic pain, frequent feelings of fatigue, obesity, severe PMS, irritable bowel syndrome, frequent headaches, trouble sleeping, frequent vaginal infections, and overall less satisfaction with their physical health than their non-abused counterparts. [24-25] The results of these studies are intriguing and represent the newest area of interest in the study of the effects of child sexual abuse. The symptoms described above were originally assumed to be psychosomatic in origin. However, recent research on the effects of chronic stress on health at least suggests that these symptoms may have a physiological basis as well. [26-27] For example, Sapolsky [27] describes how patients with a history of irritable bowel syndrome are much more physiologically sensitive to environmental stressors than are patients without IBS. This sensitization may have developed during a time of chronic stress, such as an on-going sexually abusive relationship.

A history of sexual abuse can also be related to a woman's physical experience of pregnancy and birth. Jacobs [28] found that adult survivors of sexual abuse experienced longer labors, longer pregnancies, higher birth weights, more terminations, earlier age at first pregnancy, more medical problems, greater stress during pregnancy and more use of ultrasound. In contrast, Benedict, Paine and Paine's study [4] of 360 primiparous women

(12% of whom were sexual abuse survivors) found no significant differences between survivors and non-abused women on rates of cesarean sections, induction/augmentation of labor, anesthesia use or failure to progress.

Summary of Long-term effects

Sexual abuse of children can have long-term consequences that affect adults in many ways. There are seven domains where adults might be affected: post-traumatic stress disorder, cognitive distortions, emotional distress, impaired sense of self, avoidance, interpersonal difficulties, and health problems. Some of the specific problems adult survivors face are depression, low self-esteem, parenting difficulties, diminished ability to cope with stress and increased risk of physical illness. In the following section, some specific strategies for lactation consultants are described.

Intervention Strategies

There are a number of specific steps lactation consultants can take to help sexual abuse survivors have positive breastfeeding experiences. It is not the role of the lactation consultant to investigate possible sexual abuse or provide psychiatric intervention. Rather, lactation consultants who are informed about the possible effects of sexual abuse will be able to help mothers deal with breastfeeding problems related to their abuse experiences—even if they never reveal that they have been abused.

Whether lactation consultants should ask mothers directly about sexual abuse depends on the rapport established with individual mothers. Lactation consultants may decide to gently ask, either separately or as part of a standard intake interview. But gently and respectfully asking is *not* the same as confronting mothers with your "suspicions" that they may have been sexually abused (as some recent literature recommends). Confrontations with mothers is a *very bad idea*; one that could quite harmful. Some mothers may talk about their experiences, while others will not. Lactation consultants must allow mothers to set boundaries.

Offer Suggestions That Will Make Breastfeeding More Comfortable

With any mother who is having trouble, lactation consultants should try to find out which situations make her uncomfortable psychologically or emotionally. These can vary from woman to woman, but lactation consultants who can anticipate times and situations where mothers might be particularly vulnerable, enhance their ability to intervene. Three particularly difficult situations include early postpartum, night-time 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 psychologically traumatized by the experience or where it reminded her of her abusive past. 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.

Night-time breastfeeding may be difficult for the entire period of lactation, especially if the woman was typically abused at night. The association of night-time 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. Others find that they are more comfortable with expressing milk and using a bottle all the time.

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 are just too uncomfortable to allow it to continue. Lactation consultants may find it helpful to reinterpret the behavior of playful infants for mothers, 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, lactation consultants can show the mother how to re-direct the baby's behavior. Lactation consultants can also let mothers know that they can set limits with their babies.

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. Lactation consultants can offer reassurance, or perhaps even bring up some of the pleasurable aspects of breastfeeding. Further, by emphasizing the biological function of breasts, lactation consultants can tone down their connotations as sexual organs.

Make A Referral

If a mother reveals that she has been sexually abused, the lactation consultant should talk with her about the importance of seeing a mental health professional who can help (if she is not already doing so). The best situation would be for lactation consultants to work in conjunction with mental health providers. While lactation consultants want to be sympathetic and supportive, they should 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, lactation consultants must refer.

Educate Care Providers About Normal Course Of Breastfeeding, Including Breastfeeding On Demand, Co-Sleeping And Late Weaning

This is an area where the expertise of lactation consultants 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. Lactation

consultants can educate mental health providers, either directly or via the mother, about the normality of these practices, especially from a global perspective.

Conclusion

There are a wide range of reactions to past sexual abuse, and not everyone who has been sexually abused will have the problems described in this paper. 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 their babies is enormously healing. Still others have more neutral feelings, but breastfeed because they want the best for their babies. With awareness of possible difficulties, and perhaps in conjunction with a mental health provider, lactation consultants can help mothers who have survived childhood sexual abuse have a positive breastfeeding experience.

References

1. Finkelhor D, Dziuba-Leatherman J: Victimization of children. Am Psychologist 1994; 49:173-83.
2. Finkelhor D: Current information on the scope and nature of child sexual abuse. Future of Children 1994; 4:31-53.
3. Gorey KM, Leslie DR: The prevalence of child sexual abuse: Integrative review adjustment for potential response and measurement biases. Child Ab Neg 1997; 21: 391-8.
4. Benedict M, Paine L, Paine L:Long-term effects of child sexual abuse on pregnancy and pregnancy outcome. Final report, Department of Maternal & Child Health. Washington, DC: Department of Maternal & Child Health, 1994.
5. Kendall-Tackett KA, Simon AF: Molestation and the onset of puberty: Data from 365 adults molested as children. Child Ab Neg 1988; 12:73-81.
6. Briere J, Runtz M. Post sexual abuse trauma: Data and implications for clinical practice. J Interpers Vio 1987; 2: 367-379.
7. Briere J, Elliot DM. Immediate and long-term impact of child sexual abuse. Future of Children 1994; 4: 54-69.
8. Gelinas D. Persisting negative effects of incest. Psychi 1983; 46: 312-332.
9. Herman JL. Trauma and recovery. New York: Guilford Press, 1994.
10. Rhoades N, Hutchinson S. Labor experiences of childhood sexual abuse survivors. Birth 1994; 21:213-20.
11. Finkelhor D, Browne A. The traumatic impact of child sexual abuse: A conceptualization. Am J Ortho 1985; 55: 530-541.
12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th Ed. Washington DC: Author, 1994.
13. Beitchman JH, Zucker, KJ, Hood JE, daCosta GA, Akman D. A review of the long-term effects of child sexual abuse. Child Ab Neg 1992; 16: 101-118.

14. Mullen PE, Martin JL, Anderson JC, Romans SE, Herbison GP. The long-term impact of the physical, emotional, and sexual abuse of children: A community study. Child Ab Neg 1996; 20: 7-21.
15. Pipher M. Hunger pains: The modern woman's tragic quest for thinness. New York: Ballantine, 1995.
16. Fox KM, Gilbert BO. The interpersonal and psychological functioning of women who experienced childhood physical abuse, incest, and parental alcoholism. Child Ab Neg 1994; 18: 840-58.
17. Williams LM. Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. J Consult Clin Psy 1994; 62: 1167-76.
18. Becker-Lausen E, Mallon-Kraft S: Pandemic outcomes: The intimacy variable. In Kantor GK, Jasinski JS, eds. Out of Darkness: Current Perspectives on Family Violence, 1997: 49-57.
19. Gibson RL, Hartshorne TS. Childhood sexual abuse and adult loneliness and network orientation. Child Ab Neg 1996; 20: 1087-93.
20. Alexander P, Anderson CL, Brand B, Schaeffer CM, Grelling BZ, Kretz L. Adult attachment and longterm effects in survivors of incest. Child Ab Neg 1998; 22: 45-61.
21. Banyard V. The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. Child Ab Neg 1997; 21: 1095-1107.
22. Egeland B, Jacobvitz D, Sroufe LA. Breaking the cycle of abuse. Child Dev 1988; 59: 1080-1088.
23. Zuravin S, McMillen C, DePanfilis D, Risley-Curtiss C. The intergenerational cycle of child maltreatment: Continuity vs. discontinuity. J Interpers Viol 1996; 11:315-334.
24. Moeller TP, Bachman GA, Moeller JR. The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. Child Ab Neg 1993; 17: 623-640.
25. Walling MK, Reiter RC, O'Hara MW, Milburn AK, Lilly G, Vincent SD. Abuse history and chronic pain in women: I. Prevalence of sexual abuse and physical abuse. Obstet Gyn 1994; 84: 193-99.
26. Lovallo WR. Stress and health: Biological and psychological interactions. Newbury Park, CA: Sage, 1997.
27. Sapolsky RM. Why zebras don't get ulcers: A guide to stress, stress-related diseases and coping. New York: WH Freeman, 1994.
28. Jacobs JL. Child sexual abuse victimization and later sequelae during pregnancy and childbirth. J Child Sex Ab 1992; 1: 103-112.