

Violence against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy and Postpartum

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Violence against women (VAW) is an unfortunate fact of life for millions of women around the world. And mothers are not immune. A recent study of 332 postpartum women in Toronto 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, both past and present, can influence women throughout the childbearing cycle. Below is a summary of what we know so far on how VAW influences women during pregnancy and postpartum.

Pregnancy

VAW influences women's health during pregnancy. The effect of intimate partner violence (IPV) during pregnancy has been well-documented. What is less well-known is that past violence could also impact 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 non-abused peers (Hulme, 2000; Kendall-Tackett, 2003; Raj et al., 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 et al., 1997). High-risk sexual activity increases the risk for unplanned pregnancies among teens (Raj et al., 2000; Springs & Friedrich, 1992) and adults (Prentice et al., 2002). In a nationally representative U.S. sample of mothers of children under age three ($n = 1220$), women with a history of child sexual abuse were more likely to have both 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 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 et al., 2006).

The Effects of Poor Health Behaviors, Depression and PTSD on Pregnancy

A history of abuse also impacts women's antenatal health through their behaviors and through the effects of depression and posttraumatic stress disorder (PTSD).

In a study from Norway of women with low birth weight ($N = 82$) and term babies ($N = 91$), 56% of sexual abuse survivors smoked during pregnancy compared to 31% of non-abused women. Abuse survivors also reported more health problems during pregnancy and used more healthcare services than their non-abused counterparts (Grimstad & Schei, 1999).

Depression and PTSD are common sequelae of both childhood abuse and current intimate partner violence (IPV). As two recent studies found, women suffering from either of these conditions have an increased risk of pregnancy, neonatal complications, and interventions during labor. For example, depressed women have higher rates of preterm birth than their non-depressed counterparts, even when controlling for other risk factors (Kendall-Tackett, 2007, 2008).

A prospective study of 959 women in Hong Kong found that women who were depressed in the third trimester

had higher rates of epidural anesthesia, cesarean sections and instrumental vaginal deliveries. Their infants were also more likely to be admitted to neonatal intensive care units. These effects were still present even after researchers controlled for pregnancy complications, showing an independent effect of depression (Chung, Lau, Yip, Chiu, & Lee, 2001).

In a study that compared 455 women with PTSD to 638 without PTSD, Seng and colleagues (2001) found that women with PTSD had significantly higher odds ratios

for ectopic pregnancy, spontaneous abortion, hyperemesis, preterm contractions, and excessive fetal growth. While 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 has ended. 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.



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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 et al., 2004). In North Carolina, 6.9% were beaten before pregnancy, 6.1% during pregnancy, and 3.2% postpartum ($n = 2648$; Martin et al., 2001). Finally, in Bristol Avon, UK ($n = 7591$), 5% were beaten during pregnancy and 11% postpartum (Bowen et al., 2005).

At this point, it's difficult to know whether pregnancy vs. 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 intimate partner violence was highest at three months postpartum (21%) and lowest at 24 months (13%). Seventy-five percent of mothers beaten during pregnancy were also beaten during their first two years postpartum. And 78% who experienced IPV at three months postpartum had not reported IPV during their pregnancy (Harrykisson et al., 2002).

Lutz (2005) also described the continuity between past and present violence in her qualitative study of 12 women who were survivors of intimate partner violence 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 intimate partner violence and substance abuse; current intimate partner violence; adult sexual assault; and community violence. The women experienced each exposure to violence as influencing and flowing into the next. They viewed intimate partner violence 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 both depression and physical health symptoms in the postpartum period (Ansara et al., 2005). A three-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 non-abused 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. But 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 et al., 2004), women who had been sexually abused were more likely than non-abused women to be single parents, cohabitating in their current relationships or step-parents. They also reported less satisfaction with their current partners. Although the study authors are 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 both depression and health problems.

Even among non-abused women, lack of partner support increased the risk of postpartum depression. In a study of married women at two months postpartum, spouses' lack of help with childcare and household tasks predicted depression severity (Campbell et al., 1992). Further, 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 two 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 both 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,

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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 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 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 and colleagues (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 healthcare, 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 impacts women's health postpartum.

In a review, Salovey and colleagues (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 both their families and communities. Social support shielded these teens from some of the effects of family violence. Social support 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 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, Scanlan, Zhang, Savage, Brummett, Barefoot, & Siegler, 2001).

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. 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. 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.

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PTSD Criterion A and Betrayal Trauma: A Modest Proposal for a New Look at What Constitutes Danger to Self

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Why and how does psychological trauma harm people? The traditional assumption in trauma research has been that extreme fear is at the core of post traumatic responses to events like war and natural disasters. This assumption is at the heart of the PTSD Criterion A definition in the *DSM IV-R*: “witnessed or experienced an event threatening to safety or life.” Is terror the only cause of traumatic distress and harm? Some patterns of events (such as sexual abuse by a parent, acquaintance rape, or government mistreatment of citizens) generate strong symptoms of trauma even absent intense fear, perhaps

because they involve social betrayal. Betrayal trauma theory (Freyd 1996; 2001; Freyd, DePrince & Gleaves, 2007), drawing on developmental, cognitive, and evolutionary psychology,

posits that (a) there is sometimes a social utility in remaining blind to betrayal and (b) betrayal traumas can be particularly toxic.

In Figure 1 two independent dimensions of trauma are identified as particularly likely to cause psychological harm: the terrorizing and life-threatening aspect of traumatic events and the social betrayal aspects of traumatic events. Recent research has suggested that betrayal may be a particularly potent aspect of trauma when it comes to long lasting harm. For instance, DePrince (2001) discovered that trauma survivors reporting traumatic events high in betrayal were particularly distressed. Freyd, Klest, and Allard (2005) found that a history of betrayal trauma was strongly associated with physical and mental health symptoms in a sample of ill



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