Exploring the Impact of Intimate Partner Violence on Breastfeeding Initiation: Does It Matter?

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NUMEROUS MEDICAL ASSOCIATIONS recommend breastfeeding for the health of both a mother and her child, yet life circumstances can make this a challenging endeavor. Traumatic events can position barriers in the way of a new mother's attempts to initiate and sustain breastfeeding. While we acknowledge there may be many barriers to breastfeeding initiation, including, but not limited to, lower socioeconomic status, lack of education, childhood physical and emotional abuse and neglect, sex assault histories, and community violence, this article focuses on intimate partner violence (IPV) and how healthcare professionals may want to consider the role of IPV in mothers' breastfeeding decision-making.

More than 20% of women experience IPV during their lifetime.¹ It has been well documented that pregnancy is not protective of such abuse, and sometimes a pregnancy can be associated with the initiation or exacerbation of IPV. Numerous studies have documented the physical and mental health consequences for victims of IPV as well as victims' complex decision-making processes. After recognition of their IPV status, women must decide whether and when to get help. Many concerns such as economic resources, housing, custody, and social support weigh against the perceived danger and risk to safety in favor of remaining with an abusive partner.

These issues may be compounded for new mothers experiencing IPV, who are navigating complex legal and social support systems while simultaneously adjusting to parenting. To initiate and sustain breastfeeding in busy, chaotic environments such as court and social service agencies may seem overwhelming and intimidating. In the mid-1980s, legislative policies resulted in the criminalization of IPV, with courts becoming a main portal for relief from IPV. Courtroom waiting rooms are often noisy and overcrowded, not to mention that victims may experience mounting anxiety waiting for their cases to be heard. Unfortunately, cases are rarely resolved in one visit.

Courts' organizational demands often require IPV victims to make repeat appearances for the case, including origination and arraignment through motions and pre-trial conferences. These events can be particularly traumatizing and draining on victims, as they often include long days that can result in a mother's lack of attention to her own basic need for good nutrition and sleep.

Breastfeeding advocates have made some progress in infusing breastfeeding into the work environment. This has

not been an easy struggle, and much work remains. However, progress has undeniably occurred. Similar initial steps have not been accomplished in the court environment, but the court environment is permeable, and strides can be made. Settings such as properly equipped family courts, emergency drop-off centers for children at court, and victim-only waiting rooms may provide much needed havens for those who choose to breastfeed. One upstate New York courtroom provided wall dividers and a rocking chair for mothers to find calm in what can be chaotic public courtroom space. Yet, the chair often sits empty. Such simple solutions are possibilities waiting to be explored and tested.

Children who are exposed to IPV are at greater risk for a host of bad outcomes, including poorer health. Because breastfeeding can improve the health of both the child and the mother, it may make sense to provide IPV victims with this alternative despite the obstacles they face. Understanding and acknowledging mothers' feelings of shame, humiliation, and inadequacy related to the IPV may help caregivers understand IPV victims' perceptions that they may fail at breastfeeding. These mothers may need affirmation that it is the right choice for them and their baby, despite their batterers' ridicule and harassment. One victim reported her attempts to breastfeed were quashed because her abuser focused his abuse on her nonexistent inadequacies as a mother, his belief that she was now little more than a "cow." Of course, this was his abusive commentary about the fact that she carried weight after the delivery and provided her milk to the baby. Predictably, such abuse led her to believe that her breastfeeding would infuriate him.

An earlier study reported that IPV status was not statistically associated with breastfeeding when controlling for other sociodemographic characteristics in a multivariate analysis.² Yet, among mothers who chose not to initiate or sustain breastfeeding, IPV-positive mothers are statistically overrepresented. More research is warranted to disentangle the complexities around IPV, the negative health consequences, and breastfeeding decision-making. Such inquiries must include multilevel longitudinal analysis and sound empirical randomized designs. The complexity of IPV motivates us to move beyond the dichotomous yes/no variable and consider childhood histories, prevalence, severity, types of violence, and perceived danger.

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It is also imperative that future inquiry adheres to the principles of community-based participatory research. Our attempts to improve systematic opportunities for IPV-positive mothers to initiate and sustain breastfeeding will be thwarted if we do not include the mother's voice at the table: Women who have experienced IPV and are willing to share their complex decision-making regarding breastfeeding play an important role in understanding how to best support IPV-positive moms during the perinatal period.

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