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Breast Feeding

Providing support for the challenges women face

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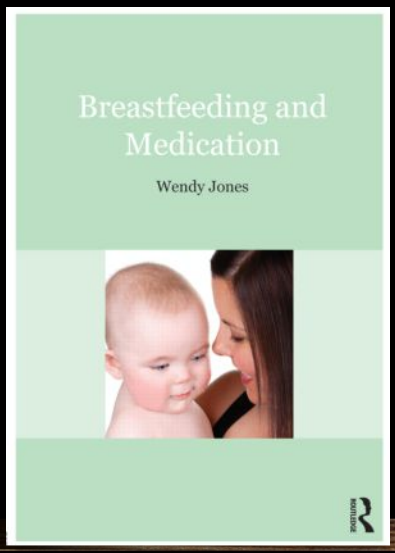

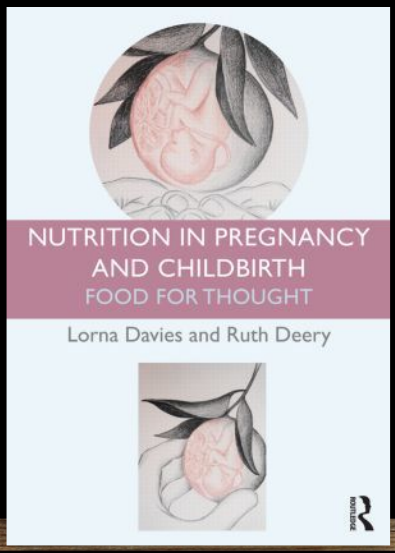

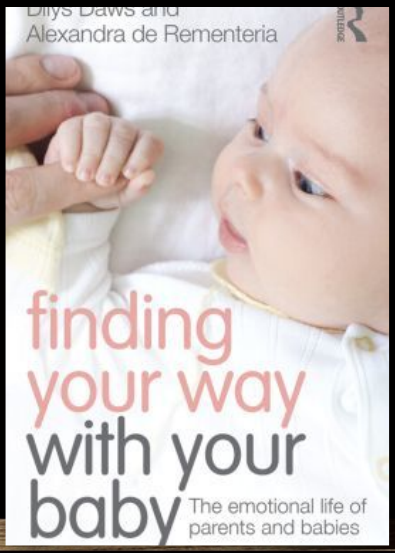

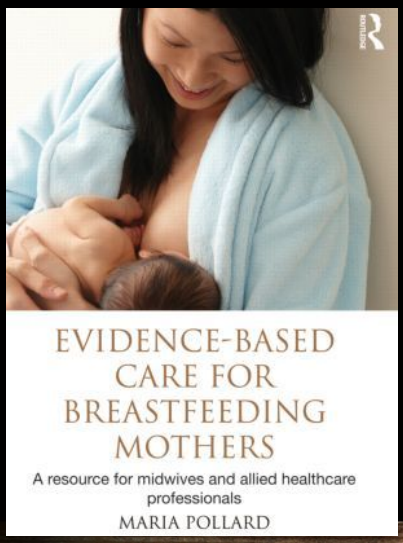

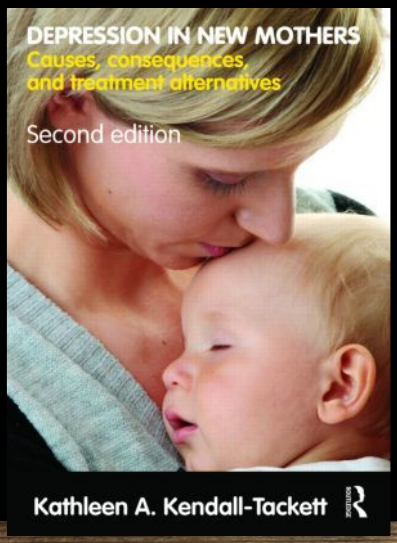

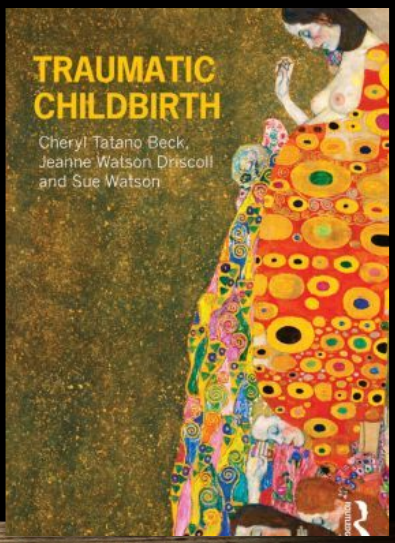

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Introduction

HOW TO USE THIS BOOK

The World Health Organization (WHO) guidelines recommend exclusive breastfeeding for the first six months, but globally only 38% of babies are exclusively breast fed. To help health care workers, midwives, Social Workers and parents during World Breast Feeding week, and all year round, Breast Feeding: Providing support for the challenges women face, provides a handy compendium of direct insights and practical advice. In this FreeBook, you'll discover why breast feeding is so important to mother and baby, the factors that can influence a mother (including pressures from friends/family and understanding and space in the work place), advice on baby-led feeding, the implications on breast feeding for new mothers with depression and the extra support women who've experienced a traumatic birth might require. And remember that if you're in search of more in-depth coverage of any of these topics, all of the titles featured are available in full from our website.

Chapter 1 and 2

In these excerpts from ***Breastfeeding and Medication***, Wendy Jones explains the impact on society of breast feeding, and looks at what factors influence a mother's decision not to breast feed, such as lack of public places to feed and the influence of friends and family. She then explores the benefits for breast feeding, both on healthcare systems and the mother and baby.

Wendy Jones is an independent pharmacist prescriber with over 20 years' experience as a breastfeeding support worker for the Breastfeeding Network (BfN). She runs the BfN Drugs in Breastmilk Helpline and has presented widely to healthcare professionals, volunteers and mothers on this subject.

Chapter 3

What is baby-led feeding is and why does it make sense to support parents to implement this type of approach? In this chapter from Nutrition in Pregnancy and Childbirth (edited by Lorna Davies and Ruth Deery), Gill Rapley looks at how baby-led feeding and then baby-led weaning, gives babies the best start in life. Gill Rapley has been a lactation consultant and a voluntary breastfeeding counsellor and is a former deputy director of the UNICEF UK Baby Friendly Initiative. She is also a qualified midwife and worked for 20 years as a health visitor.

Lorna Davies is a principal Lecturer in Midwifery at Christchurch Polytechnic

Institute of Technology, NZ and a part time lecturer for the New Zealand College of Midwives. Ruth Deery is Professor in Maternal Health at the University of the West of Scotland, UK.

Chapter 4

In this chapter from ***Finding Your Way With Baby,*** Dilys Daws and Alexandra de Rementeria explore will explore some of the feelings associated with feeding that might make it hard to get going and how fathers can help mothers and babies manage some of them that might be overwhelming. They go onto look at the bond that develops between mother and baby as well as the benefits, pleasures and difficulties associated with breast feeding.

Dilys Daws is Honorary Consultant Child Psychotherapist at the Tavistock and Portman NHS Foundation Trust, London, and continues to practise at a baby clinic at the James Wigg Practice, KentishTown. She has fifty years of clinical and teaching experience, much of that on work with parents and babies and has lectured on infant mental health widely in the UK and abroad. Alexandra de Rementeria is on the doctoral training programme for child psychotherapy at the Tavistock and Portman NHS Foundation Trust and works at Lewisham Child and Adolescent Mental Health Services. She is the author of numerous articles for publications including the Journal of Psychodynamic Practice and the Journal of Infant Observation.

Chapter 5

Breastfeeding mothers need ongoing support from professionals, their peers and society in general to continue breastfeeding for as long they would like to. In this chapter from ***Evidence-based Care for Breastfeeding Mothers***, Maria Pollard focuses on particular issues such as accessing different types of support, returning to work and assisting mothers with relactation or induced lactation, family planning and breast-feeding during pregnancy.

Maria Pollard is Programme Leader for the MSc Maternal and Child Health Programme at the University of the West of Scotland. Maria has completed a doctorate in education, exploring how student midwives learn about breastfeeding, and is Project Leader for the implementation of the UNICEF education standards in the curriculum.

Chapter 6

Do women need to wean in order to recover from depression? And what do mothers want to do? In this excerpt from Kathleen A. Kendall-Tackett's ***Depression in New Mothers*** she looks to answer these questions, exploring the risks and benefits (real and feared) to mothers continuing to breast feed when depressed. Kathleen A. Kendall-Tackett is a health psychologist and an International Board Certified Lactation Consultant. She is a Clinical Associate Professor of Pediatrics at Texas Tech University School of Medicine in Amarillo, Texas. She is also the author of more than 220 journal articles, book chapters and other publications, and author or editor of 19 books in the fields of trauma, women's health, depression, and breastfeeding.

Chapter 7

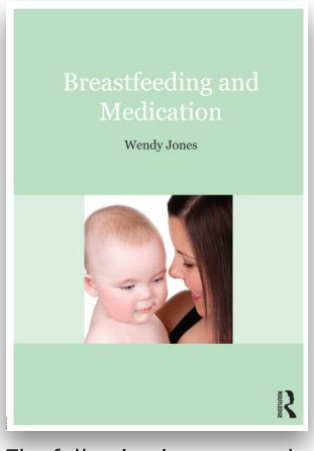
Using real life examples and looking at the evidence, in this chapter from ***Traumatic Childbirth***, the authors explore the question of how a traumatic birth can affect breast feeding. They look at the physical and mental trauma mothers in this situation can face, how that can affect the bond between mother and baby, and what support professionals can offer.

Cheryl Tatano Beck is Distinguished Professor at the School of Nursing, University of Connecticut, USA.

Jeanne Watson Driscoll is a board certified clinical nurse specialist in adult psychiatric-mental health nursing. Sue Watson is co-founder of Trauma and Birth Stress (TABS), an organization dedicated to raising the profile of traumatic birth and the devastation it causes. She currently works as a childbirth educator in Auckland, New Zealand.

Breastfeeding and Medication: Breastfeeding in Context

Chapter 1:: Breastfeeding in Context



The impact of society on breastfeeding

Society has a massive impact on breastfeeding – if we do not see breastfeeding but see only bottle feeding, the latter becomes normal. Breastfeeding reached a low point in 1975 with only 50% of women initiating breastfeeding (Foster 1997). In that era, mothers were instructed to feed their babies no more frequently than every 4 hours and for a maximum of 10 minutes on each side with frequent supplementation with formula milk. A certain way to set the mother up to 'fail' at breastfeeding. Since then the breastfeeding rate has slowly increased, with an early indication of an initiation rate of 82% in 2010 (Infant Feeding Survey 2010). Exclusive, baby-led breastfeeding is now being encouraged (see Figure 1.1).

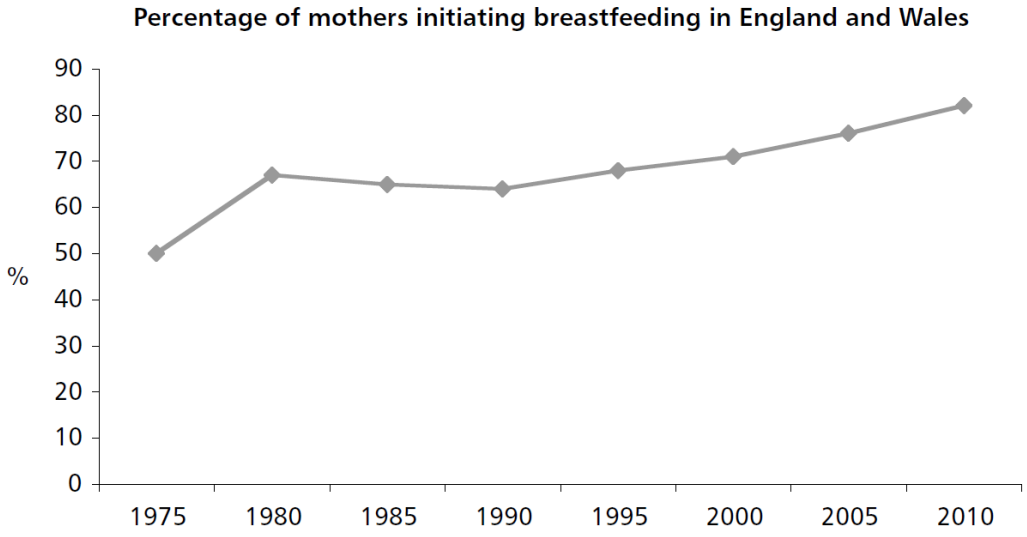


FIGURE 1.1 Initiation of breastfeeding in England and Wales

With the majority of mothers now choosing to breastfeed at least initially, healthcare professionals need to consider how they can better protect, promote and support mothers in their chosen method of infant feeding. The intention of this book is not to make women who choose to bottle feed feel guilty or imply that they don't love their babies, merely to support those who have chosen to breastfeed to do so for as long as they wish.

In the USA, the Healthy People 2020 objective is to increase the percentage of the population ever breastfed to 81.9% and those exclusively breastfed to 6 months to 25.5%. Data collected in the Breastfeeding Report Card 2011 showed that, nationally, 74.6% of babies were breastfed at delivery, 44.3% received some breastmilk at 6 months and 14.8% were exclusively breastfed. It is interesting to note that 24.5% of

breastfed babies received some formula before they were 48 hours old (see Figure 1.2).

In Australia (ANIFS 2010), 96% of babies were initially breastfed but only 15% continued exclusively at 6 months, although 21% continued to receive some breastmilk. See Figure 1.3 for data in support of this from a different organisation, the Australian Institute of Family Studies (AIFS).

'To increase the percentage of babies who are fully breastfed from birth to six months of age, with continued breastfeeding and complementary foods to twelve months and beyond' was an objective set by the Australian National Breastfeeding Strategy 2010–2015, in line with the view that:

• Australia is a nation in which breastfeeding is protected, promoted, supported and valued by the whole of society.

• Breastfeeding is viewed as the biological and social norm for infant and young child feeding.

• Mothers, families, health professionals and other caregivers are fully informed about the value of breastfeeding.

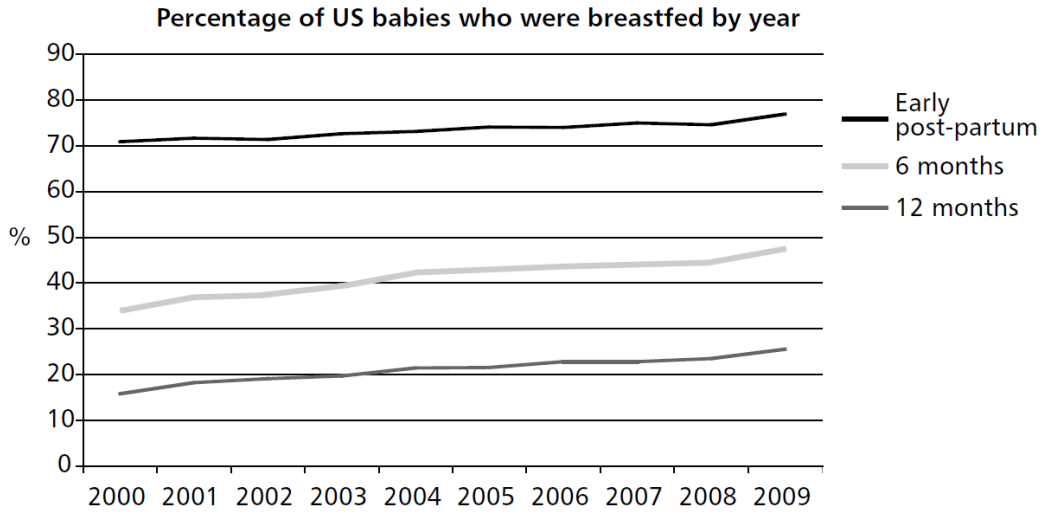


FIGURE 1.2 Breastfeeding rates in children born in USA 2000–2009 (CDC National Immunisation Survey 2011)

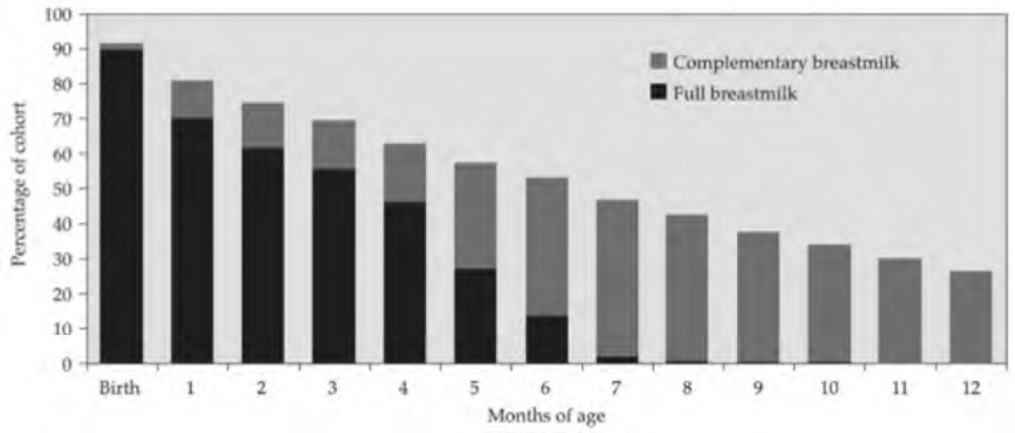


FIGURE 1.3 Breastfeeding rates in Australia 2008 (AIFS)

Health inequalities and the promotion of breastfeeding

Stuart Forsyth noted that breastfeeding is the only health intervention that can lead to better health outcomes for a child from the lowest socio-economic groups compared with an artificially fed counterpart from a more affluent family (Forsyth 2005).

In 1998 Sir Donald Acheson published the *Independent Inquiry into Inequalities in Health* report (Acheson 1998), which is the cornerstone on which many health interventions are founded. He suggested that starting with maternal and child health is likely to bring about the most rapid benefits in improving the health of society. This report drove the strategies to increase the initiation and prevalence of breastfeeding in the UK.

Maternal and Child Nutrition was published by the National Institute for Health and Clinical Excellence (NICE PH11 2008) (updated in 2011), which proposed to help improve the nutrition of pregnant and breastfeeding mothers and children in low-income households. These guidelines aimed to address disparities in the nutrition of low-income and disadvantaged groups compared with the general population.

NICE PH11 recommends that all healthcare professionals should have appropriate knowledge and skills to give advice on:

- the nutritional needs of pregnant women, including use of folic acid and vitamin D;
- promoting and supporting breastfeeding; and
- the nutritional needs of infants and young children.

There is also a recommendation on prescribing for breastfeeding mothers that will be

discussed further in the Drug Reference section.

Obesity and infant feeding

The increasing number of children who are obese has become a major concern for the future health of the public in the UK. The role of breastfeeding in reducing the risk of excess weight in later life was highlighted in the white papers *Healthy Weight, Healthy Lives – a cross governmental strategy for England 2008* and *Healthy Lives, Healthy People 2010*. The Government undertook to invest in an information campaign to promote the benefits of breastfeeding as part of wider campaigns on healthy development. It also funded the setting up of a national breastfeeding helpline for mothers.

Breastfeeding in public

The 2005 Infant Feeding Survey (Bolling 2007) noted that although women in the UK are now more likely to breastfeed in public (54% in the UK), more than a quarter reported difficulties in finding a place to breastfeed and 8% had never attempted to feed in public. Interestingly, more than a third of bottle-feeding mothers said that they had never attempted to feed their baby away from home either.

In November 2004 The Breastfeeding (Scotland) Bill became law (Breastfeeding Scotland Bill 2005). This made it an offence in Scotland to stop anyone feeding milk (by whatever means) to children under two in public or in family-friendly licensed premises. The Equality Act became law in England in 2010 (Equality Act 2010). It makes it clear that a woman cannot be discriminated against for breastfeeding her baby in public places such as cafes, shops and buses. For example, a bus driver could not ask a woman to get off the bus just because she is breastfeeding her baby.

A focus group study in the UK (McFadden 2006) found that women feel breastfeeding in public is unacceptable, while bottle feeding was accepted by everybody and in all places. Some women reported breastfeeding in public toilets as the only option and wished that cafes and shops would provide more facilities for breastfeeding.

Influences on breastfeeding initiation

Mothers from the lowest socio-economic groups, who are younger at the time of delivery and who have left full-time education at a younger age, are less likely to breastfeed than their socially more advantaged counterparts (Bolling 2007). In 1995, Jamieson suggested that a tentative breastfeeding mother faced with a professional lacking in skills and encouragement will inevitably fail. Sadly the result is probably still likely to be the same.

Influence of friends and family

Some women in the McFadden study (McFadden 2006) said that even family and friends found it 'repulsive' to be in the same room when they were breastfeeding and that grandparents, more than fathers, felt excluded if they had no opportunity to feed the baby. It was apparent that the opinion of family and friends was a stronger influence than that of health practitioners input on the advantages of breastfeeding.

Of mothers who were bottle fed themselves as babies, 63% were breastfeeding at 4 weeks compared with 82% of mothers who were entirely breastfed as babies (Bolling 2007). Mothers generally follow the example set by their own mothers (see Figure 1.4).

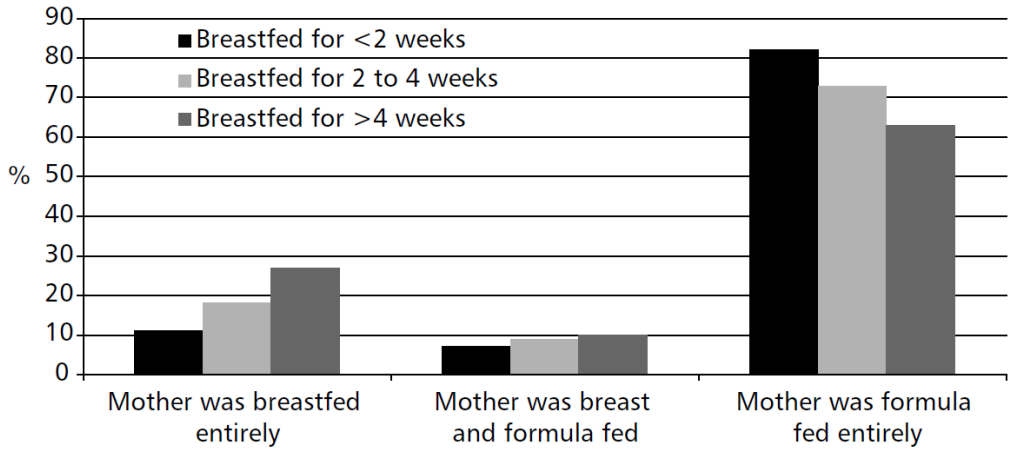


FIGURE 1.4 How mother was fed as a baby affects breastfeeding duration

Similarly, for those mothers whose friends entirely formula fed their children, 59% were still breastfeeding at 4 weeks compared with 85% whose friends entirely breastfed their babies (Bolling 2007).We are more likely to follow the example of our peers in order to fit into the group.

Impact of education on breastfeeding initiation

In a study (van Rosem 2009) of 2914 women, 95.5% of those educated to the highest level initiated breastfeeding while only 71.3% of those reaching the lowest educational level did. Educational level influenced breastfeeding experiences until the babies were two months of age, but not thereafter (see Figure 1.5).

The Infant Feeding Survey Results (2007, 2010) have shown the same variation inbreastfeeding initiation.

Peer support in populations where breastfeeding rates are historically low

Until breastfeeding is seen as normal it will remain difficult for mothers to initiate and sustain breastfeeding while they feel themselves to be acting in a manner which is not common or acceptable within their local society. To influence those mothers, an alternative means of support is required. One of these methods is the introduction of peer support workers. These are mothers who have breastfed and have undertaken additional training to work with other mothers in their neighbourhood. Their support has been shown to help initiation and prevalence in any area (NICE PH11 2008).

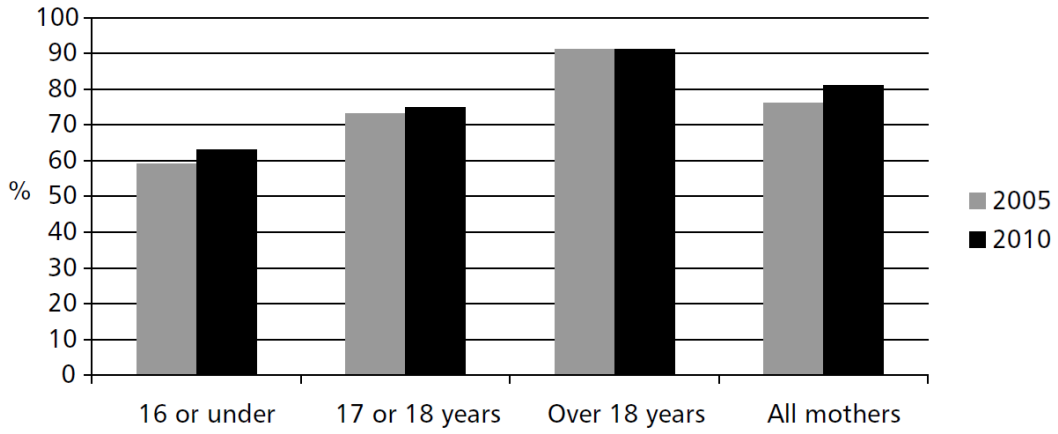


FIGURE 1.5 Percentage of mothers in England and Wales initiating breastfeeding according to age at which mother left full-time education

Difficulties experienced with breastfeeding

Many women and healthcare professionals perceive breastfeeding to be difficult, painful, messy, restrictive and tiring. However, studies show us that breastfeeding is important for the future health of mothers and children. So why is there this disparity between the importance and the practicality of breastfeeding?

Of mothers who initiated breastfeeding, 39% had stopped because they experienced painful breasts and/or nipples with 26% giving up in the first week (Bolling 2007). A further 14% reported that it took too long or was tiring while 4% were unhappy that the baby could not be fed by others. These mothers fulfilled the expectations that, despite their original commitment to breastfeeding, they had found it to be difficult. The reasons given for stopping breastfeeding continue in a similar vein up to 9 months after birth (see Figure 1.6).

However, if we look at how many women would have liked to have fed longer compared to those who have breastfed for as long as they wished very few would probably

describe themselves as 'succeeding' in breastfeeding. If we could ensure that all mothers who choose to breastfeed their infants could continue to do so for as long as they wish, the negative picture of breastfeeding might be addressed.

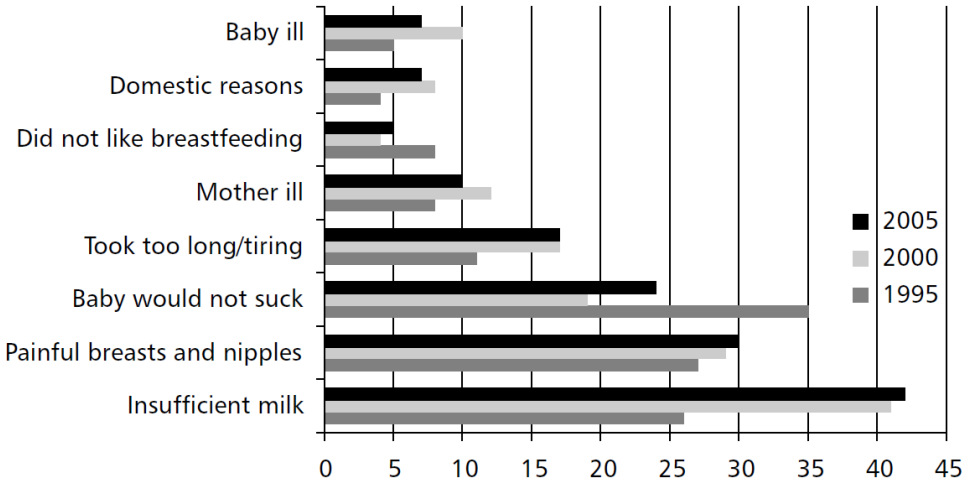


FIGURE 1.6 Reasons given for stopping breastfeeding baby less than 1 week old

The purpose of this book is to reduce the number of mothers told to stop breastfeeding because of their need for medication and to add to the knowledge of why breastfeeding may falter and how it can be better supported and therefore maintained (see Figure 1.7).

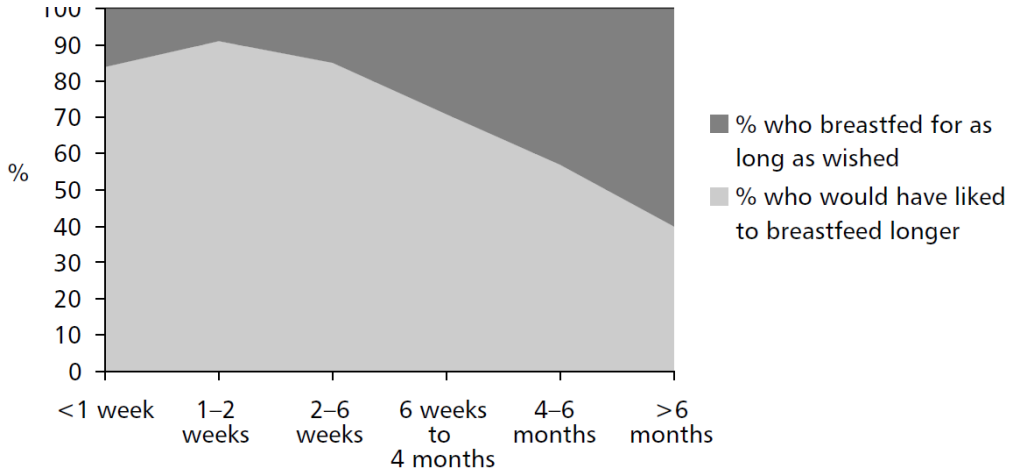


FIGURE 1.7 Satisfaction of mothers with duration of breastfeeding achieved

Prevalence of breastfeeding

So what progress has been made in increasing the prevalence of breastfeeding? In

1975, 50% of women in England and Wales initiated breastfeeding (Foster 1997) while in 2010 this had risen to 82% (NHS Information Centre 2011).

Of the 77% of mothers who initiate breastfeeding in 2005, only 48% continued to provide any breastmilk to their child by 6 weeks of age – a loss of 29% of breastfeeding experiences for the mother and child. In a short period of time and breastfeeding has become a minority activity (see Figure 1.8).

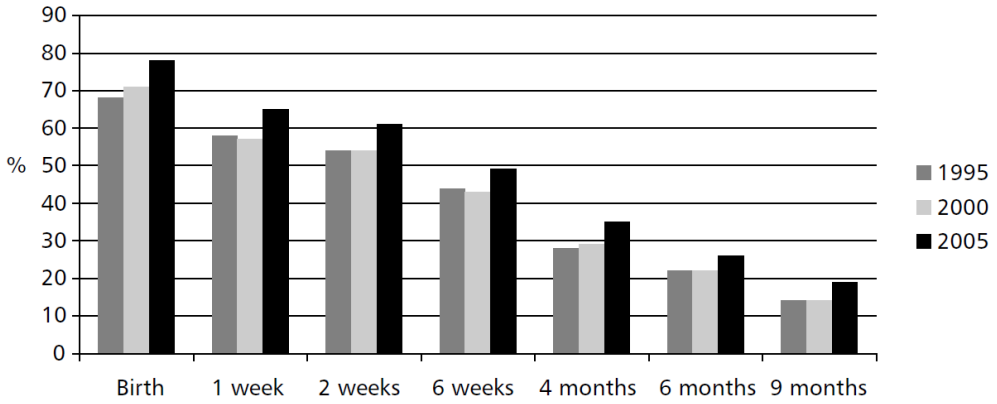


FIGURE 1.8 Percentage of mothers breastfeeding in England and Wales with age of baby

In 2000, 60% of women in manual and routine occupations initiated breastfeeding (Hamlyn *et al.* 2002) compared to 86% of women in managerial and professional occupations. By 2005 (Bolling 2007) the gap had narrowed with 67% manual workers and 89% of professional women beginning to breastfeed their babies (see Figure 1.9).

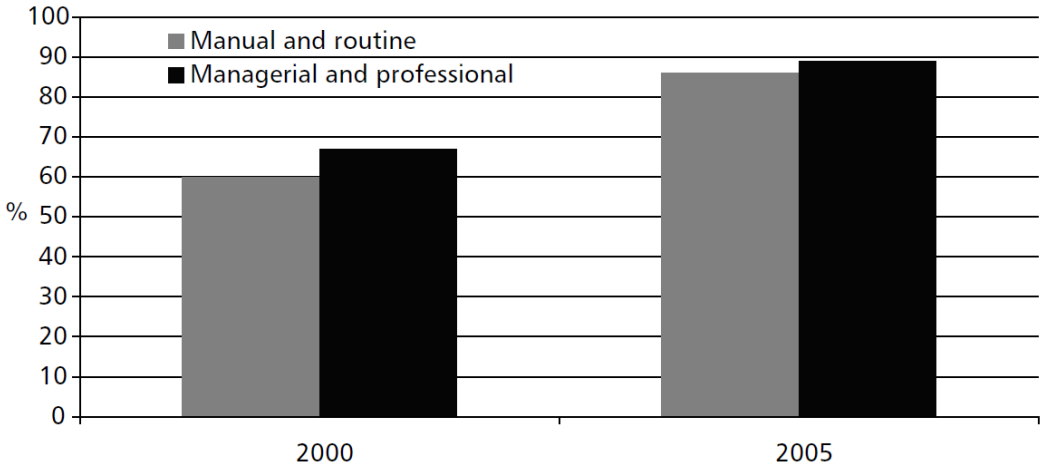


FIGURE 1.9 Percentage of mothers breastfeeding according to occupation

Exclusive breastfeeding rates

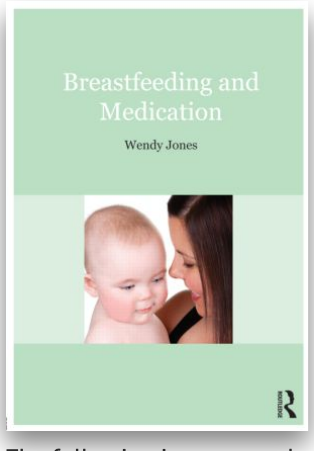
The definition of exclusive breastfeeding is that an infant receives 'only breast milk, and no other liquids or solids, with the exception of medicine, vitamins, or mineral supplements'. The UK Department of Health and World Health Organization (WHO) guidelines recommend exclusive breastfeeding for the first six months (Off to the Best Start, WHO 2007).

In 2005 the Infant Feeding Survey for the first time attempted to identify the duration of exclusive feeding (Bolling 2007). Across the UK, approximately two-thirds of mothers (65%) were exclusively breastfeeding at birth. Mothers who gave something other than breastmilk on day 1 were defined as not exclusively breastfeeding at birth. This means that 11% of mothers who initiated breastfeeding lost the exclusivity within the first 24 hours after delivery, generally while still in hospital. By 1 week less than half of all mothers (45%) were exclusively breastfeeding, and this had fallen to around a fifth by 6 weeks. At 6 months, the optimal duration, levels of exclusive breastfeeding were negligible.

So there is a wide gap between what research says is the best way to feed babies and what actually happens. Much work is therefore still needed to meet the recommendations of the Acheson report (Acheson 1998) if we are to improve the health of society by increasing rates of breastfeeding and improving the diet of infants.

Breastfeeding and Medication: Understanding the importance of Breastmilk

Chapter 2:: Understanding the importance of Breastmilk



The positive health benefits of breastfeeding

Historically we have always looked at research in terms of studying and quantifying the size of the effect of the advantages to the health of a baby of being breastfed. More recently it has become standard to look at outcomes from the point of view that breastmilk is the natural nutrient for an infant. We should not begin from the point of view that breastfeeding has advantages to the health of mother and baby but that alternatives (formulated from the milk of other mammals) may have risks because they are not bio-specific. So for the baby any change in health is produced by the consumption of artificial formula milk.

The Child and Adolescent Health and Development section of the WHO states that 'breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants'. (WHO 2002).

In a clinical review, Hodinott *et al.* (2008) recommended that breastfeeding should be actively supported by all healthcare professionals as an important way to improve child health. They suggest that better implementation of existing evidence is needed to improve the education of all, to address health inequalities and to facilitate breastfeeding outside of the home.

There are many acknowledged and well-researched positive health benefits for infants to support the promotion of exclusive breastfeeding. These will briefly be discussed here with further information being available in the references cited:

Less risk of gastro-enteritis (Howie *et al.* 1990; Kramer *et al.* 2003; Wilson *et al.* 1998; Quigley 2007; Rebhan *et al.* 2009).

• Fewer middle ear infections (Aniansson *et al.* 1994; Duncan *et al.* 1993).

• Reduction in urinary tract infections (Marild *et al.* 2004; Pisacane *et al.* 1992).

• Fewer lower respiratory tract diseases (Virginia *et al.* 2003; Howie 1990; Ball *et al.* 1999).

• Lower incidence of juvenile onset, insulin dependent diabetes (Alves 2011; Sadauskaite-Kuehne *et al.* 2004; Virtanen *et al.* 1991; Mayer *et al.* 1988).

• Reduced risk of developing Type 2 diabetes in later life if ever breastfed (Liu *et al.* 2010).

• Lowered blood pressure – measurable by the age of 5 but lasting in adulthood (Martin *et al.* 2005).

• Total cholesterol reduced by 0.18–2 mmol per litre if ever breastfed compared with

being formula fed as an infant (Owen 2002).

• Normal weight-gain patterns leading to reduction in obesity (Arenz *et al*. 2004; Fewtrell 2004; Gillman et al. 2001; Owen *et al*. 2005; von Kries *et al*. 1999; Horta 2007; Li 2010).

• Reduced rates of acute lymphocytic leukaemia and acute myelogenous leukaemia (Kwan 2004).

• Reduced risk of atopic dermatitis in children with a family history of atopy (Burr *et al*. 1989; Fewtrell 2004; Lucas et al. 1990; Saarinen and Kajosaari 1995; Host 1991; Rothenbacher 2005).

• Reduced risk for infants without a family history of asthma in children. The evidence in families with a family history of asthma is less clear (Oddy 1999; Ip 2007).

• A reduction in sudden infant death with any breastfeeding compared to exclusive formula feeding (McVea 2000; Ip 2007).

Mothers who do not breastfeed at all show an increased risk of breast cancer, particularly pre-menopausal – a reduced risk of 4.3% for each year of breastfeeding (Ip 2007); ovarian cancer risk reduced with any breastfeeding (Ip 2007); and the metabolic syndrome as a result of failure to lose excess weight gained during pregnancy (Gunderson *et al*. 2009).

Furthermore, there are health benefits for mothers who breastfeed. Compared to women who have not had babies those who do not breastfeed have about a 50% increased risk of Type 2 diabetes in later life (Liu 2010). For women without a history of gestational diabetes, each additional year of breastfeeding was associated with a reduced risk of developing Type 2 diabetes (Ip 2007).

Three studies found an association between early cessation of breastfeeding or not breastfeeding and an increased risk of post-natal depression cause and effect cannot be determined. However, the studies were not of the highest quality and did not screen for depression as a baseline (Ip 2007).

Women who have breastfed are at lower risk of hip fractures and reduced bone density (Paton 2003; Polatti 1999). Delay in return of menstruation leads to less depletion of iron stores.

In addition there are health risks from the preparation of formula (Renfrew *et al*. 2003; WHO 2007):

• under or over concentrating the formula;

• the use of formula powder that, due to production cannot be totally sterile,

contains high levels of potentially harmful bacteria including Enterobacter

sakazakii and Salmonella, which may multiply if freshly boiled and cooled water is not used to reconstitute it;

• storage of prepared formula milk at room temperature allowing bacteria to multiply; and

• potential contamination of bottles and teats or other feeding vessels.

Implications for the healthcare system

In addition to individual benefits of breastfeeding for mother and child, there are economic savings for the health economy. The NICE Post-natal care guidelines (NICE CG 37 2006) identified potential savings from cases of gastro-enteritis avoided by babies being breastfed. These savings are based on the observation from Howie (1990) that the rate of hospital admission for gastro-enteritis of breastfed infants is 1.4% and the rate of hospital admission for gastro-enteritis of bottle-fed infants is 7.8% (Department of Health 1995).

The national tariff cost for an episode of infectious or non-infectious gastroenteritis (HRG P26) is £662 for an emergency episode (NHS Payment by Results 2010–11). Using these data, the economic evaluation for a 10% increase in breastfeeding suggests 3900 cases of gastro-enteritis would be avoided, at a saving of £2.6 million.

In 1995, it was estimated that the National Health Service would save £35 million per year for every 1% increase in breastfeeding rates, in reduced hospital admission for gastro-enteritis alone (Breastfeeding; good practice guidance to the NHS, Department of Health 1995), which exceeds the estimate from the data above. This is because in 1995 a treatment episode consisted of a 4-day in-patient stay, resulting in a unit cost of around £1300 per case of gastro-enteritis treated. The national tariff for HRG P26 suggests that the average length of stay for treatment of gastro-enteritis is now 2 days.

Babies in the UK who are fed with artificial formula or breastfed for only a short time are five times as likely to be admitted to hospital during their first year of life with gastro-intestinal illness compared with those breastfed for a minimum of 13 weeks.

Ball and Wright (1999) showed that there were 2033 more doctor visits, 212 extra days in hospital and 609 additional prescriptions in the first year of life for every 1000 babies who were never breastfed compared with those exclusively breastfed for a minimum of 3 months. These are costs to the health system but also have a heavy impact on babies and their parents in terms of stress and perhaps time away from employment.

Riordan in 1997 estimated that annual healthcare costs in treating diarrhoea,

respiratory syncytial virus, insulin-dependent diabetes and otitis media in infants who were not breastfed were US$1 billion each year – this figure will be significantly higher now following inflation over the past 15 years.

Data from the Millennium Cohort Study showed that exclusive breastfeeding, compared with not breastfeeding, protects against hospitalisation for diarrhoea and lower respiratory tract infection. The effect of partial breastfeeding was found to be weaker. Analysis of the data, allowing for confounding variables, suggests that an estimated 53% of diarrhoea hospitalisations could have been prevented each month by exclusive breastfeeding and 31% by partial breastfeeding. Similarly, 27% of hospitalisations for lower respiratory tract infection could have been prevented each month by exclusive breastfeeding and 25% by partial breastfeeding.

However, the protective effect of breastfeeding declines soon after weaning from the breast. The authors conclude that breastfeeding, particularly when exclusive and prolonged, protects against severe morbidity in the UK today. A population-level increase in exclusive, prolonged breastfeeding would be of considerable potential benefit for public health (Quigley 2007). Data collection on hospital admissions was a critical focus of the longitudinal study of 18,819 infants born in the UK in 2000–2002.

The UK Standing Committee on Nutrition (SACN 1994; Williams 1994) issued the following statement in 1994:

The health benefits of breast feeding in industrialised countries are sometimes questioned on the grounds that modern, hygienically prepared infant formulas are safe and nutritionally complete. Uncertainties increase about this view as more is learned about the complex composition of breastmilk. From a teleological perspective, the complexity of breastmilk implies that it possesses numerous functions of biological importance . . .

However, 33% of breastfed babies included in the data collection in the Infant Feeding Study 2005 received bottles of formula or water during their stay in hospital (Bolling 2007), and very few babies are exclusively breastfed for 6 months.

Table 4.1 shows the estimates of savings produced by the NICE Postnatal care guidelines economic evaluation (NICE CG37 2006b).

Table 4.1 Net saving of improvements in breastfeeding

	2006/07	*2007/08*	*2008/09*	*2009/10*	*2010/11*	*2011/12*
Additional babies breastfeeding	21,134	31,622	42,478	53,334	59,509	60,416
Cumulative improvement in breastfeeding	3%	5%	7%	9%	10%	10%
	£000s	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*
Saving from cases of otitis media avoided	178	266	357	448	500	507
Saving from cases of gastro-enteritis avoided	913	1,366	1,835	2,304	2,571	2,610
Saving from cases of asthma avoided	829	1,263	1,697	2,130	2,377	2,377
Saving from reduced use of formula and teats	36	53	72	90	100	102
Net saving	1,956	2,948	3,961	4,972	5,548	5,596

Maternal beliefs about breastfeeding and its advantages

Virtually all mothers can breastfeed provided that they have accurate information, and support from within their family, within their community and by the healthcare system. Breastfeeding is natural but it does not always happen naturally and without problems. Mothers may need active support from their caregivers to establish breastfeeding.

The Infant Feeding Survey (2007) asked women what had influenced their feeding choice. That breastfeeding was 'best for the baby' was cited by 81% of all mothers with being 'more convenient' the second most popular reason (28%), but less important than in 2000. That breastfeeding is natural and better for the mother's health were mentioned more frequently in 2005 than in 2000. A full list of the reasons given is shown in Figure 4.1.

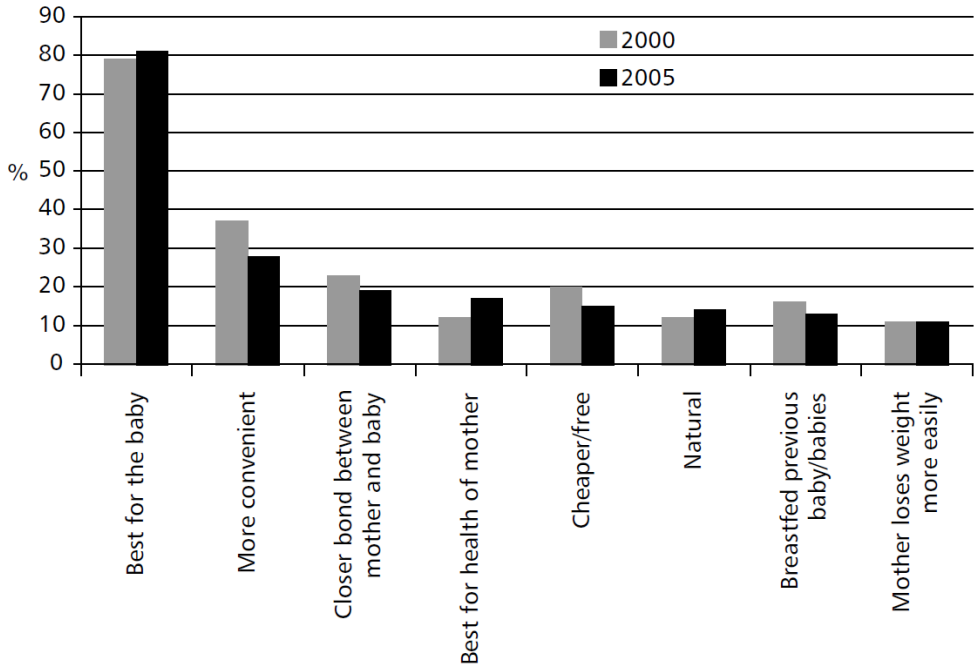


FIGURE 4.1 Reasons cited by mothers for breastfeeding (Bolling 2007)

Mothers who had breastfed a previous child were more likely to mention 'bonding', 'convenience' and 'cost' as a reason to choose breastfeeding than first-time mothers were. First-time mothers were more likely to concentrate on the health benefits.

When asked why they chose to formula feed from birth, 25% of mothers said that it gave more flexibility with other people being able to feed the baby. However, 32% said that they simply did not like the idea of breastfeeding (this factor was higher in first-time mothers (45%). A further 13% felt that bottle feeding fitted in better with their lifestyle. Perhaps the saddest reason given, and which healthcare professionals can do most about, was the 15% who had been put off by an earlier breastfeeding experience.

The health benefits named by mothers are shown in Figure 4.2.

Disadvantages of breastfeeding

Lawrence (2005) stated that:

> Disadvantages of breastfeeding are those factors perceived by the mother as an inconvenience to her since there are no known disadvantages to the normal infant.

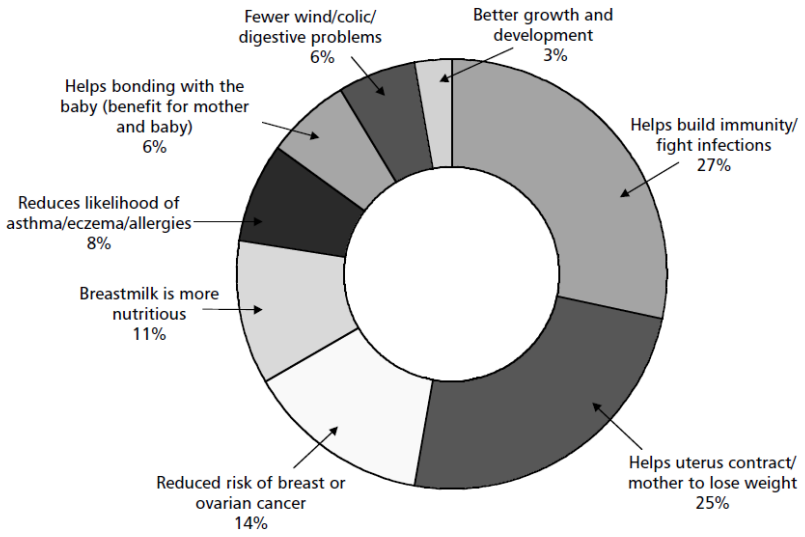


FIGURE 4.2 Named health benefits of breastfeeding cited by mothers (Bolling 2007)

It has long been claimed that the disadvantages of breastfeeding include:

- the inability to measure the volume of the milk that the baby has consumed;
- that no-one else can care for the baby;
- that breastfeeding can be painful, messy and tiring;
- that breastfeeding may be difficult to establish;
- that breastfed babies wake more often during the night to feed;
- that it is more difficult for mothers to return to work; and
- that the mother may need to modify her diet.

These reasons for choosing to bottle feed exclusively were almost all cited by mothers in the Infant Feeding Study (see Figure 4.3).

In the 2000 Infant Feeding Survey (Hamlyn 2002), 10% of mothers said that they felt pressurised into breastfeeding. Of these, 36% gave up breastfeeding within two weeks compared with 21% of all breastfeeding mothers. The large majority reported that they were subject to pressure from midwives (76%) with 25% feeling pressure from health visitors and 20% from friends.

For the percentage of mothers who reported feeling pressurised into bottle feeding (2%), the pressure was as likely to originate from their mothers (25%) as healthcare professionals (37% midwives; 12% health visitors).

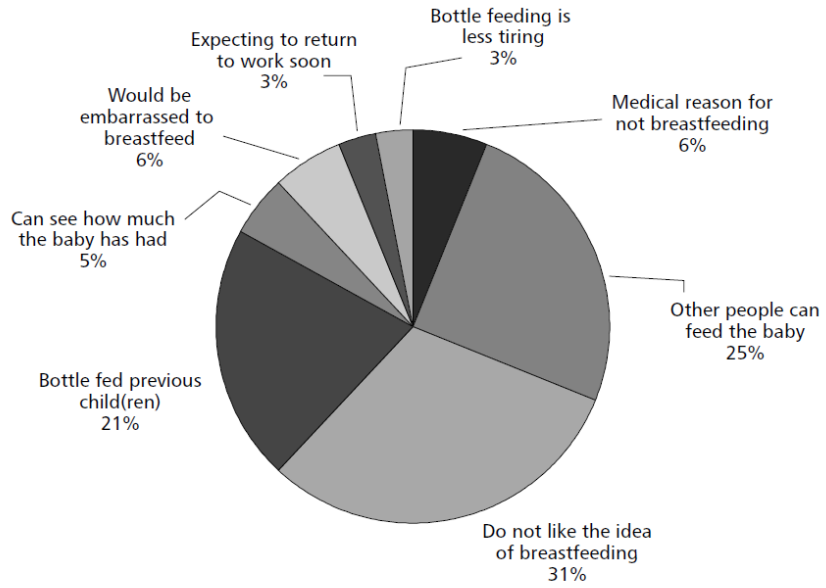


FIGURE 4.3 Reasons cited by mothers for bottle-feeding from birth (Bolling 2007)

Medical disadvantages of breastfeeding

Medical reasons for not breastfeeding may include very rare, hereditary conditions, which affect the baby's ability to metabolise breastmilk. These conditions include:

Galactosaemia

A hereditary disease affecting carbohydrate metabolism which occurs in approximately one in 60,000 live births (Walker 2006). Symptoms typically include jaundice, enlarged liver, vomiting, poor feeding, lethargy, irritability, convulsions and possibly death. Diagnosis is made by blood screening and a lactose-free formula is generally substituted for breastmilk, although partial breastfeeding may be possible.

Maple syrup urine disease

This is caused by a mutation in at least four genes (Walker 2006). Maple syrup urine disease affects approximately two live births per year. The classic condition is recognised in newborns between 4 and 7 days after birth although breastfeeding may delay the onset until the second week of life. A delay in diagnosis longer than 14 days is invariably associated with mental retardation and cerebral palsy. Treatment relies on dietary restriction of branched-chain amino acids for life.

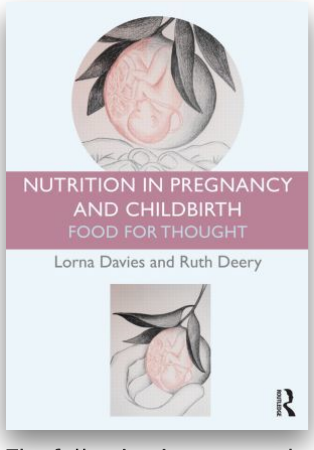
Phenylketonuria

This is an inherited condition affecting one in 13,500–19,000 live births (Walker 2006).

It is due to a deficiency of the enzyme responsible of the metabolism of phenylalanine into tyrosine. Unchecked, the levels of phenylalanine accumulate and interfere with brain development resulting in mental as well as growth retardation. Phenylketonuria is treated by dietary restriction of phenylalanine. Breastfeeding can continue in combination with phenylalanine-free formula while blood levels are monitored.

Nutrition in Pregnancy and Childbirth: Baby-Led Feeding - The Best Start to Life (Gill Rapley)

Chapter 3:: Baby-Led Feeding - The Best Start to Life (Gill Rapley)



Introduction

Healthy mammals of any age are equipped to feed themselves. At birth, a term baby is able to find his mother's nipple, attach and feed. Subsequently, his body tells him when he needs to eat and how much of his mother's milk to drink. These are essential survival skills that ensure the continuation of the species; but their existence should not surprise us. Non-human mammalian mothers do not know (in any cognitive sense) that their babies have to be fed, and they have no guides to tell them what or how much food to give. If it were up to the parent to think about what they should do, the baby's chances would be poor. Instead, mammalian mothers follow what their instincts and their hormones tell them – to keep their young close and let them nuzzle. The baby takes care of the rest.

Human babies are born with similar skills, and their parents, too, can take a baby-led approach to feeding their offspring – not just during the first few months of breastfeeding but throughout the introduction of solid foods, and beyond. Provided the foods offered are appropriate and in a suitable form, the baby will know what to eat, when and how much. As he becomes more independent, continuing to follow a baby-led approach ensures that breastfeeding winds down gradually, at a pace to suit the child and his mother, finally ending when it is no longer needed.

This chapter explains what baby-led feeding is and why it makes sense to support parents to implement this type of approach.

Baby-led breastfeeding: from birth onwards

The system that governs breastfeeding is remarkable. At birth, the primary hormone of labour – oxytocin – and the hormone of motherhood – prolactin – combine to bring about the onset of lactation. They also make the mother want to hold her baby close. The baby, meanwhile, is born with the instinct to search for his mother's breast. Held against her abdomen and chest, and attracted by the smell produced by the Montgomery's tubercles surrounding her nipples, he starts to explore her breasts. When he finds a nipple, he instinctively attaches and starts to feed.

The baby is stimulated to keep feeding because it soothes him, and because he recognizes and likes the taste of his mother's milk, having been exposed to similar tastes in the amniotic fluid that surrounded him in the womb. The mother is prompted to allow him to keep feeding because her circulating hormones give her a feeling of calmness and pleasure. As the feed continues, the baby's touch promotes the production of yet more maternal oxytocin and prolactin, strengthening the mother–infant bond and helping to ensure on-going milk production.

This system is secure, provided that the baby is held in way that allows him to feed, and provided that he is not separated from his mother in the first crucial hours after birth. Skinto- skin contact in a warm, supportive and unhurried environment, and a laid-back maternal position have been shown to encourage and support the instincts of both mother and baby, so that breastfeeding becomes the natural fourth stage of labour (Anderson *et al*. 2007; Colson *et al*. 2008).

In the days and weeks that follow the birth, keeping her baby close and responding to his requests to be held and to feed ensure that the mother's milk production keeps pace with the baby's needs – both on a feed-by-feed basis and over time, as the baby grows. When the baby is supported to feed in the way that he wants, whenever he wants, for as long as he wants, breastfeeding proceeds naturally and the risk that things will go wrong is drastically reduced.

Babies breastfeed; not mothers. As any mother who has tried to persuade her baby to feed when he does not want to will testify, you cannot 'do' breastfeeding to a baby. The whole process is designed to be baby led. A breastfeeding mother is not someone who breastfeeds her baby, she is someone who makes herself available to her baby so that he can breastfeed. A useful mnemonic, *FEEDS,* encapsulates the features of baby-led breastfeeding (Rapley and Murkett 2012):

Frequent: Breast milk is digested rapidly, so most babies want to feed frequently, both during the day and at night. This can easily mean twelve or more feeds in 24 hours. This is not a design fault – it helps to ensure that the mother stays near, as a source of comfort, warmth and security as well as of food and drink. Artificially soothing the baby with a dummy (pacifier) can mean fewer breastfeeds and reduced milk production.

Effective: Babies need to be held in a way that enables them to tilt their head back, scoop up a good mouthful of breast – with the nipple pointing at an angle towards the soft palate – and feed in a relaxed and rhythmic way, with deep, yawning sucks and audible swallows. To assist him to achieve this easily, the baby's body must be supported in close contact with his mother's, with his head and trunk in alignment, his nose opposite his mother's nipple and his head and arms free to move. A Biological NurturingTM position (Colson et al. 2008), in which the infant lies prone on his mother's gently sloping abdomen, is ideal in the early days, and especially for the first breastfeed. Actions such as holding the baby's head, or trying to insert the breast into his mouth, or the use of an artificial teat or dummy (pacifier) interfere with the consolidation of babies' innate feeding skills, with potentially adverse consequences for both mother and infant.

Exclusive: Breast milk provides perfect and complete nutrition for at least the first six months of life (Butte et al. 2002; Kramer and Kakuma 2002). Exclusive breastfeeding

ensures that the baby also receives a full complement of growth and protective factors, so maximizing his chances of optimal health and development. The vast majority of mothers can produce plenty of milk for their baby during this time, provided that the baby is allowed to put in the appropriate 'order'. If his appetite is dulled by formula, water, juices, teas or solid foods, diminished milk production may be the result. Exclusive breastfeeding is the key to maintaining flexibility in the balance of supply and demand.

On Demand: Allowing the baby to feed whenever he wants, for as long as he wants (from either or both breasts), ensures that the mother's body is stimulated to produce the amount and type of milk that the baby needs. If her breasts are uncomfortably full, she can offer him a feed before he asks. This flexibility to the needs of both not only ensures nourishment for the baby; it also minimizes the risk of complications such as damaged nipples, engorgement and mastitis for the mother.

Skin to skin: When the baby and his mother are skin to skin, their instincts and hormones are maximized, supporting effective feeding and milk production. Such close contact also enhances the baby's sense of security and allows his mother to learn to interpret his movements and signals, thus facilitating the development of a close bond between them. Skin-toskin breastfeeding is especially valuable in the early weeks, when lactation is being established and the two halves of the new dyad are getting to know one another.

Unsurprisingly, this approach to feeding is what underpins the World Health Organization and UNICEF's Ten Steps to Successful Breastfeeding (UNICEF, 2012). Steps 4 to 9 deal specifically with the importance of:

- skin contact at birth (Step 4)
- effective breastfeeding (Step 5)
- exclusive breastfeeding (Step 6)
- keeping the baby and mother together, or 'rooming in' (Step 7)
- breastfeeding on demand (Step 8)
- avoiding teats and dummies (Step 9).

Baby-led breastfeeding ensures that the vast majority of mothers will be able to nourish their babies, without discomfort, for as long as they wish. Interfering with this natural process, for example by restricting the baby's free movement at the breast, introducing bottles or attempting to follow a schedule, is what triggers most of the problems that are nowadays all too common. Baby Friendly hospitals worldwide provide their staff with training to implement policies that support baby-led

breastfeeding, thereby giving both mother and baby the best start to their feeding relationship.

The first two weeks have been found to be crucial for long-term milk production for mothers whose babies are born early (Jones and Spencer 2007). It seems likely that a focus on responding to the baby's requests and supporting him to become proficient at breastfeeding *for at least the first two weeks* would benefit mothers of term babies, too. Relatives and professionals can do much to support new parents, simply by encouraging them to invest time and effort in getting breastfeeding up and running during this important 'babymoon' phase.

Starting solid food: baby-led weaning

In many countries, the word 'weaning' (or its equivalent) is used to describe the end of breastfeeding – whether this occurs after only one or two breastfeeds, three or four months of breastfeeding or many years. Under this definition, a baby may be weaned 'off' the breast and onto either full formula feeding or a range of foods, depending on his age. In other countries (notably the UK) the word 'weaning' is more often used to refer to the introduction of solid foods, alongside milk feeds, for any baby, whether breast or formula fed.

Although, superficially, these two interpretations appear to be in conflict, a broader definition can comfortably incorporate them both: *Weaning is the gradual process by which a baby's total dependence on breast milk (or a suitable breast milk substitute) is transformed into complete independence of it, nutritionally speaking*. In other words, weaning begins with the first solid food and ends with the last milk feed – a process that can normally be expected to take at least six months, and quite possibly several years. It is in this sense that the term is used in this chapter.

When baby led, weaning is part of a natural continuum with breastfeeding, based on the abilities and instincts of all babies to feed themselves. The baby can be trusted to take the lead not only as breastfeeding ends but also at the very beginning of weaning, when solid foods are first introduced. However, in order to embrace a baby-led approach to weaning, we need to let go of some of our preconceptions about what the introduction of solid foods must entail.

Why baby-led solids?

The World Health Organization (WHO) currently recommends exclusive breastfeeding for the first six months of a baby's life (WHO/UNICEF, 2002), with complementary foods being added gradually from then on. The majority of countries have incorporated this into their own recommendations. As a result, many parents – encouraged by health professionals – circle on their calendar the date when their baby will be 26 weeks old,

and make preparations for how they will manage this momentous event, without consulting their baby at all.

Most people would consider it a ludicrous idea to decide the date on which a baby should walk, and to introduce a 'walking programme' on that day. They would also consider it positively cruel to prevent a child from walking before the designated day arrived. Yet we have been happy to take exactly this type of adult-managed approach to introducing solid foods. It seems ironic that we should consider babies competent to know what they need and how to feed themselves when they are newborn – and at their most vulnerable – but incompetent to do these things half a year later. In fact, we need only to look at how babies develop to see that, by six months, they have all the skills they need to begin the transition to solid foods unaided.

The newborn baby relies mainly on smell and feel to locate the breast. Later, he begins to use his hands in a more focused way, to help him access the breast. As his postural control, hand–eye co-ordination and manual dexterity improve, he begins to use his hands and mouth to explore objects within his reach. At six months he can maintain an upright sitting position with minimal support, reach out easily to grasp interesting objects and take them to his mouth. By seven months he can usually chew on them. These are the skills he uses to learn about his environment – but they are also self-feeding skills. Their emergence indicates that the baby is ready to expand his eating experience into the world of solid foods. Unfortunately, their importance has not been widely recognized because of the genuinely held belief – prevalent for the last few generations – that breast milk alone could not be relied on to provide sufficient nourishment beyond the age of four months.

If we believe that the majority of four-month-old babies need foods other than breast milk, the fact that a six-month-old might be able to feed himself is an irrelevance; the challenge is how to get food into this younger baby, who can't. Spoons and purees are the obvious answer, which is why they have come to be seen as an integral part of feeding babies. But now that there is good evidence to support exclusive breastfeeding for six months, we need to take another look at just how much help a baby of this age needs when it comes to eating solid foods. Even a cursory look at the skills that he possesses will show that, in the same way that there is no rationale for 'doing' breastfeeding to a baby, there is nothing to justify 'doing' solid feeding to him, either.

All healthy, able-bodied babies roll over, sit up, crawl and walk when they are developmentally ready to do so, provided that they are given the opportunity. What tends to go unnoticed is quite how long the opportunity has been present, nor exactly how the baby has made use of it in the run-up to the milestone being achieved. The baby of two weeks who is put on the floor 'for a kick' is actually being given the opportunity to walk; only his level of development is holding him back. Every day he

uses the opportunities he is given to practise new skills, in different combinations, until the day when he finds that he can stand, lift one foot and take a step. He does not just 'learn' to walk over a few days: he develops the strength, balance and co-ordination to enable him to walk, over many months.

In the same way, baby-led weaning relies on the baby being given an opportunity to practise his developing self-feeding skills, and this can follow a similarly gradual and barely noticeable path – as the following vignettes from the life of baby Jack illustrate.

Scene 1, one week old: Jack is lying in his mother's arms while she eats a meal. He is either breastfeeding or asleep. He is dimly aware of her eating, through the noises she is making. He is able, through her breast milk, to taste some of what she has eaten earlier that day, so he is already, in one sense, sharing her food.

Scene 2, two months old: Jack is being held in a sitting position on his father's lap while his parents eat a salad. Jack looks with interest at his mother, the plates, the colourful food and the cutlery, as well as other objects within his field of view. He responds excitedly when he is spoken to. He is 'joining in' the mealtime, if not the meal.

Scene 3, four months old: Jack is being supported in a sitting position on his father's lap while his parents eat spaghetti Bolognese. He watches as they twirl their spaghetti and lift it to their mouths, and he waves his arms enthusiastically. He reaches out towards his father's plate and gives the pile of pasta and sauce a hefty smack. He has made the acquaintance of his first solid food.

Scene 4, five months old: Jack is being supported in a sitting position on his mother's lap while his parents eat a roast dinner. He watches as she lifts food to her mouth and he tries to grab her hand. She puts some pieces of carrot on the table top in front of him. Jack looks at them, pushes them around, then picks one up, squeezes it and drops it. He brings his hand to his mouth and sucks his fingers. He has experienced a new texture and an interesting taste – but he has not eaten anything.

Scene 5, six months old: Jack is sitting in his high chair, with a rolled-up towel tucked around him for support. His parents are eating a chicken casserole. His mother puts a piece of potato, a broccoli floret and a chicken drumstick on his tray. Jack has a go at all three, doing a lot of squishing, squashing and banging, and occasionally biting off small amounts, which he chews, and which then fall out of his mouth. He experiences several different flavours andtextures but does not swallow any measurable quantity of food.

Scene 6, seven months old: Jack is sitting in his high chair, sharing a meal of bread, avocado, cheese and fruit with his parents. By the end of the meal there is noticeably less food in his chair and on the floor than has been the case in the past. His parents have noticed that his stools have become darker and stronger-smelling in recent days, too, and that they contain occasional bits of partly digested food. They know Jack is

eating some of what they offer him but they cannot say exactly when he swallowed his first mouthful.

As this sequence illustrates, with a truly baby-led approach, the move to solid foods is not identifiable as a single moment. Even when the opportunity to begin exploring solid food is not provided until the infant is six months old, there is commonly a time gap of several days or weeks between the moment the baby first meets solid food and the moment he first eats it. In this context, the phrase 'starting solids', like much of our other language around weaning, is almost meaningless (Rapley 2011). Parents who choose baby-led weaning do not decide when to 'start' their babies on solid foods, they simply decide when to begin providing the opportunity for their babies to do this themselves.

Allowing a baby to practise skills as soon as he shows readiness to do so is crucial to the optimal development of those skills (Illingworth and Lister 1964; Jindrich 1998). Indeed, children who are not introduced to lumpy foods at a relevant point in their first year can present with feeding problems later in childhood (Northstone et al. 2001). It follows that taking a skills-led approach to the introduction of solid foods is likely to maximize a child's eventual proficiency with food. By the same token, helping a baby to become familiar with a wide range of foods, and ensuring that eating is a pleasurable experience from the beginning, will tend to lead to a varied diet and a healthy relationship with food in later life.

As discussed in the early part of this chapter, the natural appetite of a breastfeeding baby can be relied upon to ensure an appropriate intake of food. There is no reason why this mechanism should become faulty when solid foods are introduced – provided that the baby himself is allowed to continue to make his own decisions about how much to eat, how quickly and how often. Thus, baby-led weaning may have implications in the fight against obesity, and there is already some evidence to support this (Townsend and Pitchford 2012).

Baby-led weaning may also have a part to play in preventing food refusal, which has been found to be common among older babies and toddlers (e.g. Young and Drewett 2000). Sharing mealtimes encourages babies to copy others, and to eat what they are eating (Nicklas *et al*. 2001). Babies who are spoon fed are often fed separately from the rest of the family. Even if they share the mealtime, their food is not the same in appearance as that of the other people present. So the opportunity to copy others is limited. In addition, being able to separate the ingredients of, say, a casserole, and to sample them individually, allows babies to identify foods they like or dislike in a way which is not possible when a complex dish is made into a single puree. If a disliked element cannot be isolated, the baby is likely to refuse the whole meal.

To date, we cannot be certain about the health outcomes of taking a baby-led approach to weaning but we cannot escape the fact that BLW (as it is known) has spread rapidly since the phrase was coined in 2002, chiefly by word of mouth among parents and via the internet. Its popularity can be explained by the reports of parents who say that it 'makes sense', prevents mealtime battles and enables them to enjoy feeding their babies (Rapley and Murkett 2008; Brown and Lee 2011). These are the everyday benefits that resonate with parents and encourage them to look beyond the conventional norms of solid feeding.

Baby-led solids: the practicalities

Baby-led weaning is more than just allowing babies to feed themselves when they are ready. It's a concept that revolves around shared mealtimes, where the whole family chooses from food that is nutritious, safe and, as far as possible, free from added salt, sugar, chemicals and other extras unsuitable for babies.

The baby is supported (if necessary) in an upright sitting position, either in a high chair or on an adult's lap, so that he can use his hands and arms freely. He is offered a few pieces at a time of the same food as everyone else (or a selection from it), in a shape and size that he can handle easily and of a consistency that is firm enough to grasp but soft enough to chew. To start with, this will mean sticks or strips of food but, gradually, he will show that he can manage smaller pieces and a variety of consistencies.

The motivation for a baby to begin exploring solid food appears to be curiosity, not hunger. He therefore needs, when he joins in the mealtime, to be in a frame of mind to explore – not distracted by hunger or the need for a nap. Once at the table, the whole experience will be new and he may need help to focus on the food. For this reason plates and cutlery are often best omitted in the beginning; they will come into their own once the baby is more skilled. Water can be offered with the meal, although most breastfeeding babies will continue to quench their thirst at the breast for several weeks or months after they have started to eat

solid foods. The digestive tract of a six-month-old is ready for solid foods, so there is no need to restrict him to one new food at a time. Indeed, the chance to experience a variety of flavours and textures is one of the things that makes this way of learning about solid foods so enjoyable. The exception is any foods which the family history suggests may be linked to allergy.

The principle behind baby-led weaning is a developmental one and this is closely linked to its safety as a feeding method. Allowing the baby to remain in control is the key. The normal sequence of oral skill acquisition in the period between five and seven months of age is as follows (Naylor, 2001):

1 bringing things to the mouth

2 biting and munching

3 chewing

4 purposeful swallowing.

It seems likely that progress through this sequence keeps pace with the development of the gut and the immune system, such that a baby who is not ready to digest solid foods will not be able to get them into his mouth in the first place. Similarly, if he is not able to bite off a piece of food, this suggests that he is not ready to chew. It is therefore important that no one attempt to 'help' the baby by putting pieces of food into his mouth for him.

The fact that the ability to chew develops before the ability to move a bolus of food to the back of the mouth for swallowing means that most early bites of food will fall forward, out of the baby's mouth. This protects his airway until he is mature enough to swallow safely. However, while safety is generally assured if the baby is in an upright position, commonsense rules should nevertheless be observed. Thus, whole nuts should not be offered, while small, round fruits should be stoned, if necessary, and cut in half.

Gagging (or retching) is common in the early stages of baby-led weaning. The gag reflex acts to prevent food from being pushed too far back in the mouth without having been chewed adequately, and it is particularly sensitive between six and eight months (Naylor 2001). As the baby matures, he becomes more adept at chewing and the point at which the reflex is triggered moves farther back in the mouth, so gagging occurs less often. Although gagging can appear alarming to parents, babies are rarely bothered by it and it may be that it has an important protective function during this learning period.

It is likely that, given the opportunity, the majority of babies will start feeding themselves spontaneously, at the time that is right for them (Wright *et al*. 2011). However, for a minority of babies this may happen too late to ensure adequate nutrition. Preterm infants, for instance, or those with developmental delay, may require additional nutrients before they are physically capable of feeding themselves. Usually, vitamin and mineral supplements will suffice, but some paediatricians may recommend that a start be made with pureed food. Provided that the baby is given the opportunity to handle pieces of food once he can sit upright, he will develop the necessary skills in his own time and the need for spoon feeding will gradually fade.

Baby-led weaning will be effortless if the family is already in the habit of eating foods that are suitable for a baby. Pregnancy provides an ideal opportunity for expectant parents to make any necessary adjustments to their diet, such as learning to cook with fresh ingredients and without salt, not only in order to optimize the health of mother

and baby during and after the gestation but also so that the whole family will be able to share their meals easily once the baby is ready to join in.

Baby-led weaning: maintaining breastfeeding

We have seen that a baby's innate instincts and abilities are what equip him both to breastfeed and to begin to discover other foods, but it is the interplay of these two activities that makes baby-led weaning the ideal approach for a breastfed baby. In the past, the information given to parents about introducing solid foods commonly included instructions on how to cut out milk feeds and introduce other drinks as solid meals increased. The implied aim was that the changeover should be quick – to be completed, ideally, by the first birthday. Not only was this an unphysiological approach, which recognized neither the on-going importance of breast milk for older babies nor the baby's need to explore and handle food, but it assumed steady progress throughout and made no allowance for variations along the way.

Once solid foods have been introduced, breastfeeding can and should continue to be baby led. Complementary foods are intended to complement breast milk, not replace it. In the early weeks only very small amounts are needed, mainly to supply iron and zinc (Palmer 2011); not sufficient volume or calories to reduce the infant's appetite for milk. Indeed, it is unlikely that the baby's intake of breast milk will start to lessen noticeably until he is at least nine months old, so frequent breastfeeding will continue to be the norm during this time. Even when solid foods do begin to edge out the need for breast milk as a food, many breastfeeding babies continue to have all their drinks at the breast for several more months. Baby-led weaning thus ensures a much greater intake of breast milk over a longer period of time than does a managed approach, which aims to reduce milk feeds from the outset. This may have important implications for blood levels of nutrients such as iron.

The natural progress of the transition from total reliance on breast milk to total reliance on foods other than breast milk is gradual and slow. It can also be far from constant. Allowing the baby to continue to breastfeed whenever he wants, for as long as he wants, enables him to regulate his intake of food and milk on a daily basis, thus ensuring a well-balanced diet throughout. For example, if the baby is unwell or teething or simply 'off' solid foods for no apparent reason, he will naturally want to feed more at the breast. This will stimulate his mother's milk production, ensuring an abundance of easily digestible food and important protective factors. Once he is well again, his increased appetite for solid foods and diminished appetite for breast milk will allow the breasts' output to settle back naturally to its previous level. This flexibility requires no calculations on the part of the mother – it is all under the control of the child.

Sometime after the baby's first birthday, solid foods will begin to take over from breast milk as his main source of nourishment. As the frequency of feeds and the amount of time spent at the breast decline, so milk production is gradually reduced. As this happens, the milk becomes more like colostrum again – packed full of antibodies but low in volume. This means that, although the nutritional role of breast milk may diminish, its relevance to the baby's health is still significant. Breastfeeding will also continue to play a part in his emotional well-being, and benefit his mother's long-term health, for as long as this special relationship exists.

Baby-led weaning: the natural end to breastfeeding

Biologically speaking, human babies are probably designed to breastfeed for six or seven years (Dettwyler 1995). This is the age when the baby's immune system can be said to be fully mature and, coincidentally (or perhaps not), when he begins to lose his 'milk' teeth. Commonly, it continues for at least two years. Provided that the mother is happy to follow her baby's lead, breastfeeding can continue to be baby led throughout this time, so that the last breastfeed happens when the baby is ready.

When the end of breastfeeding is chosen by the baby it can happen suddenly, with him pushing the breast away or proclaiming that he does not need it any more, or it can be a much more gradual process, with the last feed not being recognized as such by the mother, except in retrospect. Sometimes, as with the start of weaning, the end can be difficult to pinpoint, as when a toddler refuses the breast for a few weeks and then decides to resume breastfeeding as if nothing had happened.

Ironically, a baby-led end to breastfeeding does not necessarily mean that the baby is ready for it to cease. In some cases, circumstances arise that make stopping preferable to continuing. One of the most likely scenarios is that the mother is pregnant again. Pregnancy can make breastfeeding physically awkward for the child, because of the 'bump', but it can also alter the taste, quantity or flow of the milk in a way that he does not like.

To some children, the arrival of a new sibling renews their interest in breastfeeding or their need for 'mummy time', so that a period of tandem breast feeding follows naturally from the pregnancy. Others take the birth of a new baby as a sign that they are now 'grown up' and ready to explore more exciting activities. Either response can be encouraged or discouraged, while still allowing the decision to remain the child's. For older children, especially, it is not unusual for the end of breastfeeding to be something that is negotiated between them and their mother. Although not fully 'baby led', such an arrangement is nevertheless based on respect for the child's wishes and a willingness to allow him to share in such an important decision.

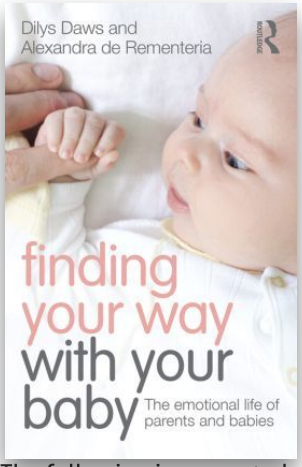
Baby-led feeding: the full picture

Baby-led breastfeeding has been around for as long as humans have existed; it has simply fallen out of favour – at least in the western world – in the last few hundred years. Babyled weaning is probably equally old but has tended to be practised in secret, for fear that the (experienced) mother will be exposed as a lazy or undisciplined woman. The signs are now that a baby-led approach to the continuum of infant feeding is being seen as logical and natural by increasing numbers of parents, and that more and more professionals are willing and able to support it.

Most adults appreciate being able to choose what to eat, how to eat, how often, how much and how quickly. Why should babies not feel the same way, particularly if their instincts and abilities are driving them to want to make these decisions for themselves? Research strongly suggests that denying the very young the opportunity to make feeding choices has the potential to lead to serious consequences; we should be wary of interfering in matters about which babies probably do know best.

Finding Your Way with Your Baby: Feeding

Chapter 4:: Feeding



Bowlby (1982) said that the comfort given by the mother, more than the food, was the essential basis for the relationship. It is not, however, always easy or straightforward to get started. This chapter will explore some of the feelings that might make it hard to get going and how fathers can help mothers and babies manage some of the overwhelming feelings.

Your baby's perspective

Being fed is one of the most important experiences of your baby's early life. It not only directly keeps her alive and growing, but also provides the basis for optimism in life. When her hungry cries are reliably answered with a breast or bottle, she can feel loved and cared for, and this helps her build up a feeling of trust. Held close to you, she can study your face, listen to your voice, and get to know the person most central to her world: you, her mother.

Yet, like every other experience she has had since birth, feeding is entirely new to her. After nine months of having had all her food and energy provided for inside the womb, she now has to learn not only how to suck and swallow milk, but also how to digest and excrete it. This may take some time to manage but, instinctively, the baby is ready to get going. She has an instinct to root and to suck and a preconception of something that is there for her to suck on. You could almost say that she expects a breast, or bottle, to be in place for her. Winnicott urges us to:

> Imagine a baby who has never had a feed. Hunger turns up, and the baby is ready to conceive of something; out of need the baby is ready to create a source of satisfaction, but there is no previous experience to show the baby what to expect. If at this moment the mother places her breast where the baby is ready to expect something, and if plenty of time is allowed for the infant to feel round, with mouth and hands, and perhaps with a sense of smell, the baby 'creates' just what is there to be found. The baby eventually gets the illusion that this real breast is exactly the thing that was created out of need, greed, and the first impulse of primitive loving. Sight, smell and taste register somewhere, and after a while the baby may be creating something like the very breast that the mother has to offer. A thousand times before weaning the baby may be given just this particular introduction to external reality by one woman, the mother. A thousand times the feeling has existed that what was wanted was created, and found to be there. From this develops a belief the world can contain what is wanted and needed, with the result that the baby has hope that there is a live relationship between inner reality and external reality, between innate primary creativity and the world at large
>
> which is shared by all. (1964: 90)

So, she is establishing a relationship with you but also establishing the kind of relationship she will have with the world and reality.

What you may be concerned about

Feeding a baby can be an enormous pleasure or it can feel completely awful. It's possibly the most responsible job you will ever have to do, literally keeping a baby alive. You may worry whether you are doing it properly, and whether your baby is getting enough – or too much – milk. All the anxieties about being a bad parent can get focused onto feeding the baby. This can connect with what your own infancy was like, an idea explored more fully later. Feeding is as much a learning process for you as it is for your baby and it may take time to feel confident about when, where and how to feed her. Getting a rhythm and pattern going for feeds is one of the main preoccupations of the early weeks.

From parents . . .

> *'I felt so humiliated that I couldn't get the feeding right. I had so much milk that my breasts were engorged, and the baby hadn't a chance to latch on. The breastfeeding counsellor sat with me until the baby and I sorted it out. I could never have done it by myself.'*
>
> *'I became a breastfeeding counsellor after having struggled to establish breastfeeding myself. The problem is that women are given to believe that because it is "natural" they won't need to work at it. In fact most women have to work pretty hard before they get their "Madonna and child moment".'*
>
> *'The pre-natal breastfeeding classes were informative but the first time I fed her I got a bit too focused on remembering technique – like getting enough of the breast in for her to make a good latch, and then didn't notice how intrusive I was being stuffing her gaping crying mouth. Luckily a nurse appeared from nowhere and told me to slow down and let the baby show me how to do it, then we were fine and I really enjoyed feeding her after that.'*
>
> *'It took us several days to get going and we needed a lot of support at the hospital but once we were at home everything just completely fell into place. Then with my second it was easier from the beginning. As soon as she was born they gave her to me to hold and she latched onto my breast, rooting as if she knew exactly how to do it. I don't know what made the difference: my increased confidence with a second baby, or the babies' own different characters.'*

Breastfeeding is an embodied activity. It reminds us that we are mammals. When it goes well, there is great pleasure in doing a job that your body was designed to do. At other times it can be unnerving to be in touch with your mostly forgotten animal self.

From parents . . .

> *'While my baby was asleep I prepared dinner, listening to a news story about the use of DNA tests to prove maternity and thus reunite mothers with their children that had been stolen for an illegal adoption market. I was only half listening, actually wondering why I wasn't more upset by the story considering I was a new mother. Suddenly I realised that milk was seeping through my top. I think my body was reacting to emotions I was not even aware of having. I felt like I had been given a glimpse at a more primitive or animal me I don't usually know about.'*

A bit like the lioness who suckles the young of her own prey, women can feel at the mercy of powerful instincts. It might feel frightening or empowering to let the mind relinquish some control and move into a more physical plane of being.

Should I breast- or bottle-feed my baby?

How to feed your baby is one of the first important decisions. Both breast- and bottle-feeding will nourish a baby and support your bond with her. But the question involves much more than just straightforward facts. Your feelings are just as important, so don't let anyone else pressurise you into doing something that just doesn't feel right.

From parents . . .

> *'External pressures can make normal difficulties seem so much worse. My baby cried to be fed almost constantly. My family referred to this as "the famine" because they felt I ought to have given him formula to fill him up. Others told me that I did have enough milk, I just needed to believe that I did. I felt undermined and patronised by everyone but in the end we found our way.'*

Breastfeeding

There are a lot of advantages to breastfeeding. First is the irreplaceable satisfaction of being able to nourish your baby from your own body. There are also the direct bodily pleasures. Some mothers feel an intense physical enjoyment as powerful as sexual feelings in feeding their babies. The sensation of the baby's mouth on your nipples, her hands stroking your breast can be very enjoyable. However, these pleasurable feelings can be a deterrent to some women, it can make them feel shy and embarrassed, or indeed feel that the sexual connotations of breasts make them unsuitable for babies. Such worries usually subside once you get used to breast-feeding.

From research on the biochemistry of breastfeeding . . .

It can be helpful to be reminded that physiologically both sex and breastfeeding are about making and growing babies. Both breastfeeding and sex release oxytocin which makes us feel good physically and well disposed to others. It is a biochemical that supports bonding between couples and between parent and infant. From an evolutionary perspective, the function is to support the survival of our genes. This works on two levels. Because oxytocin makes us feel good, it rewards the two behaviours, breastfeeding and sex, in the moment. In the long term it supports those relationships that the infant's survival often depends upon. The hormones prolactin and vasopressin are also produced during breastfeeding. These further support bonding because they are involved in feelings of protectiveness and love.

The practical facts are that breast milk is easy for your baby to digest and contains important antibodies that will help her fight disease and protect her from allergies. It changes in composition to suit her changing needs as she grows, and reduces the risks of stomach infections. From a mother's point of view, breastfeeding is convenient as it's always available, clean and needs no preparation; easy for night feeds and travelling. It also helps you regain your shape more quickly. However, it can feel frightening at the beginning or burdensome after time. You might even feel that this strange new little creature is going to attack you or drain the nourishment out of your own body.

From parents . . .

> *'I would look at him and feel scared.'*
>
> *'Because she was in with us I wasn't really disturbed by the night feeds. Sometimes it was a nice sleepy little interlude but the four o'clock feed always made me bad tempered. It felt like I had a limpet stuck to me. I'd think "oh just get off!" but by the morning it would be all lovely again.'*
>
> *'Once we got going I found breastfeeding quite pleasurable, but then he started to want to feed for hours and hours of every day. Pinioned to the sofa I got quite low. I never remembered to make myself tea before we started, so I did end up feeling depleted.'*

This is a tiring time and although producing milk is not tiring in itself, it can feel like it contributes to the exhaustion. Many mothers worry they are not producing enough milk to nourish their babies – particularly as it is impossible to see just how much milk is being drunk. Weighing is useful here. If the baby's weight is following a normal growth curve, you must be producing enough milk.

Despite the naturalness, breastfeeding has in the past gone in and out of fashion. Today it is becoming increasingly popular and more widely accepted, but it was less so amongst the previous generation. If you weren't breastfed yourself, it can be hard to

make the decision to breastfeed your own child: it may seem like a criticism of your mother and her parenting.

Of course, the more women who breastfeed, the easier it becomes for others to do so. If as a girl, or more recently, you've seen babies being breastfed, you have an example to follow. It can be a great help during your pregnancy to watch and talk to a breastfeeding mother. What you observe may vary widely, the process can look very peaceful, and as though two people – mother and baby – have got into a very nice rhythm of doing a job together; or it can look turbulent, as if the baby were attacking the mother. In either case, breastfeeding is a very physical and 'earthy' business. The excitement of feeding and the passionate expression of loving and aggressive feelings can be seen more openly when the baby is dealing directly with the mother, without the intermediary of the bottle. Winnicott said 'the survival of the mother is more of a miracle in breastfeeding'. Certainly the sight of a breastfeeding mother and baby can be overwhelming at first. You may feel you shouldn't be looking. Breastfeeding cafes can be a wonderful place to start if you are worried about feeding in public. You can look up your nearest one online: www.thebabycafe.org/your-nearest-baby-cafe.htm.

After the birth: the best time to start

If you are able to hold your baby directly after the birth, you may find yourself quite naturally putting her to your breast. It's a good way not to notice any medical procedures that are still being done to you. This first little nuzzle can break the ice and help you feel you know how to do it. Even so, most mothers and babies have some problems at first. It takes some getting used to. Give yourselves time to calm down and work out what to do. Babies can coast along for a day or two with a bit of a suck, getting the colostrom, and with a bottle if necessary for a few days without you losing your milk. Penelope Leach (2010) talks about newborns needing to learn the sucking = food = comfort equation. While all babies are born with a sucking reflex, in some it will be stronger than others. Some will have discovered that they can suck on their fingers in the womb. They emerge already knowing about sucking something and will not take long to find the breast. None has yet experienced having their hunger sated through sucking. Some babies will need more time and careful attunement in order for them to make these connections. Getting started is a process, not an event.

If you had intended to breastfeed and it doesn't work out for you, don't be overwhelmed by feelings of failure. When it works, breast-feeding is practical and pleasurable but being able to breastfeed, or have a natural birth, is not a virtue. Closeness and being there for your baby are what matter most to her and breastfeeding is only one of the ways to provide this.

The pleasure of breastfeeding

One of the pleasures of breastfeeding is getting to know a baby's particular ways of asking to be fed or conducting a feed. A great deal is going on in this apparently simple scene. A feed is a gratification of an instinctual need; it is also a sensual experience and a learning one. When you sit, holding your baby close to feed, you and she are likely to gaze at each other. She has your nipple in her mouth, the taste of the milk, the feeling of being held by arms and body, the sounds of her own swallowing, of your heart beat, perhaps stomach-rumbles, words or murmurs from you and the sight of your face, especially your eyes and the feel of your breast if she strokes or clutches it. So touch, taste, sound and sight all come together to form the experience in the present, and build up memories for the future. When she digests the feed, she is also digesting the learning she has done about the texture of the world and how she can come to know it by putting together all these cross-sensory experiences. Babies can distinguish the smell of their own mother's milk at the age of forty-eight hours. They come to anticipate your particular milk and the particular experience you have together. The rhythm of these repeated experiences also help to orientate her in time.

We see how in pauses during the feed or in time afterwards the baby is able to do several things: to go on exploring mother's body, away from the urgency of taking in the milk; and to assimilate the experience and deal with the *idea* of mother who is there to feed her, but also exists in addition to this function. An idea that grows in this time is of mother and baby as two separate beings who have been wordlessly together and are now about to move apart. It could well be that how a mother and baby manage this time influences and is significant for how they will manage the separation aspect of the baby falling asleep (see Chapter 9). If, on the one hand, the feed is carried out only as a necessary routine piece of care, with no time allowed for exploratory playing, then there is not a period of transition for the baby to change from the *idea* of being fed to the *idea* of the end of the feed. If, on the other hand, the mother plays too long after the feed, it may be because she is not able to face with the baby that 'all good things come to an end' and cannot bear the small separations that happen many times daily. So, a great deal, indeed, is going on during and after a feed.

Feeding twins

> Mothers with twin babies often feel frantic and guilty as they are unable to give their full attention to either baby. If one baby sleeps while the other feeds, there is some peace. But this is not an ideal solution as it cannot be relied upon and it may be that the sleeping baby is avoiding overwhelming feelings by cutting off and sleeping. The babies will each have their own individual pattern of feeding. This might play on the mother's guilt about not treating both babies equally.
>
> (Lewin 2004: 64)

Mothers of twins generally want them to be treated equally but right from the

beginning the differences between their two babies will be evident in the way they want to feed. Piontelli (2004) describes how one twin might cling to the mother during a feed while the other just sucks from the tip of the nipple, keeping his distance. Another mother she worked with always used one breast for one twin and the other breast for the other: one nipple was smooth and unscathed while the other was nearly torn, evidencing their different feeding styles.

From research on the relationship between feeding and sleeping . . .

Research has shown that having a period of play after a feed is important in establishing sleep rhythms. Babies who spend ten to twenty minutes in their mother's arms after they have finished sucking, sleep better than those who spend either more or less time in such play. It seems that mothers who do this are able to discriminate between their baby's need for playful and loving contact with them, and do not confuse this with a need only for feeding.

From parents . . .

> *'My first would stroke my breast, and I felt very much appreciated. My second baby had a way of going Tap Tap with her little hand on my breast with cheerful assurance that a feed was coming her way!'*
>
> *'Some feeds were hungry purposeful ones, head down, concentrating. At other times it was about sucking herself to sleep. Then there were feeds that were social occasions. She would love lying in my arms, having a suck, pulling away to "talk" to me or look around the room and then settle back to the job in hand. It was touching to see how rosy cheeked and round faced she looked after the feed. She looked full of love and satisfaction.'*

The difficulties of breastfeeding

There can be more difficulties involved in setting up breastfeeding than bottle-feeding. It can take time before mother and baby are at ease with breastfeeding, it can hurt at first and it may not feel worth it to everyone. However, most feeding problems are about getting started and most who do persevere are glad that they did.

Bottle-feeding

Breastfeeding may not feel right to you, especially if you weren't breastfed yourself, and bottle-feeding may come much more easily. Bottle-feeds involve more preparation but it might feel 'safer' not to have the baby latched on to your breast. Paradoxically, having the bottle between the two of you, creating some distance, might actually help you to feel more relaxed and confident about coming together emotionally. You can still hold the baby close, enjoying the feeling of each other's bodies, and getting a nice rhythm going. Feeding a baby with a bottle separates her physical well-being from your own,

and you may feel happier if you can see exactly how much milk your baby is taking. It can also allow fathers to participate. Emotional security does not seem to be affected by whether the feeding is by breast or bottle. What matters is that the baby is held close when fed, looked at and responded to. If such intimacy still feels too frightening, you might need to talk to someone about it.

If you can leave the decision about bottle- or breastfeeding until after the baby is born and you have held her a few times, if you give her the chance to have a little nuzzle at your breast, making her own little sounds, then you leave your options open. Sometimes mothers find that when they have got the whole experience of the birth over with, they feel more able to take on the challenge of breastfeeding than they had anticipated.

It is probably best even with a bottle for you, the mother, to give your baby most of her first feeds. A new baby may find it simpler to learn the style and rhythm of one person only. If you have a maternity nurse or someone else to help in the first week or so, don't let her help you out by taking over the feeds. If you are feeling really exhausted or angry, you might think you must have time to yourself, or even that you want to protect the baby from your feelings. If not, you need the privilege of giving your baby her first feeds more than you need a rest. Maternity nurses may have expertise but they are not you. Each feed is a separate experience, but there is also a continuity between feeds, and in the first dream-like days and nights, the baby should, as much as possible, be fed only by someone closely emotionally involved.

Fathers and feeding

Some mothers may feel, not necessarily correctly, that the father, or indeed other people in the family, will envy their unique relationship with the baby, and they may not be confident enough to claim it for themselves. In fact now that fathers tend to be more involved in the intimate physical care of young babies, they are less likely to feel excluded by the bond between mother and baby or jealous of the intimacy of breastfeeding. With generosity, the father can vicariously enjoy the closeness and enjoy looking after both of them.

From parents . . .

> *'My son has Down's syndrome, which meant he was very docile and apt to fall asleep with the effort of feeding before he had got enough. In the night my husband would tickle his feet to keep him awake.'*
>
> *'In those early weeks I needed both hands to hold my daughter while I fed her. My husband would bring me water with a straw and hold it in position so that I could drink*

from it hands free. I felt a bit like a feeding baby myself, face tilted up to suck from proffered straw, arms down by my body. We were like a nest of Russian dolls, each feeding a smaller one.'

'My husband read a book with all sorts of good positions for feeding. We had such a laugh, lying on the carpet, him showing me these positions with pillows and what have you; it was like we'd taken something. We just couldn't stop giggling. Later feeding came to be more of a bore because my son wanted to feed all day long, but it had been lovely, we had got off to a good start.'

As a father you can be the most valuable support to mother and baby as they struggle to get to grips with each other and the whole business of nursing. It is a great advantage to a family that one parent is not breastfeeding and can get a wider perspective on the emotions going on.

If your partner is afraid of being trapped by breastfeeding into something too intense, she may be glad to know that you are there, able to help take some of the heat out of the situation. Or she may become too enmeshed in her relationship to the baby and exclude you. This actually means they both need you to help them separate a little, so that they can let you in and so that they can come to appreciate each other as separate people. Don't let your concern be dismissed as 'male insensitivity' but your ideas about solving problems may be more welcome if you are involved practically. Doing some of the care of your baby during the night, changing the baby's nappy, or if she has difficulty in settling, rocking her back to sleep after a feed, will all bring you closer to your baby and help your partner.

Feeding on demand or routine

Many mothers find they naturally choose a pattern of feeding that seems to suit their own personality. If you like everything organised and tidy you might feel your baby should fit into a clear routine. If you are more laid-back you won't mind the lack of order that demand-feeding can bring to the day.

Perhaps there is a middle way to aim at, in which you slowly work out a compromise with your baby. New babies are still establishing a pattern in their lives; they may wake, feed and sleep at irregular intervals, regardless of day or night. They do, however, need attention whenever they cry. It can be difficult at first to work out what they really need, so offering the breast or bottle seems the obvious thing to do. If you are breastfeeding, your baby may well be asking to suck very often at the beginning. Because it is a supply and demand system, it may be important at first to let her suck when she wants to. Leach (2010) says that at this stage if you ration sucking then you ration food. While this is true, it is also true that many breastfed babies seem to get enough milk even when a routine with three- or four-hour gaps is imposed on them from early on. This

might be explained by research (Daly and Hartmann 1995) showing that mothers' capacity to store milk varies by up to 300 per cent (this is not correlated with breast size). Mothers with smaller storage capacity will be likely to need to feed their babies little and often. This does not mean there is not enough, just that the pace of feeding is likely to be different to a mother with greater storage capacity, whose babies are likely to have bigger, more spaced-out feeds. As ever it is about getting to know yourself and your baby.

Part of getting into a rhythm of feeding that suits you both will be noticing that your baby's cries have many other meanings too. As the weeks go by you may both come to appreciate the space between feeds – a time to digest the previous feed emotionally as well as physically, and also to look forward to the next feed. At this stage you and she can start to negotiate with each other, finding some sort of pattern that works for you both. She needs to know that you are there for her when she really needs food or comfort, but you both need to establish where the boundaries lie, and learn that she can sometimes wait a bit longer. The negotiating of this, as much as the achieving of it, influences how you and your baby get on together in the future. It can be helpful to keep this in mind. You are establishing a relationship as well as a routine in all that you do around feeding and it is the relationship that will endure. In the context of the rest of your lives together the period of coming together in this particular way is relatively short.

Overcoming common feeding problems

Parents often worry that their babies are getting too much or too little to eat. Such worries are usually unnecessary because, unlike adults, babies tend to take just what they require metabolically. However, if you do find that your baby is gaining insufficient weight or, conversely, feeding constantly, then identifying the cause – which may be practical or emotional – is an important step towards resolving the problem.

Babies who feed too much

Some mothers find they are feeding their babies much of the time, with virtually no space between the feeds, exhausting both mother and child. Only you can know if what is happening feels reasonable. If it does not, it is worth thinking about what your baby's signals mean: she may be crying for you rather than for a feed.

In Chapter 4 the idea of maternal ambivalence was discussed and this is important here too. Parents who can let themselves know of conflicting feelings of love and hate for their babies are in a much stronger position and may not need to act out these feelings so dramatically as those who do not know how to tolerate opposites. It often seems that mothers who let their babies feed constantly are not facing saying 'no' to the baby. It is as though feeding or being with the baby is seen as 'good' and spaces

between as bad. You could say that this leaves the baby without having had a feed with a definable beginning, middle and end, followed by a time for digesting the food physically and the experience of the feed emotionally. It deprives the baby of the pleasures both of memory and of anticipation.

Endless feeding becomes a demanding chore which not only exhausts a mother but also saps her imagination so that she can't think what else to do. She may need help from the father or another adult to think about a way out. Some parents have found that they can extend the gap between feeds by gently soothing the baby back to sleep if she still seems drowsy, or by distracting her by talking to or playing with her if she is alert. Similarly, during a feed you might encourage her to keep awake and concentrate on the task in hand, so each feed has a clear beginning and end. So long as you remain receptive to your baby's communications, this sort of thing can be done in the spirit of negotiation rather than domination.

From psychoanalytic theory and clinical practice . . .

Surprisingly often, mothers who feed their babies continuously have experienced a loss, bereavement or another painful separation. They know only too well how it feels when someone they love isn't there, and this can confuse their judgement about what their baby really needs. Mothers who feel compelled to immediately feed their baby when she cries may seriously feel that if they do not their baby will die from lack of nourishment. When in the presence of a mother and baby in the grip of this feeling, the logic seems inescapable, the sense of a hunger that must be met is palpable. Sometimes mothers who endlessly feed seem to be expressing hunger in themselves, perhaps an emotional hunger, and are not able to feel reciprocally fed and satisfied by their baby's satisfaction.

Too little weight gain

It can be very worrying if your baby is not gaining enough weight. You may feel guilty and inadequate – or, even worse, as if the professionals are accusing you of being a bad mother (they're not but they will be worrying about your baby, and about you). Whether by breast or bottle, feeding is a learning process and perhaps you and your baby simply need time to settle down with each other and get accustomed to this rather scary business.

Some feeding problems may have a simple cause – and an easy solution. For instance, your baby may get painful wind swallowing air along with the milk. By holding him upright against your shoulder and gently rubbing his back, you can release the excess air and relieve the discomfort. But even here all may not be as simple as it seems. Swallowing air may come from mother and baby not finding a mutually comfortable position for feeding, perhaps not close enough – it takes courage to hold a baby close.

From research on the biochemistry of breastfeeding . . .

Feeding is of course a physical function, but it can be affected by the emotional state of either you or your baby. Fatigue, lack of confidence, and stress may inhibit the let-down of your breast-milk, while your baby is unlikely to feed adequately if he can sense your anxiety or is stressed or unhappy himself. It is important for both of you, therefore, for you to look after yourself so you can try to be relaxed when you begin a feed. A mother laughing while she feeds will produce milk with higher levels of immunity-enhancing hormones for protecting her baby's health (Kimata 2007). So, just as problems around breastfeeding tend to have physical and emotional elements that compound one another, if breastfeeding can become something you enjoy rather than endure; the rewards will be physical as well as emotional.

Working out how to hold a baby for feeding is an emotional matter as well as a practical one. When the baby is held close to 'wind' him, you may feel the tightness in his tummy – your physical 'getting' of this helps you understand the emotions and he may start to feel that his mother is getting things under control, and he may relax more easily into feeding.

Give yourself time to think about where the problems came from. Anxieties about feeding can be brought on by all sorts of emotions and experiences. Some mothers feel the closeness of their baby as a kind of intrusion on their bodies or an attack, while if you are suffering from post-natal depression you can feel pessimistic about the complexity of it all. If your baby is not easily taking milk from your breast or from the bottle you are offering her, it can feel like a rejection of you.

In rare cases, babies who are under weight may be undemanding and sleep for long periods. For these babies, advice to respond to what they ask for is not helpful. These babies give out weak signals and need to be actively offered feeding.

From psychoanalytic theory and clinical practice . . .

One mother had experienced a bad relationship with her mother. When her daughter was born, she felt as though another generation of trouble was about to start. She said: 'Here we go again.' If you didn't get on with your mother, or worse still were actually neglected in childhood, you may feel you don't have the resources to give your baby the care he needs. Also, many mothers who have had an eating disorder worry about passing their problems on to their baby, and this can in itself lead to feeding difficulties.

Finding someone to help you

If you are having trouble, you really need someone to help you and give you confidence. Most early problems with feeding can be overcome simply with the support and

encouragement of your partner or mother, a friend, your health visitor, paediatrician or a counsellor. You need to trust them and let yourself believe they are on your side as well as the baby's. When you feel low, it's easy to feel that people are siding with the baby and blaming you.

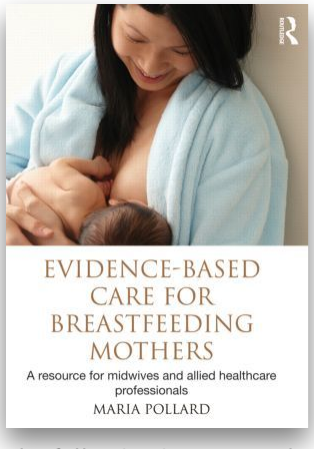
If someone can offer you care and attention – sitting with you for a bit, bringing you food and drinks, or letting you cry if you want to, the panic is likely to subside. By listening to you instead of only offering technical problem-solving tips, they will help you calm down so that you begin to notice your baby's signals: how she wants to be held, how to help her get at the nipple or teat, and how not to gulp the milk. You may find that holding her close is less of an ordeal if someone is there to comfort you too. Books about breastfeeding can be supportive and help you feel that someone really knows what it's like and has understood your situation (e.g. The Breastfeeding Book by Maire Messenger Davies, 1989). Breastfeeding groups can be especially helpful – the equality of mothers sharing their experiences can be easier to take in than being shown by an expert. As we have said, you can find breastfeeding groups online.

More serious problems

If you have really serious problems about feeding your baby, it might be that you have suffered severe deprivation or neglect in your ownchildhood and feel you have very little to give your baby. If you felt that the food and sustenance you were given was begrudged, you might not have the chance to develop the altruism that allows people to share. You might feel your baby is just 'greedy' or a 'monster', perhaps that was how you were regarded as a baby – made to feel that having needs was shameful. If so, I think it is optimistic that you are reading this book – you know that there are ideas that can help. It may be a cliché but ideas can feed your mind. We have mentioned before that if you have not been looked after well, it may be hard to believe in the possibility of people who really want to help. Your baby needs you to be able to feed her and this might be the time to make that leap of faith and ask for help.

Evidence-based Care for Breastfeeding Mothers: Ongoing Support for Breastfeeding Mothers

Chapter 5:: Ongoing Support for Breastfeeding Mothers



Breastfeeding mothers need ongoing support from professionals, their peers and society in general to continue breastfeeding for as long they would like to. Although many of the issues that influence duration of breastfeeding have been discussed throughout this book, this chapter will focus on particular issues such as accessing different types of support, returning to work and assisting mothers with relactation or induced lactation, family planning and breastfeeding during pregnancy.

Learning outcomes

By the end of this chapter you will be able to:

• discuss the need for ongoing professional, social and peer support;

• advise mothers about both the legal and practical aspects of returning to work;

• assist mothers who have ceased breastfeeding to relactate or to induce lactation in those who wish to breastfeed;

• provide advice about family planning, sexual activity and breastfeeding during pregnancy.

Mapping the UNICEF UK BFI educational outcomes

> 8 Be equipped to provide parents with accurate, evidence-based information about activities which may have an impact on breastfeeding.
>
> 9 Understand the importance of exclusive breastfeeding for the first six months of life and possess the knowledge and skills to enable mothers to achieve this.
>
> 11 Understand the importance of community support for breastfeeding and demonstrate an awareness of the role of community-based support networks, both in supporting women to breastfeed and as a resource for health professionals.
>
> 12 Be able to support mothers who are separated from their babies (e.g. on admission to SCBU, when returning to work) to initiate and/or maintain their lactation and to feed their babies optimally.

It is clear throughout this book that the evidence supports the fact that breastmilk is the best form of nutrition for human infants and has positive health benefits for both mother and infant, and the longer the infant is breastfed the greater the benefits are. The *Infant Feeding Survey 2005* (Bolling *et al.*, 2007) demonstrated that the breastfeeding initiation rate for the UK was 78 per cent in England, 70 per cent in Scotland, 67 per cent in Wales and 63 per cent in Northern Ireland. However, this was followed by a rapid decline over the first few weeks. They found that 48 per cent of all mothers were breastfeeding at six weeks postpartum, and 25 per cent at six months.

However, only 48 per cent of all mothers were exclusively breastfeeding at one week, and only 25 per cent of these were still exclusively breastfeeding at six weeks, and this figure dropped to less than 1 per cent at six months. These figures are alarming and are a long way from meeting the WHO (2002) and DH (2003b) recommendations for exclusive breastfeeding for six months and to continue for two years and beyond. Bolling *et al.* also reported:

> Nine in ten mothers who gave up breastfeeding within six months would have preferred to breastfeed for longer, this level declining as breastfeeding duration increased. Although even among those who breastfeed for at least six months, 40 per cent would have liked to continue. (2007, p. x)

Bolling *et al.* (2007) identified young mothers, those from lower socioeconomic groups and those with lower levels of education to be least likely to commence breastfeeding and those who do breastfeed do so for a shorter duration and are more likely to wean before six months of age. Evidence suggests that a lack of access to appropriate information is a major contributing factor and that the reasons women gave were embarrassment, lack of support and conflicting advice from healthcare professionals. As these women are the least likely to breastfeed, the cycle of deprivation continues and the SACN (2008b) recommends that these groups be 'targeted' for healthcare policies and interventions, and that health professionals and peer supporters should be trained to meet the needs of this vulnerable group.

McInnes and Chambers highlighted that, in general, mothers reported that 'a lack of breastfeeding knowledge acted as a barrier to their receiving and accepting postnatal support' (2008b, p. 423). This is supported by O'Brien *et al.* (2009), who identified that the strategies mothers used to successfully breastfeed included increasing breastfeeding knowledge, goal-setting and challenging unhelpful beliefs. However, as demonstrated throughout this book, the factors that influence the initiation and duration of breastfeeding come from international, national and regional levels as well as from the individual (Dyson *et al.*, 2006). Table 10.1 summarises these issues.

Breastfeeding support

Professional support

McInnes and Chambers (2008b) conducted a review of qualitative literature to produce a synthesis of mothers' and healthcare professionals' experiences and perceptions of breastfeeding support. They concluded that mothers did not receive the support they wanted from healthcare professionals and that healthcare professionals were not the main source of postnatal support; instead, social support was considered to be of greater value. Both mothers and professionals reported that poor staffing levels in postnatal wards resulted in conflicting advice and in a lack of information and support.

They suggest that conflicting advice and poor techniques may be a result of a lack of education and training and recommend practical skills training, updates, mentoring and assessment for staff, as well as the need to include interpersonal and com munication skills. Building a therapeutic relationship is important when providing support for breastfeeding, as mothers are more receptive if they feel comfortable asking questions and do not feel judged. Practical and consistent advice and information, encouragement and emotional support are crucial elements in developing this relationship, as is continuity of care or carers where possible.

Social support

Mothers are more likely to breastfeed if they have a supportive social network. According to McInnes and Chambers (2008b, p. 422), support with breast - feeding can be split into three categories:

- practical housework, caring for other children;
- information knowledge of breastfeeding;
- emotional empathy, approval, praise, feeling nurtured.

Social support depends on the societal norms for infant feeding and the knowledge, views and beliefs of family and friends. A supportive family net - work is considered essential for some mothers to overcome challenges they may face. Mothers also value support from those they perceive as 'role models' or who have had experience of breastfeeding, often their own mothers.

Although McInnes and Chambers (2008b) suggest that mothers value support from those with experience of breastfeeding, fathers also play an important role. Where this was positive towards breastfeeding, fathers were able to provide practical, physical and emotional support in the decision to breastfeed as well as to support continuation (Sheriff *et al.*, 2009). However, some men lack knowledge about breastfeeding and believe it will interfere with their relationship, particularly with regard to sex (Hewitt, 2008). In western culture, breasts are often portrayed as sexual objects and are often discussed as the 'man's property' (Dickens, 2008).

It is clear that family and friends also need to be educated about the benefits of breastfeeding and the risks of formula feeding, so that they can provide adequate support for breastfeeding mothers. Many hospitals and community areas have developed innovative ways of doing this, from inviting fathers and prospective grandparents to breastfeeding classes, to developing posters to inform fathers of the benefits (Hewitt, 2008), to campaigns such as the 'Be a Star' campaign, aimed at increasing the number of breastfeeding young mothers by showcasing them as confident women. 'Be a Star' produces posters and radio advertisements and has a

website with useful information and tips aimed at all the family (www.beastar.org.uk).

However, if the social network is unsupportive, breastfeeding can be easily undermined and mothers may feel pressurised into stopping breastfeeding or develop a lack of confidence in their ability. Some will seek out other forms of social support, such as peer support groups, and will join voluntary organisations. This was highlighted as particularly important when information was not forthcoming from healthcare professionals or they were unable to help solve problems (McInnes and Chambers, 2008b).

TABLE 10.1 Examples of factors (often interrelated) that influence infant feeding at international, national, regional and individual levels

International and national factors	*National and regional factors*	*Individual factors – amenable to medium- to long-term change at the macro socio-economic level*	*Individual factors influencing decision to breastfeed – amenable to change in the short term at the micro socio-economic level*	*Individual factors influencing a woman's decision to stop breastfeeding before she wishes – amenable to change in the short term at the micro level*
Globalisation of formula feeding in developed countries promulgated by commercial interests	Lack of importance/ understanding of breast-feeding in the organisation of health services; embedded practices or routines that interfere with successful breastfeeding	Maternal age – younger mothers are less likely to breastfeed	Attitudes of partner, mother and peer group	Mother's or health professionals' or family's perception of 'insufficient milk'
Cultural shift to regimented feeding patterns and growth monitoring based on formula feeding regimes	Lack of appropriate education and training for health and related professionals	Maternal education – breastfeeding rates are lowest among those who left school at 16 or less	Social support provided by woman's partner, family and friends	Painful breasts and nipples; baby would not suck or 'rejected the breast'
Increase in work opportunities for women without supportive childcare/ feeding facilities	Lack of integration across sectors – acute, community, social services, voluntary	Socio-economic status of mother (and partner) – breastfeeding rates become lower for lower socio-economic groups	Loss of collective knowledge and experience of breastfeeding in the community, resulting in a lack of confidence in breastfeeding	Breastfeeding takes too long, or is tiring

TABLE 10.1 *continued*

International and national factors	*National and regional factors*	*Individual factors – amenable to medium- to long-term change at the macro socio-economic level*	*Individual factors influencing decision to breastfeed – amenable to change in the short term at the micro socio-economic level*	*Individual factors influencing a woman's decision to stop breastfeeding before she wishes – amenable to change in the short term at the micro level*
Media portrayal of bottle feeding as the norm and as safe	Lack of supportive environments outside the home and in the workplace	Marital status Ethnicity – cultural tendency for white women to choose not to breastfeed	Whether mothers were breastfed themselves as babies	Mother or baby is ill Difficult to judge how much baby has drunk
Increased media portrayal of women's breasts as symbols of sexuality	Lack of breastfeeding education in schools	Biomedical factors (parity, method of delivery, infant health)	Embarrassment about, difficulty in, or perceived unacceptability of, breast-feeding in public, both in and outside the home, especially for younger mothers	Baby can't be fed by others
Lack of full implementation of WHO *Code of Marketing of Breast-milk Substitutes*		Return to work before the baby is four months old	Difficulty of involving others, especially partner, in feeding Perceived inconvenience of breastfeeding and anxiety about total dependence of the baby on the mother	

Source: Dyson *et al.* (2006, p. 17).

Peer support

Peer support programmes were originally set up in areas of deprivation with poor breastfeeding rates. They either provide support on a one-to-one basis or to groups of women. Mothers appear to value face-to-face contact rather than telephone support (McInnes and Chambers, 2008b). The aim is to improve breastfeeding rates in local communities by putting mothers in touch with other mothers with breastfeeding experience, who can provide support, encouragement and practical advice. The intention is that a peer supporter will have similar demographic characteristics and understanding of the cultural expectations within the local area. Peer supporters receive training but are encouraged to refer complex problems to healthcare professionals. However, this training appears to be different throughout the UK. Dykes (2005) found that the role of listener and confidence builder was more prominent in England and the mechanics of breastfeeding more prominent in Scotland. There was

also limited emphasis on building relationships and developing communication skills in most areas. Britten et al. (2006) also found a difference in the perceived roles of peer supporters, from friend and role model to breastfeeding expert, which changes the relationship from an equal partnership to one where the supporter has the power, suggesting that roles need to be more clearly defined to avoid confusion with healthcare professionals' roles.

A number of studies have been carried out since the introduction of peer supporters, demonstrating varying success of programmes (Muirhead *et al.*, 2006); however, Renfrew *et al.* (2005) suggest that peer support is effective in increasing the duration of breastfeeding for those who intended to breastfeed, if it is offered soon after birth. Furthermore, Briton *et al.* (2007) claim that peer support combined with professional support is most effective. NICE (2006b, 2008b) recommend that commissioners and managers of maternity units should introduce breastfeeding peer support groups and, in 2010, NICE published a new commissioning and benchmark tool for peer support programmes for women who breastfeed (www.nice.org). The Health Promotion Agency in Northern Ireland (2004) also recommends that peer support be used as a multifaceted approach and that volunteers and healthcare professionals must be proactive in making contact with mothers. It is evident from the literature, however, that further research is required about peer support groups to evaluate their cost-effectiveness and value to mothers.

Activity

• Find out what peer support programmes are available in your area and what the mechanism for referral is. How do women know about them?

• How do you educate family and friends about breastfeeding to support breastfeeding mothers?

Other support organisations

Midwives and other healthcare professionals should be familiar with the national and local breastfeeding support organisations. Some examples of such organisations are:

• Association of Breastfeeding Mothers (ABM)

ABM was established in 1980 by mothers to give other mothers support and accurate information about breastfeeding.

• La Leche League (www.laleche.org.uk)

The La Leche League was formed in 1956 by seven mothers who wanted to support breastfeeding friends. Today they have branches in over 60 countries and their aim remains the same: to offer accurate mother-tomother breastfeeding support. The

organisation is predominantly run by volunteers who lead local groups. As well as providing training for breastfeeding supporters, La Leche also publishes valuable information for mothers and healthcare professionals; many will be familiar with The Breastfeeding Answer Book, which is a valuable resource in many healthcare settings.

- **National Childbirth Trust (NCT) (www.nct.org.uk)**

The National Childbirth Trust is a UK organisation and was formed in 1956. Volunteers provide support for breastfeeding mothers through training and education for parents, counsellors and health professionals.

- **Breastfeeding Network (BFN) (www.breastfeedingnetwork.org.uk)**

The Breastfeeding Network is a recognised Scottish charity. Its aim is to promote breastfeeding, disseminate accurate, evidence-based information to parents and health professionals, and set standards for breastfeeding support.

- **UNICEF Baby Friendly Initiative (BFI) (www.babyfriendly.org.uk)**

The UNICEF Baby Friendly Initiative predominantly promotes best practice for breastfeeding mothers within healthcare and higher education settings and offers assessment and accreditation to acknowledge that these institutions achieve high standards. It also provides information for parents; however, it is unable to offer this on an individual basis.

- **Baby Café Charitable Trust (www.thebabycafe.co.uk)**

Baby Café 'drop-ins' were developed in 2005 and are part of the Baby Café Charitable Trust network run by paid facilitators (voluntary or healthcare professionals). They usually open once a week in a variety of venues and promote open access for all pregnant and breastfeeding mothers.

- **Little Angels (www.littleangels.org.uk)**

Little Angels was founded in 2004 by mothers who identified a need for local breastfeeding support. It is now a Community Interest Company funded by service-level agreements, contracts and grants. Little Angels provides peer support from the local community.

Activity

There are numerous voluntary organisations throughout the UK to support breastfeeding mothers.

- Do you know the groups in your area of practice?
- Prepare a list of local groups that you can give to mothers in your care.

Returning to work

Many mothers want to continue breastfeeding after they return to work but often perceive this as a barrier to continuing breastfeeding. The benefits of continuing breastfeeding in line with the WHO recommendations (exclusive breastfeeding for six months and to continue for up to two years) for mothers and infants are well known, but there are also benefits for employers. Health Scotland (2009, p. 12) states that these are:

- reduced parental absence as breastfed infants are less likely to be ill compared to formula-fed infants;
- lower recruitment and training costs;
- recruitment incentives;
- increased staff morale.

Legislation

Employers are legally bound to facilitate continued breastfeeding outside normal break times. It is best if this is planned in advance and employers are notified in writing before the mother returns to work so that preparations can be made. The following legislation protects breastfeeding mothers.

Management of Health and Safety at Work Regulations 1999 (2000 Northern Ireland) and Employment Rights Act 2002

The employer has a duty to carry out a risk assessment to assess whether working conditions are a risk to the health of the breastfeeding mother or infant. Some employers may not appreciate the dangers of not breastfeeding and therefore the mother may provide them with some literature.

If a risk is identified, it is the employer's responsibility to reduce the risk (see www.hse.gov.uk/pubns/indg373hp.pdf). This may include temporarily adjusting the mother's working conditions and/or hours of work; or if that is not possible, offering her suitable alternative work (at the same rate of pay) if available; or suspending her from work on paid leave for as long as necessary to protect her health and safety and that of her child (HSE, 2010). If working hours need to be changed, for example to avoid night shifts, this request can be supported by a medical certificate from the GP. If no alternative work schedule can be found, the employee can be suspended on full pay.

Workplace (Health, Safety and Welfare) Regulations 1992

The Workplace Regulations require employers to provide suitable rest facilities for workers who are pregnant or breastfeeding. Ideally, these should be private, have hand-washing facilities and include facilities for the storage of breastmilk.

EU Council Directive 92/85/EEC

This directive is for those working in the public sector. If the employee's work causes problems with breastfeeding, the employer must change the working conditions/hours for as long as she is breastfeeding.

Sex Discrimination Act 1975 (1976 Northern Ireland)

If a woman is required to work particular hours without justification or has unfavourable conditions for breastfeeding, it can be considered as indirect discrimination.

Maternity Leave and Parental Rights 2003

Statutory maternity leave is for 52 weeks. This is 26 weeks of ordinary maternity leave (when a mother is entitled to all her contractual rights such as annual leave) and 26 of extra maternity leave (partially paid). Both parents are allowed up to 13 weeks' unpaid parental leave per child until its fifth birthday, if they have worked one year by the date they wish to take it. This can follow maternity leave but requires 21 days' notice.

Practicalities of returning to work

Mothers may choose different options for providing their infants with breastmilk while they are at work:

• Express breastmilk and leave it for a carer to give the infant. This may mean expressing milk during working hours, which will also maintain lactation and prevent the breasts becoming overfull.

• Use childcare facilities near the workplace so that they can either breastfeed during the day or immediately before or after work.

• Negotiate shorter or flexible work hours.

The Health and Safety Executive (HSE, 2009) has produced a useful leaflet for new and expectant mothers who work, which can be found at:

www.hse. gov.uk/pubns/indg373.pdf

Expressing milk at work

Mothers should not be expected to express milk in the toilet or other unsuitable environment. A clean, warm and comfortable room should be made available with hand-washing facilities and somewhere to store equipment. If a fridge is not available, breastmilk should be stored in a cool bag. Depending on facilities, a mother may use a hand or electric pump or hand express. See Chapter 3 for further details about expressing and storing breastmilk.

Sexual activity

It is suggested that breastfeeding mothers are more keen to resume sexual activity than non-breastfeeding mothers following birth (Lawrence and Lawrence, 2005), but this is not the case for all. Some mothers report milk ejection during sexual activity and increased vaginal dryness. If the milk ejection is a problem for the couple, the mother can wear a bra with breast pads. For vaginal dryness she should be assured that this is due to inhibited hormones during lactation. Vaginal dryness can lead to discomfort during intercourse and a lubricant can be used as a temporary solution.

Family planning: lactational amenorrhoea method

Lactational amenorrhoea method (LAM) is a natural method of family planning. During breastfeeding, prolactin inhibits the release of gonadtrophinreleasing hormone and levels of oestrogen and progesterone are reduced, inhibiting ovulation. It is thought that LAM is 98 per cent effective in the first six months postpartum (Lawrence and Lawrence, 2005), however it is reliant on:

- exclusive and regular breastfeeding;
- the infant being less than six months old;
- there having been no menstrual bleeding after 56 days postpartum.

If these factors do not apply, the mother should not rely on breastfeeding alone as a method of contraception and will require advice on appropriate alternative contraceptives. The progesterone-only contraceptive pill may be used when breastfeeding but the combined oestrogen-progesterone pill must be avoided because it will reduce milk supply.

Breastfeeding during pregnancy: tandem nursing

Many mothers will, however, become pregnant while breastfeeding and may express concerns that they will have to wean the infant from the breast despite wanting to continue. Many mothers are misinformed and told they will have to stop breastfeeding; however, there is no danger to the fetus and breastfeeding can continue in most cases. Advice should be sought if the mother has had a previous miscarriage or preterm birth or experiences bleeding. There is no evidence to suggest that the oxytocin released during breastfeeding will cause the uterus to contract, as oxytocin receptors in the uterus are inhibited until near term. Mothers will need support and advice regarding taking adequate rest and appropriate diet, given the additional demands on them both physically and psychologically.

Some mothers complain of tender nipples during pregnancy and therefore attention to position and attachment is required. Also, during the second and third trimester, the

milk changes to colostrum (Lawrence and Lawrence, 2005) to prepare for the new infant. The milk volume decreases and it changes in taste and smell, which may encourage the breastfeeding infant to stop breastfeeding independently. Abrupt weaning initiated by the mother should be avoided, but if the mother intends to wean once the new infant is born this should be a gradual and planned process. The La Leche League recommends the 'don't offer, don't refuse' approach (2006). However, many infants will be happy to continue to breastfeed like this and it must be remembered that many of the benefits of breastfeeding are dose-related.

Once the new infant is born it should be fed first, because an adequate supply of colostrum is essential for newborns and the older infant is getting nutrition from other sources at this point.

Relactation or induced lactation

Relactation or induced lactation is the stimulation of the breast to lactate to breastfeed an infant where pregnancy has been absent, or to restimulate lactation following cessation of breastfeeding (Worgan, 2002). Some mothers may have a reduced milk supply or have discontinued breastfeeding for a variety of reasons and regret the decision. It is important that healthcare professionals are aware that this situation is reversible and develop the skills to enable the mothers to lactate and commence or recommence breastfeeding.

The aim is to trigger the release of prolactin and oxytocin to commence milk production; however, for some mothers not all the prolactin receptors will have been primed initially and therefore full production may not be possible. Inducing lactation requires great commitment and therefore the mother should be very motivated and made aware that it may take a few weeks to establish adequate milk production. Skilled help and support from professionals is required to teach the skills needed to induce lactation and to give the mother confidence in her ability to do so on a day-to-day basis. She will also need support from her family and friends so that the process is not undermined. Putting her in contact with other mothers who have relactated or induced lactation may be helpful.

Before induced lactation commences, a full history must be taken as to why the mother had a poor milk supply or why she discontinued breastfeeding, in order to ensure that there are no factors that may continue to inhibit milk production, such as prolonged separation from the infant, supplementary feeding, use of teats/dummies, smoking, the combined contraceptive pill or medical reasons. Once the reason is identified this must be rectified, where possible, before continuing the process.

The process of induced lactation

The WHO (1998b) suggests there are two essential requirements for inducing lactation: 'a strong desire by the mother or foster mother to feed the infant, and stimulation of the nipple'.

Maximum stimulation of the nipple and breast can be achieved by the following techniques:

• There should be long periods of uninterrupted skin-to-skin contact and access to the breast. Co-bathing is one way of providing a comfortable and relaxing environment.

• Position and attachment should be retaught, along with recognising feeding cues.

• Breastfeed and/or express milk 8–12 times per day. Include night times when there is an increased production of prolactin.

• Practice breast compression if the milk flow is slow.

• Avoid artificial teats and dummies.

• Use of a breastfeeding supplementer (see Chapter 8) during breastfeeding may encourage the infant to suckle when the milk supply is poor.

While the mother is establishing her milk supply it is important that the infant's nutritional needs are met. If expressed breastmilk is available, this should be given following a breastfeed; however, this may not be available for all infants and they may require formula milk. As it is important to avoid teats, this can be given by cup or spoon. The infant should be closely observed to ensure its nutritional needs are being met by assessing wet nappies and stool as well as weight gain.

If the above methods are not effective, pharmacological methods (galactagogues such as domperidone or metoclopramide) or herbal remedies (such as fenugreek, garlic or fennel) may be tried, but further research is required to assess their effectiveness when milk production has ceased altogether (WHO, 1998b).

Concluding comments

Professional, social and peer support is an important element in providing mothers with help and information to enable them to continue to breastfeed for as long as they want to. UNICEF BFI supports this and recommends that healthcare professionals 'identify sources of national and local support for breastfeeding and refer mothers to these prior to discharge from hospital' (2010e, p. 21); and Point 7 also recommends continued cooperation between healthcare staff, breastfeeding support groups and the local community.

To ensure community support is effective, healthcare professionals must be educated and develop the knowledge and skills required to be able to support and advise mothers with practical and useful information as well as provide evidence-based

information for fathers, family and friends. How they develop this knowledge and skill will be the focus of the following chapter.

Reflective questions

1 How do mothers in your area of practice know about the support groups available to them?

2 How is information disseminated to fathers, families and friends in your area of practice?

3 What follow-up mechanisms are in place for breastfeeding mothers in the community to assist them to continue to breastfeed exclusively until their infants are six months old?

Resources

- HSE Guide for New and Expectant Mothers Who Work
  www.hse.gov.uk/pubns/indg373.pdf
- La Leche League
  www.laleche.org.uk
- NHS Breastfeeding and Work
  www.breastfeeding.nhs.uk/en/materialforclients/downloads/breastfeedingandwork.pdf
- UNICEF Baby Friendly Initiative
  www.babyfriendly.org.uk

Depression in New Mothers: Depression and Breastfeeding

Chapter 6:: Depression and Breastfeeding

Some providers and advocates caring for women with postpartum depression consider breastfeeding a risk factor for depression. Based on this belief, mothers are often urged to quit in order to recover. While this advice is well-intended, we need to question whether it is medically sound. Do women need to wean in order to recover from depression? And what do mothers want to do? Some of these same providers argue that even if mothers want to continue, what we really need to do is give them "permission" to quit. When actress Brooke Shields experienced postpartum depression, her family strongly urged her to stop breastfeeding. She adamantly refused because she felt that breastfeeding was the one thing that was helping her to hang on to her sanity.

> If I were to eliminate that [breastfeeding], I might have no hope of coming through this nightmare. I was hanging on to breastfeeding as my lifeline.
>
> (Cited in McCarter-Spaulding and Horowitz, 2007: 80)

When providers urge mothers to quit who want to continue, breastfeeding can become a barrier to treatment. Mothers may delay or avoid treatment because they believe that they will be told to wean. In my experience, this fear is realistic – and unfortunate and unnecessary because almost all treatments for depression are compatible with breastfeeding. In addition, this view does not take into account recent research demonstrating breastfeeding's protective effect on maternal mental health. This research is summarized below.

The adaptiveness of breastfeeding

A recent review found that rates of depression are lower in breastfeeding mothers than their non-breastfeeding counterparts (Dennis and McQueen, 2009). This is not to say that breastfeeding mothers never get depressed – for they certainly do. This is also not to say that we should ever coerce a mother into breastfeeding when she is simply too overwhelmed to deal with it. On the other hand, some depressed mothers report that breastfeeding is the only thing going well for them, so we should not be cavalier about chucking it aside as if it were of no consequence. Recent studies indicate is that there are very good reasons to support mothers who want to continue breastfeeding and that it can become an important part of their recovery.

In Chapter 4, I describe the results of studies from the field of psychoneuroimmunology (PNI) and the role of the stress response in depression. Researchers in PNI have discovered that breastfeeding is protective of maternal mental health because it downregulates the stress response. This down-regulation confers a survival advantage by protecting the breastfeeding mother and directing her toward milk production, conservation of energy, and nurturing behaviors (Groer, *et al.*, 2002). Hormones related to lactation, such as oxytocin and prolactin have both antidepressant and anxiolytic

effects (Mezzacappa and Endicott, 2007).

Mezzacappa and Katkin (2002) presented data from two studies that indicated that breastfeeding buffers mothers against negative mood. In the first study, they compared 28 breastfeeding and 27 bottle-feeding mothers on levels of perceived stress in the past month. As predicted, the breastfeeding mothers reported less stress, even after controlling for possible confounding variables.

The second study included 28 mothers who were both breast- and bottle-feeding (Mezzacappa and Katkin, 2002). The researchers measured mothers' stress levels immediately before and after both types of feeding. This study was a major methodological improvement over previous studies in that women served as their own controls. Since there were not pre-existing differences between breast- and bottle-feeding mothers, it was possible to attribute the observed difference in mood to feeding method alone. The researchers found that breastfeeding decreased negative mood and bottle feeding decreased positive mood in the same women.

A study of 43 breastfeeding women found that both breastfeeding and holding their babies without breastfeeding significantly decreased adrenocorticotropic hormone (ACTH), plasma cortisol, and salivary free cortisol (Heinrichs, et al., 2001). Breastfeeding and holding the infant led to significantly decreased anxiety, whereas mood and calmness improved only in the breastfeeding group. In response to an induced stressor, breastfeeding exerted a short-term suppression of the hypothalmic-pituitary-adrenal (HPA) axis response to mental stress. The authors concluded that suckling provided a short-term suppression of the stress-related cortisol response and HPA-axis response to mental stress. They argued that this short-term suppression provided several evolutionary and biological advantages. It isolated the mothers from distracting stimuli; facilitated their immune system; protected the babies from high cortisol in the milk, and prevented stress-related inhibition of lactation.

In a study of lab-induced stress, breastfeeding women had a significantly attenuated stress response (Altemus, *et al.*, 1995). There were 10 breastfeeding and 10 non-breastfeeding women who were all 7 to 18 weeks postpartum. They performed a 20-minute treadmill exercise program at 90% of maximal oxygen capacity in order to measure stress. Plasma ACTH, cortisol, and glucose were significantly lower in the breastfeeding than in the non-breastfeeding mothers. The same was true of basal norepinephrine. However, overall sympathomedullary responses were similar in both groups. Prolactin levels were elevated throughout the exercise condition for breastfeeding women and there was a difference in prolactin levels over time between the groups. Oxytocin levels did not change.

Another study compared stress levels of three groups of women: women who were

exclusively breastfeeding (N=84), women who were exclusively formula feeding (N=99), and non-postpartum healthy volunteers (N=33). The researcher found that breastfeeding women had lower perceived stress, depression and anger, and more positive life-events than the controls. Serum prolactin was inversely related to stress and mood in formula-feeding mothers, but this was not true for the breastfeeding mothers (Groer, 2005). More recently, the same researcher and a colleague (Groer and Morgan, 2007) found in a study of 200 women at four to six weeks postpartum, that depressed women were significantly less likely to be breastfeeding and that they had significantly lower serum prolactin levels. The researchers also reported significantly more life stress and anxiety.

Groer and Davis (2006) examined the question of whether breastfeeding protected mothers from the deleterious effects of stress on immunity. They specifically examined levels of interferon-gamma (IFN-γ) and the ratio of IFN-γ/interleukin (IL)-10. They noted that when formula-feeding mothers were exposed to stress, depression, anxiety, anger, and negative life-events, they had decreased IFN-γ and a decreased serum ratio of IFN-γ/IL-10. Breastfeeding mothers were protected from these effects. The researchers' findings suggested that formula-feeding mothers had potentially diminished cellular immunity when they experienced stress.

Breastfeeding's down-regulation of the stress response appears to have long-term effects, and it probably explains another set of recent finding regarding cardiovascular disease (Schwartz, *et al.*, 2009). This study included 139,681 postmenopausal women (Mean age=63 years). The researchers found that women with a lifetime history of breastfeeding for more than 12 months were less likely to have hypertension, diabetes, hyperlipidemia, or cardiovascular disease than women who never breastfed. This was a dose-response relationship: the longer women lactated, the lower their cardiovascular risk. The authors noted that lactation improves glucose tolerance, lipid metabolism and C-reactive protein. Another study found that breastfeeding was related to lower C-reactive protein, another inflammatory marker for cardiovascular and other chronic diseases, in 26-year-old women who participated in the Dunedin Multidisciplinary Health Study (Williams, *et al.*, 2006).

Since stress is related to the onset of depression, Mezzacappa and Endicott (2007) examined the impact of parity and whether it mediated the effect of feeding method on maternal stress. This study compared primiparae who were breast- or bottle-feeding and multiparae who were breast- or bottle-feeding. The authors found that oxytocin was greater in multiparae than in primiparae. Further, breastfeeding had greater stress-reducing effects on multiparae than it did on primiparae. In this study, among the primiparous women, 35% of those bottle feeding and 16% of those breastfeeding were depressed. Among multiparous women, 37% of those bottle feeding and 12% of those

breastfeeding were depressed. After controlling for confounding variables, breastfeeding by multiparous women was associated with significantly decreased odds of having depression compared with women who bottle fed. The authors indicated that parity was a critical factor mediating the effect of lactation on depression (Mezzacappa and Endicott, 2007), and suggested that previously contradictory findings be re-examined with this framework in mind.

Nighttime breastfeeding and maternal mental health

Another issue related to depression and breastfeeding is nighttime feeding. If mothers want to continue breastfeeding, they are frequently told to eliminate nighttime breastfeeding so they can get more sleep. This advice is more and more common in postpartum depression treatment programs and books written for new mothers. But is this good advice? At first glance, it may seem to be. Since breast milk is lower in fat and protein than formula, we might assume that breastfeeding mothers sleep less than their formula-feeding counterparts. However, recent research has revealed the opposite: that breastfeeding mothers actually get more sleep – particularly when the baby was in proximity to the mother.

Breastfeeding and maternal fatigue

In a study of 33 mothers at four weeks postpartum, Quillin and Glenn (2004) found that mothers who were breastfeeding slept more than mothers who were bottle feeding. Data were collected via a questionnaire that recorded five days of mother's and newborn's sleep. When comparing whether bedsharing made a difference in total sleep, the researchers found that bedsharing, breastfeeding mothers got the most sleep and breastfeeding mothers who were not bedsharing got the least amount of sleep. Mothers who were bottle feeding got the same amount of sleep whether their babies were with them or in another room.

Sleep patterns of 72 couples were compared from pregnancy to the first month postpartum via sleep diaries and wrist actigraphy (Gay, *et al.*, 2004). Most of the mothers were at least partially breastfeeding (94%) and 80% were exclusively breastfeeding. Most of the babies slept in their parents' room and 51% regularly slept in their parents' beds. Sleep and fatigue outcomes were not associated with type of birth, parent-infant bedsharing, or baby's age. Mothers who were exclusively breastfeeding had a greater number of nighttime wakings (30 vs. 24) compared with mothers who were not breastfeeding exclusively. The exclusively breastfeeding mothers slept approximately 20 minutes longer than mothers not exclusively breastfeeding.

A study from France compared fatigue levels in exclusively breastfeeding (N=129) and exclusively formula-feeding mothers (N=114) at two to four days, six and twelve weeks

postpartum (Callahan, *et al.*, 2006). The study found no significant difference between the groups at any time point on the measure of maternal fatigue. The authors suggested that all mothers experience postpartum fatigue, independent of feeding method, and informing mothers ahead of time that breastfeeding is not likely to be the cause of their fatigue may help them persist.

In a study of mothers and fathers at three months postpartum, data were collected via wrist actigraphy and using sleep diaries (Doan, et al., 2007). The study compared sleep of exclusively breastfed infants with those supplemented with formula. In this sample, 67% were fed exclusively with breast milk, 23% were fed a combination of breast milk and formula, and 10% were exclusively formula fed. Mothers who exclusively breastfed slept an average of 40 minutes longer than mothers who supplemented. Parents of infants who were breastfed during the night slept an average of 40 to 45 minutes more than parents of infants given formula. Parents of formula-fed infants had more sleep disturbances. The researchers concluded that parents who are supplementing with formula under the assumption that they are going to get more sleep should be encouraged to breastfeed so they will get an extra 30 minutes of sleep per night.

Another sleep study compared 12 exclusively breastfeeding women, 12 age-matched control women, and 7 women who were exclusively bottle feeding (Blyton, *et al.*, 2002). They found that total sleep time and REM sleep time were similar in the three groups of women. The marked difference between the groups was in the amount of slow-wave sleep (SWS). The breastfeeding mothers got an average of 182 minutes of SWS. Women in the control group had an average of 86 minutes. And the exclusively bottle-feeding women had an average of 63 minutes. Among the breastfeeding women, there was a compensatory reduction in light, non-REM sleep.

Depression and breastfeeding cessation

Depression also has a role in breastfeeding cessation, with depressed mothers being more likely to quit. Forty women (20 depressed, 20 non-depressed) were recruited into a study at 21 weeks' gestation (Field, et al., 2002b). At eight months postpartum, the researchers found that depressed mothers often breastfed less, stopped breastfeeding significantly earlier, and scored lower on the Breastfeeding Confidence Scale than their non-depressed counterparts.

A study of 226 women from Barbados also showed a relationship between breastfeeding and maternal depression (Galler, *et al.*, 2006). This study assessed women's feeding practices and attitudes in the first six months postpartum. Women's belief that breastfeeding was better than bottle feeding was associated with lower postpartum depression at seven weeks and six months postpartum. Mothers with depressive symptoms were less likely to believe that breastfeeding was better for

infants and more likely to believe that breastfeeding was private and restrictive. Even after controlling for maternal feeding attitude, maternal mood at seven weeks was still significantly associated with infant feeding practices at six months.

In a study from England (Bick, *et al.*, 1998), 906 women were interviewed 45 weeks after delivery. In this sample, 63% had breastfed, but 40% of these had stopped within three months. The predictors of early cessation included depression, return to work within three months, and regular childcare from female relatives. A study from Turkey showed similar results (Akman, *et al.*, 2008). In this study, 60 mothers of newborns were enrolled prospectively. Mothers and babies were assessed at one and four months postpartum. The percentage of mothers exclusively breastfeeding was high: 91% at one month and 68% at four months. Mothers with higher EPDS scores at Time 1 were less likely to be breastfeeding at Time 2.

A study from Pakistan produced results that were consistent with those of the other studies (Taj and Sikander, 2003). In this sample were 100 women with breastfeeding-age children ranging from 2 months to 2 years. Thirty-eight percent of these women had stopped breastfeeding, and their average scores on the Urdu version of the Hospital Anxiety and Depression Scale (HADS) were 19.66, compared with 3.27 for the breastfeeding women. Of the women who had stopped breastfeeding, 36.8% reported that their depression had preceded breastfeeding cessation. The authors concluded that maternal depression causes mothers to stop breastfeeding.

In a sample of 209 women from Oklahoma, researchers examined risk factors associated with a score of over 13 on the EPDS (McCoy, et al., 2006). The risk factors they identified included formula feeding (OR=2.04), a history of depression (OR=1.87), and cigarette smoking (OR=1.58). Breastfeeding is associated with a significantly lower occurrence of postpartum depression. Approximately 39% of this sample had an EPDS score indicating possible depression. This high incidence of postpartum depression could be due to the relatively high percentage of low-income women in this sample.

Women were assessed for depression with the EPDS at six and twelve weeks postpartum (N=185) (Hatton, et al., 2005). At six weeks, depressive symptoms were related to lower rates of breastfeeding. This relationship persisted even after controlling for prior history of depression, life stress, and current antidepressant use. There was not a relationship between breastfeeding and depressive symptoms at twelve weeks postpartum. The authors concluded that depressive symptoms in early postpartum may lead to early breastfeeding cessation. They offered several possible explanations for their findings including that depressed women may not have initiated breastfeeding, or that perhaps early depression impacted milk production or let-down. They also noted that stressful life events can have a negative impact on breastfeeding, and are also predisposing factors for postpartum depression.

A study from Canada had similar results (Dennis and McQueen, 2007). This sample included 594 community women who were surveyed at one, four, and eight weeks postpartum. The women were surveyed about their feeding method and depressive symptoms on the EPDS. The researchers found no relationship between maternal mental health and feeding at one week postpartum. However, mothers with an EPDS score of 12 or greater at one week postpartum were significantly less likely to be breastfeeding at four and eight weeks. They were also more likely to have been unsatisfied with their infant feeding method; to have experienced serious breastfeeding problems, and to have reported lower levels of breastfeeding self-efficacy. Mothers who thought breastfeeding was progressing terribly at Week 1 were more likely to develop depressive symptoms. But when depression was removed from this analysis, the effects disappeared. The authors felt these findings reflected depressed mothers' moods and cognitions rather than objective problems. They concluded that early identification of mothers with depressive symptoms can both halt morbidity associated with depression and increase breastfeeding duration.

Postpartum anxiety can also impact breastfeeding initiation and duration (Britton, 2007). In a study of mothers at discharge and one month postpartum, predischarge anxiety was inversely related to breastfeeding confidence. Mothers who were high in post-discharge anxiety were less likely to be fully or exclusively breastfeeding and were more likely to have stopped breastfeeding at one month.

A study of 852 pregnant women in Brazil (Rondo and Souza, 2007) found that distress and worry about breastfeeding, concern about body changes, and work outside the home were negatively related to intention to breastfeed. However, depression and anxiety scores were not related to intention to breastfeed.

One hundred twenty-two depressed women described their breastfeeding experiences (McCarter-Spaulding and Horowitz, 2007). The researchers collected data during three home visits. They noted that in this sample, severity of depression was not related to breastfeeding, but older maternal age, living with a partner, and higher income were. Maternal education was the most important predictor of exclusive breastfeeding and combination feeding. Depression was most severe at the four- to six-week assessment, dropping off after that. By 14 to 18 weeks postpartum, 78% had EPDS scores below the cut-off. All of the women were encouraged to seek outside care for their depression, but only 11% to 12% had gone to psychotherapy, and 3% to 6% had used medications. In terms of breastfeeding patterns, by 14 to 18 weeks, exclusive breastfeeding had dropped from 34% to 22%. At 14 to 18 weeks, 33% were using a combination of feeding methods and 45% were exclusively formula feeding. McCarter-Spaulding and Horowitz (2007) noted that their findings of high rates of breastfeeding, despite severity of the mothers' postpartum depressive symptoms, are consistent with previous

research that suggests a link between depression and early weaning. What depression seemed to affect was exclusive breastfeeding, which was lower than in the larger sample from which the respondents were drawn.

In a qualitative review of 49 articles that specifically examined the link between depression and breastfeeding, Dennis and McQueen (2009) found that depressive symptoms in early postpartum may be related to decreased breastfeeding duration, increased breastfeeding difficulties, and decreased levels of breastfeeding self-efficacy. Further, depressed women may be less likely to initiate breastfeeding and to breastfeed exclusively. Mothers with depressive symptoms were more likely to discontinue breastfeeding earlier than non-depressed mothers. Depressive symptomatology was related to lower breastfeeding self-efficacy, demonstrating that depressed mothers were less confident in their ability to breastfeed.

Implications

1 Since depression is a major risk factor for breastfeeding cessation, lactation specialists should screen for it.

2 Maternal stress and fatigue reduce prolactin levels and may lead to breastfeeding cessation. High levels of cortisol can delay lactogenesis II.

3 Breastfeeding difficulties, especially nipple pain, can lead to depression and need to be addressed promptly (see Chapter 5).

4 Breastfeeding mothers actually get more sleep than their formula-feeding counterparts. When mothers try supplementing with formula at night to get more sleep, they may encounter the opposite effect.

5 Depressed mothers should be encouraged to continue breastfeeding since it protects

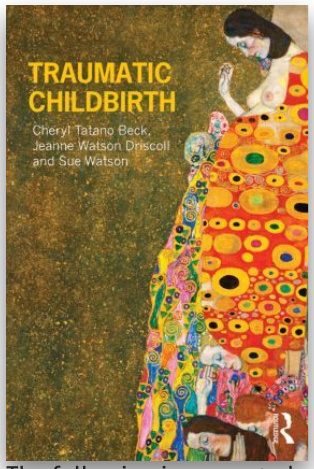
infants from the harmful effects of maternal depression (see Chapter 7).

Regarding the role of healthcare providers caring for women who are breastfeeding and depressed, McCarter-Spaulding and Horowitz (2007:10) noted the following.

> Nurses caring for women who are at risk or struggling with PPD also may feel that breastfeeding is perhaps an unnecessary burden that should be discontinued. Although nurses might expect that mothers with depression may not want to continue or may not be able to maintain breastfeeding, such assumptions may not be accurate.

Traumatic Childbirth: Impact of Traumatic Childbirth on Breastfeeding

Chapter 7:: Impact of Traumatic Childbirth on Breastfeeding



A question that was triggered as part of the process of Cheryl and Sue's research and the narratives that women emailed to them led to the investigation of the breastfeeding relationship. Was there an impact on this relationship positively, negatively, or not at all? In this chapter, first, is a review of the literature highlighting factors that have been reported to impact mothers' breastfeeding experiences. Next, Cheryl and Sue's qualitative study is described (Beck & Watson, 2008).

Delivery Type

Conflicting findings have been reported in the literature between type of delivery and breastfeeding. Janke (1988) did not find any difference in breastfeeding rates at 6 weeks postpartum for women who had vaginal and cesarean births. Reasons for stopping breastfeeding were similar for both groups of women. In a randomized control trial study, conducted by Hannah and colleagues (2002), no differences at 3 months postpartum in breastfeeding rates were found between women who had planned cesarean as opposed to planned vaginal delivery for breech presentation. On the other hand, in another study when compared to women who delivered vaginally, mothers who had cesarean births were more likely not to breastfeed and those who did choose to breastfeed were more likely to stop within the first 2 weeks after delivery (Samuels, Margen, & Schoen, 1985). In an earlier study, Procianoy, Fernandes-Filhio, Lazaro, and Sartori (1984) reported that mothers who had cesarean births were significantly less likely to breastfeed at 2 months postpartum compared to women who had given birth vaginally. These two groups did not differ significantly in socioeconomic, prenatal, and neonatal factors. Nissen *et al.* (1996) reported that compared to women who had vaginal births, mothers who had cesarean deliveries had lower pulsatile oxytocin release patterns and lower levels of prolactin. Both oxytocin and prolactin hormones are critical hormones needed for successful lactation. Oxytocin is the hormone that is connected to milk ejection or let down and prolactin is involved in milk production.

Compounding this physiological research finding about the hormonal levels is the issue that there seems to be a delay in the sucking responses in babies born via cesarean delivery. Otamiri, Berg, Leden, Leijon, and Tagercrantz (1991) reported delayed neurological adaptation in infants delivered by cesarean during the first 2 days after birth. Infants born by cesarean birth were less excitable and had a significantly decreased number of optimal responses compared to infants born vaginally. On day 5 postpartum, there were no significant neurological differences reported between these two groups of infants. On a practical level, these early days are when the lactogenesis and milk ejection reflexes are maturing; the infant's delay in early suckling can alter the maternal feelings of success with breastfeeding so the health care providers need

to support and encourage the aspects of learning new behaviors and trusting the process that the baby will indeed become an active participant in the breastfeeding relationship. The mother may need to be taught pumping skills so that she can be working physiologically along with her body while her baby responds to extrauterine life and suckling.

Labor Stress and Lactogenesis

In a sample of 40 women at delivery, it was reported that the mothers who had experienced longer labors had elevated stress hormone levels in their blood, and lower breastfeeding frequency on the first day postpartum (Chen, Nommsen-Rivers, Dewey, & Lonnerdal, 1998). Also in Chen et al.'s study on day 5 postpartum, primiparas who had a long duration of labor had a lower milk volume. Dewey (2001) reported that a delay in lactogenesis (milk making) was related to prolonged duration of labor and emergency cesarean delivery. In a sample of 136 Guatemalan women Grajeda and Perez-Escamilla (2002) reported that stress during labor and delivery, as reflected by cortisol levels, was a significant risk factor for delayed onset of lactation. Primiparous women who had emergency cesarean births were more likely to have a significant delay in onset of lactation compared to the rest of the sample.

Postpartum Mood and Anxiety Disorders

The only research located on the impact of any postpartum mood and anxiety disorder on breastfeeding focused on postpartum depression. No consistent pattern has been confirmed in the literature between breastfeeding onset or duration and postpartum depressive symptomatology. No studies, quantitative or qualitative, examined the impact of PTSD due to birth trauma on breastfeeding until 2008 when Beck and Watson conducted a qualitative study on mothers' perceptions of the impact of traumatic childbirth on their breastfeeding experiences.

Beck and Watson (2008) conducted an Internet qualitative study with an international sample of 52 mothers who experienced a traumatic birth. In the study, women were asked to describe how their birth trauma impacted their breastfeeding experiences. The range of duration of breastfeeding for these mothers was from 48 hours to 27 months. Eight themes emerged from the analysis of the mothers' stories. These themes revealed that the impact of traumatic childbirth on mothers' breastfeeding experiences can lead women down two strikingly different paths to either impede or promote their breastfeeding attempts. The eight themes were portrayed as weights on a scale (Figure 9.1). Three of the themes helped to promote breastfeeding while five themes impeded or disrupted the women's experiences related to breastfeeding. Not every mother experienced all eight of the themes. Each woman experienced a different combination of the themes and it was the individual combinations which determined which path the

women followed; which direction the breastfeeding scale tipped. The first three themes dealt with aspects of birth trauma that facilitated mothers' breastfeeding attempts.

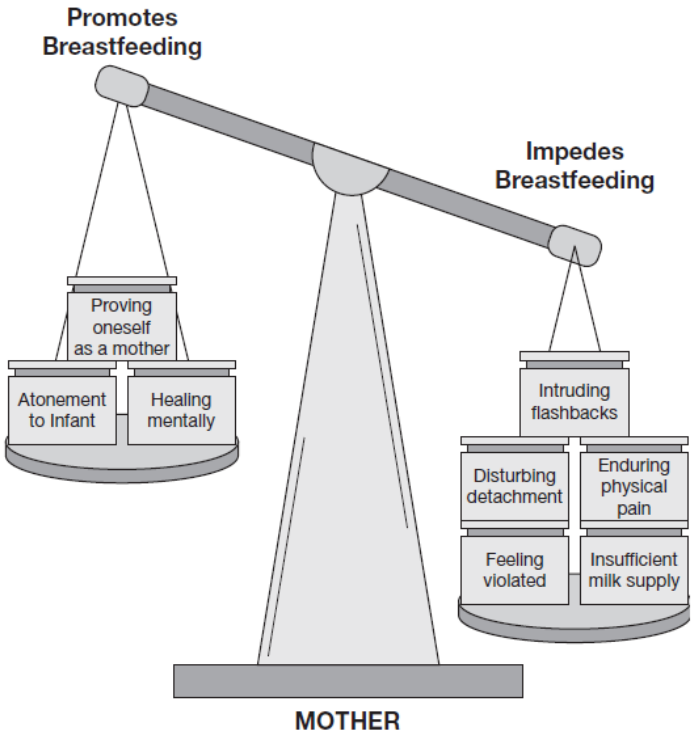


Figure 9.1 Breastfeeding scale

Source: Reprinted with permission from Beck & Watson (2008, p. 232).

Theme 1: Proving Oneself as a Mother: Sheer Determination to Succeed

Women who had a traumatic birth often felt as if they had "failed" at giving birth. In their eyes they needed to succeed at breastfeeding to "prove" to themselves and to others that they could do something right in motherhood. Women were tenacious in their desire to breastfeed. As one mother shared, "It was part of my crusade, so to speak, to prove myself as a mother and . . . being able to breastfeed successfully was the only and last chance I had to 'normalize' my horrible experience with giving birth" (Beck & Watson, 2008, p. 233).

Theme 2: Making up for an Awful Arrival: Atonement to the Baby

Women were steadfast in their resolve to make amends to their infants for the traumatic way they were brought into the world. Mothers felt strongly that they had to atone for their "sin" of the traumatic birth. As one mother in this sample, who breastfed the longest time, explained: "Breastfeeding became a form of forgiveness for me. Giving my daughter the best possible start, I breastfed her for 27 months" (Beck & Watson, 2008, p. 233).

Theme 3: Helping to Heal Mentally: Time-Out from the Pain in One's Head

For some women the time they spent breastfeeding their infants was soothing for them. As one mother shared:

> Breastfeeding was a time-out from the pain in my head. It was a "current reality"—a way to cling onto some "real life." Whereas all the trauma that continued to live on in my head belonged to the past even though I couldn't seem to keep it there. (Beck & Watson, 2008, p. 233)

Successful breastfeeding helped mothers to heal by restoring their faith in their bodies and increasing their self-esteem as illustrated by the following quote:

> My body's ability to produce milk, and so the sustenance to keep my baby alive also helped to restore my faith in my body, which at some core level, I felt had really let me down, due to a terrible pregnancy, labor and birth. It helped to build my confidence in my body and as a mother. It helped me heal and feel connected to my baby. (Beck & Watson, 2008, p. 233)

This theme was validated in the literature by a study conducted by Olza-Fernandez, Garcia-Murillo, and Palanca-Maresca in 2011. They reported in their case study that breastfeeding helped calm a mother with PTSD due to her emergency peripartum hysterectomy and helped her to feel more attached to her infant. The remaining five themes focused on aspects of birth trauma that hindered women's breastfeeding attempts.

Theme 4: Just One More Thing to Be Violated: Mothers' Breasts

Frequently women admitted that their childbirth felt like they had been raped with everyone watching and no one offering to help them. They felt as if their bodies had been violated and they had been stripped of their dignity. Protecting their bodies from being further violated became paramount as they needed to regain control of their bodies. The following quote from a mother who had been traumatized giving birth illustrates this vigilance to protect especially one part of her body, namely her breasts:

> I was sick of everyone grabbing my breasts like they didn't even belong to me. My breasts were just another thing to be taken away and violated. When I breastfed my baby, I felt like it was one more invasion on my body and I couldn't handle that after the labor I had suffered. Whenever I put her to breast, I wanted to scream and vomit at the same time. After a horrible 8 weeks, I made the decision to stop breastfeeding. It was crucial to me in reclaiming some power for myself, in taking back control of my life, my body and my right to choose what kind of care was best for my child. (Beck & Watson, 2008, p. 233)

Theme 5: Enduring the Physical Pain: Seeming at Times an Insurmountable Ordeal

Not only did psychological trauma impact breastfeeding but also physical trauma as vividly explained by one woman:

> Nursing required sitting up, putting pressure on my pointless episiotomy. When the nurses would check my bottom, they would visibly wince before pulling the blanket back up. I snuck a peak at myself at one point and was appalled to see that my labia were so swollen that they looked like testicles. I hated breastfeeding because it hurt to try and sit to do it. I couldn't seem to manage lying down. I was cheated out of breastfeeding. I feel I have been cheated out of something exceptional.
> (Beck & Watson, 2008, p. 234)

Theme 6: Dangerous Mix: Birth Trauma and Insufficient Milk Supply

Women described that their "meager milk supply" was due to the repercussions of their birth trauma. A mother who had a severe postpartum hemorrhage followed by a uterine infection recalled: "I think the trauma definitely affected my milk supply. It wasn't an easy decision but a continuing inadequate milk supply and a desperate need to reduce the pressure, I was forced to 'call it quits'" (Beck &Watson, 2008, p. 234).

Another mother who had suffered from preeclampsia, a torn pelvic ligament, and a severe reaction to a drug given to decrease her high blood pressure admitted that: "My body was so traumatized by the delivery and days after it that it never fully recovered from it. My milk never really came in well" (Beck & Watson, 2008, p. 234).

Theme 7: Intruding Flashbacks: Stealing Anticipated Joy

Some women, who had endured a traumatic childbirth, described that when they breastfed, intrusive, distressing flashbacks to their birth trauma haunted them. One primipara who had a long, painful labor due to an ineffective epidural, followed by a high forceps delivery, shared:

> I had flashbacks to the birth every time I would feed him. When he was put on me in the hospital, he wasn't breathing and he was blue. I kept picturing this, and could still feel what it was like. Breastfeeding him was a similar position as to the way he was put on me. I would get really upset and cry when I fed him which would cause my baby to cry. (Beck & Watson, 2008, p. 234)

Theme 8: Disturbing Detachment: An Empty Affair

This theme spotlighted the insidious effects of traumatic childbirth on mother–infant bonding. Women shared that they felt detached from their infants as this quote highlights:

> Breastfeeding my son in the first few months, certainly the first 6, but possibly as much as 9 months, was an empty affair. I felt nothing at all. Breastfeeding was just

one of the many things I did while remaining totally detached from my baby.
(Beck & Watson, 2008, p. 234)

Implications for Clinical Practice Based on Beck and Watson's (2008) Study

This study highlighted to the researchers the need for women to have time to process their birth experiences prior to discharge from the hospital. Health care providers need to spend time with women as they describe their perception of the birth experience, so that assessment of a traumatic experience can be completed and the care plan developed for their hospitalization as well as after discharge. The care plan needs to include the referral to mental health providers so the women's experiences are validated as real to them and they know that their experience been taken seriously by the postpartum health care providers. As we have discussed in this book, it is the perception of the experience to the individual woman that is the identifying variable in the etiology of PTSD secondary to traumatic birth, not the perceived experience of the care provider. Clinicians need to provide an empathic connection with new mothers that facilitates mental health and integration of experiences. As was also reported in this study, mothers who have experienced traumatic births may need intensive one-on-one support to establish breastfeeding. Respect must always be given to a new mother in the form of asking permission to touch her breasts when assisting with breastfeeding. Clinicians must be cognizant of body boundaries and personal space.

The disturbing detachment from their infants that some women felt when breastfeeding is alarming since during the postpartum period mothers should be developing a relationship with their infants. Traumatic childbirth can impede mother–infant bonding. Nursing staff need to watch for altered attachment in mother–baby dyads and implement a care plan that facilitates the mother–baby attachment: teaching about the unique behavioral skills of newborns, asking women to describe how they see their babies, who they look like, how they feel about them, etc. This is a time when continuity of care providers is critical.

It is important to allow and encourage women to talk about how they feel about breastfeeding rather than just assuming infant feeding methods. Clinicians should be aware of their projecting onto mothers their personal beliefs about infant feeding methods. They are vulnerable and hyper-alert to other people's body language, words, and presence. It is important to help her to process her experiences and know that she has the right to choose how she feeds her baby and need not feel guilt or judgment from others, to realize that this is HER experience and she will do what is best for her and her baby. For some women who have experienced birth trauma, pressure from clinicians, family, and/or friends to continue breastfeeding, no matter what, can complicate further their feelings of failure, shame, and inadequacy. Often, health care providers are not always conscious of the nuances of women's verbalized cues for

support, guidance, and/or direction. The mother may not be able to put in clear words how she feels inside as negative emotions are not often "allowed" after the birth of the baby. People lead the conversation with their feelings, i.e. "You must be so happy about breastfeeding your baby," so clinicians should try to lead with empathic concern and open-ended questions.

The following are two mothers' experiences of their struggles and triumph at breastfeeding after their traumatic births. They both had participated in Beck and Watson's (2008) Internet study.

Debra's Story

Two hours after entering the hospital, Debra had an emergency cesarean due to severe preeclampsia. She was 31 weeks gestation and her daughter weighed 2 lbs 12 ounces and was transferred to the neonatal intensive care unit (NICU). Debra's traumatic birth of her preterm daughter set the stage for breastfeeding difficulties. Her husband said, "The NICU is its own special hell." Debra voiced that:

> Nothing can prepare you for having a child in the NICU and it takes ridiculous amounts of stubbornness and willpower to stick to the goals you had before you had your life turned inside out because of a premature birth. Stubbornness, willpower, and more support than you can imagine and from anyone, anywhere, who will give it. I had lost so much because of her premature birth that I was going to be dammed to hell before I was going to give up on nursing her, especially before it even started.

The rest of Debra's story of the impact of her traumatic childbirth on her breastfeeding experience is as follows in her own words:

> I spent the first 24 hours of my daughter's life doped up on morphine and whatever else they gave me for the pain. I spent the next 24 hours trying to get out of bed so I could finally see my daughter. The first time I saw her and changed her itty bitty diaper I thought she was a he. She had no fat on her so her little girl parts looked like little boy parts. I argued with the nurse for a minute or so over the supposed gender of my child. All of this compounded the feeling of disconnect I had between me and this little creature. It took until day three before someone finally said I should start pumping, and at that point my baby had already gotten her first bit of formula, thus negating the exclusive breastfeeding goal. However, I did not feel a feeling of failure at that time, just frustration and determination.
>
> Pumping has to be one of the most tortuous things that one can impose on themselves. You have a cold mechanical machine forcing your gift of milk out of you and it serves mostly to remind you only that there is supposed to be a baby

there at your breast. Then if you only pump a little bit, there is a strong feeling of failure and you are reminded that you didn't measure up to carrying your child, so why would you measure up here? At least that was my feeling.

The first time I pumped it barely came up to 1cc of breast milk/colostrum and if the nurses had not made a huge fuss over how amazing that was, how that little bit was still "liquid gold" and how great a job I was doing by pumping, I would have quit right there and never have forgiven myself for it. My husband was right along with them telling me what a great mother I was for doing this. I personally felt I needed to do it. I mean, damn it, I had lost nearly everything, or so it felt at the time, that there was no way I was going to lose this too. Pumping milk was the only thing that reminded me I was connected to this little creature that seemed so foreign to me.

The support of my nurse, the lactation consultant, my friends, my husband, my family, and even strangers from the Internet is the main thing that kept me from throwing in the towel. In order to keep up my supply I was suppose to pump for 15–30 minutes every 3 hours, which is an insane schedule to keep, especially when you factor in the need for sleep and to visit our child in the NICU at least once a day. I never managed to keep that schedule and sometimes I would go up to 6 hours between pumping sessions. I hated that pump so much.

Eventually my supply took a hit because of a combination of not keeping the proper pumping regime and more importantly because the pump I was renting wasn't keeping proper suction. I went from pumping 2 ounces at a time to pumping 3 ccs. I was devastated. I began doing everything I could to bring my supply back up. I pumped in hour-long sessions every 3–4 hours and I made sure to keep pictures of my baby nearby, though without feeling any motherly instinct it didn't seem to make any difference. It took a long time but I was eventually able to pump half the amount I had been up to before, and occasionally a little more, but never as much as I had gotten earlier. The supply of milk ran out and my daughter was given formula for the first time since I had started pumping. I had failed her again.

The NICU is completely counterproductive to the warm natural ways of nursing. Even with the painted walls and dimmed lights that my hospital had, it was still a cold and sterile place. Babies are fed on a schedule, which is done because there are not enough people to handle on-demand feeding. You are not allowed to put the child to your breast early on when they are still rooting and it is more instinctive to latch, which leads to babies forgetting what they were born to know. Not only do you have to pump and store, but you must also deliver the milk, which must be kept frozen. After my daughter got out of the NICU, I spent another month pumping and nursing until she finally took completely to the breast. I had to fight

hard with myself and occasionally with others to get there, and once there thought I was never able to get myself to pump again.

Breastfeeding after a traumatic birth, especially one that results in a NICU stay, is almost an act of defiance. Defiance against the detachment and almost loathing you feel toward the child. Defiance against the depression that rules so much of your mind and defiance against all the people who try and switch you to formula. Breastfeeding in these circumstances has to be supported even more than in healthy normal births, the more the better, or the mother will drown.

My daughter is now 1 year old and I am still nursing her. I nearly gave up around 10 months when she was waking every hour until I finally made my husband get up with her instead and the bottle helped her sleep longer, and which made me saner. She has five teeth now and occasionally bites so thoughts of weaning her are entering my mind but I'm OK with it because I made it a year. Her pediatrician says I am one of the only mothers of a preemie that she has that was able to breastfeed at all (let alone that long). It is a source of great pride for me and has helped tremendously in overcoming the guilt I have about her birth, because I know I got this part right.

Victoria's Story

Victoria described how her traumatic birth was filled with multiple medical interventions. Her membranes had ruptured spontaneously at 36 weeks gestation and after 22 hours of labor, Victoria was only 4 centimeters dilated. The rest of the story is in Victoria's own words:

So induction drip in place, monitoring in place, pethidine (an analgesic) pain pump in place (eyes spinning in two different directions), anti-nausea stuff in one of the trios. My labor was a really medicalized situation. After 9 hours of this, I was very sensitive to the nasty side effects of pethidine but it did very little to diminish the pain. I was permanently nauseous, hallucinating, etc. The induction was badly handled and I had several bouts of hyper-reactive activity in the uterus—extremely painful.

By the time I was 10 cms, ready to push, I was utterly exhausted and couldn't even lift my eyelids let alone push. After an hour of pushing and no progress, my midwife called the on-call obstetrician. After another hour of pushing, he finally arrived. I specifically wanted an episiotomy rather than to tear but I was too stoned from the pethidine to ask for this—and thought my husband and/or midwife would remember to say this—neither did. Actually at this point in time I just wanted to die (or at least to sleep) and I desperately wanted a c-section under general—just so I could sleep—but was too stoned to ask for this. So ventouse in place, and it slipped

off several times. Room now full of people who kept talking to me which I found incredibly frustrating as I couldn't properly understand them or answer them. Obstetrician now told me (after 3 hours of pushing), and I quote, "It's time to really push now" . . . had I been able to tell him to **** off, I would have—what did he think I had been doing for the past 3 hours?

Baby finally delivered at 9 a.m. No overwhelming sense of love, just relief. I actually said "Is that it? Thank God!", much to everyone's horror. The baby taken straight away to be checked, didn't even see her for 5 minutes, just heard her crying. Third degree tear which took an hour of painful stitching (when I told the obstetrician that it really hurt, he said, and I quote, "It can't hurt, I've given you a local") while baby had been whisked off and dressed—against my wishes for skin-to-skin contact. By the time I got the baby, she had been out for at least an hour, also against usual hospital policy. Tried to breastfeed at this time, complete failure. This is second point at which things went wrong. First, I had expected that my body would know what to do in giving birth—it didn't. Second, I had expected (and had been to classes which confirmed this), that breastfeeding would just happen—it didn't. Baby didn't even recognize that a breast was there—none of the snuggling, licking, or nuzzling that second baby did. So now I felt as though there must be something fundamentally wrong with me—my body (and indeed my baby who came out of my body) just didn't know what to do. This was compounded by a sense of failure at not having the birth I expected, and guilt at feeling that it was just a horrible, painful, bloody experience (not the wonderful empowering stuff the antenatal classes had led me to believe it would be).

I didn't actually even want to hold my baby. She looked so alien and I couldn't believe she had come out of my body. I felt guilty about this on top of the exhaustion, shock, and sense of failure. I was so exhausted that all I could think about was sleeping—for days and days and days. I couldn't sleep though, not through excitement but every time I closed my eyes, I had intense and vivid thoughts of my birth and overwhelming feelings of revulsion, fear, and failure. My poor baby spent her first weeks in a crib beside me and had hardly ever been held (guilt on top of guilt).

Second attempt at breastfeeding, same failure as first. Continued attempts to breastfeed just basically hopeless which continued for three days. My body had betrayed me again. On discharge at two days, my baby had lost an utterly 20% of her birth weight and was jaundiced. I went to a specialist postnatal facility, as before I had the baby I knew I would need more help than just two days in hospital. On admission to the postnatal facility, it was all action. Pediatrician, lactation consultant, breast pump, etc. So now, not only was I exhausted, feeling like a failure,

and utterly traumatized by my birth, now I was into "rescue" mode, with a VERY sick baby that I hadn't realized was sick. More guilt. Still couldn't sleep properly.

Because our first few days breastfeeding were so incredibly unsuccessful, my milk hadn't really come as such, more like dribbled in, which compounded the problem. My baby put on no weight at all for the next three days while I was in the postnatal facility, but I was determined to get home and get on with it—feeding, pumping, and formula top-ups on a 3-hourly basis, day and night.

Breastfeeding during this time was frankly awful. In the first two days when I was just a drugged, exhausted, shell-shocked zombie, it was frustrating and I felt that it was another thing that my body didn't know how to do. When it got to panic-situations in the next few days, it felt like it was critically important, still incredibly difficult, but now it felt like life or death (probably this was a really exaggerated response). So when it still wasn't going well in these few days, it was hugely alarming. Breastfeeding became my focus for overcoming the birth and proving to everyone else (nay-sayers) and mostly to myself that there was *something* I could do right.

Because my milk supply was so low, and the baby was not gaining weight, I continued with pumping and formula top-ups. Many people, including my mother, midwife, and husband, suggesting I just get her on formula exclusively—this would mean I could actually get some sleep as the whole feed/top-up/pump cycle took at least an hour and a half. Every 3 hours, day and night. I really wanted to give breastfeeding a decent chance although most people around me felt I had done so already. In my mind, I think being able to breastfeed successfully was the only and last chance I had to "normalize" my horrible experience with giving birth so I was bloody determined to do it. Lucky that I'm incredibly bloodyminded and persistent otherwise my baby would most definitely be a bottle baby. I think, had I bottle-fed, my bond with my baby would have been even more compromised.

I was utterly shocked by my birth experience. It actually wasn't until weeks later that it really hit me and I really started having trouble sleeping, feeling anxious and indecisive, and having momentary flashbacks about parts of the birth that I had sort of forgotten. I became quite obsessed with trying to work out what had happened. Later on when I felt really comfortable with breastfeeding (probably around 4–5 months), breastfeeding was just bloody hard work. But it was part of my crusade, so to speak, to prove myself as a mother. Once breastfeeding got easier, it was just a normal part of life, but never really became something I enjoyed. It was just convenient for me and good for the baby.

Victoria breastfed for one year. Victoria went on to have another baby. This time her

childbirth was not traumatic and she could then compare the difference this made in her breastfeeding of her second baby.

> With baby number two breastfeeding has been and continues to be an absolute joy. I get the rush of hormones (that the books tell you about) that makes me feel calm and relaxed and I always feel particularly "madonna and child"-like when I breastfeed him. It is, and always has been, an essential part of our bond, and something I do as much out of love as for nutrition. It was never that way with my first baby. I now feel I've cheated her out of something really special and I'm just so sad about that. No one told me that the circumstances of my birth would be so tied up on my own experience that bonding with my baby would need to be worked at. Perhaps if this emotional aspect of breastfeeding had been explained to me before I gave birth, it might have been easier.

Clinician's Reaction

These narrative stories of two women who experienced traumatic births and described breastfeeding experiences trigger such sad feelings in me as a nurse and retired lactation consultant. The mental well-being of these women is critical and I believe it is the role of the nurse to provide the individual support and care that postpartum women deserve. Each of these experiences, as described by the women, presents situations where my question is, where are the nurses? Why did these women have to be in essence re-traumatized by the breastfeeding experience? And thank goodness for their personal stubbornness and resiliency. It is physiologically known that the initiation of lactogenesis occurs secondary to suckling behavior on the nipple/areola area, be that the baby or the pump, so why didn't that happen for Debra, where were the postpartum nurses to help her initiate lactation while her baby was in NICU? An individualized care plan must be developed by the nurse on the postpartum unit in collaboration with the new mother and her unique experience. So if we think of what that might be, it basically falls into three domains: maternal care, initiation of breastfeeding, and the facilitation of maternal–infant attachment. I do believe that care of the father is also necessary in the postpartum experience as he has seen his wife go through the experience and he too needs to process the events which can affect the couple's relationship and paternal development. So let's begin with maternal care.

The physiological care of the new mother includes vital signs, assessing urination, bowel function and adequate hydration. Pain management is critical as is the application of psychosocial care principles: relationship development, emotional connection, facilitation of the integration of the experience into the woman's self system. Often when providing physical care there is an opportunity to encourage and facilitate the processing of the birth experience. Open-ended questions are especially useful in that they allow the woman to share her own unique perception and take on

the birth events. An example might be, "Tell me about your birth experience, how much was it what you had imagined?" Another example, "Many women have an idea of what their birth experience will be like. How was this for you?" The woman will hopefully sense the empathic connection and feel safe to speak her voice and share her experience. It is so important that HER experience be validated, and not judged or critiqued. Remember the experience is in the "eye of the beholder."

The assistance with breastfeeding is another critical opportunity to allow for the processing of events as well as a time to support the woman's boundaries and sense of self. It is important to assess the woman's motivation and skills level and it is critical to ask permission to touch her breasts if it will be needed to guide the feeding experience. Sometimes it is helpful to put your hands over hers and guide the feeding that way. Again, be cognizant that you have no idea what the woman's past history is with regard to trauma prior to the birth, so you want to lead with respect and clear boundaries. This is another critical time for assessment of preconceived ideas regarding feeding as well as time to process the labor, delivery and birth experience.

Facilitation of maternal–infant attachment is promoted at every nursing assessment and visit, encouraging the woman to identify with her baby: What are his/her unique characteristics? Does he/she resemble anyone in the family, etc.? This is also a time to teach and demonstrate all the unique aspects of the baby: rooting reflex, self-soothing, competency, etc. These "Kodak moments" of mother–baby interaction are times of connection and care for both mother and baby. The father/partner is also a main player in the development of this trio, so make sure that he/she is being asked their perceived experiences also.

It is in the utilization of every patient encounter that the integration of birth experience takes place and the internal processing of events is given priority. If the nurse has a feeling or an intuitive awareness that this woman will need additional psychosocial services, this is a good time for referral to mental health services or to give names of resources upon discharge. Documentation is important as well as shift-to-shift reports on the emotional aspects of the mother's care.

Mother's Reaction

This is a dynamic situation. Take all cues from the mother. You will see in which direction she moves. It could be the "Lioness" syndrome, where the first three themes apply. Or, sadly, the trauma will affect or even consume her, and she will go down the "impeded" path. From the research it is clear: preparedness could be a great help for mothers and their precious babies—not to walk away from breastfeeding, but to persevere, thus giving the best start for mother and baby. The beautiful hormonal bodily gift associated with breastfeeding will help lift the mood of the mother and

make it more likely that the impact of the trauma will not be so great. Yet moving into breastfeeding is still a journey in itself.

Take time to observe and then support, support, support. This would be the essence of the way forward. Affirm what the mother is saying, listen, hear, and do not judge. Be mindful of how you communicate, of what messages your body language is giving, and so on. It is a fine balance for the mother. She already knows it is best to breastfeed, so do not let this be an additional trauma. Provide whatever she is asking for by way of support.

If the trauma is ongoing, for example, preeclampsia, then there is time to set breastfeeding support in place. Start talking early. Do this, too, for a birth that follows a previous traumatic birth. Good support can come from many quarters. Think outside the square. Consider the family, the partner, the mother, and the usual health professionals in the couple's lives. Be practical. Be prepared.

For those who show the "Lioness" syndrome, success in breastfeeding is wonderful. Work with them to make it happen. But be aware that the trauma is still there, and treatment will still be necessary. As the words of the mother clearly state, this is their way to heal themselves. Affirm her actions, yet still keep the need for counseling in view.

To those who are impeded by their birth trauma, offer practical relevant support. Ask open-ended questions. Try to distinguish the psychological from the physical. Try NOT to increase the burden of failure for those who do not continue in breastfeeding. Their traumatic birth may be the most appropriate focus for them. Therefore, affirm the mothering skills you see. Celebrate what is going on, rather than censuring for what is not. Being shell-shocked and just coping is using all their available energy. Nurture the mother. Acknowledge the good that she is doing. Involve appropriate professionals, for example, chaplains, social workers, and family members too. The first phase is important. Keep the channels of communication open. Permit birth reviewing at a time that is right. Encourage the mother's delight in the relationship with baby. It is, again, her birth, and it is her equilibrium that is at stake.

Conclusion

Cheryl and Sue's qualitative research on the impact of traumatic childbirth on women's breastfeeding experiences provides clinicians with a glimpse into the world of these mothers as they struggle to breastfeed. Further research, both qualitative and quantitative, is needed to investigate the effect of birth trauma on breastfeeding. In Chapter 10, another long-term effect of traumatic childbirth on women is the focus. This time it is the anniversary of mothers' birth trauma which is always the child's birthday.