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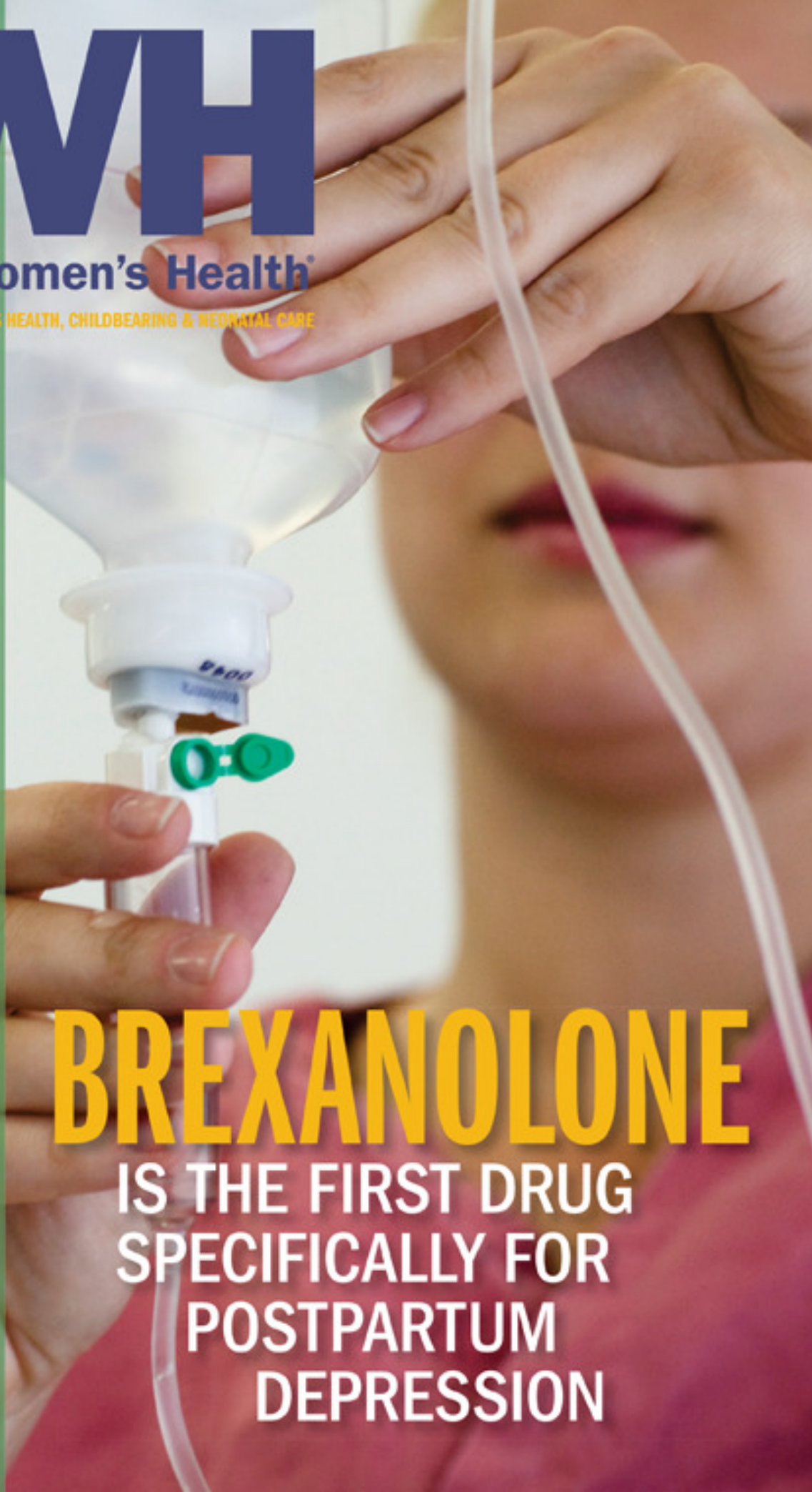

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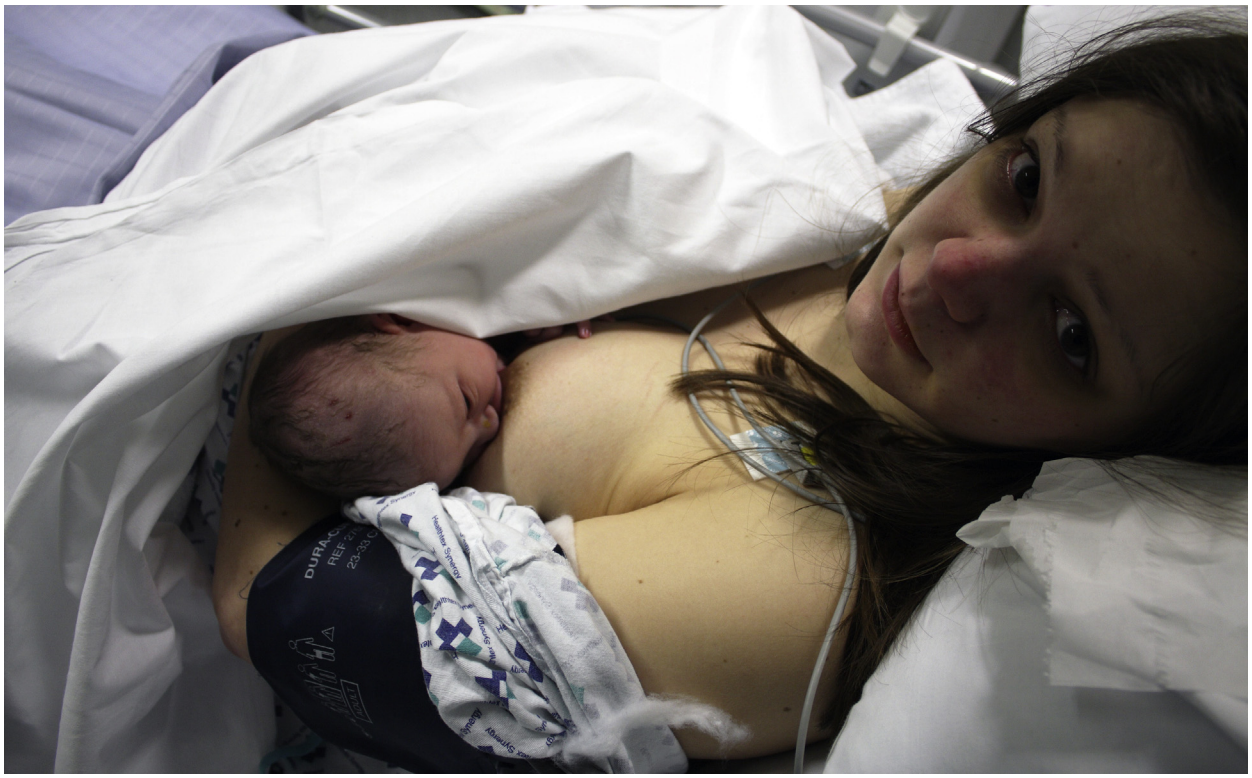

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Women's Choice Regarding Breastfeeding and Its Effect on Well-Being

Ana Diez-Sampedro, Monica Flowers, Maria Olenick, Tatayana Maltseva & Guillermo Valdes

ABSTRACT: Because of the many known maternal and neonatal health benefits of breastfeeding, there have been significant efforts to encourage exclusive breastfeeding, and many hospitals follow the guidelines of the Baby-Friendly Hospital Initiative. However, even with the right support, many women are unable to exclusively breastfeed, which may make them feel anxious and/or depressed. Psychological pressure to exclusively breastfeed has the potential to contribute to postpartum depression symptoms in new mothers who are unable to achieve their breastfeeding intentions. In this commentary, we focus on the well-being of the mother–infant dyad and argue for further research on maternal stress related to breastfeeding difficulties or pressure and the need to physically and psychologically assess and support women who are unable to breastfeed successfully or exclusively.

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KEYWORDS: breastfeeding, lactation, postpartum depression, pressure, stress

The benefits of breastfeeding are extensive and have been thoroughly documented in the literature. Maternal health benefits include increased postpregnancy weight loss (Jarlenski, Bennett, Bleich, Barry, & Stuart, 2014), lower risk of breast and ovarian cancer, and a decrease in the risk of Type 2 diabetes (Chowdhury et al., 2015). In addition, breastfeeding releases oxytocin, which is involved in social bonding, trust, and love (Szymanska, Schneider, Chateau-Smith, Nezelof, & Vulliez-Coady, 2017). The release of oxytocin during breastfeeding "increases relaxation, lowers stress and anxiety, lowers blood pressure, and causes muscle contractions" (Murray, 2016, p. 1), reducing postpartum bleeding and facilitating uterine involution. Studies have noted that breastfeeding, through effects mediated by oxytocin, is associated with decreased risk of postpartum depression and anxiety (Dias & Figueiredo, 2015; Murray, 2016).

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CLINICAL IMPLICATIONS

- Excessive or unrealistic pressure or expectations to breastfeed can lead to negative psychological impact on women, including postpartum depression symptoms.
- Health care providers must provide accurate and unbiased information on feeding choices and refer women to appropriate resources when warranted, neither pushing them one way or the other nor encouraging feelings of guilt about the choices they make.
- Psychological distress due to unsuccessful breastfeeding can influence a woman's ability to care for and relate to her infant.
- It is important for health care providers to be cognizant of women's infant feeding intentions and supportive of the choices they make, whether they agree with them or not.

Neonatal health benefits of breastfeeding include lower risk of having asthma or allergies; higher scores on intelligence measures; appropriate weight gain; prevention of sudden infant death syndrome; and lower risk of Type 2 diabetes, childhood obesity, and certain cancers (American Academy of Pediatrics, 2012; Centers for Disease Control and Prevention [CDC], 2018a; Dietrich, Felice, O'Sullivan, & Rasmussen, 2013). In addition, breastfed infants have lower risks of ear infections, respiratory illnesses, and bouts of diarrhea and vomiting (American Academy of Pediatrics, 2012). Given the empirical evidence, numerous governmental and nongovernmental agencies and organizations currently promote exclusive breastfeeding for the first 6 months of an infant's life.

Breastfeeding Statistics

According to the CDC (2018c), an average of 20.7% of U.S. infants born between 2009 and 2015 were exclusively breastfed for the first 6 months of their lives. Thus, 79.3% of infants never breastfed, did not exclusively breastfeed, or were exclusively breastfed for less than 6 months. Between 2009 and 2015, an average of 79.8% of U.S. mothers and infants attempted breastfeeding. At 3 months after birth, only 42% of mothers were breastfeeding exclusively. By 6 months after birth, 51.3% of mothers and infants were still engaged in some breastfeeding, either exclusively or formula supplemented. Thus, between 2009 and 2015, 1 in 5 mothers of infants did not breastfeed, and only 1 in 4 mothers of infants who did breastfeed did so exclusively for 6 months (CDC, 2018c).

Pressures to Breastfeed

There have been significant efforts to promote exclusive breastfeeding as the first choice for early infancy. Throughout the course of a woman's pregnancy, health care providers often ask whether or not she plans to breastfeed and provide her with information about the benefits of breastfeeding. The consistent message is that "breast is best." If a newborn is born in a hospital, the influx of information regarding the benefits of breastfeeding continues, especially in Baby-Friendly–designated hospitals. The Baby-Friendly Hospital Initiative (BFHI) was launched in 1991 by the United Nations Children's Fund and the World Health Organization in an "effort to implement practices that protect, promote and support breastfeeding" (World Health Organization, 2018, para. 1). Through Baby-Friendly USA, Inc., the accrediting body and national authority for the BFHI (Baby-Friendly USA, 2018b), an increasing number of hospitals in the United States are following the BFHI.

In 2007, fewer than 3% of births in the United States occurred in Baby-Friendly–designated hospitals. This number rose to 25% by 2018 (Baby-Friendly USA, 2018b). Baby-Friendly–designated hospitals adhere to *The Ten Steps to*

> Health care providers should be prepared to offer emotional support to women with unrealistic or unachievable expectations or who are experiencing breastfeeding difficulties and to reinforce women's maternal identity, even in the face of breastfeeding difficulties

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Successful Breastfeeding, which include "Inform all pregnant women about the benefits and management of breastfeeding," "Help mothers initiate breastfeeding within one hour of birth," "Give infants no food or drink other than breast-milk, unless medically indicated," and "Encourage breastfeeding on demand" (Baby-Friendly USA, 2018a, para. 2).

Andrews and Knaak (2013) interviewed 60 Canadian and Norwegian women and found that greater breastfeeding rates were supported by cultures of pressure and judgment in these countries. Lagan, Symon, Dalzel, and Whitford's (2014) study in Scotland, based on focus groups and 40 semistructured interviews, found that women perceived that formula-feeding was not a topic to be discussed by health care providers and that they felt pressure to breastfeed. The authors concluded that health care practitioners' interpretation of the U.K. Baby-Friendly Initiative may be preventing prenatal discussion about infant feeding choices.

Sheehan, Schmied, and Cooke (2003), in a small qualitative study in Australia, found that some women initiate breastfeeding in hospitals to avoid judgment by their health care providers. Cooke, Schmied, and Sheehan (2007), in a survey of 364 women, found that among women who had ceased breastfeeding by 3 months after birth, those for whom breastfeeding was strongly related with maternal identity, as measured by the Maternal Role Attainment subscale of the Maternal Breastfeeding Evaluation Scale (Leff, Jefferis, & Gagne, 1994), were seven times more likely to show psychological distress than those who had low Maternal Role Attainment scores. In a qualitative study encompassing 10 focus groups conducted with 51 health care professionals involved in breastfeeding promotion, Marks and O'Conner (2014) documented concerns about the dichotomy between breastfeeding promotion versus coercion and reported that some women also believed that promotion was not always carried out appropriately.

Familial and/or religious pressures to breastfeed can also contribute to the pressure to breastfeed that some women experience. Regular attendance of religious services is associated with increases in both breastfeeding initiation and duration among new mothers (Burdette & Pilkauskas, 2012; Stroope, Rackin, Stroope, & Uecker, 2018).

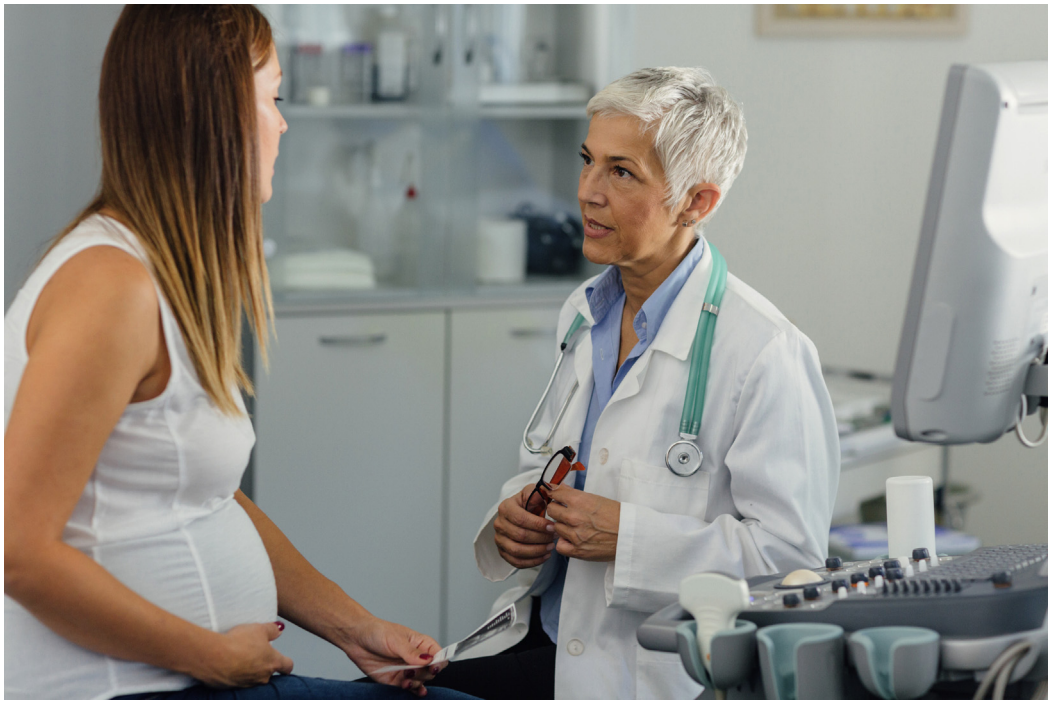
Based on these studies, we believe it is reasonable to extrapolate that women who choose to breastfeed and have difficulty breastfeeding or who have negative early breastfeeding experiences and must discontinue breastfeeding prematurely may experience increased stress due to their own internal pressure to breastfeed or/and external pressure, potentially from well-meaning hospital health care staff who are expected to promote and support exclusive breastfeeding.

Impact of Breastfeeding Decisions

Breastfeeding women have been reported to have more positive moods, report more positive events, and have less perceived stress than women who formula-feed (Groër, 2005). This implies that women who do not breastfeed must, therefore, experience less positive moods, more negative events, and more perceived stress. Studies show that breastfeeding difficulties can contribute to depression and anxiety. Women with negative early breastfeeding experiences are not only more likely to stop breastfeeding but are also more likely to have depression symptoms after birth (Borra, Iacovou, & Sevilla, 2015; Hamdan & Tamim, 2012; Pope & Mazmanian, 2016; Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011). In a study of more than 1,800 women, mothers' expectations for breastfeeding appeared to play a role in their postpartum psychological health, because women who met their breastfeeding expectations reported fewer postpartum depression symptoms than those who did not meet their expectations (Gregory, Butz, Ghazarian, Gross, & Johnson, 2015).

Although it is accepted that psychological distress, including depression symptoms, in mothers can lead to cessation of breastfeeding, it has also been proposed that women suffer psychological distress, including anxiety and depression, because they stop breastfeeding earlier than intended (Ritchie-Ewing, Mitchell, & Christian, 2019). In a longitudinal cohort study of more than 42,000 women, Ystrom (2012) concluded that cessation of breastfeeding is an independent risk factor for increased anxiety and depression. Several studies have similarly found that for some women, distress is caused by breastfeeding cessation (Brown, Rance, & Bennett, 2015; Hinic, 2016; Hvatum & Glavin, 2016; Lindau et al., 2015). It is reasonable to assert that some women who are unable to meet their breastfeeding intentions, and who cease breastfeeding, may be negatively affected psychologically. In a literature review, Dias and Figueiredo (2015) found that postpartum depression predicts and, importantly, is predicted by breastfeeding cessation. The data show that the relationship between breastfeeding cessation and psychological distress may work in both directions—women prone to mental health disorders may be more likely to cease breastfeeding early, and early cessation or breastfeeding problems may lead to mental health disorders (Akman et al., 2008; Ali, Ali, & Azam, 2009; Chaudron et al., 2001; Dennis & McQueen, 2007; Gagliardi, Petrozzi, & Rusconi, 2012; Galler, Harrison, Biggs, Ramsey, & Forde, 1999; Galler, Harrison, Ramsey, Chawla, & Taylor, 2006; Hasselmann, Werneck, & da Silva, 2008; Henderson, Evans, Straton, Priest, & Hagan, 2003; McCarter-Spaulding & Horowitz, 2007; Nishioka et al., 2011; Taveras et al., 2003; Watkins et al., 2011; Ystrom, 2012).

Sheehan, Schmied, and Barclay (2013), in a small qualitative study of Australian mothers, found that although health care providers understood *best* to encompass breastfeeding, women's decisions regarding infant feeding were complex and involved often competing intentions. Developing the intention to breastfeed is linked to the belief that a good mother breastfeeds, and mothers who formula-feed may do so with the expectation that they will be judged for their choice (Schmied & Barclay, 1999; Sheehan et al., 2013). Similarly,



the notion that "Breast is best" implies that formula-feeding is negative. Women may start to believe that if they are not successfully and exclusively breastfeeding, they may be causing harm to the infant. A discursive analysis based on focus groups conducted with 35 women found that good mothers who do not breastfeed report feeling guilt as a natural consequence of this choice (K. Williams, Donaghue, & Kurz, 2012). Numerous media reports are consistent with this view (Clements, 2013; Stanley, n.d.; J. Williams, n.d.). These data suggest that, in addition to stress from the pressure to breastfeed, the actual decision to stop breastfeeding or the decision to not initiate breastfeeding can be a potential source of psychological distress for mothers.

External Challenges to Breastfeeding

New mothers today are expected to return to work earlier than ever before and carry more of the family's financial burdens. Lauren Smith Brody, author of *The Fifth Trimester: The Working Mom's Guide to Style, Success, Sanity, and Big Success After Baby* (2017), describes the fourth trimester as the time when infants adjust outside the womb and the fifth trimester as the time when new mothers return to work, often before they are emotionally or physically ready to do so. The fourth and fifth trimesters constitute the first 6 months of life, when it is recommended that infants be exclusively breastfed. However, the majority of American employers do not offer paid maternity leave, forcing many women back to work earlier then they would have otherwise preferred (Aleccia, 2016), thus increasing the difficulty of maintaining exclusive breastfeeding. Lack of lactation rooms at work or school is also an obstacle.

According to the Bureau of Labor Statistics (2018), only 16% of U.S. workers receive paid family leave. The U.S. Family and Medical Leave Act of 1993 requires employers to provide 12 weeks of unpaid family leave, but the law applies to only approximately 59% of workers (AEI-Brookings Working Group on Paid Family Leave, 2017). This lack of family leave and the dearth of lactation-friendly work or school environments affects the decisions of women and their choice to breastfeed (or not), because breastfeeding significantly affects a woman in a multitude of ways, including less sleep, more frequent feedings, and more commitment in terms of preparing and storing breast milk versus formula-feeding (which may include help from family/household members). As a society, we attempt to educate women and promote breastfeeding as the method of choice for feeding babies, but by not fully supporting that choice with policies or environments that maximize the chances for success, we may be causing undue stress to women who do wish to breastfeed.

> Educating women and families about the benefits of breastfeeding without exerting undue pressure for them to conform, or judging their choices, may be the safest way to encourage breastfeeding without putting women at risk of psychological trauma

Implications for Practice

Health care providers, including nurses, have a responsibility to regularly update their skills and knowledge and incorporate the most recent evidence-based best practices. For those health care providers who care for childbearing families, this includes being able to provide advice on breastfeeding as well as information on the benefits of breastfeeding. At the same time, it is important for these health care providers to acknowledge that research has shown that difficulties in breastfeeding are not uncommon and that failure to meet breastfeeding intentions correlate with increased postpartum

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depression symptoms (Borra et al., 2015; Gregory et al., 2015; Hamdan & Tamnin, 2012; Odom, Li, Scanlon, Perrine, & Grummer-Strawn, 2013; Watkins et al., 2011). This may be related to the degree to which women identify breastfeeding with maternal identity. Nursing assessments of new mothers should include not only assessment of a woman's psychological state, sometimes performed with a standardized screening tool, but also a conversation to assess a woman's breastfeeding intentions. This conversation represents an opportunity to correct unrealistic expectations about breastfeeding and to discuss common difficulties and strategies to combat them.

Along with referrals to breastfeeding support systems, such as lactation consultants or breastfeeding support groups, health care providers should be prepared to offer emotional support to women with unrealistic or unachievable expectations or who are experiencing breastfeeding difficulties and to reinforce women's maternal identity, even in the face of breastfeeding difficulties. They may also need to educate family members to be realistic and supportive of women who may have difficulties with exclusive breastfeeding or who decide to stop breastfeeding early, whether due to physical, emotional, or practical issues. Health care providers also need to be supportive of women who choose to supplement with formula or who eschew breastfeeding altogether. It is not possible for health care providers to be aware of all the factors that play a role in forming a woman's infant feeding intentions, but so long as a woman is provided appropriate education to make informed decisions, clinicians must trust that a woman will choose to do what is best, even if the woman's definition of *best* is different than that of the health care provider.

The benefits of breastfeeding are many, but it is important to recognize that only a minority of mothers continue to exclusively breastfeed their infant for the first 6 months of life. The reasons for this are varied, including concerns about milk supply (perceived or actual), maternal or infant illness, medications, the need to return to work, fatigue, or even simply the personal choice of the mother (CDC, 2018b). There should be conversations related to the well-being of not only the infant but also the woman. We must not forget that a physically and psychologically healthy mother is likely better to care for an infant than one suffering from depression symptoms or exhaustion.

Educating women and families about the benefits of breastfeeding without exerting undue pressure for them to conform, or judging their choices, may be the safest way to encourage breastfeeding without putting women at risk of psychological trauma. Failure to acknowledge that the majority of mothers will not breastfeed exclusively for 6 months may contribute to undue stress in mothers who may not be exposed to or even educated about best practices in formula-feeding or formula supplementation, which most mothers are likely to benefit from. Educating women on safe formula-feeding represents an opportunity to protect the health and well-being of infants who might otherwise suffer as a result of potentially poor practices by well-meaning mothers.

Efforts to promote breastfeeding have an extensive history but in many hospitals are associated with the BFHI. One of the central tenets is that "every mother should be informed about the importance of breastfeeding and respected to make her own decision" (Baby-Friendly USA, 2018a, para. 2). The literature suggests that this standard is not always being met, because some mothers feel that formula-feeding cannot be discussed with their nurses or other health care providers, and some mothers breastfeed in the hospital to avoid censure by their providers (Andrews & Knack, 2013; Lagan et al., 2014; Marks & O'Conner, 2014; Sheehan et al., 2003).

The literature thus suggests a potential association of stress and feelings of guilt with not breastfeeding which may or may not be exacerbated by pressure to conform to exclusive breastfeeding. Further research, using the Edinburgh Postnatal Depression Scale (or another reliable and valid instrument), among other methods and measures, is warranted to determine whether mothers feel pressure to breastfeed; what or who they feel is the source of this pressure; and whether any pressure, independent of ability to meet breastfeeding intentions, might inadvertently result in a psychologically unhealthy mother who would be less able to care for her child and herself. Study results can also help health care providers guide women to make an informed decision about breastfeeding without judgment, coercion, or undue stress.

Conclusion

In the nearly 30 years since the introduction of the BFHI, studies of the benefits of breastfeeding have continued, and the prevalence of breastfeeding has risen substantially. However, there is scant research on whether there is an association between the pressure that women feel to breastfeed and psychological outcomes, such as postpartum depression symptoms. Given the potentially grave consequences of postpartum depression for families, such research is warranted.

Health care providers who work with new mothers and newborns regularly deal with breastfeeding issues and should undoubtedly be aware of the importance of watching for any signs or symptoms of psychological distress and postpartum depression. Women who have difficulty breastfeeding can be subject to pressure to continue, which may contribute to anxiety and/or depression symptoms. Despite clinicians' best intentions to promote women's and infants' health by encouraging exclusive breastfeeding, health care providers must continue to offer emotional support and reassurance to those women who cannot or will not breastfeed exclusively to avoid unduly stressing mothers about their infant feeding choices. Finally, given that women who do stop breastfeeding will likely do so after having left the hospital, we recommend that breastfeeding intentions and current infant feeding practices be regularly included in the psychological aspect of

each woman's postpartum follow-up appointments with her health care provider. **NWH**

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