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Breastfeeding: A Healing Tie

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Abstract

The impotance of breastfeeding for the short- and long-term physical well-being of infants and their mothers is so thoroughly documented that there is no need to repeat it. But the emotional benefits, the power of breastfeeding to bind and to heal psychologically is still hotly debated.

Undeniably, it is harder to quantify psychological phenomena than data from hard sciences, but there are, nonetheless, good studies and reliable indicators that breastfeeding is every bit as advantageous psychologically and it is physically. For the vulnerable premature ir ill infant, these advantages are all the more significant.

Studies from many parts of the world have demonstrated that infants – both fill- and pre-term – who have early, frequaent body contact with their mothers not only grow better, but also breathe more easily, sleep better and are more responsive. This body contact can be achieved without breastfeeding, but it requires conscious planning and is thus contrived in a way that breastfeeding is not. For the infant and mother who have gotten out of touch, breastfeeding may be the only acceptable way to be in close contact and gradually weave their ties anew.

Breastfeeding offers the additional advantages of synchronizing mother's and baby's breathing and sleeping patterns. There is considerable speculation that this may account for the greatly reduced incidence of SIDS among fully breastfed infants. More certain is that the fully breastfed child and his mother have a symbiotic relationship which enables the child to better communicate his needs and the mother to meet them more consistently.

For an infant who has suffered early (and perhaps anavoidable) trauma because of prematurity, medical interventions and separation from his mother, breastfeeding offers not only optimal nutrients for body and brain growth, but also an intense hands-on nur-

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turing that heals his wounded psyche and encourages its growth as well.

Zusammenfassung

Die Bedeutung des Stillens für die kurzfristige und langfristige Gesundheit der Kinder und der Mütter ist so ausgiebig dokumentiert, daß keine Notwendigkeit zur Wiederholung besteht. Aber die psychologischen Vorteile und die Möglichkeit durch das Stillen Bindungsprozesse zu fördern und positive psychologische Wirkungen zu erzielen, sind noch das Thema heißer Diskussionen.

Wennn auch psychologische Vorgänge schwieriger zu quantifizieren sind als objektiv meßbare, gibt es doch nichtsdestoweniger verlässliche Studien und Hinweise darauf, daß das Stillen in psychologischer Hinsicht ebenso positive Wirkungen hat, wie im somatischen Bereich. Für das empfindliche frühgeborene oder kranke Kind sind diese Vorteile nur umso entscheidender.

Untersuchungen aus vielen Teilen der Welt haben gezeigt, daß Kinder, seien sie nun zum Termin oder zu früh geboren, mit der Möglichkeit zu häufigem Körperkontakt mit ihren Müttern nicht nur rascher wachsen, sondern auch eine bessere Atmung haben, besser schlafen und allgemein lebhafter reagieren. Dieser Körperkontakt kann nun ohne das Stillen hergestellt werden, aber dies erfordert dann bewußte Planung und ist nicht so natürlich wie beim Stillen. Für eine Mutter und ein Kind, die aus der Gemeinsamkeit ihres Kontaktes herausgeraten sind, kann das Stillen eine günstige Möglichkeit sein, in den Kontakt zurückzufinden und die Bindungen zu erneuern.

Das Stillen bietet den zusätzlichen Vorteil, die Muster von Atmung und Schlaf von Mutter und Baby aufeinander abzustimmen und zu synchronisieren. Man hat spekuliert, daß dies der Grund dafür sein kann, daß die Häufigkeit eines plötzlichen Kindstodes bei vollgestillten Kindern sehr gering ist. Jedenfalls ist sicher, daß das vollgestillte Kind und seine Mutter eine symbiotische Beziehung haben, die es dem Kind ermöglicht, seine Bedürfnisse besser zu vermitteln und es der Mutter leichter macht, sich auf die Bedürfnisse des Kindes beständiger einzustellen.

Für ein Kind, das wegen einer Frühgeburtssituation, medizinischer Eingriffe und Trennung von seiner Mutter frühe und vielleicht unvermeidliche Traumen erleiden mußte, bietet das Stillen nicht nur bestmögliche Ernährung für den Körper und das Hirnwachstum, sondern ebenso eine intensive unmittelbare Zuwendung, die die psychischen Wunden heilen kann und gleichzeitig sein allgemeines Gedeihen fördert.

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Undeniably, it is harder to quantify psychological phenomena than data from hard sciences, but there are, nonetheless, good studies and reliable indicators that breastfeeding is every bit as advantageous psychologically as it is physically. For the vulnerable premature or ill infant, these advantages are all the more significant.

The premature infant is born too soon, thrust from the warm, secure environment of this mother's womb into a noisy chaotic world for which he is not yet ready, physically or psychologically. It is routine in many parts of the world to place prematures in the Newborn Intensive Care Unit where they "may be exposed to inappropriate stimulation such as high-decibel mechanical noise and high-intensity flourescent lights, both of which contribute to physical stress and are suspected of playing a role in hearing and vision impairment."[1]

In some cases this is a necessary evil. A very premature, or very ill baby may need all that modern technology has to offer if he is to survive. But his survival is bought at a price. Technology can scar as well as save. Respirators which breathe for a baby when he cannot, may cause pulmonary dysplasia[2]. Oxygen has long been thought to be a contributor to retinopathy in the premature (ROP). One in six very-low-birth-weight prematures develop it. Recently flourescent lighting has been considered as a possible contributor as well[3]. These babies suffer from environmental assaults on their delicate nervous systems, from separation from their mothers and from too little contact. This latter problem is being adressed in many NICUs with protocols that prescribe stroking and handling at each feeding or diaper change[4], with primary nursing care or best of all, encouragement of parental contact. "Babies need their parent's care, feeding, and handling in order to thrive, just as parents need to perform these nurturing activities to facilitate bonding."[5]

In some cases the problems of the NICU can be minimized or avoided altogether with so-called "Kangaroo Care". This was pioneered out of necessity in Bogota's Hospital Materno Infantil[6]. Because incubators could only accommodate 15–20% of the prematures[7] and infection caused a great many deaths[8], Drs. Edgar Rey and Hector Martinez asked the mothers of otherwise healthy infants to carry their babies "upright and prone between the breasts"[9] and encouraged them to go home as soon as possible. Mother and child together produce the ideal temperature and humidity for the child[10] and studies indicate that these babies have adequate oxygenation, suffer less apnea, maintain stable temperatures and cry virtually not at all[11]. A child in Kangaroo Care can conserve his energy. His mother provides the comforting movement he was used to *in utero*, stimulates his breathing and encloses him in a safe environment where he has limited mobility[12].

Breastfeeding is greatly simplified by Kangaroo Care because the infant has ready access to the breast. Some babies are ready to nurse at 900 grams[13] and if they cannot yet suck they can usually swallow milk expressed directly into their

mouths or given off a spoon [14]. Larger babies, from about 1600 grams can successfully be fed their mother's milk out of a cup [15] until they can suck. And sucking at the breast is far less stressful than bottle feeding as judged by more stable vital signs in the infant as he breastfeeds [16].

The mother who carries her premature infant on her body and nourishes him with her milk knows that she is essential to her baby's well-being – even to his survival. She is far more confident in both her ability to breastfeed and to mother her baby than is the mother who is kept at arms's length while the experts take over [17]. She will produce more milk and will breastfeed for longer [18].

In Western countries, prematurity has often been used as a reason to *discourage* breastfeeding and substitute some product specially designed for prematures. But mother's milk *is* especially designed for prematures. It is higher protein and higher energy than full-term milk [19], it's as it is far better utilized than the fat of cow's milk-based formula (90% absorption versus 68%) [20] and its composition changes to meet the child's changing requirements. Very low birthweight infants may need to have vitamin and mineral supplements added to mother's milk. A fortified mother's milk including milk from the baby's own mother and heat treated donor milk has also been used in trials with infants from 710 to 1510 grams [21]. Growth of these babies is reported to be more akin to intrauterine growth than growth in babies on other regimines. But for the most part, hospitals which encourage the feeding of the mother's own freshly pumped milk with donor milk supplements as needed have very satisfactory growth rates in their prematures.

Mother's milk for prematures is routine in some contries. Most of Czechoslovakia, for instance, practices exclusive mother's milk feeding for all prematures under 2000 grams. If the mother does not have sufficient milk of her own, pooled, pasteurized donor milk is used. In some hospitals, management of prematures encourages mothers to breastfeed their own infants. The special care nursery at Thomayer's Hospital in Prague, for instance, sends 96% of its prematures home fully breastfeeding. Kangaroo Care and a very enthusiastic clinic director account for much of this success [22].

Mother's milk feeding of prematures has also been common practice in Eastern Germany with government support for milk banks as a back-up. Until recently, donor milk from many milk banks was not pasteurized, but West German rules applicable since the 1st of January will change that. In Leipzig where 93 donors provided 10 000 litres of milk in 1989 [23], there is some concern that necrotising enterocolitis rates – until now a very low .05% – will go up as they did in Finland when pasteurization of mother's milk was introduced [24]. But whatever the merits of pasteurization for donor's milk, there can be no case for pasteurization of the milk a mother provides for her own baby – and certainly none for the practice of throwing it away and feeding the baby on infant formula which is still all too frequent. This is yet another reason for hospitals to encourage mothers to stay and care for their own infants and to send them home as soon as it is safe to do so.

Kangaroo Care infants frequently go home very soon after birth – sometimes within 24 hours if vital signs are stable. In Bogotà these babies are followed up

at special clinics, sometimes several times in a week and their mothers are given extensive support and health education. In other cases, Kangaroo Care infants may need to stay until they have stabilized and begun to gain weight. Very low birth weight infants – as low as 500 grams in Bogotà and 700 grams at Hammersmith Hospital in London [25,26] – may, of course, need special care in addition to the kangaroo mothering they receive. Studies at Hammersmith show very clear benefits of kangaroo care even for the tiniest premature. Babies as small as 700 grams "maintained stable skin temperatures, respirations, and heart rates while being held in this way for up to three hours" [27]. Mother's milk supply and self-confidence also improved under this regimine.

Clearly, prevention, as described above, is better than cure, but for those infants and mothers who have not been able to have close contact and begin breastfeeding early, an intense hands-on nurturing and breastfeeding, whenever they are introduced can be critical for the healing of both their wounds and the development of an attachment to each other. Mothers frequently feel guilty about having a premature baby, guilty about their disappointment in the child, guilty about what they perceive to be a failure of their bodies to function correctly [28]. If they are then given to understand, as they often are, that only the "experts" are capable of caring for their babies adequately they may feel thoroughly incompetent and distant from their babies. At best they may feel like one mother who said: "I had the feeling that I'd had an amputation – a part of me, important for my life – was gone and had been removed far away from me." [29]

This distancing threatens the mother-child bond and can be life-threatening for the child. Premature infants and those who experience early separation from their mothers (often one goes together with the other) are at greater risk for abuse [30], probably because bonding never happened and the built-in protection that keeps most children from being abused – even when they are at their most exasperating – is missing. If, as soon as a child is with his mother, he is given a chance to be in constant body contact and is offered the breast at very frequent intervals, there is a good chance that mother and child will grow attached, however belatedly. Anything that gets mother and baby in touch will help – baby massage, bathing together, the family bed. It needs to be impressed upon both parents that frequent body contact is as essential for a premature infant as any other medicine that has been prescribed – even if he doesn't care for it at first. Normal, healthy babies crave body contact and seek it out, but some babies have given up if, as is common in an NICU, they are only touched at fixed intervals or their crying is ignored. Crying is *not* a sign of well-being in a newborn and it is *not* good exercise for the lungs. It is a legitimate call for attention that needs to be answered. When a baby is allowed to cry there are negative physical effects – increased cortisol levels and intercranial pressure and depletion of energy, for instance [31], but equally important, the baby learns he cannot depend on anyone and may withdraw, starting a lifetime of skewed relationships.

Breastfeeding will not necessarily be easy if the baby had been bottlefed – a common practice associated with the erroneous belief that bottlefeeding is less stressful than breastfeeding. When the baby must first "prove" himself on a bottle, not only does that delay breastfeeding (an ability which appears a good two

weeks ahead of the ability to suck at a bottle), it may complicate it with nipple confusion. A baby who is nipple confused needs patient teaching to learn the correct technique for nursing – and meanwhile he continues to need nourishment.

The mother of a baby resistant to the breast needs the practical help of someone skilled in teaching infants to suck and a great deal of emotional support because the baby's resistance to the breast can feel like a rejection – just one more way she has failed. It takes a good bit of insight to realize that it is nothing of the sort and considerable effort not to take it personally.

Using cup or spoon feeding instead of the bottle and eliminating the pacifier can be helpful in encouraging a baby to take the breast. Some mothers find a nursing supplementer helpful because the baby is rewarded with milk each time he sucks at the breast. Continuous body contact affords much more opportunity for the baby to nurse – even "acccidentally", in his sleep, for instance. Most babies under four months can learn to suck at the breast. Some babies learn even beyond that point. But the stress can be very great on both mother and child unless they are well-supported. Continuous body contact – with or without breastfeeding – will do much to help them bond to one another. As the mother feels closer to her baby, her confidence will grow. If she is supplying him with her milk – even if she has to express it, this will also increase her confidence. As confidence grows she will relax and every aspect of mothering – breastfeeding included will be easier.

Some mothers, for lack of well-timed support mostly, may not be able to breastfeed fully – their premature infants, but the effort made – to produce milk and to reproduce as much as possible the sort of body contact a breastfed baby gets almost automatically, is worthwhile. If we can reassure these mothers that they are providing a very special sort of mothering for their babies, that only they can give, then we need not worry that our encouragement will lead to more disappointment should breastfeeding not work out as they hope. The woman who perceives herself as a successful mother, loved by her baby, is able to absorb the occasional times when her efforts don't bear fruit. She will be creative enough to find alternative ways of meeting her baby's need for nurturance and confident enough to try breastfeeding again with another baby.

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