

Is It Really Mothers' Choice? Systemic and Provider Barriers to Breastfeeding

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Much of the debate about breastfeeding is framed as the “mother’s choice.” As providers, we must always respect mothers’ choices about how they feed their babies. However, there are provider-level barriers that undermine breastfeeding and, therefore, limit mothers’ feeding choices. We address two systemic/provider-level barriers: birth interventions and providers’ attitudes. Both birth interventions and negative provider attitudes about breastfeeding undermine the oxytocin system, making breastfeeding more difficult. Becoming aware of these barriers, providing mothers with effective support during labor and postpartum and changing provider attitudes are essential for increasing exclusive breastfeeding rates.

Keywords: breastfeeding; health care providers; attitudes; birth interventions; oxytocin

Recent social media campaigns have made much about how we should support mothers’ choices about how they feed their babies. Mothers, they argue, are pressured to breastfeed, and this pressure can have disastrous consequences for both mothers and babies when it fails. An example of this rhetoric was a recent article on Forbes.com that claimed that breastfeeding promotion within Baby-Friendly Hospitals is a human rights violation (Senapathy, 2017).

As if often the case, mothers are caught in the middle. They are told “breast is best,” they know all the reasons why they should and they try so hard. Unfortunately, our current system works against them in some surprising ways. The mothers often feel like failures, and then they “choose” formula (see Figure 1). Is it really their choice? And what happens to them when they are not able to breastfeed?

When mothers want to breastfeed and cannot, they are more vulnerable to depression. Borra, Iacovou, and Sevilla (2015) found that mothers who intended to breastfeed and did not had higher rates of depression than mothers who intended to breastfeed and were able to. They used data from the Avon Longitudinal Study of Parents and Children (ALSPAC) study, a study of 14,541 pregnancies in Avon, UK. The results of this study were widely reported. Reporters often interpreted these findings to mean that our culture was putting too much pressure on mothers to breastfeed. But you could look at it another way; mothers who wanted to breastfeed could not because they didn’t get the support they needed.

Researchers and policymakers have written much about cultural barriers to breastfeeding, such as lack of postpartum support, formula marketing and distribution, and public attitudes about breastfeeding in public. These barriers certainly undermine breastfeeding. Unfortunately, there are other barriers within the very systems that are supposed to support breastfeeding. Until we address these barriers that are within our own system, mothers will continue to struggle. In this article, we’d like to explore two provider-level barriers that get less attention and are also important to address: birth interventions and provider attitude and bias.

Birth Interventions

Birth interventions are common in the United States. Mothers are often told that they have “no effect” on breastfeeding. Is that accurate? Recent studies indicate that birth interventions can substantially influence their “choice” about breastfeeding. A study of 5,332 mothers in the United Kingdom found that mothers who had forceps deliveries or unplanned cesareans had more breastfeeding difficulties and depression at 3 months postpartum (Rowlands & Redshaw, 2012). Similarly, a study of 1,280 mothers from Hong Kong found that induction, opioid pain medications, and emergency cesareans were related to lower rates of both “any” and “exclusive” breastfeeding (Bai, Wu, & Tarrant, 2013).

Epidurals are one of the most common interventions, and they can also influence breastfeeding. A prospective study of 1,280 mother–infant pairs in Australia assessed mothers at 1 and 24 weeks postpartum (Torvaldsen, Roberts, Simpson, Thompson, & Ellwood, 2006). They found that epidurals were

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Figure 1. Infant feeding is often framed as simply a matter of mothers' choice. Is that always true?

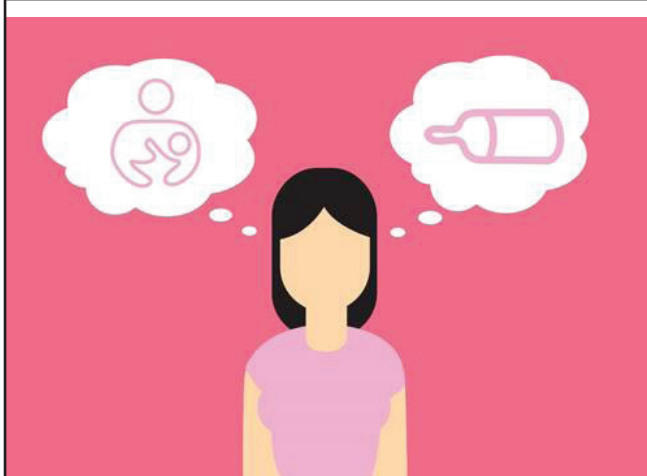


Illustration credit: Ken Tackett.

associated with partial breastfeeding and breastfeeding difficulties in the first weeks postpartum. Women who had epidurals were also twice as likely to stop breastfeeding by 24 weeks.

Similarly, mothers in the Survey of Mothers' Sleep and Fatigue, a study of 6,410 women with infants 0–12 months, birth interventions affected both breastfeeding and maternal mental health (Kendall-Tackett, Cong, & Hale, 2015). Women who had unassisted vaginal births had, by far, the highest rates of exclusive breastfeeding: 83% compared to 69% to 71% for all other types. Opioid pain medications had an even more devastating impact on breastfeeding, with only 24% exclusively breastfeeding.

Only 42% of women who had epidurals were exclusively breastfeeding. They were more likely to be mixed-feeding (65%) or exclusively formula-feeding (68%). Mothers who reported having an epidural also had higher depressive symptoms, even after controlling all other birth interventions, parity, the number of hours they were in labor, income and education, history of depression and sexual assault, current anxiety, and current anger and irritability (Kendall-Tackett et al., 2015). According to the Centers for Disease Control and Prevention (CDC), 61% of mothers have epidurals. The number is higher for White mothers (69%) and Black mothers (62%), based on 2008 statistics (the most current available; Osterman & Martin, 2011). Mothers with higher levels of education were more likely to have epidurals.

Birth Interventions and Maternal Mental Health

Maternal depression, anxiety, and posttraumatic stress disorder (PTSD) are all significant barriers to breastfeeding, and they are often a consequence of interventive births (Adedinsewo, Fleming, Steiner, Meaney, & Girard, 2014). This is an indirect way that birth interventions affect breastfeeding. For example, in the U.S. Listening to Mothers II survey, 9% met full criteria for PTSD, with 18% reporting clinically significant posttraumatic stress symptoms (Beck, Gable, Sakala, & Declercq, 2011). Similarly, a prospective study of 933 pregnant women in Australia found that 46% of women described their births as traumatic (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010). Their rates of PTSD were lower than U.S. studies, ranging from 3.6% to 6.3%, but the percentage of women with clinically significant depression and anxiety were concerning. Researchers assessed the women at 4–6, 12, and 24 weeks postpartum. Clinically significant depression ranged from 47% to 66%, and anxiety ranged from 58% to 74%.

A study from Belgium found that 4% of women met full criteria for PTSD at 6 weeks postpartum (De Schepper et al., 2016). Women were assessed at 1 week ($N = 340$) and 6 weeks postpartum ($N = 229$). More concerning was the high percentage of women with symptoms of PTSD: 22%–24% had symptoms at 1 week, and 13% to 20% had symptoms at 6 weeks. These symptoms are not surprising, considering the high percentage of interventions: 74% had epidurals, 33% were induced, and 22% had cesareans (61% of which were planned).

Medical interventions influence, and often block, the oxytocin system (Uvnas-Moberg, 2015). Because of that effect, they influence both breastfeeding and maternal mental health.

Why Birth Interventions Matter

Lactation consultants are often not there when practitioners decide to use these interventions. During a birth, interventions can absolutely be the best decision for both mother and baby. For example, a mother with a prolonged labor may benefit from an epidural. A baby who is in distress may need to be delivered by cesarean section. As lactation consultants, we often must work with what we have versus what we wished had happened.

However, we need to acknowledge that mothers may encounter problems breastfeeding if their births include interventions. That may mean watching them more closely for potential problems and ensuring that they have good follow-up in the community. In most cases, we should be circumspect when talking to mothers about the effects of

birth interventions. We do not inadvertently communicate to them that we think breastfeeding will fail because they have had interventions. Collectively, we can advocate for births that are both baby friendly and mother friendly. Until we provide mothers with continuous labor support, which lowers the rate of birth interventions, mothers will continue to struggle with breastfeeding.

Clinical Implications

Our attitude about birth interventions should be that they can be the right choice in certain situations. But like other types of medical interventions, there are benefits *and* risks. If mothers have birth interventions or traumatic births, they need extra support postpartum. We need to plan for that and make sure these mothers don't fall through the cracks. These procedures have an impact. Let's stop saying that they don't. Out in the wider world, actions have consequences. Why would this be less true for actions and interventions used during birth?

Provider Effects

During labor and early postpartum period, mothers have high levels of oxytocin. This makes them open and highly attuned to other people. If their interactions are positive, there are long-term positive effects. Conversely, they are quite vulnerable to negative interactions and attuned to pick up negative cues from others (Uvnas-Moberg, 2015). These negative interactions can also have long-term effects.

Healthcare providers have an enormous effect on breastfeeding in ways that they often do not even realize.

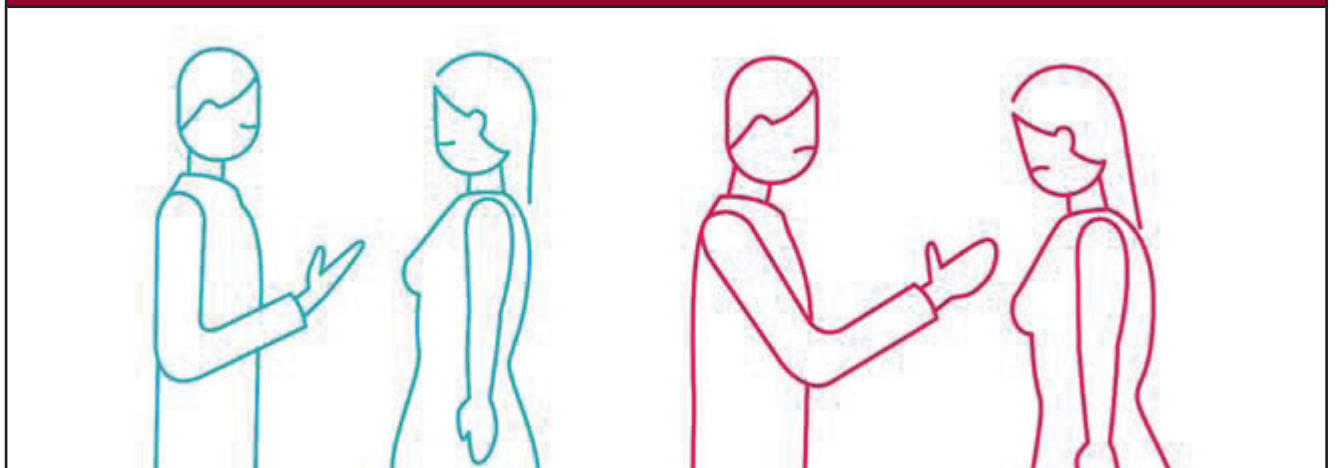
It's so much more than just providing information. Mothers often turn to healthcare providers for support and advice. Providers need to have accurate information to be sure. However, there is another important component that is frequently overlooked: providers' attitude about breastfeeding. A provider's attitude is something mothers have no control over. Unfortunately, it can influence mothers' ability to breastfeed, even when they are not consciously aware of it (Figure 2). It is another factor that can influence their "choice."

The effect of provider attitude is clearly shown in studies on the placebo effect. The placebo effect happens when providers are confident; patients believe that a treatment will work—and it does—even when they have received no active substance. For example, in depression research, the placebo effect reduces symptoms in 30% of patients. Because of the strength of the placebo effect, a medication must exceed 30% to show that it is efficacious (Sonawalla & Rosenbaum, 2002).

This effect can also work the opposite way. If a provider expresses that a treatment will not work, patients' beliefs can negate the effects of even powerful medications. This is called a nocebo effect. Nocebo effects also refer to patients experiencing side effects, even when they have received inert substances (Webster, Weinman, & Rubin, 2016). Research on the nocebo effect demonstrates the effect providers' negative attitudes can have.

Providers' negative beliefs about breastfeeding can become a nocebo and can undermine women's ability to feed their babies. Even if they say all the "right things," their attitude creeps through. High oxytocin means

Figure 2. Provider attitude can have a tremendous positive or negative impact on mothers' ability to breastfeed. Illustration credit: Ken Tackett.



Note. Illustration credit: Ken Tackett.

that mothers are highly attuned to providers' attitude. Unfortunately, providers' attitudes about breastfeeding, overall, have become more negative. A recent study of American pediatricians examined changes in their breastfeeding recommendations and beliefs from 1995 to 2014 (Feldman-Winter et al., 2017). On the positive side, the researchers found that pediatricians were more likely to recommend exclusive breastfeeding and a day 5 postpartum visit. They also were more likely to indicate that their hospitals had applied for baby-friendly status.

Unfortunately, these same pediatricians were significantly less likely to believe that mothers could successfully breastfeed, or that the benefits outweighed the risks, thus communicating with mothers that breastfeeding was unsafe (Feldman-Winter et al., 2017). Furthermore, only 47% referred mothers to community support groups, and 47% recommended avoiding pacifiers until breastfeeding is established. In addition, pediatricians felt less confident that they could manage breastfeeding problems.

These findings are ominous. Of all healthcare providers, American mothers are most likely to turn to their pediatricians. These doctors are saying all the politically correct things. Yes, "breast is best." Yes, mothers should exclusively breastfeed. And yes, their hospitals should be baby friendly. Yet, their attitude communicates something else. Practitioner's lack of confidence can come out subtly, as an off-hand remark or facial expression. They can suggest that the mothers *try* breastfeeding, implying that it probably won't work. Or it may be more direct, with a quick use of supplements rather than trying to solve the problem. Confidence is so important in breastfeeding support. Tina Smillie often says we must "ooze confidence" that breastfeeding will succeed. If pediatricians lack confidence, mothers will know.

Fortunately, we can address this lack of confidence. A Swedish study found that training that provides both factual information and addresses providers' beliefs can increase mothers' breastfeeding success (Ekström & Thorstensson, 2015). In this study, 585 mothers were randomly assigned to providers who were in either the intervention or control group. In the intervention group, midwives and child health nurses were given process-oriented training, which included participants' processing and self-reflection about their own breastfeeding experiences and practical counseling skills and how to work with other providers. Providers in the control group were provided with training on evidence-based practices on breastfeeding support (i.e., the type of training providers typically receive in the United States).

Mothers were blinded to the treatment condition of their healthcare providers, so they did not know what kind of training their providers received.

At 1-year postpartum, mothers in the intervention group believed that they received more support, even from providers who were not in the study, than mothers in the control group. This suggests a halo effect due to oxytocin. The mothers received positive input during their sensitive period, and they were so happy with the care they received that they felt supported, even when with other providers. This is similar to the effect of having a doula during labor.

The care they received influenced their breastfeeding. Mothers in the intervention group initiated breastfeeding earlier, breastfed more frequently during the first 24 hours, and used formula less often in the hospital and after discharge. After discharge, mothers were more satisfied and had fewer breastfeeding problems, such as insufficient milk, and they breastfed longer. They also felt more positively about their babies than mothers in the control group. This study was conducted in Sweden, a country with one of the highest breastfeeding rates in the world. Even there, provider attitude made a difference.

Ekström and Thorstensson's (2015) findings suggest that addressing practitioner attitude is important for mothers' breastfeeding success. If mothers are treated badly during labor, or they sense negative attitude from their providers postpartum, they close down and become less receptive to practitioners who try to help. So many providers have had personal negative breastfeeding experiences. We need to acknowledge the trickle-down effect that these experiences have. We must also improve the care that we provide to other healthcare providers as their experiences can potentially impact thousands of mothers.

Implicit and Systemic Bias

Provider beliefs and stereotypes can impact mothers in another important way: the amount of breastfeeding support offered to them while in the hospital. This has been shown regarding both race/ethnicity and mothers' body mass index (BMI). In both cases, providers made presumably unconscious decisions about who would receive care that supports breastfeeding, and it impacted mothers' breastfeeding experiences.

Race/Ethnicity

A study from the CDC found that predominant race and ethnicity of a neighborhood influenced

how much support hospitals in those neighborhood provided to mothers (Lind, Perrine, Li, Scanlon, & Grummer-Strawn, 2014). This study used data from the 2011 mPINC survey. The mPINC survey is a biennial census of maternity facilities in the United States ($N = 2,727$). The data were analyzed for WHO/UNICEF's Ten Steps to Successful Breastfeeding, the basis for the Baby-Friendly Hospital Initiative. They analyzed data for a 5-year period and compared zip codes that had a population >12.2% African American or non-Hispanic Black with zip codes where the population had <12.2% Black. They found that women living in a zip code with higher percentages of Black residents had less access to facilities implementing recommended maternity-care practices. Specifically, these facilities were less likely to encourage early initiation of breastfeeding, were more likely to use breastfeeding supplements and pacifiers, and less likely to provide rooming-in and post-charge support. The authors speculated that these practices likely contributed to the lower rates of breastfeeding among African Americans.

Size Bias

A similar pattern of systemic bias exists for women with a BMI >30 kg/m². This is another group of mothers with consistently lower rates of both breastfeeding initiation and duration (Donath & Amir, 2008; Mehta, Siega-Riz, Herring, Adair, & Bentley, 2011; Oddy et al., 2006). One study hypothesized that women with a BMI >30 kg/m² have lower breastfeeding rates because they have lower prolactin in response to suckling (Rasmussen & Kjolhede, 2004). This study was quite limited and only included 17 women with BMIs >25 kg/m². The hypothesized link only appeared on one of the two assessment days. Furthermore, the proposed mechanism for lower prolactin in response to suckling, progesterone in the adipose tissue, was not supported by their data. In other words, the data did not support their hypothesized mechanism. Unfortunately, this study is cited often, perhaps, because it reinforces providers' biases. Behavior of hospital staff more likely accounts for the difference in breastfeeding rates in mothers with a BMI >30 kg/m².

Mothers with higher BMIs are more likely to experience more birth interventions, including planned cesarean sections (Marshall, Guild, Cheng, Caughey, & Halloran, 2010; Poobalan, Aucott, Gurung, Smith, & Bhattacharya, 2009). This can account for some of the difference in breastfeeding rates, but it is not the whole picture. Using Pregnancy Risk Assessment Monitoring System data ($N = 19,145$) from three U.S. states, researchers found that if women had a prepregnancy BMI >30 kg/m², they were significantly less likely to

initiate breastfeeding than mothers with a prepregnancy BMI <26 kg/m² (Kair & Colaizy, 2016). Providers' biases come into play here too. Specifically, practitioners were significantly less likely to offer mothers with BMIs >30 kg/m² breastfeeding support in the hospital. They had higher odds of using a pacifier in the hospital and lower odds of hospital personnel providing them with information about breastfeeding, breastfeeding in the first hour after delivery, being given a telephone number for breastfeeding help, rooming in, or being instructed to breastfeed on demand. The authors concluded that obesity stigma might underlie the outcomes for mothers with BMIs >30 kg/m². This is really quite unacceptable and reflects nothing more than size bias.

Clinical Implications

We need to be aware that our attitudes and biases matter. Mothers are so susceptible to our influence during the postpartum period. If we have negative attitudes, we need to be able to process them in a safe environment. Breastfeeding education is not only about information. Our beliefs about it—and about mothers—make a difference.

Conclusions

Many mothers struggle with breastfeeding and stop before they want to. For them, hearing the “breast is best” message adds to their feelings of failure. They use formula not because they choose to but because so many barriers were put in their way. They must feed their babies. The very systems that were supposed to support them undermined them. In many cases, mothers had no choice. No wonder some mothers push back and become avid apologists for formula. When we look at the history of many of the prominent antibreastfeeding organizations, we often see women who were not able to breastfeed at the helm. They didn't fail. The system did. If we are going to improve breastfeeding rates, we must address the systemic and provider barriers that undermine it.

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Global Breastfeeding Scorecard

The Global Breastfeeding Collective has released "Enabling Women to Breastfeed Through Better Policies and Programmes: Global Breastfeeding Scorecard 2018": <http://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2018/en/>. The Global Breastfeeding Scorecard periodically reviews national progress on implementing seven actions needed to enable women to breastfeed, including funding of breastfeeding programs, regulation of marketing of breast-milk substitutes, maternity protection in the workplace, compliance with the Baby-Friendly Hospital Initiative, access to breastfeeding counselling and training, availability of community support programs, and consistent monitoring. The scorecard reports that only 41% of babies younger than 6 months of age are exclusively breastfed. The interactive website includes country profiles and world maps to display data.

Source: USBC