Can Breastfeeding Ease the Effects of Racism and Discrimination?

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Editorial

The summer of 2016 will go down in history as a particularly awful one in terms of gun violence in the United States. Black men and police officers being shot, and the horrific shooting deaths of patrons of a gay club in Orlando, Florida. We grieve those losses and hope that changes in our system will result. Only time will tell if that happens.

In the face of these violent events, and the discrimination that led up to them, is breastfeeding even relevant? The short answer is yes. Breastfeeding can't stop racism and discrimination, but it can protect new mothers from their effects. To understand why this is so, you need to understand what happens to people physiologically when others discriminate against them.

The Biology of Discrimination

A fascinating book called *Social Pain* summarizes many studies and describes the neurobiology of social exclusion (Dickerson, 2011; Eisenberger, 2011). The basic premise is this: We are designed to be in relationships with others. It's important for our survival. When we are not—when we are excluded—our stress response is triggered, including the inflammatory response system. These are our survival mechanisms. Social exclusion activates the same part of our brains as physical pain—the anterior cingulate cortex (ACC). The ACC is the same part that is activated for other mammals in the separation-distress response. The response to social exclusion is hardwired for all mammals, including human beings.

The act of discrimination says to the recipient, "You are not one of us. You are not part of our group." These behaviors can be in the form of threats of overt violence, or they can be in the form of microagressions. Some people dismiss microaggressions, saying that people are "too sensitive." Sometimes, that can be the case. There could be misunderstandings. But what we need to keep in mind is how it affects the people who experience them. These often careless utterances still have a physiological effect on the person who hears them. Microaggressions tell people that they are being excluded from the group, and that is why it is important to be aware of them.

So what happens when people experience discrimination on an ongoing basis? You get a chronic activation of the stress response system, which increases chronic inflammation and disturbed sleep. Many researchers have studied this effect. One study asked a series of questions, such as "you get poorer service in restaurants or stores," or "people think you are not smart." The more of these questions that people said yes to, the higher their levels of inflammation (Lewis, Aiello, Leurgans, Kelly, & Barnes, 2010).

Inflammation and disturbed sleep are physiological time bombs and increase rates of heart disease, diabetes, and body mass index (BMI) >30—in other words, the exact pattern you see in many of our minority populations (Suarez & Goforth, 2010). The obesity statistics are particularly relevant. Consistently, what you see across countries, that marginalized populations tend to have higher BMIs. The more marginalized they are, the higher the percentage of people with a BMI >30. In the United States and United Kingdom, women of African descent have the highest rates. But other groups, such as American Indians and people from Southeast Asia, tend to also have a higher percentage of people with BMIs >30 than Whites. In the United Kingdom, Irish are split out as a separate group from British Whites. Interestingly, a similar pattern of higher BMIs emerges. You also see a similar pattern for people who have lower incomes (Goodman, McEwen, Huang, Dolan, & Adler, 2005).

The Critical Role of Breastfeeding

Exclusive breastfeeding acts as a powerful counter to these physiological effects (Groer & Kendall-Tackett, 2011). It is one of the mechanisms that downregulates, or turns off, the stress response. Baby at the breast actually lowers two important stress hormones in the short term: adrenocorticotropic hormone (ACTH) and cortisol. Furthermore, when the researchers tried to stress the mothers in their study, they couldn't because of the lovely little cloud floating around them (Heinrichs et al., 2001). In other words, it was a short-term lessening of the stress response. When mothers experience that day after day, it lowers lifetime risk of the number one killers of women in the United States—heart disease and diabetes—in a study of 139,000 women with a mean age of 63 years (Schwartz et al., 2009).

There is an important caveat to these findings: In most of these studies, *exclusive breastfeeding* lowered risk, partial breastfeeding did not. In our study of 6,410 new

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mothers, we found that exclusive breastfeeding improved mothers' sleep, lowered their risk of depression, and had a dramatic effect on self-reported anxiety and anger (Kendall-Tackett, Cong, & Hale, 2011). This was even true when women had a history of sexual assault, which puts them at high risk for both sleep problems and depression. There was still an effect of the sexual assault, but it was significantly lower (Kendall-Tackett, Cong, & Hale, 2013).

I was honestly surprised that we found no significant difference between partial breastfeeding and exclusive formula feeding. I thought we would see a dose–response effect: The more they breastfed, the better the response. Instead, we found a threshold effect: that exclusive breastfeeding is a very different physiological experience than partial breastfeeding. It is one more reason to continue to support exclusive breastfeeding wherever possible.

How Shall We Then Treat?

As individuals, and as a culture, we must continue to eliminate discrimination. One way for you to do that locally is to foster trust and then have open discussions with the population you serve. How do they describe themselves? Is there any terminology that they find offensive? A Jewish friend once told me that the term *Nipple Nazi* was highly offensive to her and asked that I not ever use it. I hate that expression too, so I was happy to comply with her request. Other terms may seem more benign to you, and you don't understand why they are problems. The best strategy is to ask.

As a woman with a disability, I've been on the receiving end of many microaggressions. For example, I have a hard time with stairs, so a conference organizer once volunteered to "carry" me up the stairs—a very demeaning way to speak to me. I'm sure she was trying to help and had no idea how offensive that was. It took me a long time before I started speaking up, and it was only after I was actually injured at a conference because the organizers ignored my requests.

Sometimes, these conversations can be uncomfortable and really tense. I've seen some ugly ones that were not at all productive. So it's important to set some ground rules about communicating respectfully, even if frustrated. And you'll probably make some mistakes along the way. But having these conversations will deepen your relationships within the community and will make you even more effective in helping the women you serve.

In summary, breastfeeding can be a radical act that helps women who experience discrimination take back their health. American Indian lactation consultant and social worker, Camie Goldhammer, describes breastfeeding as "food sovereignty," a powerful way to take back your culture. You can help women overcome the physical effects of discrimination, one woman at a time. By doing so, these women can become powerful agents for change the broader culture.

Thanks for all you do for mothers and babies. You make a radical difference.

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References

Dickerson, S. S. (2011). Physiological responses to experiences of social pain. In G. MacDonald & L. A. Jensen-Campbell (Eds.), *Social pain: Neuropsychological and health implications of social loss and exclusion* (pp. 79–94). Washington, DC: American Psychological Association.

Eisenberger, N. I. (2011). The neural basis of social pain: Findings and implications. In G. MacDonald & L. A. Jensen-Campbell (Eds.), *Social pain: Neuropsychological and health implications of loss and exclusion* (pp. 53–78). Washington, DC: American Psychological Association.

Goodman, E., McEwen, B. S., Huang, B., Dolan, L. M., & Adler, N. E. (2005). Social inequalities in biomarkers of cardiovascular risk in adolescence. *Psychosomatic Medicine*, *67*, 9–15.

Groer, M. W., & Kendall-Tackett, K. A. (2011). *Clinics in human lactation, Vol. 9: How breastfeeding protects women's health throughout the lifespan: The psychoneuroimmunology of human lactation*. Amarillo, TX: Hale.

Heinrichs, M., Meinlschmidt, G., Neumann, I., Wagner, S., Kirschbaum, C., Ehlert, U., & Hellhammer, D. H. (2001). Effects of suckling on hypothalamic-pituitary-adrenal axis responses to psychosocial stress in postpartum lactating women. *The Journal of Clinical Endocrinology and Metabolism*, *86*, 4798–4804.

Kendall-Tackett, K. A., Cong, Z., & Hale, T. W. (2011). The effect of feeding method on sleep duration, maternal well-being, and postpartum depression. *Clinical Lactation*, *2*(2), 22–26.

Kendall-Tackett, K. A., Cong, Z., & Hale, T. W. (2013). Depression, sleep quality, and maternal well-being in postpartum women with a history of sexual assault: A comparison of breastfeeding, mixed-feeding, and formula-feeding mothers. *Breastfeeding Medicine*, *8*(1), 16–22.

Lewis, T. T., Aiello, A. E., Leurgans, S., Kelly, J., & Barnes, L. L. (2010). Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults. *Brain, Behavior, and Immunity*, *24*(3), 438–443.

Schwarz, E. B., Ray, R. M., Stuebe, A. M., Allison, M. A., Ness, R. B., Freiberg, M. S., & Cauley, J. A. (2009). Duration of lactation and risk factors for maternal cardiovascular disease. *Obstetrics and Gynecology*, *113*(5), 974–982.

Suarez, E. C., & Goforth, H. (2010). Sleep and inflammation: A potential link to chronic diseases. In K. A. Kendall-Tackett (Ed.), *The psychoneuroimmunology of chronic disease* (pp. 53–75). Washington, DC: American Psychological Association.

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