HEALTH PROFESSIONAL ACADEMY®

Breastfeeding: Preparing women for the fourth trimester

This CPD module can be used by GPs, Health Visitors, Midwives and Maternity Support Workers

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In the first 3 months after their baby is born, women have to recover from giving birth, adapt to plunging hormone levels and learn to change nappies, bathe, feed and care for their babies. Women often struggle to breastfeed and lack confidence in their ability to provide sufficient milk, leading many to give up breastfeeding before they really want to. This module aims to help health professionals prepare women for the fourth trimester, enabling them to breastfeed for longer.

Learning Objectives

After reading this module and completing the online assessment, you should:

- Have a good understanding of the common reasons women stop breastfeeding
- Understand the psychological impact of early cessation of breastfeeding
- Be able to prepare women for their fourth trimester, enabling them to breastfeed for longer

Questions

Visit our website to test your knowledge.
Our questions cover:

- Reasons women stop breastfeeding
- Antenatal preparation
- Breastfeeding guidance and support

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FOR HEALTH PROFESSIONALS ONLY

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Preparing for the fourth trimester

The fourth trimester refers to the first 3 months following birth, when a baby is adjusting to life outside the uterus and its mother is recovering from giving birth, learning to breastfeed and adjusting to parenthood. After the euphoria of giving birth, hormones, tiredness and the responsibility of caring for a baby can create a challenging emotional rollercoaster. Attention is focused on the baby, and the mother has little time to think of her own wellbeing. Before the baby arrives, health professionals can help prepare women for the realities of breastfeeding and the significant physical and emotional changes they will experience. If women are informed of the potential challenges ahead, they will be more prepared to deal with any difficulties and better able to appreciate the many highs of motherhood.

Breastfeeding and mental health

Transient low mood, often referred to as the 'baby blues', is common following birth. Some observational studies give an estimated prevalence of up to 85%.[1] Symptoms may include insomnia, fatigue, tearfulness, anxiety, irritability, impaired concentration and mood lability.[2] These symptoms usually peak around Day 2-3 and resolve by Day 5.[2]

Postnatal depression (PND) is more serious but affects far fewer women (around 4.5 to 28%).[1] It presents as a low mood, poor sleep, tearfulness and feelings of helplessness, which continue for more than 2 weeks. It can be extremely distressing but commonly resolves within a few months.[2] However, about one third of women who have PND are still unwell one year after childbirth, and about 13% after 2 years.[2] Risk factors include a personal or family history of depression, lack of social support, poor partner relationship, young age, stressful life events and adversity.[2]

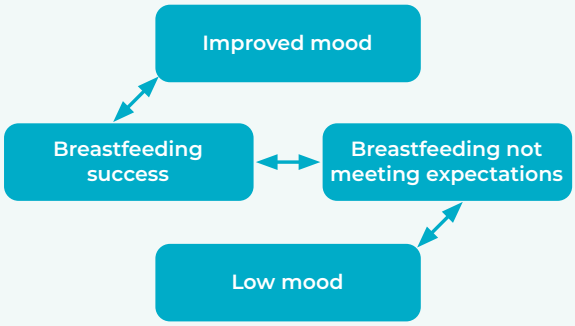
Postpartum psychosis (puerperal psychosis) is a severe mental illness affecting about 1-2 mothers in every 1000 (0.1%).[3] Women are at more risk if they have:

- A personal or family history of mental health illness
- A diagnosis of bipolar disorder or schizophrenia
- Had a traumatic birth or pregnancy
- Developed psychosis after a previous pregnancy

Psychotic symptoms (such as hallucinations, delusions, manic or low mood, paranoia and extreme confusion) present suddenly within 2 weeks postpartum, and usually require hospital treatment.[2] The worst symptoms tend to resolve within 2-12 weeks and although most women do make a full recovery, some women do not fully recover and may be unable to care for themselves or their babies.

Health professionals should be aware that poor mental health may threaten breastfeeding success.[4] Depressed mothers are less likely to initiate or continue breastfeeding. Furthermore, mothers who do not breastfeed are at greater risk of depression.[2] Women who find they cannot breastfeed when they had planned to may be most vulnerable.[5] Many women believe that breastfeeding will be simple and then when they have difficulties, they feel guilty, upset and a failure. In a cross-sectional self-report survey of 217 women, Brown *et al* (2016) found that having to stop breastfeeding due to physical difficulties and pain was particularly predictive of a high depression score.[5]

Figure 1: Relationship between breastfeeding and mood



Fortunately, as well as its many other health benefits, breastfeeding provides important emotional and psychological benefits.[6,7] Oxytocin and prolactin, the hormones responsible for lactation, promote nurturing and relaxation. Krol and Grossmann (2018) compared evidence of psychological effects from mothers who breastfed with those who didn't, and found that breastfeeding mothers:

- Report reductions in anxiety, negative mood and stress
- Have lower blood pressure and heart rate reactivity
- Have lower cortisol responses when faced with stress
- Have longer and better quality sleep patterns
- Respond better to emotions in others
- Show more sensitivity and secure attachment with their babies[6]

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All our online CPD modules are developed in partnership with a team of leading academics, so you can be sure the module you've chosen is credible, referenced and up to date. All information by HPA is in line with guidance from the NHS, NICE and Royal Colleges, as well as Unicef's Baby Friendly Initiative.

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Breastfeeding mothers are thought to benefit from lower rates of depression. There is some evidence that breastfeeding protects against depression and helps women recover faster from depressive symptoms.[6] However, a systematic review and meta-analysis (Chowdhury *et al* 2015) found that evidence of a clear association between breastfeeding and maternal depression was lacking.[8]

Breastfeeding often stops in the fourth trimester

Although intention to breastfeed is high with 81% of mothers initiating breastfeeding at birth, the 2010 UK Infant Feeding Survey (IFS) found that many women stopped breastfeeding in the first few weeks, with only 17% of mothers exclusively breastfeeding at 3 months, and just 1% of mothers achieving the recommended 6 months of exclusive breastfeeding.[9]

Reasons for stopping are complex and may encompass physical difficulties, pain, social pressures, inconvenience, embarrassment, poor body image or feeling unsupported, but finding breastfeeding difficult is a common feature. In the IFS, the most frequently cited reason mothers gave for stopping breastfeeding was the *perception* that they had insufficient milk (31%).[9] Other reasons given were:

- Problems with the baby not latching on properly (19%)
- Painful breasts or nipples (12%)
- Baby feeding too often or being constantly hungry (10%)
- Breastfeeding taking too long or being too tiring (8%)[9]

Pain following vaginal or Caesarean birth also contributes to early cessation of breastfeeding. In a UK survey of 1000 women, over a quarter of respondents (26%) who couldn't follow their breastfeeding plan reported that pain relating to the birth impacted their ability to breastfeed.[10] Holding their infant, picking up their infant and sitting comfortably to breastfeed were all painful for many respondents.

Women who have a Caesarean birth may have more difficulties with breastfeeding. Though NICE state that women birthing by lower segment Caesarean section are no more likely to discontinue breastfeeding than women who give birth vaginally, a prospective survey (Hobbs *et al* 2016) of 3021 women found that those who had a planned Caesarean section were more likely to discontinue breastfeeding before the end of the fourth trimester compared to those who gave birth vaginally.[1,11]

In the IFS, many women (63%) who stopped breastfeeding over the survey period reported that they would have liked to have breastfed for longer.[9] This emphasises how crucial it is that mothers are educated about breastfeeding antenatally so that they can negotiate challenges with confidence. Although there is little evidence of a clear link between breastfeeding and maternal mental health, enabling women to breastfeed for longer may be key in helping to prevent postnatal depression.

What helps mothers to continue breastfeeding?

The main factors that mothers report could influence them to breastfeed for longer are:

1. More support and guidance from hospital staff, midwives and family (17%)
2. If the baby had latched on the breast easier (17%)
3. Naturally producing more milk (15%)
4. Less pain and being more comfortable (10%)[9]

It is vital these issues are addressed antenatally so that women are able to continue breastfeeding when they encounter difficulties. There is evidence that good antenatal preparation enhances breastfeeding initiation rates.[9] Mothers who recall receiving information about the benefits of breastfeeding are more likely to initiate breastfeeding (83% compared with 73% of those who do not recall receiving information).[9] Breastfeeding support interventions have also been found to be effective in reducing early breastfeeding cessation.[12] In the IFS, fewer mothers stopped breastfeeding in the first 2 weeks when they received support with breastfeeding in the hospital, birth centre or unit (26% of mothers who were given support versus 34% of mothers who were not) and after returning home (15% versus 27%).[9] However, a Cochrane Review (2016) found no good evidence from randomised controlled trials to suggest that antenatal education translates into longer breastfeeding, and ensuring antenatal education services for all women is a huge challenge.[13]

Providing support and guidance

Prior to giving birth, women (and their partners and wider family) should be informed about the reality of breastfeeding and the physical and emotional changes they will experience.[1] Health professionals must ensure mothers are fully informed about the benefits of breastfeeding, know what to expect when they give birth and the support that will be available to make breastfeeding successful.[1]

Some women may have had little exposure to breastfeeding, lack support from friends and family, and have no practical experience of caring for a baby. As well as teaching women how to hold and care for a baby, antenatal classes should cover the most important aspects of breastfeeding, such as the benefits of colostrum, establishing the milk supply, positioning and attachment, expressing and how to manage common

problems, such as engorgement and mastitis. Educating mothers as to what normal patterns of breastfeeding are like, how to ensure their baby latches onto the breast correctly, the signs that their baby is receiving sufficient milk, and how to manage any pain or discomfort may play an important role in reducing both breastfeeding difficulties and emotional distress. Partners also need support to adapt to their new role and should be included in antenatal education too.[14]

Babies need to be supported to use their instinctive behaviours which can be facilitated by the mother adopting a laid-back breastfeeding position.[15] Uninterrupted skin-to-skin contact and initiation of breastfeeding should be encouraged as soon as possible after birth, ideally within one hour. From this first feed, women should be offered skilled 'hands-off' support to enable them to achieve comfortable positioning and ensure the baby learns to attach successfully to establish effective feeding and prevent concerns such as sore nipples.[1]

Additional support should be offered to women having a:

- General anaesthetic or opioid analgesic (e.g. pethidine) as the baby may not initially be responsive to feeding
- Caesarean section, to assist with lifting and positioning the baby to protect the abdominal wound
- Delayed initiation of breastfeeding or separation from their baby[1]

Women who are obese also require additional support. Women with a BMI > 30 kg/m^2 are less likely to initiate lactation, have delayed lactogenesis, lowered prolactin responses to suckling and are prone to early cessation of breastfeeding.[16] Furthermore, comfortable positioning of the baby at a larger breast may be a challenge.

Extra support is also needed to ensure successful breastfeeding in women who have diabetes. Diabetes can delay lactogenesis.[17] Also, babies born to diabetic mothers have a higher risk of hypoglycaemia following birth. Prompt feeding is required to raise the baby's blood sugar levels. In preparation for birth, diabetic mothers may need to express their colostrum and freeze it, so there is extra colostrum readily available should their baby need it.[18]

Women need to know that when they return home, they will receive support from skilled health professionals and mother-to-mother support in their community. Women should be helped to identify a wide support network, which may include members of local breastfeeding support groups, as they will benefit from having partners or friends who can provide both emotional and practical support.

A Cochrane Review (2017) found that the key characteristics of effective postnatal support included support delivered by trained health professionals or lay supporters or both; ongoing scheduled visits tailored to individual needs and face-to-face support.[12] Support that is only offered reactively, in which women are expected to initiate the contact, is unlikely to be effective.[1] Healthcare professionals should discuss progress with breastfeeding at every postnatal contact, and identify any need for further support.[1] This should be documented in the care plan.

Ensuring baby is latching on well

As part of their antenatal education, women should be informed that improper latching may begin a cascade of negative events that undermine breastfeeding, including nipple pain, ineffective milk transfer and insufficient milk production.[19] Women should be advised of the indicators of good attachment and successful breastfeeding (see Box 1).[1]

Box 1: Indicators of breastfeeding success

Indicators of good attachment and positioning:

- Baby's mouth wide open
- Less areola visible below the lips than above them
- Chin touching the breast
- Lower lip rolled down and nose free
- No pain

Indicators of successful feeding in babies:

- Audible and visible swallowing
- Sustained rhythmic suck
- Relaxed arms and hands
- Moist mouth
- Regular soaked/heavy nappies

Indicators of successful breastfeeding in women:

- Breast softening
- No compression of the nipple at the end of the feed
- Woman feels relaxed and sleepy[1]

Producing sufficient milk

Perceived milk insufficiency is the most common reason women give for early cessation of breastfeeding.[9] Many women worry that they do not have enough milk, when in fact they have plenty. Very few women (less than 5%) are biologically incapable of producing sufficient milk.[19] Prior to giving birth, it needs to be explained that women produce only small amounts of nutrient-rich colostrum in the first few days, that larger amounts of milk will not 'come-in' until around Day 3, and that milk supply is under local autocrine control. Suckling, skin-to-skin contact and removal of milk stimulates the breast to produce milk, so the amount of milk the mother makes will increase or decrease depending on how often her baby feeds. Most women will just need to ensure their baby is well attached and that they are feeding often enough.[1]

Feeding patterns

Unrealistic feeding schedules can be the source of much frustration and disappointment. It needs to be explained that babies have very small stomachs so they need to feed frequently to meet their needs. In the first few days, babies take just a teaspoonful of colostrum at each feed but may want to feed every hour. After a few days, they begin to have fewer, but longer feeds and as they grow, may tend to cluster feed in the evening in preparation for longer stretches of sleep.

As a rough guide, women can expect to feed their baby at least 8 to 12 times, every 24 hours during the first few weeks. Women who are not expecting their baby to feed this often may assume that their milk isn't satisfying their baby and offer formula instead or try to teach their baby to go longer between feeds. Less stimulation of the breasts will then reduce the milk supply.[5]

Reciprocal and responsive breastfeeding with unrestricted frequency and duration should be explained. Mothers need to breastfeed whenever their baby shows signs of hunger, such as increased alertness, activity, mouthing, turning their head and opening their mouth (rooting) and making murmuring sounds, including during the night. Night-time breastfeeds are essential for both initiation and maintenance of breastfeeding, as they have a much greater effect on the hormone (prolactin) needed to support milk production.

Mothers need to keep their babies close so that they can respond to their baby's need to feed before their baby becomes distressed. Keeping the baby close with lots of skin-to-skin contact (particularly in the early neonatal period) will promote bonding and help the baby feel calm and secure. Babies who sleep alone are at more risk of sudden infant death syndrome (SIDS) compared to those who sleep in the same room as a parent, including for naps.[20]

Sleeping patterns

Parents may be under the impression that good babies sleep through the night, but expecting babies to sleep for prolonged periods is unrealistic and unsafe. Babies wake because they need feeding and reassurance that their mother is there. Newborns sleep for 18-20 hours a day, but tend to wake every 2-3 hours - sometimes more.[20] By the time babies are 3 months old, some sleep for stretches of up to 5 hours. Generally though, babies do not sleep all night until they are about a year old. After this first year, overall sleep duration falls to about 15 hours, and the baby spends more time sleeping at night. However, there is a lot of variation.[20] Therefore, women should not worry if their baby doesn't sleep through the night by a particular age.

Coping with fatigue

Tiredness will be experienced by most mothers. Disturbed nights can be hard to cope with. Women should consider sleeping (or at least resting) whenever there is a gap in their baby's demands. Hot flushes and postpartum night sweats may occur in the first weeks after giving birth. These can also disturb sleep and cause irritability, but they will pass. In a study involving 429 women, 29% reported postpartum hot flushes.[21] These peaked at 2 weeks postpartum and then declined, presumably as hormone levels normalised.

The importance of continuing to breastfeed despite tiredness should be reinforced. Breastfeeding is facilitated by sleeping near the baby and mothers who sleep near their baby get more sleep and report more weeks of breastfeeding.[20] Emotional support and practical help from a partner can be invaluable and allow the mother to rest. Once breastfeeding is established, a partner may be able to help further by feeding the baby expressed breastmilk.

Addressing pain and discomfort

Many women who stop breastfeeding before they want to, report that having less pain and being more comfortable could have helped them breastfeed longer.[9] There are things that they will be able to do to ease any discomfort so that they can continue breastfeeding. Women should be reassured that brief discomfort at the start of feeds in the first few days is not uncommon. Oxytocin, released when breastfeeding, makes the uterus contract. Mothers are likely to feel quite painful period-like cramps and notice their lochia (bleeding which soon reduces to streaking on a pad and stops within 24-36 days) is redder and heavier following a feed.[22] Problems such as sore or cracked nipples and painful breasts often occur when the baby is not positioned or attached well at the breast. Women need reassurance that they can seek support so that these issues can be addressed promptly (as detailed in the module *Supporting parents through early breastfeeding challenges*) and will be able to continue breastfeeding.

Perineal pain is a common complaint.[1] Up to 90% of first-time mothers who have a vaginal birth will have some sort of perineal trauma in the form of a tear or episiotomy.[23] Antenatal educators should inform women of the likelihood of a perineal wound and how to look after it.[24] Surgical repair of perineal damage uses dissolvable stitches. To enable optimal healing, suturing is commenced within an hour of the birth - during the critical time of skin-to-skin contact when breastfeeding is initiated.[25] Mothers can usually continue to hold their baby skin-to-skin during suturing, provided they are alert and have adequate pain relief.[26] A good suturing technique helps. The stitches will have dissolved by the time the wound has healed (within a month).[27] Pelvic floor exercises can strengthen the muscles around the vagina and may increase blood flow to the area, thus increasing white cell activity and aiding removal of damaged tissue. Prolonged sitting should be avoided. Topical cold therapy (i.e. applying an ice pack or cooled compress) can provide pain relief and does not delay healing.[1] If oral analgesia is required, paracetamol should be used. If this is not effective, a non-steroidal anti-inflammatory may be considered. It's unusual for pain to last longer than 2 to 3 weeks.[23]

Summary

Good antenatal breastfeeding education helps prepare women for the fourth trimester and may enable them to breastfeed for longer. This may be key in reducing the risk of postnatal depression. Women also require reassurance that the stage when their baby will take up all their physical and emotional energy won't last forever. As the baby grows the mother will start to sleep longer at night. Her body will gradually recover, feeding will become more comfortable, and baby blues will pass as her hormone levels settle down. Regardless of how long their breastfeeding journey lasts, and how many challenges are encountered, mothers should be encouraged to take pride in their breastfeeding achievements and focus on the progress being made.

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How you can support mums to breastfeed during the fourth trimester

In the first 3 months after their baby is born, women have to recover from giving birth, adapt to plunging hormone levels and learn to change nappies, bathe, feed and care for their babies. Women often struggle to breastfeed and lack confidence in their ability to provide sufficient milk, leading many to give up breastfeeding before they really want to.

Lansinoh® - a company founded by a mother with a passion to support and encourage breastfeeding – have a range of breastfeeding products to assist new mums in providing their babies with the best start in life.

Here are four Lansinoh® products that can help overcome common breastfeeding challenges you may be asked about by mothers in your care.

Breastfeeding Pillow

When a mother finds a comfortable breastfeeding position, her baby is more likely to have a deep latch and feed efficiently. Unlike a traditional U-shape or V-shape nursing pillow, Lansinoh's Breastfeeding Support Pillow slips over the arm rather than around the waist allowing mums to lift their baby comfortably to the breast rather than leaning forward. The pillow's ergonomic design promotes good posture, reduces back strain and eases aching wrists and shoulders.

A breastfeeding pillow is ideal for women recovering from a c-section, as it keeps pressure away from the mother's abdomen during feeds.

Nipple Shields

Lansinoh® Contact Nipple Shields can be used as an effective, short term tool to support mums to breastfeed, under the encouragement, support and appropriate advice of a healthcare professional. The shields can be used to help with flat or inverted nipples, tongue and/or lip tie, and overactive let-down. They can also be used for feeding a premature, small or ill baby.

Latch Assist™

Using Lansinoh LatchAssist™, mothers can gently draw the nipple out just long enough for baby to grasp the nipple and areola and establish a good latch, which is the first step in successful breastfeeding. Simple, effective and easy to operate with one hand, this is the ideal solution to what can be a troubling issue for new mums.

Thera°Pearl 3-in-1 Breast Therapy packs

The Lansinoh® Thera°Pearl Breast Therapy packs can be used hot or cold to help relieve mastitis, engorged breasts and plugged ducts. Flexible and reusable, Thera°Pearl 3-in-1 Breast Therapy packs have soft covers that can be slipped comfortably inside the bra to relieve any discomfort caused by some conditions associated with breastfeeding. This product can also be used with a breast pump to encourage milk let-down.

Exclusive breastfeeding is recommended for the first six months of a baby's life. Breastfeeding should continue alongside complementary foods for up to two years, in line with the World Health Organisation (WHO) and national health recommendations to promote and support breastfeeding.

You can discover more about helping mums to breastfeed at:
www.lansinoh.co.uk/professional

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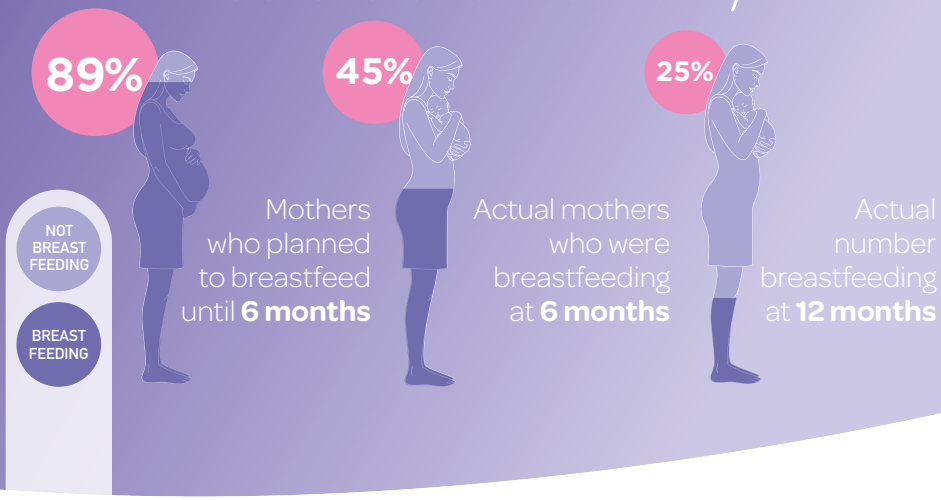
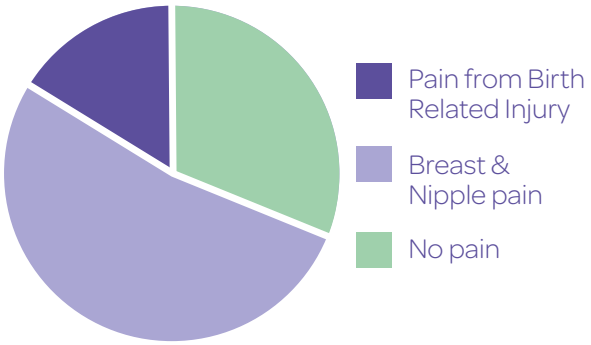
THE IMPACT OF BIRTH RELATED INJURY AND PAIN ON BREASTFEEDING OUTCOMES*

Mum's plan on breastfeeding before birth vs reality



Was the drop in rate due to pain?

71% EXPERIENCED DISCOMFORT OR PAIN WHILST BREASTFEEDING



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* Study based on 1000 UK women, youngest child was under 24 months all recently completed their breastfeeding journey. OURDILLON K, McCAUSLAND T and JONES S (2020) The impact of birth-related injury and pain on breastfeeding outcomes. Br J Midwifery 28(1): 760-769.