Typologies of postnatal support and breastfeeding at two months in the UK: Response to comments by Harpur & Haddon

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Abstract

We welcome the comments by Harpur & Haddon (2020) on our paper on the typologies of social support and its associations with breastfeeding at two months in a UK sample. We share their concerns around the under-acknowledged costs of breastfeeding, and the need for a truly family-centred approach to breastfeeding support. However, they are mistaken to assume we do not view breastfeeding problems as an important cost of breastfeeding: We explicitly comment on breastfeeding challenges within our paper, and such challenges are theoretically incorporated into the "costs of breastfeeding" following an evolutionary anthropological framework. They are also incorrect in their statement that we recommend breastfeeding promotion messages to wider family members. In fact, we outline in our manuscript that breastfeeding promotional messages can have negative consequences for mothers, and are unlikely to be supportive. What we do suggest is a family-centred approach that recognises that women interact with, and may be supported by, a wide range of individuals (including fathers and grandmothers); and the importance of taking a nuanced approach to support without assuming that all types of support necessarily leads to "more breastfeeding." We hope our response is useful in clarifying the key points of our paper.

Key words: Breastfeeding, infant feeding, maternal experience, social support, public health, United Kingdom

Main Text

We would like to thank Harpur & Haddon (2020) for their detailed response to our paper, including the elaboration of their own lived experience as participants of the survey. We welcome their call for the need to pay more consideration to the experiences of women who formula feed, either by choice or necessity, and the ways in which they too can be best supported. Indeed, this is an area we plan to explore going forward (e.g., see Myers, Page & Emmott, 2019 for analysis pre-registration). We are also in strong agreement with Harpur & Haddon (2020) that breastfeeding is indeed a highly costly activity. As Harpur & Haddon (2020) acknowledge, we broadly outline some of these costs – including energetic and time costs. The specific costs we discuss draw on an evolutionary anthropological framework, which primarily focuses on the costs and benefits around time/energy allocation (Emmott & Page, 2019). While we did not explicitly specify breastfeeding problems as a cost, we do state "many women find breastfeeding challenging." These challenges of breastfeeding are conceptually incorporated into "total costs," as any problems that are encountered (and the consequent stress that is experienced), feeds into total breastfeeding effort, energetics and time allocation. For instance, regarding the physical costs of breastfeeding, mothers who face breastfeeding problems may devote significantly more time, energy and focus to the activity. This is likely to reduce their ability to invest in other activities and their own wellbeing - meaning the cost of breastfeeding is significantly increased, relative to the benefits.

To clarify, we do not think breastfeeding problems are unimportant, reflected by how we refer to multiple research papers explicitly discussing these issues in our literature review. As acknowledged by Harpur & Haddon (2020), many women report that their experiences of breastfeeding problems (which, conceptually, increase the costs of breastfeeding) lead to breastfeeding cessation. Given their potential importance as a mechanism influencing breastfeeding cessation, we have in fact been working on further analyses exploring the relationship between breastfeeding problems and breastfeeding duration, and how this may be moderated by different

types of social support (see Page, Emmott & Myers, 2020 for analysis pre-registration). In our survey, for mothers who reported ever breastfeeding, we asked about any problems they encountered with breastfeeding. In our raw data, of the 601 women who responded to these questions, the most common problems were sore, cracked or blistered nipples (69.7%; n=419), and problems with latching (55.7%; n=335). Only 5.3% (n=32) of participants reported that they did not experience any breastfeeding problems. While we request caution with interpretation as these are findings from our raw, unprocessed data, our preliminary findings suggest that *most* women experience breastfeeding problems. This is particularly notable given that the majority of women in our survey breastfed for longer than the UK average - implying that women who breastfeed for longer experience problems too, not just mothers who stop breastfeeding early.

Our preliminary findings suggest that some women continue to "feed through their problems," while others stop. Why is that? We agree with Harpur & Haddon (2020) that, as reviewed in the introduction of Emmott et al. (2020), part of the issue may be the promotion of breastfeeding as "natural" and "easy." This can create unrealistic expectations of breastfeeding, and this mismatch between reality and expectation may mean many women are not prepared for the challenges of breastfeeding (Williamson et al., 2012; Fox et al., 2015; Brown 2016), with negative implications for maternal mental health (Beck, 2002). Logically, for mothers to adequately tackle breastfeeding challenges, they need to know what problems to expect and how to resolve them effectively. We therefore agree with Harpur & Haddon (2020) that public health policies inadvertently encouraging withholding of accurate information, for example where health workers must not 'undermine breastfeeding by implying that it is inherently hard' (UNICEF, 2014, p.2; as cited in Harpur & Haddon, 2020), is unlikely to be a helpful approach. Rather, it reflects and reinforces medical paternalism with an assumption that mothers cannot be trusted to make the best decision for themselves, their child and their families.

In relation to this, we reiterate the importance of distinguishing and clearly conceptualising the different types of support around breastfeeding. In our paper, we discuss informational, practical and emotional support, which are all hypothesised to have different pathways to breastfeeding. In particular, regarding informational support, we note:

> *"The positive association between informational support and breastfeeding is contingent on the information being accurate, useful and helpful: Studies suggest conflicting and inaccurate information can undermine breastfeeding. Further, mothers in England have reported receiving information which "pushed breastfeeding". Such dictative informational transfers have been perceived as unhelpful and even harmful by mothers, meaning information in itself is not necessarily supportive."* (Emmott et al., 2020, p.3)

Inaccurate information, including withholding information on the potential challenges of breastfeeding (and the costs and benefits of different infant feeding practices in general), are unlikely to be viewed as supportive once women begin breastfeeding. Rather, such information is perhaps better conceptualised as breastfeeding *promotion*, which is about normalising breastfeeding behaviours rather than supporting mothers *per se* (Emmott & Mace, 2015). As we outline in our paper, advice and information from professional sources have indeed been described as "unhelpful" by some mothers(Lamontagne, Hamelin and St-Pierre, 2008), including in our own sample (Emmott et al., 2020). Clearly, informational 'support' is not always supportive. We believe this is also reflected in the lived experience outlined in Harpur & Haddon (2020), exemplifying how practical and informational support from health professionals, if they predominantly focus on promoting exclusive breastfeeding without recognising costs, may not co-exist with emotional support. We are therefore encouraged by the changing direction of breastfeeding support in the UK, such as an increased emphasis on "providing personalised support which responds to individual need" (UNICEF UK, 2018) and recognising the "mistake of imagining that our internationally low

breastfeeding rates can be improved simply by educating about the benefits of breastfeeding more vigorously" (Trickey & Ashmore, 2017, p.26).

Finally, Harpur & Haddon (2020) state, "we are concerned about their recommendation to include wider family members in breastfeeding promotion messages." Here they are incorrect in their interpretation of our conclusions. We do not call on breastfeeding promotion targeting family members; rather, we suggest a family-centred approach that recognises that women interact with, and are supported by, a wide range of individuals including fathers and grandmothers – which may influence breastfeeding behaviours. Consequently, we state:

> *"the "family" in family-centred approaches are often limited to the nuclear family, namely mothers and their partners. Our results highlight the potential for looking "beyond the nuclear family", in particular by including maternal grandmothers who were the largest providers of practical and emotional support after partners."* (Emmott et al., 2020, p.9)

Further, we conclude with:

> *"Our results also indicate the need for the public health literature to take a more nuanced approach to social support, including consideration of the different forms of support and the differential impact they may have."* (Emmott et al., 2020, p.10)

While we do not clarify what such support may be, it is incorrect to say we have advocated for breastfeeding promotion targeting wider family members. In fact, we mirror Harpur & Haddon (2020)'s reservations that focusing on breastfeeding promotion may not be "helpful" due to the issues outlined above, as well as in our study. Instead, we simply call for a more holistic, family-centred approach to support, recognising that women interact with a wide range of individuals (such as fathers and grandmothers) who may influence their infant feeding behaviour in different ways. For example, family-centred support could include: The provision of accurate information around the costs and benefits of breastfeeding so mothers and families have realistic expectations, and are

prepared to overcome challenges together (informational support); encouraging families to listen to and support mothers when they encounter challenges (emotional support); and encouraging family members to increase their share of day to day tasks, so mothers are less likely to be overwhelmed when they experience challenges (practical support). Of course, as rightly noted by Harpur & Haddon (2020), the evidence base is lacking regarding effective ways for wider family members to support mothers with breastfeeding in the UK (and infant feeding more generally). We therefore join their call for further research around family-centred, personalised support for mothers.

Before we end, we would like to leave a personal note of thanks for Harpur & Haddon (2020) who, as participants, have invested and engaged in our study to a great degree. We appreciate the further elaboration on their lived experience, and we hope to draw on this further as we progress in our research programme. We have found their comment valuable, and we hope this acts as a catalyst for participant engagement for other researchers. We look forward to keeping our survey participants updated in the future, including further discussions and correspondence.

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