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# **‘Linking as One’: An intimate breastfeeding moment**

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## ABSTRACT

Breastfeeding is more than the act of providing nutrition to an infant. It is a dynamic interpersonal process, frequently suggested by both women and authors to be an intimate activity. Health professionals have tended to explore the biophysical aspects of breastfeeding largely ignoring the breastfeeding woman's perspective and the effect social and psychological processes have on breastfeeding success. This grounded theory study drew on a range of data sources to describe breastfeeding women's experience of intimacy. Data included interviews with twenty women participants, observational field notes, theoretical memos, drawings, literature and pictorial work. The study supported the premise that women experienced moments of intimacy when breastfeeding. Breastfeeding is represented in the basic social psychological process 'linking as one'. Linking as one is the intimate act of gifting, for comfort, pleasure and growth, human milk and human contact to a baby or child. 'Linking as one' is mutually exclusive and mutually satisfying to both participants. It is not all women's experience nor is it associated with every breastfeeding encounter.

The findings support a substantive descriptive model of the breastfeeding process that represents and facilitates intimate breastfeeding moments. The model provides a framework for theoretical research, which may lead to further conceptual refinement. The model also provides a framework for education curricula and nursing clinical practice. Clinical application includes the use of concepts as prompts from which to explore interpersonal breastfeeding dynamics with breastfeeding clients. The concepts include breastfeeding comfort, ownership of the breast, mutual gifting and knowing. Exploration of these concepts may enable breastfeeding women to maintain and promote successful breastfeeding experiences.

## **ACKNOWLEDGEMENTS**

The understanding of interpersonal relationships can be an illusive process. However in undertaking a research work concerned with breastfeeding relationships I have learned not just about the topic of study but much about my own relationships.

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I have come to realise that good friends are those that listen to breastfeeding 'talk' even when they are tired, offer you space and quiet to write and care for those you care for, when life gets too hectic. To these folk too numerous to mention I thank you.

## **PREFACE: The personal and the professional**

As with many research projects, a personal commitment to the research topic is often born from the researcher's own experiences. This is certainly the case with this study. I often tell people I breastfed my three children. However, if anyone were to ask if I was successful I would have to admit that my breastfeeding experience with my first child was not something I would describe as a particularly successful or pleasurable experience. As with many new mothers I was keen to breastfeed my baby. As a child health nurse I had advised other women about breastfeeding and the many benefits it offers for both mother and infant. Indeed, as a child health nurse I had read widely and learned about the various types of interventions which helped women overcome breastfeeding difficulties. It was therefore, not ignorance about the problems associated with breastfeeding, neither was it a lack of commitment to breastfeeding, that contributed to my unsuccessful experience; rather an unexpected lack of appropriate assistance when it was needed most.

On reflection, my breastfeeding experience is not unique and I have subsequently heard of similar experiences from clients. It seemed to me that my experience was compounded by the fact that I was at the time a child health nurse. My expectations of a low intervention, natural childbirth were not met. My baby was born by forceps, after I had been administered an epidural anaesthetic. I required an episiotomy and thus suture for repair after delivery. While I realise this experience is not unusual for a first birth; I was disappointed with myself. This level of intervention at delivery resulted in a temporary paralysis and numbness from my waist down. I was therefore unable to move about for some hours after the birth. I did not get to hold my baby after she was born.

By the time I got to the post-natal ward I was anxious to hold her, touch her, have her to myself and put her to the breast. I asked the nurse who was caring for me if I might have my baby to myself and be 'left alone' with her. The delivery staff had told me I could not be alone with my baby until the epidural had worn off. The simple request to be left alone was recorded in my medical records, in the nursing notes, along with the fact that I was a

child health nurse. As a result during my entire hospital stay and at that very initial breastfeeding time I was left alone, quite literally.

The problems started early on, I had trouble latching the baby to my breast and by day four, post birth, at discharge from hospital, I had cracked sore nipples and a very poor let down while feeding. I would let down once the baby had been removed from the breast. By week three my baby was losing weight, the abrasions on my nipples were bleeding and I was breastfeeding for hours at a time, in tremendous pain, having tried all I knew to fix the problems.

I vividly remember my husband telling me to smile at the baby while I was breastfeeding her or she would think I didn't like her or enjoy it. "Enjoy it"! I replied " I feel like I am being beaten up and robbed". Over this terrible time I remember feeling desperate for any help and advice which might work. The child health nurse who visited me was a colleague and friend and knew as much as I did about breastfeeding. She sent another health worker to my home, who knew even less about breastfeeding and assured me the baby was swallowing, so must be latched on.

I made the obvious choice to bottle-feed when I had exhausted the available help and felt I had run out of time, because the baby's health was compromised. I weaned to a bottle and my baby thrived. I felt a sense of failure, loss, guilt and sadness. I felt that I must be something less than a good mother because I had failed to breastfeed. I worried that I would not bond to my baby and might love her less. That worry proved to be unfounded, but concerned me at the time. I understood that breastfeeding was most important for bonding, particularly that breastfeed just after delivery.

Thus, it is not surprising that I developed an interest in breastfeeding. By the birth of my second child I had undertaken to study breastfeeding in a more formal way. I enrolled in an undergraduate multidisciplinary university paper in breastfeeding. I missed the first lecture of the paper as I was in the hospital for delivery of my second baby. It was neither because of that paper, nor despite it that I breastfed like a real professional, both that

second baby and the following, my third baby. I can now comment on a number of factors that may have influenced my breastfeeding success. Factors such as, my more realistic expectation of an infant's behaviour, my more relaxed attitude toward my baby, and the fact that as a result of my studies I was a better-informed mother. It is therefore understandable that my initial considerations on breastfeeding reflected a somewhat simplistic assumption. I assumed that some form of appropriate and timely social support could improve any problematic breastfeeding experience.

This assumption was reflected in my clinical work as a nurse and subsequently as an academic. I developed a strong commitment to listening to and validating my clients' perspectives. I became aware of the difference between the problem as stated and the reality of living through the experience of that problem. That is, it is one thing to recognise that your nipples are cracked, it is another to live through the pain and suffering. I was careful to ascertain the most appropriate support for my clients to help with any breastfeeding difficulties. I found that I was concerned for the emotional welfare of my clients. As a health professional I had always been careful to offer a range of advice and choices for my clients, so they could select the most appropriate option. I found after my own breastfeeding experiences, that I was interested to hear what options the breastfeeding client might consider to be best for her and her baby. I developed a tremendous respect for women's intuitive or common sense ability to problem solve, and a tremendous respect for an individual's ability to react to their own body cues.

During this time of both personal and professional discovery I became increasingly aware of the relationship between a mother and breastfed infant. I was able to reflect on my own experiences and make comparisons between my first baby and subsequent children. Successfully breastfeeding my second baby was a completely different experience to the first baby. I felt a closeness and connectedness, particularly during breastfeeding, that I had not experienced with my first child. I had not felt that same connection during any bottle-feeding interaction with my first baby, rather that closeness was experienced during other times, like cuddles in bed or cuddles in the bath. On reflection, the close non-breastfeeding times occurred when close physical contact was afforded. I did not

voice or even consciously recognise the relationship aspects of my breastfeeding experience until my attention was aroused by other women's reports of their breastfeeding. As I listened to my clients share their breastfeeding stories and verbalise their emotions I began to recognise the very significant and pivotal role the mother-infant dynamic plays in breastfeeding success.

I continued to expand my own understanding of breastfeeding, speaking to other health professionals on breastfeeding issues. I have been most concerned with the concept of social support and breastfeeding and the mother-infant dynamic. As a health practitioner and academic I have actively engaged in breastfeeding research (Beasley, Chick, Pybus, Weber, Mackenzie, & Dignam, 1998) and have spoken to a range of health professionals and lay health workers. I am a professional member of La Leche League. In any of these more formal forums I hold to the position that women are better able to breastfeed their infants if they can access appropriate and timely support, and are engaged in positive mother-infant dynamics. I encourage other health professionals to respect and attend to the messages breastfeeding mothers share with them. These are some of the lessons I learned from my own breastfeeding experiences and have observed over time with my clients. It is not surprising then, that these basic premises are foundational to this study, as they are foundational to me.

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