BREASTFEEDING DURING PREGNANCY
MOVING FROM FEAR TO INSTINCT
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Has a pregnant mother asked you about the safety of continuing to nurse her current baby? Or has a mother nursed her toddler during a prenatal appointment with you? Although texts and training rarely discuss breastfeeding during pregnancy, it is quite common and deserves careful consideration. In a study of 179 mothers who had breastfed for at least six months, 61 percent had also breastfed during a subsequent pregnancy. Of these, 38 percent went on to nurse both newborn and toddler postpartum, an arrangement known as “tandem nursing” (1).

A mother has good reason to seek help in avoiding unnecessary weaning during a new pregnancy. Her nursing stands to gain because mother’s milk provides important nutritional and immunological boosts as long as a child nurses. Indeed, weaning before the age of two raises a child’s risk of illness (2). The American Academy of Pediatrics recommends a minimum of one year of breastfeeding, and the World Health Organization calls for two years or more. Moreover, continued breastfeeding can be helpful to a toddler’s adjustment to a new baby.

Still, many people question the safety of continued nursing. Indeed, many, though not all, obstetricians recommend weaning out of a fear of preterm labor or miscarriage. Some people express the concern that continued breastfeeding may “rob the fetus of needed nutrients.” And then there’s the more general concern that continued nursing may simply be too much, wearing the mother down.

A 1993 survey of 57 La Leche League mothers in California found that many breastfeeding and pregnant women chose a midwife specifically because they anticipated a more positive response to the prospect of continued nursing (3). Is an affirmative approach to breastfeeding during pregnancy warranted? What do we know about the safety, nutrition and well-being issues of breastfeeding overlapping with pregnancy? I have dug deep into the scientific literature and interviewed midwives, obstetricians and more than 200 mothers. Here’s what I have learned.

Breastfeeding and Contractions
Nipple stimulation releases the hormone oxytocin into a woman’s bloodstream (similar to what happens during female orgasm). Oxytocin is important for breastfeeding because it is the chemical messenger that tells breast tissue to contract and eject milk (the “milk ejection reflex”). Oxytocin also tells the uterine tissue to contract. All women experience uterine contractions during breastfeeding. Nipple stimulation can also augment labor after it is underway. Postpartum breastfeeding efficiently shrinks the uterus back to prepregnancy size.

Given these associations, it seems a short jump to guess that breastfeeding might trigger labor before its time. But this would be a false leap. Although a medical study is still lacking, preliminary data and related research on the pregnant uterus suggest that breastfeeding and healthy term births are quite compatible. Sherrill Moscova’s 1993 survey of mothers who breastfed during some or all of pregnancy concluded that breastfeeding resulted in no apparent adverse consequences to the mothers’ pregnancies (3). There are also countless anecdotal reports of mothers who have breastfed throughout pregnancy and have given birth to healthy term babies.

Few mothers (7 percent) notice contractions during breastfeeding, even during pregnancy (3). Interestingly, even those who experience intense “nursing contractions” often find that the contractions cease soon after ending the breastfeeding session. Like Braxton-Hicks contractions, nursing contractions commonly occur without disrupting the pregnancy. One mother in Massachusetts wrote to me:

“I felt contractions very strongly during my second pregnancy, some so strong that I was afraid of their intensity and ended the nursing session. Some of them were definitely more painful than Braxton-Hicks contractions. In every case where I was concerned about the number, duration or intensity, I was reassured to find that the contractions stopped within about 10–15 minutes of when the nursing session ended.

I continued to nurse my son, Everest, through pregnancy and gave birth to his brother, Alden, at 39 weeks. I had similar nursing-induced contractions during my next pregnancy, but I was reassured by my previous experiences and did not worry. I continued to nurse both Everest and Alden through that pregnancy, and their baby sister, Ellery, was born at 39 1/2 weeks.”

—Amanda (4)

The Well-protected Uterus
The specter of breastfeeding-induced preterm labor appears to spring from an incomplete understanding of the interactions between nipple stimulation, oxytocin and pregnancy.

The first little-known fact is that during pregnancy less oxytocin is released in response to nipple stimulation than when a woman is not pregnant (5). But the key to understanding breastfeeding during pregnancy is the uterus itself. Contrary to
With the oxytocin receptor sites sparse, down-regulated and blocked by progesterone and other anti-oxytocin agents, oxytocin alone cannot trigger labor. The uterus is in baby-holding mode, well protected from untimely labor (4).

**A Balanced Approach to Breastfeeding-induced Contractions**

Only direct research can definitively tell whether breastfeeding can elevate the risk of preterm labor or miscarriage in any woman. But as you can see, the available research gives valid reasons to doubt that breastfeeding could trigger labor before the body has already begun to prepare for it. Many well-respected sources assert that breastfeeding is safe in healthy pregnancies, including Ina May Gaskin, L.M. CPM, the American Academy of Family Physicians and Ruth Lawrence, MD (4, 10, 11).

Complicated pregnancies always call for more complicated decisions, but weaning can still be avoided in many cases. I have corresponded with mothers who have breastfed through high risk pregnancies, even threatened preterm labor, and have given birth to healthy term babies, and I have heard from mothers who felt that weaning during pregnancy was the best in their situations (4). These decisions are individual and personal.

You may wish to work with your client to draw up a plan for moving forward with eyes open. As in any pregnancy, the mother should be on the lookout for signs of preterm labor. Any mother who is experiencing contractions that concern her should end the breastfeeding session and see if the contractions stop. Some caregivers judge that it is helpful to observe the effects of breastfeeding on uterine contractility, fetal heart rate or the state of the cervix. Each mother deserves support in order to assess the safety of breastfeeding contractions during her pregnancy.

**Eating for Three**

Can a woman eat enough to provide for her fetus, her milk production and her own reserves? Malnourished mothers are at a disadvantage for this triple duty, but well-nourished mothers have little reason to worry. Let’s look at the data on how mothers have fared and what their increased nutritional needs may look like.

**Maternal Reserves and Weight Gain**

Malnourished mothers are already receiving too little nutrition for their own needs. One of the big concerns is that the exclusive breastfeeding period depletes fat reserves. The partial breastfeeding period, when the baby is receiving both mother’s milk and other foods, has a restorative effect on malnourished mothers’ fat reserves. The longer the breastfeeding, the more fat she will recover (12). However, a subsequent pregnancy interrupts this restorative process, and indeed if the malnourished mother continues to breastfeed during pregnancy, she can expect it to take a toll on her fat reserves (13).

When the mother is well-nourished, a common fear is that breastfeeding overlapped with pregnancy might jeopardize bone health. Recent research has dispelled this myth. It is true that the exclusive breastfeeding period can decrease nutritional needs.
POSSIBLE SIGNS OF PRETERM LABOR

Mothers should contact their caregiver immediately if they experience any of these possible warning signs:

- Four or more uterine contractions in an hour—entire uterus is tight, hard, “balled up” to the touch; may or may not feel painful
- Low backache
- Pelvic pressure
- Cramping (like menstrual cramps)
- Increased vaginal discharge, which may include mucus, blood or water

If these signs, or any contractions that concern the mother, occur during a breastfeeding session, the mother should end the session (4). It is important to remember that breastfeeding can cause contractions, and, like Braxton-Hicks, these contractions do not automatically mean you are going into labor.

If a mother has stopped nursing—or wasn’t nursing at that particular time—and she is still having or thinks she is having more than two or three contractions an hour, she should:

- Begin timing how often one occurs and how long each lasts
- Empty her bladder
- Drink a large glass of water (dehydration can sometimes lead to contractions)
- Lie on her left side, or recline with feet elevated, consciously relaxing

And again, if after this she finds she is having four or more contractions in an hour, she should call her care provider immediately.

Bone mineral density, but here’s the key: women begin to recover bone mineral density during the partial breastfeeding period. By 12 months, a mother can expect her bone mineral density to have returned to normal, even if she is still nursing. This is equally true for mothers who breastfeed during pregnancy and tandem nurse (14).

What about the fetus’ needs? Let’s look at pregnancy weight gain and babies’ birth weights. In Mosconi’s 1993 survey, weight gain was reported to be satisfactory. The babies’ average birth weight was a healthy 7 lbs. 9 oz. (equivalent to 3.43 kg.) and the range was 5 lbs. 9 oz. - 10 lbs. 14 oz. (2.52-4.93 kg.) (3).

By contrast, malnourished mothers always have difficulty gaining sufficient weight. An overlap of breastfeeding and pregnancy exacerbates this problem, particularly if, as in rural India, the mother cannot expect to receive more food than during the prepregnancy period (15). In Cebu, Philippines, poorly nourished mothers with only first-trimester breastfeeding lagged behind their nonbreastfeeding peers, but after weaning they caught up by the third trimester. Those who breastfed into the third trimester and were over the age of 35 experienced “significant negative effects on total weight gain” (16).

Similarly, if a malnourished mother does not receive more food than she did before pregnancy, the babies’ birth weights are likely to be compromised, as has been observed in rural India (15). Supplementation of the malnourished mother’s diet with an energy drink can improve the baby’s birth weight, but the mother’s own fat reserves may diminish to provide for the baby’s growth as well (13). In view of the fact that premature weaning can be dangerous for the nursing child in developing countries, public health recommendations often emphasize greater birth spacing—rather than weaning during pregnancy—as the ideal resolution to this dilemma (2, 15).

QUANTITY OF QUALITY

The Institute of Medicine’s report on nutrition during pregnancy and lactation make one resounding point: a basic mixed diet of sufficient calories covers almost all needs for almost all women who are breastfeeding or pregnant (17, 18). Our bodies were made to take care of us, indeed to make up for temporary dietary shortfalls by such adaptations as enhanced nutrient uptake (18). We can surmise that the same is true for mothers who are overlapping nursing and pregnancy. Eating a large enough mixed diet should be sufficient, unless the mother is anemic (more iron needed); under the age of 18 or avoiding dairy (more calcium); strict vegan for more than a decade (vitamin B12); or taking iron supplements (more zinc). Once again, trust, more than fear, is warranted.

Of course it can be a bit confusing to figure out just how much is enough! Milk production tends to drop off by mid-pregnancy, and sometimes mothers even notice that their appetites actually decrease as a result. It is possible to approximately gauge milk production and add up daily maintenance needs, pregnancy needs and milk production needs (4). But the two most important questions are: “Is she keeping up with her appetite?” and “Is she within healthy parameters of pregnancy weight gain?” A mother will need to gain weight the same as if she weren’t breastfeeding. As always, good weight gain (a pound a week) after 20 weeks is most critical (18).

(If she nurses both children she may need an extra 1,000 calories or more, particularly if her toddler significantly increases nursing for a while.)

Caring for a busy toddler and morning sickness are two challenges that can interfere with a mother’s caloric intake, and she may need support in finding time and appetite to eat more. When a mother is falling short, continued breastfeeding may need to come up for review (particularly if problems continue after the first trimester). How much weight is being lost, and how much milk is being produced? Would reduced breastfeeding or weaning transfer much-needed calories from milk to placenta? Or are there other ways to bolster the mother’s intake? Each mother-caregiver team must work out a game plan that takes into account the various needs and options within each situation.

When it comes to water intake, you might think that breastfeeding and pregnant moms would need a gallon—or two! In reality, a mother needs only to drink to thirst and to monitor the color of urine: pale yellow indicates adequate hydration, deep yellow indicates dehydration. Mothers’ own body wisdom is once again the best gauge.

A MOTHER’S SENSE OF WELL-BEING

After getting enough good food, the mother’s sense of well-being is the most salient issue to Ina May Gaskin when it comes to overlapping breastfeeding and pregnancy (4). What is the mother’s body telling her about how well breastfeeding and pregnancy are co-existing in her body? In our culture we tend to get caught up in our heads, but midwives know that our
bodies are the main guides for pregnancy and birth. Just like with instinctive birth, a mother should be empowered to tune into her own body's wisdom as she cares for her nursing during a new pregnancy.

Sometimes the hormones of pregnancy do unpleasant things to the mother's experience of breastfeeding. First, it hurts! Not always, but for a majority of mothers, breastfeeding during pregnancy causes a scarifying, burning or stinging sensation. Sometimes this feeling is strongest during one part of pregnancy and is milder at others; the pattern varies. And for many mothers, even when breastfeeding is not painful, it can cause a strangely agitated state. Some mothers refer to a nails-on-chalkboard sensation or a creepy crawly feeling or simply a powerful urge to push the child away.

A mother who is deeply committed to continued breastfeeding might need support in coming to terms with these unwelcome developments. She may need reassurance that there is nothing wrong with her and that these feelings do not reflect her true feelings about breastfeeding or her child and that there is no right or wrong way to proceed.

When contemplating reductions in the frequency of breastfeeding, it should be taken into account that these come at a cost to the mother. First, she loses the mothering advantages of continued nursing. Many mothers find that nursing is the only way to get their toddler down for a nap. Napping together through the afternoon can be blissfully restorative to mother and child alike. Being able to offer a picky toddler the incomparable nutrition boost of mother's milk can be a time saver. The immunological boost of mother's milk can spare her the effort of caring for a sick child, both in preventing some illnesses and in shortening the duration of others. And when a child gets the stomach flu, sweet and digestible breast milk can sometimes be the only thing the child will drink and keep down. And the option of breastfeeding can help a mother meet her child's needs from the couch better than anything else. Indeed nursing can be a magical tool when faced with a boo-boo or a building temper tantrum. And sometimes nursing is the only way for a mother to talk on the phone to friends and caregivers!

Second, weaning requires that the mother invest energy in providing substitutes and distractions. Sometimes a mother cannot sit down for the duration of weaning lest she invite an entreaty to nurse! The help of a partner can make a huge difference and can be the determining factor for night-weaning success.

As a midwife, you can play an important role by actively listening as the mother sorts through her conflicting well-being issues. Since a mother's needs are intertwined with meeting her child's needs, sometimes continued breastfeeding, despite the difficulties, is truly in the mother's self-interest. Sometimes shortening sessions can make continued breastfeeding more manageable. And reducing frequency, or even partially weaning down to one or two key sessions, can be well worth the trouble in some cases. And sometimes weaning and graduating to other forms of closeness are in the best interest of mother and child. A supportive caregiver can help a mother tune into her own body's wisdom as she makes her choices.

**Instinctive Choices**

As you hold the space for instinctive birth, you hold the space open for instinctive choices about breastfeeding. Far from fueling fears, science gives reason to trust that breastfeeding won't cause preterm labor or miscarriage in healthy pregnancies. Science gives reason to trust that a mother needn't do anything fancy to eat for three, and breastfeeding shouldn't send a healthy uterus into preterm labor. As a midwife, you can empower mothers in your care to determine how best to fit breastfeeding into their well-being plans for pregnancy.

For more on the safety, nutrition and well-being of breastfeeding during pregnancy, as well as a wealth of other information and great mothers' stories, see my new book *Adventures in Tandem Nursing: Breastfeeding During Pregnancy and Beyond*. Before doing this research, I was pregnant and breastfeeding and in search of my midwives' advice. I wanted to hold onto my breastfeeding relationship with my two-year-old Nora Jade—but I had never heard of anyone breastfeeding during pregnancy. My midwives assured me that I could continue as long as I chose to; what a difference it made. After I gave birth to my son, Miles, at home, my daughter rushed in to meet her brother, and she immediately wanted to nurse with him. As my two children nursed and gazed at each other across my chest, I wrapped an arm around each of them, marveling at my body's powers to provide. Having moved from fear to trust, I was amazed at where I found myself.

Hilary Flower is the author of *Adventures in Tandem Nursing: Breastfeeding During Pregnancy and Beyond* (2003), published by La Leche League International. She loves speaking with professional groups about this topic! She is now at work on a gentle discipline book and seeks the input of parents. She warmly invites readers to visit her new Web site at www.nursingtwo.com, and to contact her at hilory@nursingtwo.com.

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