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Induction and breastfeeding

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At every antenatal appointment I was asked *"How do you intend to feed your baby?"* to which I would reply *" I'd like to breastfeed, if I can. I've heard it can be difficult"* And each time, that was the end of that conversation. What I really didn't expect, however, was the incredibly intense and primal*need* to breastfeed that would come over me once my baby had arrived.

After six days of latching issues, nipple trauma, running out of antenatally expressed colostrum, a readmission to hospital, and panic attacks (that I'd never experienced before), I could no longer take the highs and lows of it all. We stopped exclusively breastfeeding, pumping and offered formula top-ups instead. Whilst this decision brought me huge relief, there was also desperate disappointment and an all-encompassing sense of failure. I couldn't feed my baby the way I wanted to and I was letting her down.

Yet, I wasn't willing to give up, and herein lies the beginning of a much longer struggle. After offering the breast casually and managing a twenty minute breastfeed here or there, at six weeks we returned to a significant amount of breastfeeding. I am incredibly proud of my determination and I believe this is the most important achievement of my life thus far. But, it came at a great cost to my mental health. We got stuck in a gruelling and precarious cycle of breastfeeding, pumping to top-up expressed breast milk and

additional formula top-ups.[1] This continued for six exhausting months until I could no longer sustain it. Thereafter, I clung on to morning and evening breastfeeds until my daughter lost interest at 10 months.

There are several pivotal factors that I believe contributed to our difficult feeding journey.

- Antenatal breastfeeding education was alarmingly non-existent, and in hindsight, I didn't take enough personal responsibility for seeking out that knowledge.
- Then, my labour and birth were induced, which I now believe to be medically unnecessary, and this led to my decision to have an epidural.
- Finally, to compound these challenges, my experience of postnatal breastfeeding support was poor and ultimately detrimental.

In this article I will address the impacts of my induction and postnatal breastfeeding support.

Induction and use of Epidural Analgesia

I was induced at 38+3 weeks due to Gestational Diabetes managed by insulin. I remember asking the consultant at my induction booking appointment, "*Is this really necessary?*" The justifications given to me were that the placenta can stop working sooner in people with gestational diabetes and they have concerns about the baby's ability to regulate their own sugars upon arrival. Although something in my intuition was telling me that I was well enough to continue the pregnancy and so was my baby, I trusted that the medical system knew best.

In hindsight, I now interpret the evidence as saying there is no medical necessity for early birth. My baby's monthly growth tracked perfectly along the 25th percentile, there were no issues with placental Doppler[2] (or other concerns, and finally, my own sugars were well managed with the insulin, so arguably she was not experiencing sustained high levels of sugar. Additionally, I have since discovered that NICE guidelines[3] generally recommend induction for gestational diabetes between 39+0 and 40+6 weeks, or even later if sugars are well-controlled and there are no other complications. My induction at 38+3, in the absence of other risk factors, appears to fall outside these general recommendations, further suggesting a lack of medical indication.

My induction experience itself was relatively positive, I felt I had realistic expectations of the process and it ended with the birth I had been hoping for, a vaginal birth. It took four days and several interventions - a 24-hour Propess (prostaglandin) pessary, four doses of prostin gel, and a particularly intense membrane sweep from a consultant - before my waters broke 'spontaneously'. From that point, contractions came thick, fast, and relentlessly intense. Initially, this was manageable with the ability to move freely, but with a 'need' for CTG monitoring[4] I was ushered onto the bed, thereafter unable to get myself off.

From this point on I requested every pain relief option available to me, making it clear I would want an epidural as soon as possible. Once transferred to the labour ward, the epidural provided much-needed relief, allowing me to regain some presence and even appreciate moments of labour. I was able to manage my epidural dosage, letting it wear off sufficiently before I was ready to push. However, it is important to note that the epidural reduced the frequency of my contractions. So, I was started on the artificial oxytocin drip as the next stage of induction/augmentation of labour. After 11 or so hours hooked up to the epidural and drip, and 46 minutes of pushing, my daughter was born.

When the risks of induction and epidural use are communicated, the focus seems to be largely on immediate, physical impacts such as increased likelihood of caesarean-section, infection risk, spinal injury, and, at a stretch, a brief mention of newborn alertness. But what is not made clear, are the impacts that this may have on bonding and breastfeeding - the exact outcomes that had a significant and long-term psychological impact for me.

Comparing physiological and induced labour reveals key differences in the hormone cycles that drive labour, bonding and breastfeeding. The introduction of synthetic oxytocin during induction can disrupt the body's natural hormonal rhythms, interfering with the body's production of organic oxytocin.[5] Oxytocin is one of the major hormones, crucial for bonding and successful establishment of breastfeeding. In addition to this, inducing labour with synthetic oxytocin can be associated with a reduction in oxytocin receptors, meaning that the body may have fewer sites for the oxytocin to bind on to and so less opportunity for the oxytocin to bring about the desired response.[6] Therefore, with potentially fewer receptors to respond to an already disrupted supply of oxytocin, the effectiveness of said oxytocin for bonding and breastfeeding may be diminished in the initial period after induced labour and birth, but more research is needed in this area.[7]

When it comes to epidural use, a 2019 survey carried out by the CQC (Care Quality Commission) found that 47% of induced labours included this type of pain relief, compared to 19% in spontaneous labours.[8] Thus adding another layer of potential consequences for early breastfeeding. In newborns, exposure to epidural analgesia can be associated with reduced alertness[9] and an altered behavioural state.[10] What this means is that these newborns may be less likely to spontaneously wake to feed, less able to sustain the effort required for effective transfer of milk and less able to display consistent hunger cues.

But why does this matter for breastfeeding? The effective establishment of breastfeeding largely hinges on the principle of supply and demand.[11] The more effectively and frequently milk is removed from the breast, the more milk the body is signaled to produce. When a newborn exhibits behaviours such as infrequent waking to feed, subtle or absent hunger cues, difficulty rousing, inability to effectively remove milk, or insufficient stamina for substantial feeds, this crucial supply and demand system for establishing a sufficient milk supply and a responsive dyadic[12] feeding relationship simply cannot get off to an optimal start.

When these challenges are compounded by the disruptions to oxytocin seen in induced labour, there are additional hurdles to overcome. Oxytocin causes the muscles around the milk-producing cells (alveoli) in

the breast to contract, pushing milk down through the ducts in the milk ejection reflex or 'let-down'.[13] Without an effective let-down, milk remains in the breast, leading to inefficient milk transfer and a signal that less milk needs to be produced next time. Oxytocin also has great influence over maternal bonding and calming, promoting feelings of love, calmness, and connection between mother and baby, facilitating the relaxed state conducive to milk flow and positive feeding experiences. With oxytocin's reduced effectiveness, breastfeeding which is often described as a beautiful, natural and lovely experience can instead become fraught with stress and difficulty.

Postnatal Breastfeeding support

My memories of the immediate postnatal period are blurry and fragmented, but as far as I remember, my daughter was able to breastfeed within the first two hours of birth. However, it was the student midwife who latched her for me after several unsuccessful attempts myself, and she even held my daughter for the entire first feed of apparently 45 minutes. I recall repeatedly asking to hold her myself, but she wouldn't allow it. I now understand that movement might have affected the latch or interrupted the feed (ironically important for establishing breastfeeding) and I'm sure the midwife felt proud of her decision to help in this way, but I now feel a profound sense of sadness at my lost experience.

Once transferred to the postnatal ward, my daughter was incredibly sleepy. She did not seem to wake herself up to feed, so I began setting my alarm to ensure I was feeding her every two-three hours. I tried every trick to rouse her: stripping her down to just a nappy, changing her nappy before a feed, stroking her face to encourage suckling, constant skin-to-skin contact, and using breast compressions. Despite these efforts, she rarely stayed awake long at the breast. Whether due to her epidural-related sleepiness or other factors, we consistently struggled with latching. This led to significant distress for both my daughter and, eventually, myself, which I now attribute, in part at least, to the induced labour.

When called to help at every feed, midwives and midwifery care assistants asked if they could try expressing milk from my breast to help my daughter to latch on. I watched helplessly. Sometimes, the distress of these attempts became unbearable. I requested syringe feeding with expressed colostrum; we weren't permitted to be taught this ourselves. The importance of expressing frequently during this was not communicated to me either, and these difficulties resulted in us being kept on the ward for an additional day.

Slowly, however, I felt that I was getting the hang of it. I attempted a feed without calling for help and I believed it went well. I was proud that I had not needed support and eagerly told the next midwife who came to check on me. Her response, unfortunately, was that they needed to see themselves. Determined to begin feeding well enough to leave, I resolved to then show them that I could do this. I called them at each feed and every time they told me that they were happy that the latch looked good, and yet each time it was painful. I left the hospital dangerously misinformed, thinking *"when the latch is painful in this way, I am doing it right*", I was never asked how it felt.

At home it continued; sometimes we would get a 'good' latch, but this became increasingly painful and my nipples became progressively damaged. A 'successful' feed brought huge relief, the fleeting belief that we

would finally be ok, until the next time we couldn't latch when both my daughter and I became very distressed. I found that I didn't want to pick my daughter up in between the two-three hour feeding schedule and, at some points, I couldn't bring myself to look at her. I wasn't eating, I wasn't sleeping well if at all, and I was suffering panic attacks. We were bridging the feeding gaps with my antenatally expressed colostrum and any transitional milk I could collect with a passive suction pump on my other breast during the successful feeds. Then we ran out and I simply couldn't face another feed.

My community midwives, concerned by my fragile mental health and witnessing my persistent feeding difficulties, suggested readmission to a ward specifically for postnatal feeding issues run by my NHS trust. I'd previously rejected this suggestion, I had this deep sense that it would mean I had failed. But with no expressed milk left, and no longer able to face feeding without constant professional support, I was fortunately readmitted.

At the ward, confronted with my daughter's signs of dehydration, I finally agreed to formula. She guzzled 70mls, and I initiated a pumping regime with the hospital-grade electric pump. Our feeding routine of breast, then expressed milk, then formula, was an exhausting endeavour, but at last I was sure my daughter was adequately fed. By her five-day weigh-in, her weight loss was just shy of the 10% threshold.[14] The mystery of our latching difficulties persisted, though. No midwife or change of position provided a solution, latching remained inconsistent. I could no longer endure the attempts to latch at each feed. Severe panic attacks, now triggered by topics unrelated to feeding, began. I confided in my husband that I could no longer manage to look after our daughter alone through the night, especially as he was not allowed to stay. The difficult decision to stop offering the breast was made.

We left the hospital with one piece of advice that truly stuck: after offering expressed milk and then formula, there must always be some formula left in the bottle, that is how we would know she had enough milk. But I don't recall being given any robust information on my pumping regime, or how to transition away from formula (the ultimate goal). In hindsight, I would expect anyone in my shoes to be sent away with further appointments and ongoing support to this end.

Although relieved and experiencing far less anxiety around feeding, I still wasn't satisfied. It was important to me that my daughter received the benefits of breastmilk, and I still desperately wanted to breastfeed her. In the comfort of my own home, and without the immense pressure to exclusively breastfeed, I continued to casually offer the breast. Eventually this led to a significant proportion of breastfeeding by six weeks.

I found immense support from my local La Leche League group meetings. The validation and understanding I received there were invaluable. When my daughter was eleven weeks old we were able to afford a private appointment with the group leader, an IBCLC (International Board Certified Lactation Consultant), but we simply couldn't afford the kind of ongoing support that would have truly helped. I just couldn't access the consistent, personalised guidance I needed to increase my milk supply and safely transition away from formula.

Consequently, triple feeding remained my only option, a regime typically recommended for just a few

days. I persisted until my daughter was six months old, pumping twice in the night (despite my daughter sleeping through from five weeks) to get enough milk for one out of her daily three bottles to be solely expressed milk. Sometimes I power-pumped twice a day (on and off for an hour to mimic cluster feeding), petrified in case my supply diminished and compromised our precious time breastfeeding, but inevitably, I couldn't keep up. From six months to ten months I clung on and we continued with a substantial morning and evening breastfeed, with little comfort feeds few and far between, until, one unassuming day my daughter lost interest in feeding from the breast and we stopped.

Looking back, my breastfeeding journey really highlighted the missed opportunities and limitations of the support I received. From a well-meaning but disempowering start with a student midwife holding my baby, to being on the postnatal ward where my pain was overlooked and vital information about expressing or feeding techniques wasn't clearly shared, I often felt like I was navigating incredibly complex challenges alone. The "support" sometimes felt more focused on checking boxes and only on my daughter receiving enough milk, rather than on truly helping me with my feeding goals and the psychology around this. Even after getting some fantastic validation from my local La Leche League group, the sheer lack of accessible, ongoing professional support meant we couldn't afford the consistent, personalised guidance I really needed. This often pushed me into unsustainable routines like "triple feeding," which took a huge toll on my mental and physical health. My experience really shines a light on a significant gap in how new mothers are supported through such a vulnerable and important time.

To conclude

My breastfeeding journey was defined by a powerful, almost primal need to nourish my baby, yet it was fraught with unforeseen challenges. I received little practical guidance before the birth and this left me unprepared. I believe my induced labour and the epidural, both likely to have been medically unnecessary, negatively impacted the beginning of our breastfeeding experience by affecting my daughter's alertness and disrupting crucial bonding hormones. A lack of good postnatal support compounded these issues. I believe my story highlights the critical need for comprehensive, ongoing and empathetic support that addresses both the physical and emotional complexities of this journey.

Further reading:

Smith S. (2024) Induction of Labour and successful Breastfeeding. https://realbirthcompany.com/induction-of-labour-and-successful-breastfeeding/

Author Bio: Emma is a mother relatively new to the birth world, whose own challenging start has inspired a journey to advocate for smoother parenthood transitions for all.

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1 Author's note: Something I now know should only be recommended for a few days with a strict plan of

how to move away from this approach.

2 Editor's note: Doppler ultrasound measures blood flow through the blood vessels (including those in the cord and placenta) by bouncing high-frequency sound waves off the circulating red blood cells.

3 NICE (2020) Diabetes in pregnancy: management from preconception to the postnatal period. https://www.nice.org.uk/guidance/ng3/chapter/Recommendations#antenatal-care-for-women-with-diabetes

4 Editor's note: Cardiotocography or 'CTG' is used to monitor a baby's heart rate and a mother's contractions during labour.

5 Uvnäs-Moberg, K Et Al. (2019), 'Maternal plasma levels of oxytocin during physiological childbirth – a systematic review with implications for uterine contractions and central actions of oxytocin',*BMC Pregnancy and Childbirth*,(2019) 19:285. doi: https://doi.org/10.1186/s12884-019-2365-9

6 Phaneuf, S Et Al. (2000), 'Loss of myometrial oxytocin receptors during oxytocin-induced and oxytocin-augmented labour.' *Journal of Reproductive Fertility*. 120(1):91-7. doi: 10.1530/jrf.0.1200091.

7 Bell, AF Et Al. (2014), 'Beyond labor: the role of natural and synthetic oxytocin in the transition to motherhood.' *Journal of Midwifery & Women's Health*. 59(1):35-42. doi: 10.1111/jmwh.12101.

8 Care Quality Commission. NHS Patient Survey Programme: 2019 survey of women's experiences of maternity care. 2020. https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf

9 Radzyminski, S Et Al. (2005), 'Neurobehavioral Functioning and Breastfeeding Behavior in the Newborn', *J Obstet Gynecol Neonatal Nurs* 34(3): 335–341.

10 Riordan, J Et Al. (2000), 'The Effect of Labor Pain Relief Medication on Neonatal Suckling and Breastfeeding Duration', *J Hum Lact*, 16(1): 7–12.

11 Kent J. C, Et AL. (2007). The volume of milk produced by mothers of preterm infants.*Pediatrics*, *120* (4), e934-e939.

12 Editor's note: Dyadic refers to the interactive relationship between two people or entities.

13 Uvnäs Moberg, K., & Prime, D. K. (2013). Oxytocin effects in mothers and infants during breastfeeding. *Infant*, *9*

(6), 201-206.

14 Editor's note: Up to a 10% drop from their weight at birth is considered normal. I do not know how this threshold was decided but this article may be of interest:

DiTomasso D.., Cloud M. (2019) Systematic Review of Expected Weight Changes After Birth for Full-Term, Breastfed Newborns.
https://www.sciencedirect.com/science/article/abs/pii/S0884217519304381