Breastfeeding of a Medically Fragile Foster Child

Karleen D. Gribble

J Hum Lact 2005; 21; 42
DOI: 10.1177/0890334404272392

Case Report

Breastfeeding of a Medically Fragile Foster Child

Karleen D. Gribble, PhD

Abstract

A case is presented in which a medically fragile baby was breastfed by her foster mother. As a result, the child's physical and emotional health were improved. The mechanisms whereby human milk improves health are well known. The act of breastfeeding may also have an analgesic and relaxant effect as a result of hormonal influences and skin-to-skin contact. Many foster babies may benefit from human milk or breastfeeding. However, the risk of disease transmission must be minimized. Provision of human milk to all medically fragile foster babies is desirable. Breastfeeding by the foster mother may be applicable in cases in which the child is likely to be in long-term care, the child has been previously breastfed, or the child's mother expresses a desire that the infant be breastfed. However, social barriers must be overcome before breastfeeding of foster babies can become more common. *J Hum Lact*. 21(1): 42-46.

Keywords: wet nursing, cross-nursing, breastfeeding, foster care, foster child, attachment, relactation, milk banking

Wet nursing is breastfeeding of a child by a woman other than his or her mother.[1] In the West prior to the 20th century, it was common for women to be paid to breastfeed the children of others.[2,3] Currently, however, breastfeeding of a child by a woman other than his or her mother, regardless of whether it is for pay, is not readily accepted by many within Western cultures.[4,5] The decline in wet nursing in the West parallels a general decrease in breastfeeding that has resulted from the ready availability of artificial infant milks.[3] The ensuing rarity of breastfeeding has resulted in breastfeeding's being elevated to something that is "special" rather than "normal" within this context.[6]

However, the situation is different in many nonindustrialized societies, where breastfeeding is ubiquitous and children are commonly breastfed by women other than their own mothers.[7-10] Thus, a child in a nonindustrialized society who is unable to be breastfed by his or her mother due to work arrangements, illness, or death may be breastfed by another woman. In these cases, wet nursing is a convenient way to nourish and comfort a baby when his or her mother is not immediately available or is a pragmatic necessity wherein alternative feeding methods are unacceptably risky.[7,11]

In 2001, there were 542,000 children in foster care in the United States.[12] All of these children had emotional special needs, and a proportion also had physical special needs.[13,14] Twenty-three thousand were babies under 1 year of age.[12] Despite the universal recognition of breastfeeding as the desired form of nutrition for babies, providing human milk and/or breastfeeding for babies in foster care is not usually considered. However, this

Received for review, December 10, 2003; revised manuscript accepted for publication, June 25, 2004.

Karleen D. Gribble is an adjunct research fellow in the School of Nursing, Family and Community Health, at the University of Western Sydney. Her research interests focus on adoptive breastfeeding, particularly on breastfeeding of older adopted children and the contribution of breastfeeding to the development of secure attachment in adopted children.

The author would like to thank the foster mother in the case presented for her generosity in allowing her experience of foster breastfeeding to be shared.

No reported competing interests.

J Hum Lact 21(1), 2005
DOI: 10.1177/0890334404272392

article presents a case in which a medically fragile baby was breastfed by her foster mother in the United States.

Case Report

A foster mother who had previously breastfed 5 children had a 3-week-old baby, "Anne," placed with her. Anne was drug exposed in utero, born prematurely (4 lb 4 oz at 35 weeks gestation), and had a ventricular septal defect, diaphragmatic eventration, hypotonia, and anal stenosis. She was later diagnosed with Kabuki syndrome. Anne experienced neonatal abstinence syndrome, cried constantly when awake, and slept for only 15-minute periods. Feeding was problematic. She would scream in extreme pain within 30 minutes of each feed, and medication was required to alleviate constipation. Many different artificial infant milks were trialed; however, the problem of intense postfeed pain remained unresolved. Being less than 6 lb (2.7 kg) at 3 months of age and not gaining weight, she was classified as "failure to thrive." Her health care providers were concerned that she might not survive.

Anne's foster mother believed that Anne could benefit from breastfeeding and enquired about the possibility of this to the California State Foster Care Bureau. Lawyers found that legislation did not address breastfeeding and concluded that the child's social workers could decide if it was allowed. Since Anne's social workers were agreeable, the foster mother began breastfeeding with a Supplemental Nursing System and put Anne to the breast for comfort, day and night.

Anne relaxed as she suckled. Her tightly clasped fists unclenched, and she would fall asleep. Although some improvement in stooling and reduction in crying was apparent, she continued to wake in pain after feeds as artificial infant milk was provided in the breastfeeding supplementer. This changed, however, when she was fed with human milk obtained from a donor milk bank, and over a period of 2 weeks, Anne's condition improved. She started sleeping longer and no longer screamed after feeds. She also started gaining weight and could pass stools unassisted.

When a shipment of human milk was delayed and Anne received artificial infant milk for a few days, her pain returned. Thus, her foster mother relactated over a period of several months with the assistance of breast pumping (necessary because of Anne's weak suck) and herbal and pharmaceutical galactogogues. As Anne continued to receive donor human milk, her health improved and suckling became stronger. By the time Anne was 9 months old, her foster mother was producing sufficient milk for her, and Anne continued to be breastfed almost exclusively, under medical supervision, until she was 1 year old (her only other food in her first year was a nutritional supplement, Duocal).

Anne is now aged 25 months and weighs 20 lb (9.1 kg). She continues to breastfeed, and, while she has issues associated with Kabuki syndrome, she has not had a health crisis since she began receiving human milk. Anne's doctors and social workers have moved from being skeptical of the value of breastfeeding to becoming advocates for the provision of human milk for ill foster infants.

Discussion

Impact of Human Milk and Breastfeeding

Human milk is the normal food for infants.[6,15] The World Health Organization and UNICEF[16] state that "where it is not possible for the biological mother to breastfeed, the first alternative, if available, should be the use of human milk from other sources." Given the precarious physical and emotional health of some infants in foster care, it is possible that breastfeeding might assist such children, as in the case presented.

The child described in this article had many chronic health problems, was classified as "failure to thrive," and suffered in great pain from intolerance to artificial infant milks. The provision of human milk, however, generally improved health, allowed spontaneous stooling, and removed the pain associated with feeds.

Alleviation of pain in infants is important not just for compassionate reasons but also because chronic unrelieved pain disrupts the development of the child-caregiver relationship, placing the child at risk of developing an insecure attachment.[17] An insecure attachment (for which foster children are already at risk) results in difficulties with self-regulation and relationships and negatively affects many areas of development.[18,19]

Some children are intolerant or allergic to components of artificial infant milks.[20,21] Since human milk is uniquely suited to the immature intestine of the newborn,[22] allergy and intolerance have been successfully treated with donor human milk.[23,24] Human milk also provides protection against many diseases,[25] which is particularly important for children whose health is compromised.

Although the impact of human milk on child health is appreciated, the impact of the act of breastfeeding itself

has not been the subject of much research and remains largely unknown. The child in this case found pain relief and relaxation in breastfeeding even before human milk was provided. The analgesic and calming effects of breastfeeding have been noted in healthy babies by researchers,[26,27] and the author is aware of several other drug-addicted babies who have responded similarly.[28] However, this response has not been studied in detail. In addition, it has been observed that, in children with histories of abuse or neglect, the act of breastfeeding promotes behaviors that assist in the development of a secure attachment, including eye contact, removal of tension, ability to receive comfort from the mother, and an increase in the child's desire to be close to the mother.[28] Mothers have also reported that breastfeeding resulted in a softening of their attitude toward their children. This is very important in cases in which a child is difficult to care for.[29]

The effects of breastfeeding on child and mother are likely a result of a combination of hormonal influences and the close physical proximity facilitated by breastfeeding. The relaxant hormone cholecystokinin, for example, is released simultaneously in the gastrointestinal tract of child and mother as the child suckles.[30] Many children in foster care suffer from failure to thrive, which has been associated with deprivation of nurturing touch.[31] However, breastfeeding provides frequent, intimate, skin-to-skin contact. The calming and pain-relieving impact of breastfeeding may be particularly important for drug-affected babies (who are often agitated and in pain[32]). The proportion of babies entering foster care with drug exposure in utero is extraordinarily high. In one study, 89% of babies in foster care in a California county tested positive for drugs at birth.[13]

Concerns Associated With Breastfeeding a Foster Child

A number of concerns have been expressed about breastfeeding or providing human milk for foster children.[5] These concerns are related to the risk of disease transmission and the risk of breastfeeding contributing to "overattachment" of foster child and mother.

The concern associated with the risk of disease transmission is a significant one. A very small number of serious diseases including human T-lymphotropic virus type 1 and HIV may be transmitted via human milk under certain conditions.[33] However, effective serological screening procedures exist for human milk donors, and milk banks also pasteurize milk, removing any risk associated with milk from donor milk banks.[34] It is also practicable for serological testing to be implemented for breastfeeding foster mothers, reducing the probability of disease transmission via breastfeeding to an extremely low level. Furthermore, it should be considered that feeding babies artificial infant milks is not without danger considering that not receiving human milk increases the incidence and severity of disease and the risk of death even in Western nations such as the United States.[6,25,35] Denial of human milk likely results in the morbidity or death of some medically fragile foster children.

There is also a theoretical risk that disease could be transmitted from child to foster mother via breastfeeding. This risk is not one that has been quantified, and it may in fact be a very small risk; however, it would be imprudent not to consider the possibility. Thus, it is important to take into consideration the medical history of the child, the biological mother, and the foster mother in determining the risk of disease transmission via the close contact inherent in breastfeeding.

The concern that breastfeeding may result in an overattachment of foster child and mother is based in misconception. Research has demonstrated that it is best for foster children to develop secure attachments to their caregivers.[36,37] When an attachment is secure, the child is able to use the attachment figure as a base from which to explore his or her environment.[38] Thus, if breastfeeding assists the development of secure attachment, it must be seen as a positive outcome, not a negative one.[39] The belief that breastfeeding creates a "special" bond that may cause trauma if broken (eg, if a child is reunited with birth family) does not appear to be borne out by those who have wet nursed. Rather, women frequently express the opinion that breastfeeding another's child gave them warm feelings toward the child and the child's mother.[1,40,41] In addition, while women have observed that some babies appeared surprised at being breastfed by another mother, it has not been reported that breastfeeding has interfered in any way with a child's return to maternal care.[1,40,41]

When Human Milk or Breastfeeding May Be Applicable

Scientific literature supports the view that breastfeeding is expected by babies sustaining normal growth and development.[6,15] Conversely, although it is widely unacknowledged, denial of breastfeeding results in retardation of babies' potential.[15,25,42,43] Nonetheless, the

current lack of acceptance of wet nursing means that widespread breastfeeding of foster children is unlikely in any Western nation.

However, it is possible to envisage that prescription of donor milk might become common, removing disadvantage in nutrition for foster babies. It appears that more routine use of donor milk has begun, and in some US states (including, eg, Texas) the government reimburses the cost of milk bank donor milk for foster babies with medical needs via Medicaid (Gretchen Flatau, director, Mothers' Milk Bank, personal communication, 2003).

Universal breastfeeding of foster babies is clearly not appropriate. However, there are at least 3 situations in which it may be applicable:

1. The child is likely to be in long-term care with the family (6-12 months). In such cases, breastfeeding would not disrupt the child's feeding routine (as might be the case in which a child quickly returns to the care of the birth family) but may greatly benefit the child.
2. The child was breastfed prior to placement in foster care, and continuing breastfeeding may assist the child in making the transition to care. Fadiman[44] described a situation in which a 2-year-old grieving for her family was comforted by breastfeeding.
3. A mother expresses the desire that her child be breastfed. Some mothers, as part of the process of working toward regaining custody of their child, may even maintain their milk supply with the intention of breastfeeding their child on reunion, and a breastfeeding foster mother may assist in this. Although this may seem an unlikely scenario, the author is aware of one case in which this has occurred.

If the child is physically ill or emotionally damaged or if the child resides in an area in which milk banks do not exist to supply donor milk, there might be higher imperative placed on breastfeeding than would otherwise be the case. In either case, the willingness of the foster mother to breastfeed is critical. Of course, the permission of the relevant authorities is required, and breastfeeding of foster babies may be illegal in some locations.

Social Aspects

It is clear that the most serious barrier to more widespread provision of human milk or breastfeeding to foster babies is a social one. This barrier will be overcome only as social workers and health care professionals see the difference that human milk and/or breastfeeding makes to foster babies and become sufficiently convinced of its worth to override cultural norms. As in the case presented, professionals who are originally opposed can become strong advocates for breastfeeding of foster babies when they see the benefits themselves. The other barrier to be overcome is the view of breastfeeding as "special" and as being "best" for babies rather than being a normal part of child care.[6] While this attitude persists, many will deny human milk or breastfeeding to foster children who would benefit from it because it is viewed as a luxury rather than a basic need. Human milk or breastfeeding may not be appropriate for every situation, but lactation experts have a role to play in raising the possibility with social workers and other health care professionals responsible for the care of foster children.

Conclusions

The case study presented demonstrates how breastfeeding and provision of human milk can benefit infants in foster care. Provision of human milk, particularly for ill foster babies, should be universally supported. Actual breastfeeding of foster infants is likely to meet resistance from many. Nevertheless, the fact that children hurt by abuse, neglect, or multiple placement can be assisted in their healing through suckling at the breast raises the question of whether the potential negative side effects of breastfeeding a foster child are outweighed by the known positive effects of breastfeeding.

References

1. Krantz JZ, Kupper NS. Cross-nursing: wet nursing in a contemporary context. *Pediatrics*. 1981;67:715-717.
2. Fildes VA. *Breasts, Bottles, Babies: A History of Infant Feeding*. Oxford, UK: Edinburgh University Press; 1986.
3. Golden JL. *A Social History of Wet Nursing in America: From Breast to Bottle*. Cambridge, UK: Cambridge University Press; 1996.
4. Minami J. Wet nursing and cross nursing. *Leaven*. 1995;31:53-55.
5. Wight NE. Does wet nursing have a place in the USA today? *San Diego County Breastfeeding Coalition Newsletter.* 2002;2:5.
6. Wiessinger D. Watch your language! *J Hum Lact*. 1996;12:1-4.
7. Slome C. Non-puerperal lactation in grandmothers. *J Pediatr.* 1956;49: 550-552.

8. Eggan D. Instruction and affect in Hopi cultural continuity. In: Middleton J, ed. *From Child to Adult: Studies in the Anthropology of Education*. New York: Free Museum Press; 1970;109-133.
9. Raphael D, Davis F. *Only Mothers Know: Patterns of Infant Feeding in Traditional Cultures*. Westport, Conn: Greenwood; 1985.
10. Riordan J. The cultural context of breastfeeding. In: Riordan J, Auerbach KG, eds. *Breastfeeding and Human Lactation*. 2nd ed. Sudbury, Mass: Jones and Bartlett; 1999:29-52.
11. Shann F, Biddulph J. *Paediatrics for Doctors in Papua New Guinea*. Port Morseby, Papua New Guinea: Department of Health; 1983.
12. US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *The AFCARS Report: Preliminary Estimates for FY 2001 as of March 2003*. Available at: www.acf.hhs.gov/programs/cb.
13. Halfon N, Mendonca A, Berkowitz G. Health status of children in foster care. *Arch Pediatr Adolesc Med*. 1995;149:386-392.
14. McIntyre A, Kessler TY. Psychological disorder among foster children. *J Clin Child Psychol*. 1986;15:297-303.
15. American Academy of Family Physicians. *Breastfeeding* (Position Paper). Leawood, Kan: American Academy of Family Physicians; 2004.
16. World Health Organization/UNICEF. Joint Statement: meeting on infant and young child feeding. World Health Assembly Resolution WHA 33.32; 1980.
17. Levy TM, Orlans M. *Attachment, Trauma and Healing: Understanding and Treating Attachment Disorder in Children and Families*. Washington, DC: Child Welfare League of America; 1998.
18. Drury-Hudson J. Some effects of attachment disturbance on child behaviour. *Children Australia*. 1994;19:17-22.
19. Schore AN. The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Ment Health J*. 2001;22:201-269.
20. Kerner JA. Formula allergy and intolerance. *Gastroenterol Clin North Am*. 1995;24:1-25.
21. Alarcon PD, Tressler R, Corner GM. Gastrointestinal tolerance of a new infant milk formula in health babies: a multicenter study conducted in Mexico. *Int Pediatr*. 2001;16:150-154.
22. Lonnerdal B, Nutritional and physiologic significance of human milk proteins. *Am J Clin Nutr*. 2003;77:1537S-1543S.
23. Arnold LDW. Use of donor human milk in the management of failure to thrive: case histories. *J Hum Lact*. 1995;11:137-140.
24. Tully MR. Currents in human milk banking: a year of remarkable growth for donor milk banking in North America. *J Hum Lact*. 2000; 16:235-236.
25. Oddy WH. The impact of breastmilk on infant and child health. *Breastfeed Rev*. 2002;10:5-18.
26. Carbajal R, Veerapen S, Couderc S, Jugie M, Ville Y. Analgesic effect of breast feeding in term neonates: randomised controlled trial. *Br Med J*. 2003;326:13-17.
27. Blass EM. Behavioral and physiological consequences of suckling in rat and human newborns. *Acta Paediatrica Suppl*. 1994;397:71-71.
28. Gribble K. Mother comfort: the breastfeeding of older adopted children. Paper presented at: International Lactation Consultants Association Conference; August 1-3, 2003; Sydney, Australia.
29. Dozier M, Stovall KC, Albus KE, Bates B. Attachment for infants in foster care: the role of caregiver state of mind. *Child Dev*. 2001;72: 1467-1477.
30. Uvnas-Moberg K, Widstrom AM, Marchini G, Winberg J. Release of GI hormones in mothers and infants by sensory stimulation. *Acta Paediatr Scand*. 1987;76:851-860.
31. Polan HJ, Ward MJ. Role of the mother's touch in failure to thrive: a preliminary investigation. *J Am Acad Child Adolesc Psychiatry*. 1994;33:1098-1105.
32. Johnson K, Gerada C, Greenough A. Treatment of neonatal abstinence syndrome. *Arch Dis Child Fetal Neonatal Ed*. 2003;88:F2-F5.
33. Ruff AJ. Breastmilk, breastfeeding and transmission of viruses to the neonate. *Semin Perinatol*. 1994;18:510-516.
34. Arnold L. Trends in donor milk banking in the United States. In: Newberg DS, ed. *Bioactive Components of Human Milk*. New York: Kluwer Academic; 2001;509-517.
35. Chen A, Rogan WJ. Breastfeeding and the risk of postneonatal death in the United States. *Pediatrics*. 2004;113:e435-e439.
36. Marcus RF. The attachments of children in foster care. *Genet Soc Gen Psychol Monogr*. 1991;117:365-394.
37. Stovall KC, Dozier M. Infants in foster care: an attachment theory perspective. *Adoption Quarterly*. 1998;2:55-88.
38. Ainsworth MDS, Blehar MC, Waters E, Walls S. *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Lawrence Erlbaum; 1978.
39. Schore AN. Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Ment Health J*. 2001;22:7-66.
40. Gaskin IM. *Babies, Breastfeeding and Bonding*. South Hadley, Mass: Bergin & Garvey; 1989.
41. Nursing Mothers' Association of Australia. Wet nursing. *Nursing Mothers' Association of Australia Newsletter*. 1994;30:13-18.
42. Oddy WH, Kendall GE, Blair E, et al. Breastfeeding and cognitive development in childhood: a prospective birth cohort study. *Paediatr Perinat Epidemiol*. 2003;17:80-90.
43. Gomez-Sanchiz M, Canete R, Rodero I, Baeza JE, Avilo O. Influence of breast-feeding on mental and psychomotor development. *Clin Pediatr (Phila)*. 2003;42:35-42.
44. Fadiman A. *The Spirit Catches You and You Fall Down*. New York: Noonday; 1997.

Resumen

Lactancia materna en un niño adoptivo (foster child) con una condición médica debilitante

Esta presentación de caso es de un bebé con una condición médica debilitante que recibió leche materna de su madre adoptiva. Como resultado, el estado del niño tanto físico como emocional se mejoró. Los mecanismos por los cuales la leche materna mejora la salud son bien conocidos. El acto de amamantar puede tener un efecto analgésico y relajante como resultado de influencias hormonales y el contacto piel a piel. Muchos bebés adoptivos se pueden beneficiar de la leche materna o del amamantamiento. Aun así, el riesgo de transmisión de enfermedades se debe minimizar. Proveer leche materna a todo bebé con condiciones medicas debilitantes es optimo. El amamantamiento de una madre adoptiva es aplicable en casos en que el bebé se quede a su cuidado un tiempo prolongado, haya sido amamantado previamente, o que la madre biológica exprese deseo de que su bebé lo amamante la madre adoptiva. No obstante, las barreras sociales se tienen que superar antes de que la lactancia materna de los bebés adoptivos sea una práctica común.