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NCT's journal on preparing parents for birth and early parenthood

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Parent-infant relationship, clients' needs

Issue 34 | March 2017

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Parent-infant relationship, clients' needs

Such a bumper crop for March 2017!

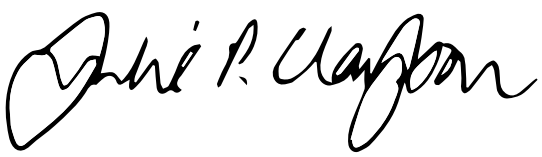
We tackle the sensitive issue of whether breastfeeding beyond 12 months might contribute to tooth decay in young children, with the experiences of mums and a consultant paediatric dentist, and a review of evidence.

Other highlights include the experiences of lesbian co-mothers and the options for women to start breastfeeding even if they have never given birth – for example, if adopting or in a same sex relationship.

We also examine the relationship between babies and their caregivers, and insights and tips for practitioners from the therapeutic approaches for parents who need support in building a relationship with their babies.

Plus, sharing of best practice around what language to use with parents and carers, helping parents to get the most from their first antenatal session, and training opportunities.

Do let us know your thoughts!



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In this issue

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Words that empower

By Kathryn Kelly, NCT antenatal Excellent Practitioner, mentor, and assessor

Background

The language we use with parents can have a huge influence on how they experience the information and support we offer; a misjudged word, phrase, or tone could leave them with an impression we didn't intend to convey. So when NCT Assessors observe practitioners for their renewal of licence to practise, we focus closely on their use of language.[1]

Defining 'appropriate' language is both a familiar and a challenging debate. In this article, I address why language is important, and suggest some ways in which practitioners might explore different use of language with parents and amongst our own practice community. This does not provide an exhaustive or definitive 'list' because that wouldn't be helpful – language and its usage continually evolve. Instead it looks at the history, current thinking, and broad suggestions for practice, touching on issues of power, accuracy, and realism.

Power and health professionals

There is plenty of material on the use of language in the perinatal period, most notably studies in the midwifery environment.[2,3,4] These have explored how language is one way in which midwives can be disempowered by a

> Imparting wisdom as parents hang on our every word may be good for our ego but this is not the way NCT works.

paternalistic hegemony in the work environment.[5,6] Some midwives may perpetuate and reinforce this abuse of power by taking advantage of their privileged access to a vulnerable pregnant, labouring, or postnatal woman.

Medical phrases, for example 'babies are delivered', negate the woman's agency; these words, context, and tone can all undermine the power of the woman and her partner in their experience.[7,8,9] From a feminist perspective, MacLellan,[10] for example, observed that vulnerable women may passively accept authority to avoid antagonising their carers, in a 'gendered response to authority'. Other women employ the language of conflict and talk of their need to 'fight' for the experience they want, as if their body is a battleground over which they have no control, despite the guidance regarding the woman's right to autonomy over her body.[11,12,13]

Power and NCT practitioners

In our role as practitioners working with expectant or new parents we are privileged to be able to affect their experience by the way we listen, act, and speak. When parents repeat common discourses around birth (i.e. 'it is dangerous', 'usually goes wrong', and 'doctors know best') we can draw attention to the language used, and challenge the confusing media messages around birth and parenting.[14] By consistently applying our own discourse – 'birth is normal, usually safe, often instinctive' – through verbal, non-verbal and written language, we build parents' self-efficacy, not only for birth, but also for feeding and parenting their new baby or babies.

Our approach embodies empathy, congruence, and unconditional positive regard.[15] However, we don't have to accept parents' stated starting point (for example, 'I'm going to give birth on the obstetric unit because it's my first baby', or even 'because my obstetrician told me so') as their finishing point. Instead, we might provide information which is new or challenging to them. Hence, sharing all possibilities (e.g. the four options for planned place of birth), supported with empirical information, will promote informed decision-making.

If we feel uncomfortable providing that information, we might reflect on why that is. Similarly, relaying the local NHS hospital trust's guidance as something that parents 'have to' abide by, is not supporting them in recognising and exercising their own ability to make decisions in line with their values and beliefs. Building their self-efficacy is perhaps one of the most crucial things they will learn from their experience with NCT.

Agency	The capacity of a person to act, in any given environment
Discourse	How we think, write, and talk about a given topic. Analysis of a discourse can explore the drivers behind why the speaker/writer might hold that view
Empirical	Based on, or verifiable by, observation or experience rather than theory or pure logic
Hegemony	(Pronounced with a soft *g*) the influence exerted by a dominant group.

Mindful of ego and power

Imparting wisdom as parents hang on our every word may be good for our ego, but this is not the way NCT works.[16,17] We give direct information sparingly, and only when a better way cannot be employed. This isn't school, so we avoid language that reinforces an 'expert' frame, as shown in Table 1, and detailed in the NCT style guidelines.[18]

Making this power of language visible is especially important when referring to the other professionals that parents will come into contact with – not some nameless, faceless, and scary '*they*', but carers, *health professionals,* or *supporters*. Hence '*they won't let you…*' can be replaced with '*your carers may suggest*', '*your health professional may recommend… and then you decide…*'.

We can also help parents employ their own power by using accurate words to relate to health professionals. For example, '*the consultant*' refers to rank rather than specialism. Pointing out that there are consultant midwives too, and asking if they mean obstetrician, midwife, or paediatrician, (and that they are just as likely to be supported by a junior doctor), can open up debate.

Normalising the helpful, minimising the unhelpful

While some parents will feel comfortable with medical language, others will not, so we should be mindful of what is appropriate. We can utilise terms such as the baby's head '*reaches*' or '*meets*', rather than '*hits*', the perineum, and the woman might choose a '*caesarean birth*', rather than a '*caesarean section*'. If we talk about women who '*decide to have*' a surgical birth because that feels the most appropriate thing to do in the circumstances, or who '*decide to stop breastfeeding*' then parents are perhaps going to be in a better psychological place postnatally than if we describe women who '*end up with*' the same birth, or who '*give up*' breastfeeding, with the connotations of inevitability, helplessness and failure.

Inclusion

Some practitioners find attention to detail when talking to a group of mixed genders to be challenging. When talking to a group of women and men, we avoid using '*your cervix*' for example, which does not address the men. While '*the woman's cervix*', or '*partners*', may feel clumsy at first, they do get easier with practice, and this a way of ensuring that all participants are acknowledged. NCT Quality Manager, Ann Carrington, remembers being taught this by her tutor, 25 years ago, so it's not a new idea.

'Need' and design

Parents may wish to explore the phrase '*when she needs pain relief*': we can challenge the assumption that pain relief is somehow necessary or of benefit to the progress of labour. The woman may '*decide*' to have pain relief, it may even help her cope, but she doesn't '*need'* it for labour to be effective or to protect her baby. By focusing on the decision, both the woman and her partner are reminded that it is she who does the deciding – not her carers. Challenging the use of these terms forces us to ask more interesting questions and think more deeply.[19]

A final trap to avoid is along the lines of '*...the pelvis is designed to...*'. Evolutionary theory suggests that the pelvis, breasts, and brain have all evolved to meet a need, rather than been designed.20 Evolution takes time – usually millennia (unless a catastrophic event wipes out those carrying a particular gene) – and hence parents can recognise that just as their ancestors carried, birthed, fed and raised their babies successfully, so will they.

Table 1. Further thoughts for practice

Think about...	**Because... it could imply...**	**Alternatives you may decide to consider or explore**
'I just want you to...'	You're in school.	'I invite you to... would you like to... you might like to...'
'They' in reference to health or other professionals	Creates an unhelpful dynamic, whether it be power, or antagonism. Parents might feel we were being negative about health professionals.	'Your carers', 'the health professionals'
'they won't want you to...'; 'allow'; 'let'; 'you have to...'	Power resides with the health professional rather than the woman.	'Your carers may suggest...', 'recommend...' swiftly followed by '...and you decide...'
Medical language	Might be obscure or make some parents uncomfortable. For others, language they deem as 'correct' may make them more comfortable or build your credibility.	Use with care. Use the words the parents use. Has any medical language been clarified at some point?
'Caesarean section', 'C-section', 'Section'	The first two refer to a type of operation, not to the experience the parents will have. The third refers to committing someone to hospital under the Mental Health Act.	'Caesarean birth'
'Early'/ 'overdue'/ 'late'	'Term' being a medical construct, this could lead to implications of failure on the woman's part.	'Shorter' or 'longer' pregnancy acknowledges both normal and unusual variations

‘Pain relief’	Are the sensations of labour something that can and should be eradicated? Not everyone will experience labour in the same way, and opening up this possibility makes space for the separation of ‘pain’ from ‘suffering’.	‘Working with pain’,[21] ‘coping with’ or ‘dealing with… the intense sensations of labour’
‘Ladies’, ‘girls’	Some feel this a regional variation, while others feel it has implications of class, demeanour, and power.[9]	It’s ‘woman-centred care’, so we could use ‘woman’, or ‘women’
‘It’ or ‘baby’	Impersonal – our aim is to help parents see their baby as a sensitive individual, helping them to adjust to the idea of a person moving in with them.	‘Your baby or babies’, ‘he or she’
‘The consultant’	This is a title of rank, rather than of specialism, and has the potential to be confusing, so we should be clear what is meant.	‘The obstetrician’, ‘the midwife’, ‘the paediatrician’, ‘your carer’, ‘your health professional’
‘Weaning’	Can be ambiguous – weaning from the breast, or weaning onto solids?	Seek clarification, and then use the correct term, which might be ‘introducing solids’
(As an afterthought) ‘…oh, and of course you could [take an alternative course of action]’	Are you making assumptions about the parents?	One of the most significant things we can do is open doors for those who believe they have ‘no choice’.

Conclusion

So, if language is an evolving tool, we as practitioners need our practice to evolve with it. If you have found this article challenging, or intriguing, you might wish to further your exploration in discussion with colleagues, friends, or family. Observing a colleague of any specialism is likely to generate further thoughtful discussion (as well as fulfilling your three year requirement), and inviting a colleague to observe your practice is a good way of identifying habits before the assessor points them out. Finally, a Study Day on the Power of Language is now available to book.

Acknowledgement

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Relactation and induced lactation

By Marianne Kaufmann, NCT breastfeeding counsellor

A continuum

A few years ago a local mother contacted me and explained that she was expecting a baby via surrogacy: she had heard that it was possible to breastfeed and asked if this was something I could help her with. Until then, my exposure to the topic of induced lactation had been limited to a presentation I had given to fellow students in my tutorial group.

Supporting this mother was very rewarding for me and involved a steep learning curve. From this experience I went on to develop an NCT Study Day on the topic of Relactation and Induced Lactation.

Relactation is for mothers who have previously given birth and wish to restart breastfeeding after having stopped, or who wish to breastfeed a subsequent (for example, an adopted) baby – even if the gap has been weeks, months or years. Induced lactation is for the production of breast milk for the first time, ie for a mother who has never given birth.[1,2,3]

Counselling a mother wishing to relactate is something that breastfeeding counsellors are familiar with. Most of us have supported a mother who:

- has gradually introduced more and more 'top ups' of formula until her milk supply has diminished[4]
- has stopped breastfeeding completely but wishes to go back to partial or exclusive breastfeeding[5]
- had a difficult birth and never established breastfeeding.

It is possible, for some mothers, without ever having given birth, to achieve exclusive breastfeeding.

Testing our boundaries

Supporting a mother who wishes to induce lactation can test a breastfeeding counsellor's boundaries as it involves emotions, hopes and fears that may go well beyond those that a counsellor experiences when supporting mothers who have given birth. Everything seems magnified.

As counsellors, we need to remind ourselves of Carl Roger's core conditions: empathy, congruence (genuineness) and unconditional positive regard (respect). We could find that it is more challenging to adhere to these core conditions. Unconditional positive regard in particular could be difficult if we hold any personal views on surrogacy, inter-country adopting, breastfeeding older adopted children, lesbian couples, older mothers – views that may affect our ability to genuinely support a mother without being in any way judgemental.

Evidence around induced lactation

There have been several studies about induced lactation, although some of the research did not clearly distinguish between relactation and induced lactation, which can be confusing.[3,6,7]

It is possible, for some mothers, without ever having given birth, to achieve exclusive breastfeeding. Other mothers who induce lactation never achieve a full milk supply, although many produce enough milk for partial breastfeeding. A small number of mothers who attempt to induce lactation do not produce any milk.[6] The difficulty is that she will not know until she tries.

There are indications that mothers who have previously given birth generally find it easier to produce milk and achieve a full milk supply, even for twins, than mothers who have never given birth.[8] However, it is just one of many different factors that affect a woman's ability to lactate.[1,7] Other factors, in the case of adoption, include the baby's age, previous breastfeeding experience and willingness to take the breast. Factors in the mother include her motivation, support from her partner and health professionals, and her physical health. Reasons why a mother may not be able to produce milk include reasons for infertility, damage to breasts after surgery and damage to the pituitary gland.

Methods for relactation or induced lactation

There are many ways to increase a mother's milk supply, and all of these ways are useful when wishing to relactate or to induce lactation:[6,9,10,11]

- Maximising skin-to-skin
- Carrying your baby in a sling
- Putting your baby to the breast more often
- Expressing milk frequently[12]
- Using a lactation aid/supplemental nursing system like the one from Medela
- Using galactagogues (herbal and/or medication, e.g. domperidone) to increase milk production.

I find it helpful to think of the issue as a continuum: increase milk supply -> relactate -> induce lactation.

Domperidone

Until recently, domperidone was the drug of choice that was used when inducing lactation. It does not cross the blood/brain barrier and was considered safer than other drugs.[13]

However, the European Medicines Agency (EMA) issued guidelines in 2014, then adopted in the UK, restricting the maximum dose and period that domperidone can safely be taken – under licensed use – to a level well below the one necessary to induce lactation.[14,15] Use of domperidone as a galactagogue is an unlicensed use which continues to be advocated by some breastfeeding experts.[16,17,18,19,20]

The protocols for inducing lactation, developed by Dr. Jack Newman and Lenore Goldbarb, involve a regime of taking the contraceptive pill together with domperidone.[21] A few weeks before the expected arrival of the baby the mother stops taking the pill, continues with domperidone, and starts expressing milk (this mimics the process of pregnancy and lactogenesis after birth). This method has been used successfully and safely for three decades by many women who induced lactation.[16]

A mother who is planning to apply one of the protocols will need to find a GP who is supportive of breastfeeding, can explain risks and benefits of taking the medication, and is willing to take responsibility for prescribing domperidone in doses that exceed EMA guidelines for licensed use.

Possible challenges and issues for the breastfeeding counsellor

We also face the decision of where to draw the line, to what extent we get involved, not just emotionally, but also in terms of interacting with other people and organisations.

Should we offer to share information with the partner?

Might it be appropriate to share our understanding with the midwives (remembering that a mother who is receiving a baby via surrogacy or adoption may get less midwife support)?

Will the mother's employer be willing to allow her to express milk frequently during working hours to induce lactation before baby arrives? Legally, is a mother entitled to take time off work to express during working hours in order to induce lactation, i.e. **before** baby is born?

Do we encourage the mother who is having a baby via a surrogate to attend antenatal classes, or the breastfeeding class? She and her partner might feel out of place when they attend an antenatal class. As practitioners we may need to review how we run our sessions for parents and be especially mindful of the inclusivity of our language.

In the case of adoption or surrogacy, is the birth mother or surrogate mother able to breastfeed the baby after birth so the baby gets some colostrum?[22] Is she happy to do this? Is this something that the intended mother would **like** to happen? The milk produced by a mother who is inducing lactation is similar to the milk of mothers who have given birth, except that she does not any produce colostrum.[7]

Antenatally, as a breastfeeding counsellor you will walk alongside the mother and explore areas of concern.

Those who may be involved:

- Mother's partner
- Birth mother (adoption)
- Surrogate mother
- Health professionals caring for the intended parent (adoptive mother or mother expecting via surrogacy):
  - GP
  - Midwife
  - Health visitor
- Health professionals caring for the surrogate or the birth mother (in the case of adoption):
  - Midwife
- Mother's employer
- The baby

Counselling and supervision

Becoming a parent is a challenge for all first time parents, perhaps even more so with mothers who are hoping to induce lactation. These mothers can be riding an emotional rollercoaster – and while we as breastfeeding counsellors are riding alongside them, we may need to remind ourselves that breastfeeding is just one of many aspects of parenthood that they experience.

It is important for counsellors to get supervision. In my case, although I was moved to tears of joy when I witnessed the mother that had I supported breastfeeding her baby a few days after the birth, I felt sad and disappointed that I had not done enough when she stopped breastfeeding within a week. 'Think about it', my supervisor said, 'she **HAS HAD A BABY!**'. To be able to breastfeed her baby, for this mother, was the icing on the cake. It allowed her a time of intimacy straight after birth and to bond with her baby – her long awaited baby after years of infertility: her baby that she had not given birth to.

Summary of skills for supporting mothers in relactation and induced lactation

- Listen
- Support:
  - What support would this mother like?
  - What support can I give (time, experience, skills)?
- Unconditional positive regard (respect)
- Watch your language:
  - Mother - which mother? (Birth mother/surrogate mother/co-mother/ intended parent)
- Increase confidence without raising unrealistic expectations (manage expectations)

- Share information:
  - Success stories from other mothers[23,24,25,26,27]
  - Technical information
- Networking:
  - Introduce mother to other mothers who have induced lactation (NCT Breastfeeding Counsellor e-group can help with finding mothers who have recently experienced this themselves)
- Draw up a plan of action[28]
- Consider boundaries
- Get supervision

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Issue 34 March 2017

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Supporting the parent-infant relationship through Video Interaction Guidance

By Deborah James, Associate Professor, Northumbria University

"She's looking at me. Oh, she's looking at me... It's me what needs to change"

(Chrissy, on viewing video of herself with her child)

A core aim of Video Interaction Guidance (VIG) is to build a parent's awareness of how they create positive interactions with their baby. As a guider, or practitioner, of VIG I achieve this through the use of positive images (video clips), viewed and discussed together with the parent, in a manner that is non-threatening and non-judgemental. Providing this space enables the parent to explore and develop an understanding of their own role in building the relationship with their baby.

Video Interaction Guidance (VIG) is a strengths-based intervention that uses video feedback of successful interactions to give parents the opportunity to see the positive impact of themselves on their child.[1] VIG is a participatory approach where the expertise of the parent in their relationship is as important as the guider's expertise in the selection of video clips. VIG and similar interventions have been included in National Institute for Health and Care Excellence (NICE) guidelines for support for young children[2] and children and young people with autism.[3]

Relating to parents as experts in their relationship

One of the most appealing aspects of VIG is that it does not involve promoting myself as the 'expert' to a 'non-expert' parent. Instead, I behave from the belief that we are *both* experts. I am an expert in video editing and the parent is an expert in their relationship. This means that the parent and I can relate to one another from our equally specialist perspectives without one or other of us feeling in an inferior position. I think this helps us to draw on each other's perspectives and so develop a new understanding of the video footage that is the product of our making a shared meaning.

So often, our public discourses give weight to the specialist voice, which in turn can force parents into believing that they too must become specialists in parenting. This may subjugate the importance of their own inner thoughts and feelings in their relationship. Parents who don't feel that they know all there is to know may feel pressurised into adopting a specialist role, resulting in them being in a third-person position in the relationship with their child.[4]

In order to practice VIG, I speak and work from the first person position, for example, I say things like, "When we were filming that moment really stood out to me". This kind of expression can give the parent an opportunity to recall her memory of the moment. She may, if given space, go on to say why it was special and what it felt like at the time. Offering my authentic responses to the video footage is done in the sure knowledge that my initiatives will be refined, redefined or rejected by the parent. My ability to receive her refinements to my initiatives lays the foundation for her to tell me what she's thinking and feeling. We can then go on to develop new meaning of the video clip. Creating meaning together results in enhanced reflexivity for both of us and we understand each other better. Working in this way with the parent provides a kind of live model of how the interactions between parent and infant builds the infant's mind: a mind that has space for the other's mind.

What does VIG involve?

VIG does not have a rigidly defined protocol. Practitioners undergo supervised training and assessment over a period of at least 18 months in order to fully understand its values and principles. After accreditation, each guider brings the intervention to life in their own way, but is trained to take high quality video recordings of parents and children in their natural environment. The guider will be able to edit clips to show especially attuned moments of interaction, and use these to help the parent envision change and to see change in their relationship with their infant over time. Guiders find out what

The video clips provide an exceptionally positive example from which the parent can go on to talk about what they see as the limits of the relationship.

the parent would like to see as a result of the session, which helps with clip selection. We typically work with a family for about three months, taking three or four video recordings and sharing clips with the parents and others involved with the child, such as family members, child carers or health workers.

VIG supports change in relationships through building upon interactional strengths. These strengths may be exceptions to the general pattern of interaction. When a guider talks to a person about the strengths, they often respond by talking about the limitations of their situation.[5] And in my experience, these words, spoken freely, are often what create change. There are particular words, which the educationalist Freire described as 'true words', that have power to transform the world for the person speaking them.[6] The term *true words* does not refer to a particular set of vocabulary, but instead denotes the parent's own verbalisation that has arisen as an outcome of reflection and expresses their intended action; they are much more than utterances that just keep the dialogue flowing. When parents express their own true words, action follows which is often swift, self-determined and owned by the parent. Their particular words have a power that a person speaking from a third person position could never muster. Below is the story of true words being spoken by Chrissy during a VIG session.

The guider records video footage and analyses it for attuned interactions, in which the parent is giving space for the infant's initiative and where positive impact on the infant is discernible. The guider listens to what the parent says about the clip, and what it might or might not show of the relationship. The guider can therefore use each clip to provoke a realisation in the parent and set up a thread of continuity between the parent's past, current and future understandings of the relationship.[7] It is important for the guider to not slip into instructor mode, telling the parent how to see the clip, because that would reduce the potential to develop shared understanding between the guider and parent. I tend to choose clips that enchant me and arouse my curiosity, without always being able to say why. This helps me to talk from a first person position and allows the parent to be the specialist in the relationship.

The video clips provide an exceptionally positive example from which the parent can go on to talk about what they see as the limits of the relationship. They may go on to speak *true words* that have the power to transform their world.

Chrissy and her baby

When Chrissy came to work with VIG she talked about how naughty her daughter was, referring to her as "the devil child". Chrissy's mum, the second main carer in the family, adopted the same stance on her granddaughter. Chrissy talked about their situation and particularly focused on their lack of sleep because her daughter routinely took about four hours to settle down to sleep at night. In the initial session, where we constructed the goals for change, we agreed that our work should result in better bedtimes. We thought that it would help if Chrissy could get more co-operation from her daughter. We recorded the first film in the family home, then viewed a selection of three clips a week or so later. The first clip was a few seconds long and showed the daughter looking at Chrissy to follow a simple instruction. When I showed the clip to Chrissy her reaction was not as I had expected. She was frustrated, even

angry, because I had shown a clip in which her daughter was not speaking. Chrissy could not see the point of this. I named what I understood of Chrissy's emotion, saying something like, "You sound frustrated because you can't see how this clip will help things change", and Chrissy confirmed that this was how she felt. I explained that I had deliberately chosen the clip because there was no talking, and that there was something important in her daughter's action of looking at her. We watched the clip again. Chrissy spoke quietly after seeing the clip for the second time. She said, "She's looking at me. Oh, she's looking at me". Her speech was slow and she was tearful. Her next words were, "It's me what needs to change".

Chrissy had a moment of deeper consciousness of the limit-situation of her relationship, seeing herself as both the cause and solution to the limits. At the last session of our video work Chrissy met me at the door of her new home, put out both hands in an open gesture, smiled and said, "Everything's changed." Later in that session she attributed the change rightly to herself saying, "I've just got to calm down when kids are here." She went on to say, "You don't understand, everything's getting tighter and tighter and there's bills what need paying, but I've just got to say, whatever."

In these words, "You don't understand", Chrissy reminded me of her specialist position as parent. I remember smiling as I heard them. She was right, I didn't know the limits of her situation, but somehow I did manage to keep us both in a place where we owned our feelings and maintained our voice without retreating in defence to a position with less power for transformational change.

I think the VIG intervention was helpful for Chrissy because it gave her the opportunity to see the impact of the financial pressure on her relationships. She never once mentioned these financial pressures to me and she didn't have to. She saw it. Then, having seen it for herself, all she needed to do was say, "It's me what needs to change".

Tips for practitioners

- Using video helps create greater awareness in the parent. How could you use pictures, literal or metaphorical, to increase conscious reflexivity in the parents you work with?
- When you use strengths-based techniques, like praise or naming positive examples that you have seen or heard, don't be tempted to close down or attenuate the parent's own reflections on the more negative aspect of their relational life. According to Freire, an increase in the parent's understanding of the limits of their situation is exactly what is needed for that parent to shape their own action for change. Allow the *true words* to be spoken.

The Association for Video Interaction Guidance UK (AVIGuk) is a UK network of accredited guiders and supervisors. Further details about the intervention, including how to train, can be found at the following website: http://www.videointeractionguidance.net/.

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NCT's journal on preparing parents for birth and early parenthood

Helping parents and carers with Parent-Infant Psychotherapy

By Ailsa Lamont, Senior Parent-Infant Psychotherapist NorPIP, and Jinny Sumner, Senior Parent-Infant Psychotherapist NorPIP

"Therapy has helped me to understand my baby's feelings and my feelings and emotions, helping us to reconnect"

(Mother of baby returned to her care following a period of time in foster care)

Babies arrive in the world ready to interact with others. They are attuned to the feelings in people around them and are particularly sensitive to the emotional tone of interactions with the people who care for them. After the first few weeks, during which babies and parents are getting used to each other, babies simply want to relate to their carers and in turn be related to. This forms the basis of what is called secure attachment and is the foundation for being able to regulate emotion and empathise with others. It is also linked to physical health and wellbeing in later life.[1]

The situation is not always straightforward, however, as a variety of feelings, thoughts, beliefs and expectations can get in the way of this earliest

> Jenny struggled with a sense of rejection from her baby... the more she tried to get his attention, the more he turned away.

relationship between the baby and her primary carers. When this happens, it can threaten the vital bonding process that is essential for early development and building a secure attachment. One effective intervention available on referral for carers and babies is parent-infant psychotherapy (PIP), which aims to promote a baby's development through the essential relationship with their earliest caregivers.

When should parent-infant psychotherapy be sought?

If the infant's carer is struggling emotionally — beyond a mum's early 'baby blues' for example — and her emotional state is getting in the way of responding to her baby's needs, then this is a signal for help. There may be many reasons including: a traumatic labour or delivery; a previous stillbirth or other bereavement; previous history of depression or psychotic breakdown; current relationship difficulties; feeling anxious; an inability to tolerate the baby's cries; feeding difficulties that can't be resolved with the midwife or other health care professionals; or issues from the parent's own childhood stirred up by the arrival of a baby.

One of the aims of PIP is to help primary carers to imagine what the baby is thinking and feeling and to understand that the baby's behaviour is meaningful and communicates what is in the baby's developing mind. This capacity is linked to secure attachment and also to resilience in the baby and young child.[2] PIP is a dyadic therapy in that it works at the level of the relationship between parent and baby to bring about change. The baby is an active participant in the therapy. Therapy takes place on a playmat on the floor at baby's level, in weekly sessions of 50 minutes, with a few simple and old-fashioned toys as the tools of therapy. All of this provides a safe structure for parent and baby to engage in therapeutic work. The sessions are usually in a local children's centre but can also be in the family home. Although the carer is usually the mother, fathers are encouraged to take part because they play a vital role during this earliest stage of life. The amount of therapy sessions is not fixed but eleven sessions are the current average for NorPIP.

"I have found it a little easier to open up about everything and I feel the bond between my baby and I has strengthened."

(Parent who found parent-infant-psychotherapy useful.)

Therapeutic Approach

Therapy takes place within the evolving relationships in the room, namely between the therapist, mother, partner and baby. It is within this new relationship setting that the therapist helps to facilitate change. The therapist's emotional and thinking capacities provide the 'container' within which change becomes possible. Parent-infant psychotherapists' training is based on psychoanalytic theory including 'ghosts in the nursery'.[3] It entails a variety of approaches including 'Watch Wait and Wonder'[4] and 'Video Interactive Guidance' (VIG).[5] Parent infant therapy groups can also be helpful for some babies and parents.[6]

'Ghosts in the nursery' occur when old experiences from parents' own childhoods are stirred up in the present and interfere with the carer-baby

relationship. Linking the past with the present only occurs once a trusting relationship with the therapist is established. Becoming aware of negative repetitions from the past can enable a parent to reflect and change, and to separate out past losses and their early difficulties from the relationship they have now with their baby.

'Watch, Wait and Wonder' is a simple arrangement of sitting back and watching the baby on the playmat for about five minutes. There is no physical interaction unless baby gestures in some way to be helped, to be played with, or talked to. The idea behind this approach is to allow the baby the 'space' to explore, to develop imagination and make sense of experiences through play, in the presence of an attentive parent. The psychotherapist supports the parent to watch carefully and think about what the baby may be thinking and feeling and how the parent feels about herself. It is a very powerful technique and can be helpful for parents who feel that they should always be actively playing with baby or for parents who struggle to know how to play with baby.

What follows is a clinical example of a mother and baby referred for PIP, written by the parent-infant psychotherapist. Names have been changed to provide anonymity.

Jenny and baby Sam

Jenny was referred to NorPIP when her baby, Sam, was two weeks old. Jenny was concerned that she could not stop crying and she worried that *she* could not soothe Sam when he cried. Jenny had experienced a complicated delivery with Sam and there were some difficulties in establishing feeding. Jenny told me that when she was pregnant she was worried that her baby would not love her and she feared that this was now being confirmed. Jenny and Sam came for weekly PIP sessions at their children's centre for six months. We sat together on the floor, with no fixed agenda, working with what was coming up for mother and baby to support Jenny in her understanding of herself in relationship to Sam and to support baby Sam to communicate with his mother.

Initially, Jenny was able to explore her mixed emotions about becoming a mother and to work through feelings around Sam's traumatic birth. In her relationship with Sam, we could begin to think about the difficult feelings in both of them, as Jenny struggled with a sense of rejection by her baby, and conversely the more she tried to get his attention, the more he turned away.

We introduced the technique of 'Watch, Wait and Wonder' to allow some space for us to follow Sam's lead for a few minutes. Jenny was able to reflect on her difficulty in allowing for this space and she linked this to an absence of her own. When she was little, she said, her mother had not spent time with her in this attentive way. This was a 'ghost in the nursery'. Understanding this, and reflecting on the feelings around this early absence, helped Jenny to allow space for Sam. Sam responded by smiling fully at his mother and they became more engaged in turn taking and a more playful relationship. This absence was an unresolved and painful issue from the past that was getting in the way of responding to the baby in the present.

As therapy progressed, Jenny told me that people had commented that Sam was developing well and that she was a good mum, but she did not feel it inside. We agreed to introduce some sessions of 'Video Interactive Guidance'

> Jenny's growing confidence led to more attuned moments of playful interactions between mother and baby.

where mother and baby are filmed for a few minutes. Afterwards, the edited film footage was used to show Jenny that Sam was not scared of her, as she had thought, and it enabled her to understand what it was that she was doing that was helping him to feel a good connection with her. In the film clips Jenny was deeply moved to see herself connecting well with her baby. The filming helped to shift the negative view she had of herself as a mother. The therapeutic relationship also helped Jenny to understand that feeling not good enough could be linked to her childhood experiences, when her own needs had not been met with understanding. Jenny's growing confidence led to more attuned moments of playful interactions between mother and baby and Sam became more actively expressive in his relationship with his mother, further increasing the bond between them.

At the close of therapy Jenny's growing self-awareness enabled her to be more emotionally available and responsive to baby Sam. Their relationship had become 'good enough' in the sense that Sam was more able to communicate his needs to his mother and she was more able to respond with understanding.

Key points

- Parent-infant psychotherapy can help develop a parent's capacity to reflect, change and separate out past losses and difficulties from the relationship with the baby in the here and now.
- Babies are hungry for communication with their parents; they are active participants in parent-infant psychotherapy and help to bring about change in the mother-baby relationship.

Tips for practitioners

- Practitioners can support new parents to understand their babies' earliest communications to promote the developing relationship between them. For example, when a baby turns away from her mother, the baby may be self-regulating after being in eye contact, but sometimes a parent can experience this as rejection leaving the parent feeling bad about herself.
- Help to normalise ambivalent feelings in parents and babies and support parents to put these feelings into words, as this can help parents and babies to enjoy their relationship more fully.
- Support parents to notice and think about what the baby may be communicating, thinking and feeling, as this is linked to secure attachment and emotional resilience in babies and young children.

Northamptonshire Parent-Infant Partnership (NorPIP) is a charity offering psychotherapeutic support from conception until infants are aged two years. Our work focuses on the developing relationship between parents (primary carers) and their babies. There are other PIPs around the country offering similar services, e.g. Oxfordshire (OxPIP), Liverpool (LivPIP), Newcastle (NewPIP), Enfield (EnPIP), and Brighton (BrightPIP). This article relates to all primary carers of infants, including mothers, fathers, grandparents and foster carers. For descriptive convenience, the article frequently refers to mothers and parents. More information can be found on the website www.norpip.org.uk

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Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

Launch of the WBTi UK Report, Nov 2016 – Alison Spiro (Steering Group and former NCT breastfeeding counsellor) talking to Andy Burnham MP

World Breastfeeding Trends Initiative UK

There is more concerted action than ever before to promote and support breastfeeding around the world, including through the World Breastfeeding Trends Initiative (WBTi), a global project that involves individual countries assessing their own strengths and weaknesses of breastfeeding support. NCT breastfeeding counsellor Patricia Wise reports on how the UK is measuring up.

WBTi was started by IBFAN (International Baby Food Action Network) a decade ago and shows the progress and shortfalls in implementing the WHO Global Strategy for Infant and Young Child Feeding in different countries.[1] The UK published its first ever assessment, the UK-WBTi report, in November 2016.[2] It revealed where the UK is doing well in breastfeeding, and where there is still room for improvement, for example in national leadership, implementation of Baby Friendly standards, implementation of the International Code of Marketing of Breastmilk Substitutes, training of health professionals, and

> The concern is the very rapid drop-off, leading to only 1% of babies being exclusively breastfed at six months.

so forth. Importantly, the UK-WBTi is the result of collaboration between many different organisations, including NCT.

A WBTi report comes in two parts (see Table 1). The assessment involves examination of different policy and practice areas, or indicators, identification of gaps and recommendations, and agreement of scores against specified criteria. An accompanying report card lists the scores and key gaps and recommendations.

Table 1: WBTi indicators

Part 1 – policies and programmes	Part 2 – infant feeding practices
Indicator 1: National policy, programme and coordination	Indicator 11: Early initiation of breastfeeding
Indicator 2: Baby Friendly Initiative	Indicator 12: Exclusive breastfeeding for the first 6 months
Indicator 3: International Code of Marketing of Breastmilk Substitutes	Indicator 13: Median duration of breastfeeding
Indicator 4: Maternity protection	Indicator 14: Bottle feeding
Indicator 5: Health professional training	Indicator 15: Complementary feeding
Indicator 6: Community-based support	
Indicator 7: Information support	
Indicator 8: Infant feeding and HIV	
Indicator 9: Infant and young child feeding during emergencies	
Indicator 10: Monitoring and evaluation	

In addition to the 2016 UK report there is an online annexe with further, more detailed, material.

Over three years ago, lactation consultants Helen Gray (also a LaLeche League leader) and Clare Meynell (a retired midwife) volunteered as Steering Group coordinators for a first UK assessment. I subsequently volunteered to represent NCT on the steering group. The initial focus was on raising awareness.

After receiving training as coordinators, Helen and Clare received IBFAN project funding and formed a core group of representatives of interested charities, professional associations and government departments in September 2015, subject to the requirement that each organisation was free from baby feeding industry funding.

Information was collected by the indicator leads, both from Core Group members and other partner organisations such as health professional royal colleges. This process involved hundreds of emails, an online survey of mothers, web searches, several parliamentary and ministerial questions, interviews with key people and Freedom of Information requests. About 150 draft pages were printed just in time for the next meeting of the Core Group in December 2015.

Meanwhile, Scottish Nationalist MP Alison Thewliss had been working to establish an All Party Parliamentary Group on Infant Feeding and Inequalities, inaugurated in January 2016.[3]

The Core Group held its final meeting in February 2016. There was also an open letter from the WBTi team that month, signed by some 30 organisations and individual experts, in response to the Lancet breastfeeding Series published in January 2016, and the discontinuation of many high quality support services due to financial cutbacks.[4]

Over spring and summer 2016 the UK's individual report chapters were finalised by the Steering Group together with the Core Group and external reviewers. Report cards for the individual countries were agreed with their representatives and scores validated by IBFAN Asia.

Alison Thewliss MP hosted the launch in November 2016 at the Houses of Parliament[5] attended by around 30 people including MPs from across the political spectrum. In a keynote presentation, Dr. Amy Brown of Swansea University emphasised the need for cultural change in the UK, underpinned by joined-up policies and programmes.[6]

The UK breastfeeding initiation rate scores quite well, because most new mothers start breastfeeding. The concern is the very rapid drop-off, leading to only 1% of babies being exclusively breastfed at six months. Thus concerted effort is needed on different aspects – legal, government guidance, training standards, commissioning of relevant services – to enable those mothers who want to continue breastfeeding to do so.

Summary of key gaps

- England has no national infant feeding strategy and there is no formal route to communicate or share best practice across the four home nations.
- The Unicef UK Baby Friendly Initiative is not mandatory in all relevant healthcare settings.
- The International Code of Marketing of Breastmilk Substitutes and subsequent Resolutions are not fully implemented or enforced.
- There is no legal requirement for breaks at work for breastfeeding/ expressing milk.
- There is insufficient minimum training of all health professionals in essential infant feeding knowledge and skills.
- Breastfeeding mothers in some areas lack access to skilled breastfeeding support.
- Data collection is inadequate.

The UK's jewel is the Unicef UK Baby Friendly Initiative, which is a world leader in its focus on relationships.

Summary of key recommendations

- UK Government to set up a permanent multi-sectoral infant feeding body in England to develop national strategy, and the home nations to have a formal arrangement to share best practice.
- All governments to achieve and maintain full implementation, with funding, of the Unicef UK Baby Friendly Initiative in all relevant healthcare settings.
- All governments to fully implement and robustly enforce the International Code of Marketing of Breastmilk Substitutes and subsequent Resolutions.
- All governments to update legislation to include breaks for breastfeeding/expressing milk and associated facilities in the workplace.
- All health professional training bodies to set standards for health professionals that meet World Health Organization/Baby Friendly Initiative guidelines.
- Commissioners throughout the UK to ensure full access to skilled breastfeeding support.
- All national infant feeding strategies to include the collection of quality data built into health systems.

The UK's jewel is the Unicef UK Baby Friendly Initiative, which is a world leader in its focus on relationships and is centred on the rights of the child.[7]

The launch was not the end of the project. Now the Steering Group is working to achieve change, through lobbying and campaigning based on the report.

Further resources

International Baby Feeding Network, IBFAN.
http://www.ibfan.org/

World Breastfeeding Trends Initiative, WBTi
http://worldbreastfeedingtrends.org

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Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

The first session – what do parents tell us?

By Helen Allmark, postnatal facilitator and NCT complaints officer

The first session of an NCT course is a crucial time for parents to build rapport and establish their goals. This article discusses feedback from parents about their experiences of their first session, and provides tips for practitioners to ensure that this session is productive, enjoyable and meets parents' expectations. It is the first of a regular series from the NCT Quality Team focusing on improving practice.

In my role as complaints officer, I hear from parents who are not completely satisfied with their NCT experience. Firstly, I think it is useful to remind ourselves that the vast majority of parents have a fantastic NCT experience. For those who are less satisfied, it is important that we hear their concerns and where possible, act on them. NCT reaches more than 90,000 parents per year through antenatal courses, postnatal courses and stand-alone sessions.

> Parents need to feel that they can trust the facilitator in terms of her ability to manage the group and also her knowledge.

We invite all parents to give feedback, and of those who do (more than 30,000 in 2016), the majority give very positive reviews. For example, of the 9,553 mothers who attended our Signature antenatal courses between January and June 2016, overall, 95% of mothers rated their course as 'Good' or 'Excellent', and only 0.9% rated their course as 'Poor'.[1]

From June to September 2016, of the 61 complaints relating to the quality of NCT courses (both antenatal and postnatal), 18% were made following the first session of that course. This dissatisfaction often results in the parent deciding to withdraw from the course. Their feedback gives us the opportunity to reflect on our practice.

The first session brings unique challenges. A group of parents, very often strangers, meet for the first time to begin their course journey with the practitioner. They bring with them their own circumstances, knowledge, experiences, expectations of NCT, fears and hopes. How can we ensure we meet all their needs?

What follows is a set of tips for practitioners on ensuring that all parents' needs are taken into account, based on their feedback.

What are the goals of the first session?

Establishing aims and learning outcomes is key to session planning. It is therefore vital that you are clear on what you would like to achieve in the first session, and how you propose to achieve it. Signature courses,[2] Essentials courses[3] and Refresher courses[4] have frameworks that will help you to write appropriate aims and learning outcomes. Parents have told NCT that they like a practitioner to be organised and to deliver structured sessions and activities that are relevant.

Before the first session

Parents book on their chosen course either after seeing the description on our website or following the recommendation of a family member or friend. They will bring their own expectations and hopes, which can strongly influence how they react to experiences. Consider how you would like to be perceived by the parents. How you introduce yourself, describe your role and communicate will have an impact on how parents respond to you and their experience of the course. Mortiboys[5] describes this as considering "What's on your T-shirt?" What words convey your messages to the group and how you would like them to relate to you?

A friendly and professional, email or phone call will provide an opportunity to introduce yourself and your course, as well as giving parents the chance to share further information with you. Occasionally, parents withdraw from a course saying that they feel it is 'not for them'. Having an opportunity to talk with the practitioner before the first session may have helped to address their concerns.

In the first session

We need to work hard in the first session to enable parents to feel welcome, comfortable and emotionally 'safe'. The group begins in a 'forming stage'[6] in which they rely on the facilitator for direction. In order to progress to more productive stages, the group needs to understand the purpose of their

sessions and what is expected of them. Parents need to feel that they can trust the facilitator in terms of her ability to manage the group and also her knowledge.

Other factors to consider are:

- **Meeting specific needs**

Consider how you welcome those who are, for example, having a planned caesarean birth, parenting alone or in a same-sex couple. It is good practice to consider the language you use, such as referring to 'partners'. Until you know the situation that parents are in, be mindful of how you approach topics such as birth partners, and don't assume anything.

One parent told us:

"I'm single so attended alone, I've been doing a fair bit alone with people in couples and haven't had a problem with that at all, but the course seemed very geared towards heterosexual couples and that led to me feeling excluded in the first activities."

- **Agenda-setting**

Some feedback highlights the fact that parents can find the agenda-setting challenging. It can be frustrating for parents to be faced with a blank sheet when they do not know what they need to know. Maybe consider a more structured activity to help the parents know what to expect. This could include asking parents to prioritise a selection of topics that you usually cover in order to plan the remaining sessions together, and then refer back to the shared plan throughout the course. Parents value this kind of approach.

- **Group work**

Parents don't always like being split from their partner too soon in the session. We know that this strategy can help people to get to know each other, but some parents say that they feel uncomfortable:

"We've been preparing for this birth together for the past year, and thought it was strange to be split apart for half of the session."

Each group is different but for the parents to feel happy to be apart from their partner, they need to feel welcome and safe in the group. Consider building relationships between couples to start with, then separating couples once the group is more settled.

- **Personality types**

As NCT practitioners, we are familiar with icebreakers, speaking in front of groups, sharing emotions and asking questions in front of others, but we need to keep in mind that not all parents will feel comfortable doing the same. It may be the first time that they have been in an adult learning group environment. Consider what activities you ask the group to do in the early weeks and how often individuals contribute spontaneously to the group (or need to be invited to contribute).

"Neither of us are extroverts and find speaking or demonstrating in front of a group a bit intimidating and stressful."

- **Activities**

Parents value activities that they perceive to be useful and serve a purpose. Quite often parents will describe activities as "pointless" if they do not understand why they are included in the session. One parent reported

> Neither of us are extroverts and find speaking or demonstrating in front of a group a bit intimidating and stressful.

feeling uncomfortable and "dreading" what she "would have to do next week". Consider what activities you can include in the first session to help parents feel physically and emotionally comfortable, and how these might be perceived. What will parents be able to do as a result of the activity?

"We spent ages drawing pictures with felt tips of our family - why?"

- **Content**

The first session is as much about forming a group and setting the tone for the rest of the course as it is about content. Parents tell NCT that they want to learn and are frustrated if they don't achieve this in the first session:

"We were expecting it to be far more factual but instead we spent the first 40 minutes of a two hour session talking about ourselves. We then spoke about our feelings whilst writing with crayons before then having a break."

Consider how you balance sharing information with building relationships. Will your session be seen as offering value for money? - a key consideration for parents:

"Having discussed it at length afterwards, we didn't feel there was anything of value we found out that we didn't know already."

How do you address content from the perspective of those planning a caesarean birth, or perhaps a parent who is also attending hypnobirthing sessions. A mother noted:

"We are planning a drug-free home birth and don't feel that the others in the group or the course material are suited to our needs."

Conclusion

The first session is challenging. Course plans and activities that work for one group don't always work for the next. In my experience, it is important to view each course as a fresh start and acknowledge that the parents will shape the course as much as you will. Balancing structure with some flexibility, and being truly responsive to the needs of the parents, is a great start. Above all, working with the group, assessing their responses to activities, how they participate and really listening to what they say (or don't say) is important as is reflecting-in-action This should ensure that parents continue to attend your course. As the saying goes "you only get one chance to make a first impression", so make yours count.

The Breastfeeding Session

by Trina Warman, NCT breastfeeding counselor and tutor

NCT Signature antenatal courses include a session on breastfeeding, usually led by an NCT breastfeeding counsellor towards the end of the course. While the parents attending may feel they know each other quite well by this point, for the breastfeeding counsellor, every breastfeeding session is a first session, as it is for someone running an Introducing solids workshop. You don't have the luxury of time to build relationships to the same depth, yet you have much to cover and want the group to understand and know that they can contact you for support after the birth.

Breastfeeding counsellors have the extra challenge of introducing a new, and perhaps contentious subject to a group that has already formed and bonded with the antenatal teacher.

The different style of each NCT facilitator may be unsettling for some parents.

So what can we do to ensure that things go smoothly? Here are a few ideas:

- It can really help to work as a team and make that point when communicating with the clients who attend the courses. No one practitioner is more important than the other. Present a joined-up coherent team to your classes and they will see you as such.
- Communicate with each other – let each other know how your session/s have been going, if there are any issues or anyone has any special needs or concerns that need addressing.
- Do be mindful of what your colleague is covering; try not to cover the same material.

One of our CPD requirements is to observe another practitioner – so why not sit in with someone you work with so you can get a really good feel for how they cover things?

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Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

Mothers' experiences of talking with dentists about breastfeeding

How do mothers experience communicating with dentists about breastfeeding and tooth decay? NCT breastfeeding counsellor Hannah Lynes summarises online discussions of mothers in the UK.

This article accompanies one by NCT breastfeeding counsellor Joanna Doherty looking at the evidence about breastfeeding and tooth decay and the support that practitioners can provide to parents.

Searching online discussions, mainly on Netmums and Mumsnet, about visits to dentists by breastfeeding mothers over the last 10 years, most relate to dentists saying that breastfeeding causes tooth decay. However, a few dentists are equally adamant that this is not the case.

> The dentist said that as soon as her teeth had come through, what I should have been doing is taking her off the breast before she fell asleep.

In particular, mothers have been told that the following practices may contribute to tooth decay:

- **breastfeeding for more than a given amount of time (e.g. six months, nine months or a year)**

  One dentist is reported as saying, "It's best for six months but then becomes counterproductive because it damages teeth." Another mother says, "My dentist blamed me bfing dd1 until 12 months for decay on dd1's teeth."

- **breastfeeding a baby to sleep**

  "The dentist said that as soon as her teeth had come through, what I should have been doing is taking her off the breast before she fell asleep, cleaning her teeth (which presumably would have the effect of waking her right up again), and then getting her off to sleep by rocking etc."

- breastfeeding at night

  "They said it's caries from breastfeeding at night and that I should stop."

  "The dentist also told me to stop bf-ing as he thought night feeding was the cause."

- **comfort feeding**

  A dental nurse says, "If the child is using the breast as a comforter rather than purely for feeding the milk CAN pool around the teeth."

Dentists describe or are reported as describing breastmilk as "very sweet," "high in sugar," and "bad for teeth." One mother says the dentist "made me feel like breastmilk was the devil's drink for teeth."

Message to stop breastfeeding

A significant number of mothers report receiving directive advice from their dentist to stop breastfeeding, in several cases as early as six months. Comments include:

"As soon as I answered about breastfeeding she said yep that's it, you need to stop!"

"My dentist told me to stop breastfeeding."

"They are also very convinced that the breastmilk causes tooth decay because of the sugar and that I need to stop breastfeeding her."

"She expressed surprise I was still breast feeding initially then suggested I stop sooner rather than later."

"Her – SO you've stopped breastfeeding (statement, not a question). Me – No, I am breastfeeding him. Her – You'll have to stop that."

"They said it's caries from breastfeeding at night and that I should stop."

"The dentist said I shouldn't be breastfeeding her, I should have stopped when she was six months old."

Mixed feelings: dread, guilt and anger

Mothers describe their dentists' reactions as "horrified," "shocked," "surprised," or "like I had two heads" when the mother said she was breastfeeding.

There are instances of dentists appearing to blame mothers for their children's tooth decay. Comments include "They gave her a bollocking for long term breastfeeding," "She then found out I had breastfed for 2 year + and again that was blamed" and "the dentists all made me feel guilty."

A mother describes her experience of taking her child to the dentist as "awful" and "negative," and another says "this is the first time anyone has ever implied that I'm doing my child harm by b/feeding so I was a bit taken aback." One mother says she is "dreading" taking her child to the dentist and another describes having to "brave the dentist."

Mothers describe having to educate their dentist and to make the case for breastfeeding.

Dental nurses, receptionists and health visitors are all also mentioned as suggesting that breastfeeding causes tooth decay.

Some mothers accept their dentists' view that breastfeeding contributed to tooth decay and these mothers tend to feel guilty and to report having been "used as a human dummy" or "used as a comforter" by their baby. One mother says, "I have always felt guilty over the excessive feeding/feeding to sleep when it went beyond nutritional need."

Others do not accept that breastfeeding contributed to their child's tooth decay and these mothers may feel anger towards their child's dentist (two mothers describe themselves as "fuming").

Questions that mothers need answering

Also reflected in the online discussions are the following questions or dilemmas:

- how to find a dentist who is supportive of breastfeeding;
- whether to stop breastfeeding;
- whether to continue to breastfeed a child to sleep; and
- whether it's OK to breastfeed a child after an operation to have teeth extracted.

See accompanying piece by consultant paediatric dentist Claire Stevens, 'Treating children with decayed teeth: a dentist's point of view', and by breastfeeding counsellor Joanna Doherty, 'Breastfeeding and dental health'.

Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

Breastfeeding and dental health

By Joanna Doherty, NCT breastfeeding counsellor

What are the issues around tooth decay in early childhood?

Tooth decay can be a significant issue for children and their families, causing chronic pain, as well as difficulties with sleep, eating and weight gain.[1] In the most severe cases, it begins soon after teeth eruption and progresses rapidly. This can lead to the removal of multiple teeth under general anaesthesia at a young age. A recent large-scale survey by Public Health England found that 12% of 3 year olds in the UK had tooth decay in their primary (baby) teeth.[2]

NICE guidelines indicate that dentists should provide patient-centred care when discussing tooth decay with parents.[3] However, dentists and other health professionals view tooth decay as a disease that is almost always preventable, resulting in some parents feeling blamed. Mothers who are breastfeeding have reported feeling under pressure to stop feeding and warned that, if they continue, their child will develop tooth decay (see summary of mother's experiences by Hannah Lynes in this issue).

This piece examines the evidence for causes of tooth decay in early childhood, with a particular focus on the evidence that breastfeeding can be a cause of tooth decay. The aim is to provide practitioners with information to support parents who are working their way through decisions about feeding and dental health.

> Dentists and other health professionals view tooth decay as a disease that is almost always preventable, resulting in some parents feeling blamed.

What causes tooth decay?

For dental caries (the medical term for tooth decay) to form, there needs to be two elements present in the mouth over a period of time: cariogenic bacteria and simple carbohydrates (in the form of free sugars).[4]

Cariogenic bacteria are bacteria that cause caries by ingesting sugars and then releasing acids as they process this sugar. Over time, this acid then eats away at the tooth enamel (demineralisation). However, this is not necessarily an irreversible process, as tooth enamel can be remineralised (effectively regrown) from components found in the saliva. Caries only begin to form when the process of demineralisation is faster than the process of remineralisation.[4] The severity of caries correlates, amongst other things, with the frequency of sugar intake, rather than the overall quantity of sugar consumed.[5]

In order to help prevent caries, the cariogenic bacteria themselves, or the sugar they digest, need to be removed from the mouth. Aside from not consuming sugars,[5] regular oral hygiene helps to prevent caries by both removing food particles from the teeth and disrupting the formation of plaque (which is a layer of cariogenic bacterial cells linked together to form a 'biofilm' covering the surface of the teeth).[4]

What is early childhood caries?

Early childhood caries (ECC) is a term referring specifically to decay in the primary (baby) teeth. These teeth usually begin to erupt between 6-12 months of age. Prenatally, a baby's mouth, like the gut, is a sterile environment. It is colonised by bacteria from birth onwards, leading to the formation of an oral microbiome. The likelihood of ECC appears to be partly correlated with the age at which a child's oral microbiome is colonised with cariogenic bacteria.[6] The earlier this occurs, the more likely a child is to develop ECC.

Furthermore, a child's risk of developing ECC differs depending on how vulnerable their teeth are to attack. There is now research which suggests that a portion of the risk of developing ECC may be genetic.[7] As an example, tooth morphology, which is part genetically determined, affects the likelihood of developing caries, as they form more easily in sheltered environments (ie teeth with lots of pits and crevices). The ability of tooth enamel to remineralise, and hence, prevent caries formation, may also be dependent partly on genetic factors.

Finally, small numbers of children who suffer from enamel defects such as hypoplasia (thinner/less enamel) are also more likely to develop ECC.[8] As well as being associated with various genetic and/or systemic conditions, these enamel defects are affected by environmental factors/events in the perinatal period (when the tooth enamel is being laid down). Malnutrition, vitamin D deficiency, traumatic and premature birth have all been implicated in the development of hypoplasia, and hence, ECC.[8]

How is ECC affected by infant feeding practices?

Although ECC tends now to be viewed as a complex, multifactorial disease, traditionally, the blame was laid at the door of infant feeding practices. Originally, ECC was called 'baby bottle caries' or 'nursing caries' because the development of ECC is much more likely if babies and toddlers have frequent access to cariogenic foods or liquids (eg bottles of formula or other liquids containing sugar). This is an even greater issue if they sleep with a bottle at night, as saliva production (which remineralises the teeth and counteracts the demineralisation) is lessened during sleep.[9]

An ongoing debate is whether breastfeeding is also linked to the development of caries in a similar fashion. Some argue that this is unlikely, as the biomechanics of breastfeeding are different from bottle feeding (eg the nipple lands at the back of soft palate and squirts milk to the back of the mouth, and milk is not released unless the baby is actively feeding).[10] Others suggest that when babies sleep with the breast in their mouth the milk is held in contact with the surface of the teeth, and thus has the potential to increase the risk of ECC.

Furthermore, formula milk and human breastmilk differ greatly in composition, and formula milk appears to be considerably more cariogenic (ie more likely to cause caries).[11] It has been postulated that the immunomodulatory factors found in human breastmilk may perform a similar role to that in the gut, by helping to establish an oral environment which is unfavourable to cariogenic bacteria. However, there is also limited evidence which suggests that although human breastmilk by itself may not be cariogenic, a mixture of sugar and breastmilk may be even more cariogenic than sugar solution alone.[12]

What does the evidence say about associations between breastfeeding and ECC?

Recent systematic reviews[13] that assessed all available research qualitatively and (where possible) quantitatively, concluded that breastfeeding for up to twelve months is associated with a decreased risk of developing ECC, as would be expected from the composition of human breastmilk. This result held for those few studies which took into account confounding factors. Thus, the most reliable evidence we have at the moment suggests that not only is breastfeeding up to twelve months correlated with a decreased likelihood of ECC, it may even be protective.

By contrast, the overall evidence for the effect of breastfeeding beyond 12 months, although more mixed, appears to be correlated with an increased risk of ECC,[13] particularly when there are certain infant feeding practices such as frequent feeding and nocturnal feeding/feeding to sleep.

Very few studies controlled for confounding factors. Beyond twelve months, even more confounding factors come into play, as the teeth most susceptible to ECC have usually erupted, and milk is no longer the main source of nutrition. For example, several studies which found a correlation between increased risk of ECC and frequent/nocturnal breastfeeding practices also found that these families were more likely to have diets which were higher in cariogenic food/liquid.[13]

> Although breastfeeding beyond 12 months appears to be a risk factor, further research is needed to understand its significance compared to other possible confounding factors.

Finally, the studies reviewed were carried out in different countries with varying socioeconomic conditions. Unlike the UK, in many low and middle income countries families who are lower down the socioeconomic scale are more likely to practise breastfeeding beyond 12 months (and associated feeding practices). Poverty is a strong risk factor:[14] amongst families living in poverty, children may be more likely to suffer from malnutrition and hypoplasia; parents are more likely to have dental disease; and oral hygiene practices may be unaffordable.

Therefore, although breastfeeding beyond 12 months appears to be a risk factor for ECC, further research is needed to understand its significance compared to other possible confounding factors, the overall cariogenicity of the diet (ie the frequency of sugar consumption) and oral hygiene practices, as well as particular breastfeeding practices.[13]

What are parents' options if they are worried about the possibility of ECC?

- Visit a dentist as soon as the first teeth come through and by a child's first birthday, and then at least once a year or as frequently as every three months if the child is at higher risk of developing ECC
- Introduce an open top or free-flow cup from six months
- Decrease their child's risk of ECC through changes in behaviour

What behaviours decrease the likelihood of ECC?

- Consuming sugary foods/liquids less frequently
- Brushing teeth twice/day with a fluoridated toothpaste, especially just before bed and spitting, not rinsing after brushing
- Breastfeeding for up to twelve months
- Being careful about oral hygiene (eg not sharing food, toothbrushes or cutlery)

What behaviours *might* decrease the likelihood of ECC in children breastfeeding beyond 12 months?

- Breastfeeding less frequently or keeping feeds to mealtimes
- Breastfeeding only in the day and not feeding to sleep
- Cleaning teeth thoroughly before nocturnal breastfeeding

How can practitioners support parents?

Do

- Remember that parents sometimes report feeling guilty or blamed after interactions with health professionals about their child's (possible) tooth decay.
- Use a person-centred model of counselling skills to interact with parents.
- Provide parents with information about the multifactorial nature of tooth decay and the reliability of the evidence if appropriate.
- Support parents to explore their options and decisions.
- Signpost to a dentist when appropriate, reminding parents that dental care for children is free and that taking children for a check-up as soon as their first teeth erupt helps to accustom them to the routine.

Don't

- Blame parents for their child's tooth decay.
- Advise parents on the likelihood of tooth decay for their child.
- Advise parents on what course of action they should take.

Acknowledgement

We would like to thank the British Dental Association and the British Society of Paediatric Dentistry for assistance in the preparation of this article.

See accompanying pieces in this issue by NCT breastfeeding counsellor Hannah Lynes, 'Mothers' experiences of talking with dentists about breastfeeding', and consultant paediatric dentist Claire Stevens, 'Treating children with decayed baby teeth: a dentist's point of view'.

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Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

Treating children with decayed baby teeth: a dentist's point of view

By Claire Stevens, consultant paediatric dentist and spokesperson for the British Society of Paediatric Dentistry

Children with decayed baby teeth are referred to me every day, some of whom will require multiple extractions under general anaesthesia. As part of my consultation, it is important for me to gain an understanding of how that child is feeding, as much as how their teeth are being cared for at home. This is a sensitive discussion as, understandably, parents are often feeling upset about treatment required. I see my role as providing both education and support, as well as planning the treatment required which will always include preventative advice to minimise the chance of the child developing further decay.[1]

One of the ways I do this is to ask a family to complete a written diet history. This allows me to give tailored advice. When I analyse this information, I am looking at not just what the child eats but when they feed. This is because it is frequency of intake and not quantity that determines caries risk. The key times to limit intakes after the age of 12 months are in the hour before bedtime (the "Golden Hour") and through the night, when feeds will increase risk of dental decay.

I breastfed both of my children until the age of 13 months and whilst there were times I found it exhausting, I remain a great supporter of breastfeeding whilst recognising that it is not always possible for a child to be fed in this way. I introduced an open top cup at six months and gave expressed milk or cooled boiled water with mealtimes.

Becoming a mother has given new depth to my consultation style. I recognise that all families are different and it is important to understand the beliefs that underpin our lifestyle choices. If a mother expresses a preference to breastfeed her child past his or her first birthday then I would discuss how she could continue to do so, whilst minimising the risk of dental decay. For example, this might be to advise against feeding on demand, especially thorough the night, and working towards bringing the bedtime feed to after a meal, essentially minimising the frequency of intakes, whether that be from a meal or a breast feed. However a child is fed, I would also ensure that oral hygiene measures are optimal – that a child is using fluoride toothpaste and that they receive placement of topical fluoride from the age of three, in line with National Guidelines.[1]

I welcome NCT's consideration of the ongoing discussion around breastfeeding and dental health. As parents, we are all trying to do the best for our children and as health professionals we have a duty to provide consistent and evidence-based messaging.

See accompanying pieces in this issue by NCT breastfeeding counsellors Hannah Lynes, 'Mothers' experiences of talking with dentists about breastfeeding', and Joanna Doherty, 'Breastfeeding and dental health'.

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Issue 34 March 2017

perspective

NCT's journal on preparing parents for birth and early parenthood

Promoting positive parent-infant relationships

From psychoanalysis to neuroscience and infant mental health, research evidence points to the powerful influence of a baby's early relationships on their social, emotional and cognitive development, explains Annie Raff, NCT Research and Evaluation Officer

The importance of early relationships

The eminent psychoanalyst and paediatrician Donald Winnicott wrote, "There is no such thing as a baby... There is only a baby and someone".[1] His point was that in the early years of life, an infant's very existence is dependent on others, particularly the primary caregiver. This stark statement sums up what we know about early child development: a baby's early interactions with others, particularly the primary caregiver, are crucial not only for physical survival but also for developing a sense of self, and mastery of the world around them. These factors are central to laying the foundations for future social and emotional development. This article delves into the

Babies exposed to difficult environments are not destined to fail, but it may well be harder for them to thrive if their early brain development is impacted by severe emotional, physical or social stressors.

evidence around early child development in the context of the parent-infant relationship, touching on emerging concepts and areas of research including infant mental health and neuroscience.

A brief history of research on early child development

Since Winnicott's insights in the 1950s and 1960s, researchers have studied why the early years of life are so crucial for development and the influence of relationships with caregivers. Winnicott himself came from the psychoanalytic tradition, building on the ideas of Freud. This is also one of the disciplines that informed the development of attachment theory by John Bowlby[2] and later Mary Ainsworth.[3] In the latter half of the 20th century, psychoanalysis gave way to cognitive theories, with two key figures, Piaget[4] and Vygotsky,[5] looking at how children develop an understanding of the world around them, and how this development is fostered through relationships.[4,5] In the past 20 years, advances in brain imaging technology and neuroscience have allowed researchers to examine early brain development, adding an extra layer of understanding to early child development and parent-infant relationships.

A new language for early child development

The increasing focus on neuroscience, particularly brain development, in the early years of life, has led to the emergence of the concept of the 'first 1000 days'.[6] The main message behind this phrase is that the brain development that happens in the first 1000 days (from conception to age two) is crucial in forming the foundations of cognitive and emotional development in later life.[7] This does not mean that outcomes are completely fixed by experiences in the first two years; babies exposed to difficult environments are not destined to fail, but it may well be harder for them to thrive if their early brain development is impacted by severe emotional, physical or social stressors.

The term 'infant mental health' is being used more and more. Unlike adult mental health, infant mental health does not refer to disorders such as depression, anxiety or PTSD, although poor infant mental health may lead to these outcomes later on. 'Infant mental health' more commonly refers to mental health in the positive sense, in terms of a baby maintaining optimal emotional and psychological development.[8] It is intrinsically linked to the quality of the relationship between infant and caregiver; the two are almost one and the same.

The building blocks of infant mental health

So what does 'good' infant mental health or a 'positive' parent-infant relationship look like?

Secure attachment is often considered the gold standard of infant mental health and the marker of a positive parent-infant relationship (for a great summary of attachment theory see Helen Hans' recent research overview[9]). A securely attached infant is able to explore the world in the knowledge that they have a secure base to return to in their primary caregiver and other important adults – they know that someone is there to protect and

support them in their exploration. Insecurely attached children are either overly needy or avoidant of their parent, whilst disorganised attachment is a mixture of the two, often due to unpredictable parenting which makes the infant unsure of the reliability of the support they might need.[3,10] It is important to note that insecure and disorganised attachments are not 'wrong'; they are the best adaptation a child can make to the emotional environment of their family. However, they mark areas of vulnerability to stress that might be a disadvantage later in life.

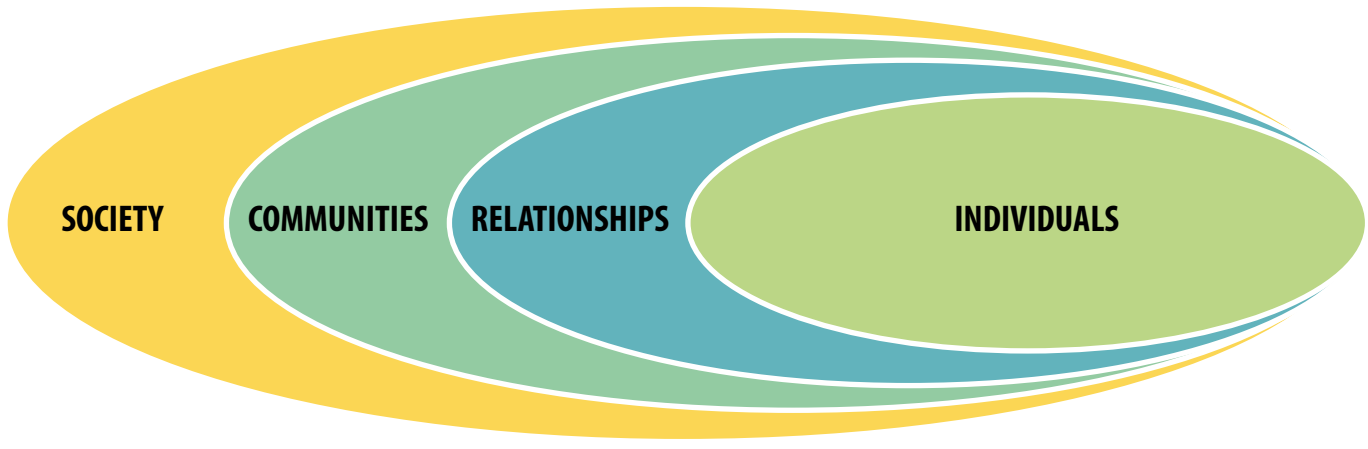
Whilst attachment provides a useful framework for thinking about relationships, it is far from the whole story. Research is increasingly examining the quality of moment to moment interactions, which are considered to be a good indicator of parent-infant relationships and infant mental health. Positive interactions are characterised by responsive, sensitive parents who notice baby's cues and engage in 'serve and return' interactions, a bit like a conversational dance.[11] This is often referred to as 'attuned' interaction, and it appears that the 'feel good' hormone, oxytocin, is released during these periods of connectedness.[12] Attachment and attunement are highly interconnected and research is increasingly looking at the links between the two.

What promotes positive infant mental health?

If, broadly speaking, a positive parent-infant relationship is characterised by secure attachment and attuned interaction, what are the factors that make these things more or less likely?

Before exploring these in further detail, it is worth briefly mentioning the Social Ecological Model of child development. This is a theory that looks at a child's development in the context of the relationships in multiple 'layers' of their environment (see Figure 1).[13] Although the relationship between parent and child is central, it exists in the wider context of families and societies, all of which can affect the parent-infant relationship and infant mental health.

Figure 1: The Social-Ecological Model can help us understand the factors that affect infant mental health[18]



Factors that can threaten or promote a positive parent-infant relationship are often present from before birth.

What factors can promote and threaten a positive relationship?

Research has looked at attachment security and quality of interactions to assess what the correlates might be. It is important to note, however, that just because something is identified as a 'risk factor' for insecure attachment, it is not inevitable that a child will develop an insecure attachment style. For example, it is wholly possible for a parent to have mental health problems but have a securely attached child. This is more likely if there are other 'buffers' such as wider social support and other available caregivers.

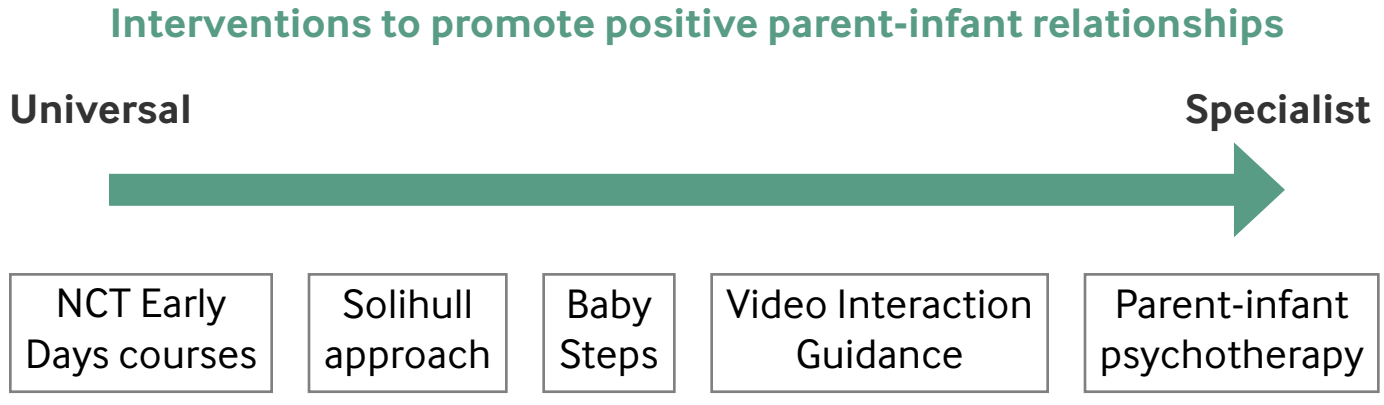
The factors associated with a positive parent-infant relationship include a parent who has a secure attachment style;[14] parents with higher reflective functioning/mind mindedness (the ability to see the baby as a person with a mind of their own);[15,16] and wider social support from family and friends. Conversely, it may be difficult for a positive parent-infant relationship to develop if a parent has an insecure or disorganised attachment style, which may be linked to past experience of maltreatment or inadequate caregiving. Other factors that may threaten the quality of the relationship include mental health problems, domestic violence, substance misuse, and lack of social support or isolation. These risk factors often co-occur.

Services and interventions to improve the parent-infant relationship

"The client is the relationship" is a remark often made in the context of parent-infant psychotherapy (see Working with Parents articles by Deborah James, Ailsa Lamont and Jinny Sumner), and applies to most interventions that seek to improve the parent-child relationship. Rather than working with the parent or the baby, or even both, these interventions are working with the interaction and emotional overlap between the two, as though the relationship itself is the person of interest.

Parent-infant psychotherapy is one of many interventions used to try to improve the relationship between parent and infant. The Early Intervention Foundation, an independent research and policy organisation that advises central government and local commissioners on evidence around children and families, published the report *Foundations for life: what works to improve parent child interaction in the early years*.[17] This examined the effectiveness of interventions for improving parent-child interactions in children under the age of five.

The report divided interventions into three broad categories according to their main outcome: Attachment, Behaviour, and Cognitive development (though many programmes address more than one). It also divided programmes by level of intervention, from universal application to specialist target groups. It assessed each intervention using criteria related to the level of evidence upon which the intervention was based and assigned a rating accordingly. Cost effectiveness was also rated. Those with 'lower' ratings are not necessarily less effective or less worthwhile interventions; they may be relatively new or not have had the resources to conduct rigorous evaluation. Two interventions that may be of particular interest to NCT practitioners are Family Foundations http://famfound.net/about-us/ and Baby Steps http://bit.ly/2mojNf8.



Conclusion

Research on infant brain development and the importance of the first two years of a baby's life reaffirms the importance of the work that NCT does to support parents. It is important to remember that whilst parents have a unique opportunity to help build foundations for their baby's development, they should not be made to feel overburdened or guilty, especially if there are factors outside of their control that may make it harder for them to form a secure attachment or enjoy attuned interactions. Support for families does exist and can be signposted to. It is also important to bear in mind that the research around infant mental health and parent infant relationships does not mean that parents need to do anything special or different to help their baby to thrive; the things many parents do automatically in their interactions with their babies, such as being responsive, making eye contact, cuddling, all help to build good infant mental health and a positive parent-infant relationship.

How can practitioners use the evidence on parent-infant relationships?

Anna Hammond, NCT Practitioner and tutor

All practitioners can support parents to provide the attuned care that babies need to thrive.

Antenatal practitioners will know that bonding begins before birth, and can support parents to think about how they will relate to their baby and even imagine them as a person. By discussing the needs of the newborn, parents can begin to picture themselves giving responsive, attuned care. It is important also to be aware that factors that can threaten or promote a positive parent-infant relationship are often present from before birth e.g. social support, mental health problems, past or present abuse. Practitioners may want to signpost parents to relevant services if appropriate.

Postnatal practitioners can reduce anxiety in mothers by encouraging them to share their feelings. By acknowledging some of the pressures that new parents may feel, they can improve the chances of the whole family having a good start. Postnatal practitioners can build resilience in new mothers, improve their confidence and help them to create supportive, affirming networks. By gently introducing some of the information about the neuroscience behind infant mental health, we can affirm their experiences and support them to be the parent they want to be. In some circumstances,

using local knowledge to signpost to specialist support services may be appropriate. Furthermore, practitioners who run courses where parents and babies or toddlers are present may have the opportunity to model responsive, attuned interactions and mind mindedness (an awareness that a baby is a person with a mind of their own).

Breastfeeding counsellors will use their skills of listening, empathy and showing unconditional positive regard to support new mothers, and can improve their experience of motherhood regardless of their feeding decisions. When feeding is not going well, it can be a barrier to bonding and influence the mother-baby relationship. Mothers who feel supported are more likely to be able to give responsive attuned care. And when feeding is going well, it can provide an excellent opportunity for parents and babies to enjoy attuned interactions and promote a positive relationship.

Key messages

- Research on infant brain development shows that the first two years are an important period for a child's future social, emotional and cognitive development
- These skills are largely developed through interaction with others, particularly primary caregivers
- This does not mean that things are set in stone in the first 1000 days but for babies who have a difficult start it may be harder to thrive
- A positive relationship between parent and baby is characterised by a secure attachment and attuned interactions
- Not all parents and babies will enjoy secure attachment or attuned interactions, for various reasons, some outside of parents' control
- It is important not to make parents feel guilty if they are struggling but to empower them and model sensitive, responsive interactions
- There are different support options available for parents and infants, from universal to targeted programmes, which aim to improve the relationship.

Further resources

PIPUK http://www.pipuk.org.uk/

Association for Infant Mental Health http://www.aimh.org.uk/

The 1001 critical days manifesto http://www.1001criticaldays.co.uk/

Center on the Developing Child, Harvard University http://developingchild.harvard.edu/

Babies in Mind: Why the Parent's Mind Matters, a free online course from the University of Warwick https://www.futurelearn.com/courses/babies-in-mind

Infant mental health online training, from the University of Warwick http://www2.warwick.ac.uk/fac/med/study/cpd/cpd/imhol/

Zero to Three https://www.zerotothree.org/

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What issues do lesbian co-mothers face in their transition to parenthood?

By Katherine Walker

Katherine Walker is an antenatal practitioner and assessor working in South East London and Kent. She recently completed the BA (Hons) Birth and Beyond degree via the University of Worcester where she spent the final year of her studies researching the experiences of the lesbian co-mother for her independent study. Katherine lives in Bromley with her husband and three children.

Introduction

Increasingly, lesbian couples are attending NCT classes, and practitioner e-groups are featuring questions about how practitioners can best meet the needs of lesbian couples. In April 2009, a change in the law permitted lesbian couples to have the same legal rights as heterosexual parents so long as they meet certain criteria, such as being in a civil partnership at the time their baby is conceived.[1] These are signs, perhaps, that a lesbian baby boom is taking place.[2]

My experience as a lesbian co-mother (anonymous)

'I remember being nervous before our first NCT class, as I wasn't sure whether we would be the only LGBT couple and whether we would fit in. I had heard about the NCT format from friends and knew that there would be group exercises for 'moms' and 'dads'- so dreaded the prospect of potentially being the only woman in a group of 'dads'. As it turned out, I was the only woman but was surprised how welcoming and unfazed the men in the group were. Nevertheless, it felt strange at times to be part of this group because there was an assumption that I would simply take on the role of a 'dad' during my partner's pregnancy but that's not how I felt.

Our teacher really put a lot of thought into accommodating me during the NCT course. She pulled me discretely aside during our first NCT class and offered that I could attend either the mom or dad group during break-out exercises but that she would suggest a group if she felt it would be better suited. She mostly recommended the 'partner group' and when I did attend a couple of the 'moms' sessions this did feel a bit odd too.

Our teacher went out of her way to refer consistently to 'partners' instead of dads, which I really appreciated. However, the course materials were exclusively 'hetero-normative', such as photographs of skin to skin featuring dads, or babies responding to their dads' familiar voice immediately after birth, and I felt that my experience as LCM wasn't reflected anywhere, at least not visually.

When we discussed breastfeeding, the teacher spoke to me privately about the option to breastfeed as an LCM and offered to provide more information if I wanted to explore this. It was the only occasion that provided LCM-specific information.

In retrospect it would have been great to attend an NCT class with more LGBT couples which would have allowed me to share my experience and understanding of my role (neither dad nor birth-mom) with other LCM.'

As an antenatal practitioner working with parents, I was interested to know how different the experience might be for same-sex couples in preparing for birth and parenthood. One LCM I spoke to antenatally found her emotional journey towards motherhood difficult. She was going to be a mother but would not be giving birth and she found it hard to identify with either the mothers or fathers on the course.

I know that in the past I may have been guilty of either making assumptions about the same-sex couple experience or trying so hard to be inclusive that I hadn't quite gauged things correctly.

After doing some preliminary investigation into the published literature, I chose to explore the experience of lesbian co-mothers (LCM) in the early postnatal period, as part of my Level 6 studies towards becoming an NCT Birth and Beyond practitioner.

By identifying the challenges faced by many LCM, I hoped to find what practitioners could do to help prepare them, and to empathise during the perinatal period.

My review focused on LCM who have not donated an egg to the birth mother. This and other family arrangements are possible, for example some female same-sex couples choose to have an involved male co-parent who has donated sperm. All of these arrangements would make for interesting further research yet at the time of writing, there was not enough research to carry out a full systematic review.

This article is a summary of my small-scale review.
The full methodology can be found on NCT's intranet website babble http://bit.ly/2mE8bVF.

One of the initial hurdles was to decide what to call LCM, as there are no universal words to describe their situation. This was an early clue as to the importance of language and eventually became one of the overarching themes of the study.

Do practitioners show heteronormative bias?

Heteronormativity is a binary concept that assumes heterosexuality to be the usual situation. It fails to acknowledge that there may be families with other types of arrangements. Recent studies have identified heteronormative health care[3] and I began to wonder if NCT practitioners including myself were unintentionally running courses that could be perceived as heteronormative. Many lesbian mothering studies are now beginning to discuss the idea of 'othering' as a place between mothering and fathering, and recognise a continuum between masculinity and femininity. There are wider links into feminist discourses too, although beyond the remit of this study.

Themes

Five main themes were identified, and language came into each of these:

- Who am I? Beyond the mother/father binary
- Bonding and breastfeeding
- Communities of support
- Educating others
- Emotional health

Who am I? Beyond the mother/father binary

Not being the birth mothers, LCM often struggle with their identity, particularly as societal norms would usually expect mothers to have given birth. However, they are not fathers either. The language to describe their new role is inadequate.

Lesbian relationships are often built on equality[5] but may change upon the birth of the baby from egalitarian to hierarchical.[6] It would therefore be helpful for lesbian couples to explore during the antenatal period, the concept of 'who does what' postnatally.

These issues may result in LCM feeling invisible and can slow down her attainment of a maternal role and identity. The issue of maternal gatekeeping,[7] in which the birth mother controls more how the baby is cared for, also needs further exploration for lesbian couples, otherwise such a situation could further contribute to feelings of insecurity for LCM.

Another issue is that lesbian relationships often fall into a butch/femme narrative, which could change if one of the couple shifts her position as a result of becoming a mother. In my review I found that there was a degree of re-negotiation of relationship roles in the postnatal period.

Bonding and breastfeeding

Many LCM felt fearful that their babies would form a stronger bond with the birth mother, and so had to work hard to achieve bonding. As with heterosexual couples, some felt that antenatal bonding was important, while postnatally many LCM found skin-to-skin contact helped with bonding. Time alone with the baby was also felt to enhance the bonding process.[8,9]

Breastfeeding is often connected to the experience of developing maternal identity.[10] For LCM, as for fathers in heterosexual relationships, there sometimes can be feelings of jealousy if the birth mother is breastfeeding.[11] Some LCM who had skin-to-skin contact then went on to attempt breastfeeding. Of course, throughout time women have breastfed babies they have not given birth to, and adoptive mothers are often able to produce milk to some degree.[12] Clearly, the benefits of breastfeeding go beyond nutrition and many babies enjoy being at the breast for the comfort it brings. It is therefore unsurprising that some LCM-baby dyads may enjoy a form of breastfeeding known as nursing. Whilst this may not appeal to, or be appropriate for all LCM, it may be helpful for LCM to explore the concept antenatally in order to normalise it, and to make an informed decision.

There is no research available about how a shared feeding plan might be established which is beneficial to the new family nutritionally. Many LCM felt that others might judge them negatively for breastfeeding their babies, and so it is appropriate for NCT practitioners to discuss these possibilities and feelings with lesbian couples.

There appears to be a need to feed in a way that is linked to bonding. Indeed, some LCMs found that they were able to enhance their bonding by feeding their babies either with expressed breastmilk or artificial milk via a bottle. Further exploration of the various ways of bonding and spending time with their babies should be part of NCT courses anyway, but this reinforces why this may be so.

Communities of support

One of the major benefits of birth education is the creation of communities of support. At times, LCM reported that they found the heterosexual community to be more inclusive than either the lesbian community or the extended families of the lesbian couple. If the families of LCM do not recognise their role as mother, this may affect how LCM see themselves and may hinder the progress towards assuming a maternal role.

According to the '*motherhood constellation*' part of the work of becoming a mother stems from the support of extended family.[13] The reduced family support that some LCM experienced further challenged the transition to motherhood.

Emotional health

Lack of support is a documented trigger for postnatal depression (PND).[14] LCM for whom family relationships have become strained may be at greater risk. The scant research available on PND specifically in LCM suggests that there may be a higher incidence of perinatal depression in lesbian women than in heterosexual women.[15] LGB&T populations are known to have more emotional health morbidities as a whole[16] so it is particularly important to support LGB&T couples, whilst recognising that much of the work for a LCM is emotional adaptation rather than physical recovery. Signposting and identifying that PND can affect partners as well as birth mothers would be of significance to practitioners.

Educating others

Prior to becoming mothers, lesbian women can choose when to come out to others. However, the process of having a baby necessitates repeatedly explaining who they are in relation to the baby. Practitioners can be well intentioned and try to be inclusive, but may need guidance from LCM about how they would like to be addressed individually. Not all LCM like to be known as a derivative of mother, and may prefer different terminology. For the LCM, educating others can help to cement the new role and relationship.

Summary

There is some debate regarding whether lesbian parents should attend traditional antenatal courses or ones specifically designed for lesbians.[17,18] In one study, feedback following attendance at mixed antenatal courses included complaints about the lack of inclusive language, the course leaders adopting a heteronormative approach, and the lack of awareness of differences between LCM and fathers.[18] Of course these barriers are surmountable and as practitioners we can work towards being more inclusive. In particular, we can avoid the assumption that LCM are simply 'partners' who are expected to share experience with men attending the same course. The need to take this into account has implications for gender group work. Although there may be some commonalities with the men attending, becoming a LCM seems to be another experience altogether than becoming a father.

Bearing in mind that this literature review was based on small-scale qualitative research from around the world, caution should be taken to avoid generalisations. It would be fascinating to commission a study based in the UK, or to survey same-sex couples attending NCT classes. When I was looking for a vignette to go with this piece, many women came forward to contribute, keen to tell their stories.

Further research into experiences from other types of same-sex family arrangements would further enhance understanding. In particular, for female same-sex couples, egg-sharing techniques whereby one woman is the genetic mother and the other is the birth mother, would be a suitable subject for further research. Such an arrangement may well counter some of the challenges found in the present study.

Practitioners' Toolkit

- LCM are not fathers! It may seem obvious, but LCM may not always want to be grouped with fathers in gender-based activities. And they may not feel like mothers yet either. Acknowledge that it can feel different for LCM by considering whether a gender-based activity is always appropriate.
- Resources should clearly reflect the variety of couples we have. If using names in scenarios, check that they are unisex, eg, Alex or Sam.
- Use photographs and pictures reflecting a diverse range of couples.
- Introduce antenatal bonding ideas: singing, reading, touching the baby whilst in the womb, joint forms of relaxation.
- Discuss the benefits of skin-to-skin contact antenatally, and encourage it postnatally.
- Explore breastfeeding and non-nutritive nursing both antenatally and postnatally.
- Engage with LCMs and ask how they are feeling and how they would like to be referred to.
- Encourage all couples to explore the concepts of partners having time alone with baby, finding their own way, and maternal gatekeeping.
- Provide opportunities for couples to explore their new roles and priorities.
- Explore emotional health & provide signposting.

Further reading and resources

LGBT Parents: peer support network
http://lesbiangayparents.ning.com

NHS Choices. Gay health: having children
http://www.nhs.uk/Livewell/LGBhealth/Pages/Havingchildren.aspx

Stonewall. Parenting rights
http://www.stonewall.org.uk/help-advice/parenting-rights

Schnell A. Breastfeeding without birthing: mothers through adoption or surrogacy can breastfeed! *J Hum Lact* 2015; 31(1): 187-8.
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perspective

NCT's journal on preparing parents for birth and early parenthood

Become an NCT supervisor!

NCT tutor and breastfeeding counsellor Ann Parker explains why being an NCT supervisor is a great role

NCT is providing new training opportunities for practitioners to become supervisors. This is a lovely way to support other practitioners and enable them to explore their practice more deeply. Supervision works by the practitioner reflecting on a chosen situation prior to the supervision session. They then explore the situation with their supervisor, their role within it, their view of it, how others might have felt, and what could be learnt from the experience for future practice.

Why does NCT need more supervisors?

For many years NCT has provided supervision for those practitioners working in a one-to-one capacity with expectant parents, and with parents postnatally. So far these have been breastfeeding counsellors and doulas. More recently, newly qualified assessors have also been offered supervision to enable them to develop their practice in supporting other practitioners. NCT now aims to roll this out to other assessors, including those who are not tutors and who therefore do not have a line manager.

Dates and location for NCT supervisor training

We offer a four-day training course: a day's training, a weekend and another day, over a reasonably short time frame. Supervision training for 2017 will probably be around the London area on the following dates:

Tuesday 9th May

Saturday 20th & Sunday 21st May

Wednesday 28th June

What does the training involve?

Prior to supervision training, prospective students will need to have Excellent Practitioner status, for their facilitation skills. For breastfeeding counsellors, successful completion of the supervision training will also qualify them as an EP in counselling skills. Students will also need to have received some supervision previously, which can be arranged prior to the course commencing if receiving supervision is not part of normal practice.

This is an in-house NCT training module. The study days involve looking at theoretical and practical aspects of supervision, and doing role-play supervision with other course members. Participants will also write a reflective assignment based on a taped supervision session that they have completed with another practitioner. The current course fee is £200, which can be paid either up front, by instalments, or through a pay-as-you-earn arrangement. Participants will need to cover their own travel expenses and purchase of books. If a practitioner is up-to-date with her specialism CPD requirements, she can use either one or two of the training days as her CPD for that year. This would mean she could claim travel from the PSA as for any other study day.

Feedback from previous students

'Now that we have finished the course, I feel that I would like to do it all again! I thought it was an excellent course... It has made me realise how much I would like to be a supervisor.'

'I gained insight from the experience and working with practitioners from other specialisms and hearing their experiences of supervision.'

'I have really valued this course both as an NCT practitioner but also on a very personal level in terms of my relationships with others and myself'

For more information and to apply, please contact Maria Dowden & Ann Parker at supervisiontraining@nct.org.uk

More information can be found on Babble at:
http://bit.ly/2mE8bVF