Government
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TWO FOR THE PRICE OF ONE
The impact of body image during pregnancy and after birth

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Executive Summary

- Eating problems of all kinds are on the rise. The most visible and obvious is obesity, which is straining the resources of the NHS. The most hidden is the chaotic eating which doesn't show but which involves individuals who intermittently restrict and binge while obsessing about their bodies, rarely feeling safe around food.

- Many factors contribute to the current epidemic. Often overlooked is the role of inter-generational transmission of eating problems and the psychological meaning of eating and body difficulties. This is especially powerful between mothers and daughters but it extends to the whole family. We see obesogenic families and families who are vulnerable to eating problems and we see families in which food restraining, fad dieting and extreme exercise are the manifestation of disturbed appetites and fear of food.

- Psychologists, neuroscientists, infant researchers, and public health professionals agree that conception to age 2 is a vitally important time in human development. It lays down patterns for life. It is also a time when attention targeted to parents and babies reaps huge dividends for society.

- Early attachment between mothers and babies creates the foundation for mental health, resilience and flexibility in children. Mothers who are preoccupied with eating and body image problems can inadvertently behave in ways that shape bonding and attachment patterns in damaging ways.

- Midwives and health visitors are crucial in the transmission of public health to mothers and new babies. They are vested with ensuring that the mental and physical health of mother and baby is optimised.

- Midwives and health visitors receive little training on the effect of eating problems on mothers' relationship with her infant, the feeding relationship and its impact on the baby's developing body. They also work with significant resource constraints and can be hard-pressed to find time to take on new issues and challenges. Nevertheless, we cannot afford to overlook their potential contribution to supporting women's body image and healthy eating behaviours at this time.

- Early intervention is the optimal chance to reach two populations in one go. Pregnancy and post-partum is a time when mothers are most receptive to 'getting things right'. If midwives and health visitors could routinely talk with mothers about these issues, it would help to identify causes of distress and unease and legitimise asking for help if mothers feel they want and need it. It gives women the opportunity to optimise their own wellbeing and therefore also the wellbeing of their babies.

What is the problem?

Body image concerns are widespread. When women overestimate their size, they feel bad about their bodies and their well-being plummets. They tend to either curtail or override their appetites in an attempt to control the feeling of real or imagined fatness and this is leading many women to have to disturbed eating.[1] When women underestimate their size, they also lose contact with basic physiological prompts signalling hunger and satisfaction.

The conjunctions of body image distress and disturbances in eating have tended to be seen as either trivial and vain, or as medical psychiatric issues. This has meant that they have rarely been in focus in considering health policies for expectant mothers. Understanding these disturbances explains why sound nutritional advice is often poorly taken up despite women wishing to do so.

Women's concerns are anything but trivial. They are making women feel deeply uneasy in their bodies. They are disturbing women's eating patterns. They are impacting on how women relate to their physical needs in pregnancy and post-partum, interrupting the focus on bonding with baby in the crucial early months when attachment behaviours are being established (Treasure 2013, Fairburn 1993, Orbach 2003).

Becoming 'an ordinary devoted mother' (Winnicott 1960) is not as natural a process in our times as we might wish.

The first few months of life are critical in establishing the foundations for well-being in the mother-infant couple and for the building of security and resilience in the baby. From Bowlby's work on Attachment to neuro-scientific studies showing the effects of brain development, motor development and the uptake of specific hormones as soothers for babies, the picture is clear. Becoming 'an ordinary devoted mother' (Winnicott 1960) is not as natural a process in our times as we might wish. It is often fraught with pressures and anxieties derived from women's relationship to their bodies – including their ability to feed and nurture themselves – along with an avalanche of often contradictory parenting advice, plus media messages that the most important thing about giving birth is the retrieval of the pre-pregnant body (Orbach 2009).

Media images that laud celebrity mothers who achieve a state of emaciation six weeks after delivery are switching the focus of the post-partum period away from mother and baby getting to know each other and finding a rhythm together. Instead there is a cultural insinuation that a mother's job is to present herself physically as though nothing as momentously life-changing or body-changing as having a baby has occurred. This critical moment, in which new life and the new mother weave together a delicate and precious bond, needs supporting in order to ensure the best possibilities for both.

[1] including obesity, anorexia and bulimia

Feeding baby, nurturing baby

Breastfeeding, weaning and establishing eating habits for a new person pose challenges. Once a baby is born its growth occurs outside the woman. Every woman has to learn how to feed their baby. The breast is best message does not mean that breast feeding is straightforward for every woman. Breastfeeding may require the help of a midwife, health visitor, grandmother or older sister. It is not "the most natural thing" for every woman so if there are initial difficulties and mothers are not taught properly and patiently, they may be disheartened, stressed and feel guilty for not being able to feed their babies 'the best'. Troublingly, this will loop back into negative feelings they may have about their body image which means that without intervention their own embodiment, that's to say, the body experience that they bring to mothering, will encode within it a sense of failure (Orbach 2009).

Images and experiences of pregnancy

Pregnancy is usually a time of hope, joy and promise. Many women enjoy being pregnant. They revel in their growing roundness and feel good on the outside as well as the inside. For others, discomfort about bodily changes causes worry and creates a background of discomfort and anxiety about how large they are, how limited their control over their own bodies, and about whether they will ever get their bodies back. For still others, the difficulties are far more serious. They may feel despair about how they look (Lemberg & Phillips 1989), unable to surrender to their body's changes, isolated from the hype and excitement of pregnancy. The lack of a "blooming pregnancy" contributes to a sense of guilt and confusion. The midwife encounters all of these concerns.

If a woman has always actively managed her body through strict food and exercise regimes, she is confronted by a body which seems to have a mind of its own. It is in rebellion. The pregnant body is felt as alien rather than natural and its changing can alarm her. Her diet is disrupted and she becomes anxious.

If she has always overeaten then she will not necessarily know how to eat appropriately in pregnancy. She may misinterpret bodily signals and 'over' eat to quell morning sickness, distancing herself further from her bodily needs. Her emotional need to eat will provide the rationale for eating for more than two (Park, Senior, Stein 2003).

For those who have long lost touch with hunger mechanisms, the solution may be continuing to eat without regard to physiological cues or nutritional common sense (Stein 1994, Fairburn, Jones, Stein 1993).

All of this is exacerbated by societal and media pressure which implicitly encourages women to restrict their eating so as to have less to lose after baby is born, while also encouraging women to indulge themselves during this period. It is a contradictory message causing considerable confusion.

For women who are inclined to the regimental, the solution may be to self-focus rather than baby-focus in a way that is not about health but is about the reclaiming of skinny jeans after delivery. For those who have long lost touch with hunger mechanisms, the solution may be continuing to eat

without regard to physiological cues or nutritional common sense (Stein 1994, Fairburn, Jones, Stein 1993).

From pregnancy to becoming a mother

Pregnancy is different from mothering. In a first time pregnancy the focus is all on the woman. As soon as the baby arrives the focus switches to the baby. Considerable hormonal shifts intensify after birth as the woman's attention is directed to establishing routines, being responsive to her baby, managing her own milk supply, finding time to sleep, to relate to her partner, to become a parent. It is an exhausting and exhilarating time for most women, although for a considerable percentage the hormonal fluctuations create a post-partum depression which is debilitating and deeply dismaying. Midwives and health visitors have been trained to identify this and intervene early so as to minimize the risk to mothers and babies.

An important task of early parenting is establishing the baby's emotional safety. Infant researchers Stern and Beebe demonstrate the significance of the early communication between mother and baby (Stern 1985, Beebe 2011, Tronick 2007). They show the importance of feeding, of play, tease, tenderness and engagement between mother and baby and how this establishes the building blocks of attachment and psychological well-being. Primary in this emotional interchange is the feeding relationship. Along with holding, hugging, smiling, bathing and helping the baby to sleep, a repertoire builds the psychic structure and internal security of the baby. It is how the baby comes to know herself (Gerhardt 2004).

When her mother reliably responds in ways similar to the way she did yesterday and the day before, the baby senses that its needs for hunger, for soothing, for sleeping, for recognition are being met. The personal rhythm of each mother baby-couple will shape the baby's experience of what is to come. If the mother is reasonably consistent, the baby will experience a consistency of care and take that as an emotional baseline. If the mother is inconsistent, the baby will find her or himself alive to a kind of jagged or varying baseline to which she or he will adapt. It will become the baby's idiom, her or his way of being in a close relationship.

Early bonding and attachment behaviours create specific neural pathways with oxytocin, the bonding hormone in ample supply in babies who are well enough related to. Where high levels of stress predominate in the mother with ensuing panic, the neural system is flooded with cortisol which is a stressor hormone paradoxically requiring increased stress, such as panic, to create soothing (Pitman 1990).

Bonding and attaching

Attachment is more than just a connection between two people. It is the model for introducing the baby to how the world is. The bond between the mother (parent, grandparent or carer) is critical. It is the emotional cradle from which the baby experiences intimate relationships within the family and then gradually to a widening community. If the mother is not aware of how her baby is feeling or is unable to imagine the baby's needs, the kind of attachment which occurs will be characterized by mis-attunement. The baby will read, feel and experience relationships in the manner of her primary relationship and this will guide her relationships from then on (Bowlby 1995, Gerhardt 2004).

Insecure and preoccupied attachments which result in mothers who are distracted are associated with troubling outcomes for child and adult mental health.

All babies are attachment seeking and develop the psychological apparatus to depend on what is offered. Thus if the mother is available and attuned, the baby will make her attachment experiencing that security. *If the mother is distracted or anxious, neglectful or preoccupied, the baby will understand in her or his very being, the experience of attachment in those terms*. This is a complicated idea to comprehend because common-sense would say that the person on the end of a negligent attachment would then reject it. But this is not so. Humans attach to what there is and paradoxically the more chaotic, the more pre-occupied, the more anxious the carer, the fiercer the connection. The baby fills in the holding which is missing and makes the bond with her or his carer out of the little she or he receives.

While secure attachment is obviously the optimum outcome for the baby (Main 1995, Fonagy, Target 2007) many things interfere in the capacity of a parent to offer a secure attachment. Insecure and preoccupied attachments which result in mothers who are distracted are associated with troubling outcomes for child and adult mental health.

Secure attachment is the building block of resilience, psychological safety and flexibility and these emerge out of the mother's attachment history, experience of being parented, her longings to do right by her baby, as well as the cultural pressures which bear down on the individual woman. The latter, particularly in a time of intense commercial focus on new parents, can make parenting a fraught and troubled time.

Hindrances to a woman's capacity to offer her baby a stable attachment arise from the woman's own experience of being parented. They arise from disrupted attachments, from difficult separations, and from parental preoccupation and focus elsewhere. *Unrecognized hindrances arise too out of women's insecurities about their self-esteem, their body image and their own eating.* These can intercept their ability to listen to the whispers of their maternal instincts. Midwives and health visitors endeavour to understand the dilemmas facing a particular mother within her specific circumstances. They speak to the difficulties and conflicts which may hinder the mother's capacity to offer a secure attachment to her baby. They gently and skilfully create conversations with mothers that address their concerns and help shift the individual isolation and quandaries each new parent faces so that a whisper becomes a confident wave (Cooper, Murray, Wilson, Romaniuk 1993).

Mothers with body image and eating problems

Understanding how a woman's body image may be affecting her wellbeing and functioning is important for the health professionals responsible for caring at this precious and vulnerable time. This issue is often missed or minimised because of our society's normalisation of pathological attitudes to food and the body.

What is neglected, as a result, is the intergenerational transmission of body and eating problems (The BODI Group 2014). We have tended to see such problems as coming from external cultural forces such as the media and the style industries – which they do – but we have underestimated the ways in which societal influences come to life in the individual woman and are integrated into her sense of self. *It is her attitudes towards bodies, and her own bodily sense which she will pass on. As she absorbs the cultural messaging about thinness and fatness, she makes the culturally praised values her own but the means to manage those values inside of herself may clash with her ability to moderate her own appetites in a healthy way*. The way she eats, her attitudes towards health, food and hunger as well as the emotional reasons why she may eat or not eat are all passed on wordlessly to her baby: the positive and the negative. She will not want to pass on the negative and yet inevitably, without intervention, she will.

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Every mother wishes to do right by their baby. For those who begin this journey already struggling with more serious eating problems and body image disturbance, the challenge to feed and nurture will be considerable and yet it may be wrapped in shame and hidden from view. The shame coupled with the wish to give baby a good start without actually knowing what that might be can make this an especially tense time for mothers (Easter, Naumann, Northstone, Schmidt, Treasure, Micali 2013).

With appropriate training, pregnancy and post-partum provides a unique opportunity for midwives and health visitors to help women transform their own body image and eating problems. In so doing they enable both an existing population get through their issues while inoculating the next generation coming up.

Building baby's secure body image

A critical but until recently overlooked aspect of child development in the very early months is around the baby's comprehension of its own body image. Body image does not happen at 5 or 10 or 15. Body image evolves as the baby grows into a child and an adolescent but the basic sense of one's body is structured into the individual very early on (Lemche 1998, Orbach 2009). This comes from how the mother relates to the baby's evolving needs for food, sleep, soothing and the like but it is also emerges out of the way in which the mother brings her own body to her baby. What does this mean?

The awareness that a woman has of her own bodily needs, her personal comfort or discomfort about feeding, her ease or uneasiness about living in a post-partum body make up an important facet of the body to body relationship between a mother and her infant. This facet folds in with other aspects which relate to her attitude towards her baby's body.

The emotional attitude that a mother brings is sewn into the fabric of her relating to the baby and if she has a stable body image she will weather the challenges which mothering an infant provoke.

Is she able to see her baby as a separate but dependent being who expresses different bodily needs than she has herself? Does she see her baby as an extension of her own body that she likes or dislikes and so on (Orbach 1978, 2009)? Does she allow her baby to relish her or his appetites or does she try to shut them down as she may try to do with her own? Does she feed the baby up to give herself a good feeling? Does she offer food when other forms of soothing or relating would more accurately meet baby's squalling?

All such questions beset new mothers and are part of the discovery of parenting and the magical power that is vested in the relationship for the mother. But in so far as the mother has a troubled relationship to her body, this will be reflected in aspects of this very intimate time together.

The body that the mother brings to her baby will form the template for the baby's sense of its body. The emotional attitude that a mother brings is sewn into the fabric of her relating to the baby and if she has a stable body image she will weather the challenges which mothering an infant provoke. In turn she will pass on a confident body to her baby which will protect the developing child from the many exhortations to have a certain kind body which now accompanies childhood. If she feels insecure in her body and relates to it chaotically, bingeing for several days and restricting eating on others, for example, the baby will sense the tension in her body as it unconsciously begins the process of developing her or his own body signature.

Save lives by saving money: the economic case for early intervention

Evidence-based and well implemented preventive services and early intervention in the foundation years are likely to do more to reduce problems than reactive services which have to respond to entrenched patterns. They deliver economic and social benefits. Such services also have an important role in making sure all children reach school ready to learn and able to achieve to the best of their abilities.

Graham Allen MP, Chair of the independent review of early intervention and now of the Early Intervention Foundation working with the Royal College of Midwives, has pinpointed the importance of the Family Nurse Project (FNP) through recognizing the role of midwives, health visitors and parenting support in order to provide health equity.

"*The aim of Early Intervention is to build social and emotional bedrock in every baby, child and young person." The costs to the tax payer by not intervening early are enormous (Allen, 2011).*

The need to provide help in relationship to women's body, food and self-esteem issues is crucial if we are to inoculate the next generation from even more severe body image and eating difficulties including anorexia, bulimia, compulsive eating and obesity.

A review conducted on a wide range of published UK and international studies into the economic case for investment in the early years came to the conclusion that returns on investment on well-designed early years' interventions *significantly* exceed both their costs and stock market returns (Wave Trust, 2013). Early intervention saves money by saving lives.

In the UK the Social Return on Investment showed returns of between £1.37 and £9.20 for every £1 invested. In an econometric analysis, Nobel Laureate James Heckman argues that structures (including knowledge and skills) are based on foundations and the stronger the foundations the more solid the structure, with the highest returns at age 0-3. He also points out that in both promoting economic efficiency and reducing lifetime inequality, *early years' interventions provide policy makers with a rare capacity to spend money in a way, which simultaneously delivers substantial social as well as economic benefits*[2].

Scandinavian countries, such as Sweden and Norway, which have adopted whole country approaches to investment in early years' prevention, have achieved not only financial returns but better health overall for the entire population. The benefits span lower infant mortality through to reduced heart, liver and lung disease in middle-age.

The Healthy Child Programme (HCP) and the commitment to provide early education for all disadvantaged 0-2 year-olds gives the UK an existing platform for universal preventive services. The FNP developed at the University of Chicago, adopted and delivered in England since 2007 by midwives and health visitors, aims to work with mothers' intrinsic motivation to do the best for her child. It has produced positive results as exemplified by mothers showing increased self-esteem, a reduction in smoking during pregnancy and an increase in initiating breast feeding. The nurses within this programme are themselves supported by supervision and training[3].

The Early Intervention literature makes a persuasive case for support to new mothers. The need to provide help in relationship to women's body, food and self-esteem issues is crucial if we are to inoculate the next generation from even more severe body image and eating difficulties including anorexia, bulimia, compulsive eating and obesity. A population living with body anxiety and its physical manifestations is fast becoming the norm. We have the tools to intervene early on to minimize the effects of commercial culture which now are affecting children as young as five and continue throughout life. By supporting mothers in this area, we ensure that this foundational aspect of parenting – the gateway to all future relationships - is wholesome, relaxed and secure.

[2] See page 105 *Conception to Age 2 – The Age of Opportunity* which gives compelling economic arguments for early intervention. It compares the expected economic return of early intervention versus the anticipated return from HS2. Wave Trust 2014

[3] This information was prepared for Lynne Featherstone MP and Susie Orbach in 2012 by DOH)

APPENDIX 1

WHAT MIDWIVES AND HEALTH VISITORS SHOULD KNOW

- *Awareness of how body image and eating problems affect women.*
- *Significance of early feeding relationship to mental health and prevention of obesity, bulimia, compulsive eating and anorexia*
- *Mother's relationship to food: helping mothers to identify their own needs for food and nutrition*
- *Teaching mothers to recognise infants and children's need for food, cues which indicate hunger and satiety, and to separate those from needs and cues for comfort, soothing, stimulation and recognition*
- *Understanding mothers with entrenched eating difficulties and the impact of this on their infant's development, as well as the relationship with their infant or child*
- *Intergenerational transmission of eating anxieties*
- *Family relationship to food*
- *How food deprivation or over eating during pregnancy and post- partum impact on the manner in which mother's bond*
- *Mother and baby attunement*
- *Ethnic and class issues in attachment and feeding relationship*
- *Knowledge of body development at the 'psychological' level*
- *Attending to the feelings which interrupt women feeding their babies and themselves post-partum*
- *Knowing how to refer on when there is concern*
- *Examination of MW and HV attitudes to body size and weight, including personal goals, and how this may influence interactions with mothers*

APPENDIX 2

WHAT MIDWIVES AND HEALTH VISITORS CAN DO

We know that midwives and health visitors are working extremely hard, and it may be difficult to imagine how you can include the subject of body image into an already heavy clinical caseload. However, you can make a valuable contribution, just by reading this report, thinking about the implications for your practice, and making small but thoughtful changes in how you discuss body and nutrition issues with the women in your care.

Here are some tips from other midwives and health visitors to get you started:

What you can do	What can help
Learn about body image and its impact on maternal and infant wellbeing	www.womenshealth.gov/body-image/pregnancy/ www.nhs.uk/Conditions/pregnancy-and-baby/Pages/your-body-after-childbirth.aspx#close Susie Orbach: 'Bodies' (Profile, 2009)
Model diversity	Try to ensure that your workplace has images of happy, healthy-looking women who are different sizes and shapes, such as these: 


You are NOT Too Heavy
to Exercise
SPARKPEOPLE

	
Be mindful of the language you use	Be careful about language that unwittingly stigmatises fat people or talks about food or bodies as having intrinsic moral worth (for example, a chocolate biscuit is not a 'naughty' food – though it is a processed sugary food that is best eaten in moderation within a balanced diet).
Talk to women about body image.	Women talk about bodies and food all the time! You will get lots of opportunities to do this in ways that allow the woman an opportunity to tell you how she is feeling. For example, you might say 'Some women really like the way their body shape changes when they are pregnant – how have you been feeling?' You can also use people in the media as a starting point for conversation. Is there a character in a soap opera that is pregnant/has recently had a baby? What does she look like? Has there been any mention of her body shape/size? This is a really good starting point for a conversation.
Act	If a woman appears to be very distressed, you will need to refer her for specialist help. This might include referring her to b-eat: www.b-eat.co.uk/ but may also include referral to the perinatal mental health team in your area. It's a good idea to ensure you know how to contact them.
Share your learning with colleagues	This would make a great topic for discussion at a team meeting or study day.

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