Breastfeeding as Co-Occupation: Occupational Therapy’s Role in Promoting Health and Well-Being

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Abstract

Background: Even with efforts to encourage mothers to breastfeed exclusively for the first 6 months, the majority of women are not able to undertake breastfeeding as the sole means of infant nutrition provision for various reasons. The role of occupational therapists working with mothers who breastfeed is complex and not strongly supported in the literature. Therefore, this qualitative study was designed to examine the role that occupational therapists may engage in supporting mothers and infants in the co-occupation of breastfeeding.

Method: A qualitative phenomenological study design was applied and included 11 occupational therapists working with breastfeeding dyads. The occupational therapists engaged in a semi-structured interview that examined how they worked with mothers and infants who breastfed in practice. Data were analyzed to identify themes that emerged from interviews.

Results: Four key themes were identified: An occupational therapy approach, patient education and direct intervention, mental health support, and understanding breastfeeding as an occupation and co-occupation.

Conclusion: Occupational therapists provided holistic and individualized treatment strategies for breastfeeding dyads. Occupational therapists have a unique understanding of the co-occupation of breastfeeding and are equipped to address a variety of maternal and infant factors, leading to improved health and well-being for both members of the breastfeeding dyad.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords
breastfeeding, co-occupation, health, well-being, women's health

Credentials Display
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Over the past decade, the World Health Organization (WHO) has consistently recommended putting babies to the breast within 1 hr after birth, exclusively breastfeeding for the first 6 months of life, and breastfeeding up to 2 years of age or beyond (2024). Similarly, the American Academy of Pediatrics (AAP) has recommended exclusive breastfeeding for 6 months, followed by continued breastfeeding for 1 year as complementary foods are introduced (2022). The current rate for exclusive breastfeeding at 6 months is 25.6% in the United States (Centers for Disease Control and Prevention [CDC], 2009). This is an improvement from the 13.6% reported in 2009 and likely correlated with the Healthy People 2020 initiative (U.S. Department of Health and Human Services, n.d.). The current Healthy People 2030 initiatives aim to improve exclusive breastfeeding at 6 months to 42.4% (U.S. Department of Health and Human Services, 2021).

**Benefits**

The benefits of breastfeeding for both mothers and infants are well documented in the literature. Infants who were breastfed have been found to have a lower risk of developing Type 2 diabetes and asthma, as well as reduced rates of ear and respiratory infections (CDC, 2023). The benefits of breastfeeding for mothers are lower risk of developing breast cancer, ovarian cancer, and Type 2 diabetes (CDC, 2023). In addition, women who breastfeed have lower rates of cardiovascular disease, hypertension, hyperlipidemia, and rheumatoid arthritis, as well as increased protective factors against postpartum depression (Bigelow et al., 2014; Tedder, 2015).

**Factors Impacting Breastfeeding Duration**

It is important to consider psychological factors that influence the likelihood of breastfeeding: anxiety, dispositional optimism, overall belief that more good than bad will occur in the future, timing of the infant feeding decision, breastfeeding expectations, planned breastfeeding duration, and faith in breast milk and breastfeeding self-efficacy (O’Brien et al., 2009; Meedya et al., 2010). Higher levels of perceived maternal stress before and after delivery are often linked to lower levels of perceived self-efficacy, implying that decreasing maternal stress could positively impact breastfeeding duration (Aziziz et al., 2018; Thurgood et al., 2022).

Many other factors may influence breastfeeding, such as cultural factors and values, nutritional intake, and access to formula (Gross et al., 2023). Two significant determinants for breastfeeding are maternal age and education level (Radzyminski & Callister, 2016). A large national study found that college graduates breastfed their infants through 12 months at a rate of 20% higher than mothers who had obtained a GED or high school diploma (Antsey et al., 2017). Mothers with higher incomes may be able to afford breastfeeding supplies, including breast pumps, lactation consultant fees, and childcare or household support, which may lead to increased breastfeeding rates (Standish & Parker, 2022). Lower-income households are associated with an increased risk for food and housing insecurity, which are both linked to decreased rates of breastfeeding (Standish & Parker, 2022). Mothers over the age of 30 also have substantially higher rates of breastfeeding at 12 months (34.3%) as compared to mothers under the age of 20 (8.7%) (Antsey et al., 2017). In the 34 states with an adequate sample size, breastfeeding initiation rates were significantly lower in black infants than in white infants in 22 states, primarily in the South and the Midwest (Antsey et al., 2017). Culturally relevant interventions, policies, and support are needed to decrease social and economic disparities and increase breastfeeding rates across the United States (Antsey et al., 2017; Standish & Parker, 2022).
Policy

For mothers who are employed, policies that support mothers in the workplace are critical to breastfeeding success. Current policies regarding breastfeeding in the United States are intended to normalize breastfeeding and protect a woman’s right to breastfeed (Danawi et al., 2016). Senate Bill S.1658 (117th): PUMP for Nursing Mothers Act expands workplace protections for employees who need to express breast milk by expanding the requirement that employers provide certain accommodations for both salaried employees and other types of workers not covered under existing law. Furthermore, the time spent to express breast milk must be considered hours worked if the employee is also working. This builds on the existing law that already required employers to provide reasonable break times for an employee to express breast milk for her nursing infant for 1 year after the infant’s birth. It also requires employers to provide a place, other than a bathroom, for employees to express breastmilk that is shielded from view and free from intrusion of co-workers and the public (PUMP for Nursing Mothers Act, 2021).

Even with changes to laws and policies, mothers often cease breastfeeding before 6 months. In a study focusing on assessing workplace breastfeeding support among working mothers in the United States, one-fourth of participants (25%) introduced formula or other foods within the first month of returning to work (McCardell & Padilla, 2020). Further, in a study of 500 mothers who stopped breastfeeding before 6 months, the majority (73.6%) reported that they stopped within the first 6 weeks (Brown et al., 2014). The most common reasons cited were inconvenience or fatigue associated with breastfeeding (22.6%), concerns about milk supply (21.6%), and return to work or school (20%) (Brown et al., 2014).

Occupational Therapy’s Role

The overarching goal of occupational therapy is to support clients in achieving health, well-being, and participation in life through engagement in occupation (AOTA, 2020). Therefore, facilitating engagement in the co-occupation of breastfeeding is also believed to support health, well-being, and participation by the mother-infant dyad, otherwise known as the breastfeeding dyad (Crippa et al., 2021). Co-occupation refers to the uniquely interactive occupations of more than one individual, where expressions of those occupations shape each other (Pierce, 2009). Occupational therapists have a unique perspective in addressing and evaluating occupations in a holistic way for both members of the breastfeeding dyad. The Occupational Therapy Practice Framework: Domain and Process (AOTA, 2020) lists breastfeeding as a nighttime caregiving activity in the context of sleep participation. Breastfeeding can be part of a shared nighttime caregiving routine that occurs before sleep and throughout the night to provide safety and comfort for an infant (AOTA, 2020). Infant feeding can also be associated with feeding under Activities of Daily Living (ADLs) as well as health management and maintenance and child-rearing under Instrumental Activities of Daily Living (IADLs) (AOTA, 2020). Recognizing breastfeeding as a co-occupation assists in the characterization of breastfeeding as transcending eating, feeding, child-rearing, and health management and maintenance occupations (Pitonyak, 2014).

An occupational therapy approach may improve outcomes for children, mothers, families, and society with respect to the following outcomes: health and wellness, prevention of disease and illness, role competence, and well-being (AOTA, 2020). Studies have found that breastfeeding initiation was significantly associated with reduced overall infant mortality (Ware et al., 2019) as well as infant deaths because of sudden unexpected infant death, infections, and necrotizing enterocolitis (Li et al., 2022). Occupational therapists can play a role in skills training, including feeding, eating, and swallowing, while also considering cultural, environmental, physiological, and psychosocial factors (AOTA, 2017).
Emerging evidence asserts that occupational therapy is poised, skilled, and well-positioned to address the unique co-occupational needs of mothers who breastfeed and their infants (Sponseller et al., 2021).

Current methods for educating women about breastfeeding occur in the context of the medical model, typically through pre-natal education, which covers lactation education (Tedder, 2015). Occupational therapists may also be able to hold a formative role on transdisciplinary teams addressing breastfeeding (Visser et al., 2016). A recent study providing group therapy sessions at a nonprofit lactation center indicated that occupational therapists supported mothers in meeting their occupation-based goals successfully while sustaining breastfeeding (S sponseller et al., 2021). Another study explored how occupational therapists in the Neonatal Intensive Care Unit (NICU) addressed breastfeeding and found they were often working as clinicians and educators, but more research is needed for practice and policy to support the health of mothers and infants (Smith et al., 2019). Other members of the transdisciplinary teams, such as speech-language pathologists (SLPs), are also trained to provide feeding intervention for infants, and their knowledge base often lies in bottle feeding and the evaluation of swallowing (Mahurin-Smith & Genna, 2019).

While the literature on the effectiveness of occupational therapy interventions for sustained breastfeeding is emerging, there is limited information regarding the role occupational therapists have in working with both members of the breastfeeding dyad in different settings. Some research has focused on the specific roles and barriers of NICU occupational therapists in addressing breastfeeding, with findings indicating that occupational therapists have the necessary skills, but further evidence is needed related specifically to breastfeeding and working with the mother-infant dyad (Smith et al., 2019). Further research is needed to explore occupational therapists’ unique understanding regarding the co-occupational experience of breastfeeding dyads (Pitonyak, 2014). Significant opportunity exists for occupational therapists to assist individuals, organizations, and populations in the promotion of breastfeeding from a holistic and occupational perspective (Pitonyak, 2014). Therefore, the purpose of this research study was to understand the perceived roles of occupational therapists in supporting mother and infant dyads through the co-occupational experience of breastfeeding.

**Method**

**Research Design**

A phenomenological qualitative research design was used to explore the role of occupational therapists in supporting dyads engaged in the co-occupation of breastfeeding (DePoy & Gitlin, 2016). Phenomenological inquiry is derived from the fields of psychology and philosophy in which the researcher describes the lived experiences of individuals about a phenomenon through participant discursive narrative (Creswell & Creswell, 2018). Semi-structured interviews allowed qualitative data to emerge through a naturalistic lens (DePoy & Gitlin, 2016). This study was approved by the University’s Institutional Review Board. Informed consent was obtained before recruitment and data collection.

**Participants**

Participants were recruited using purposive sampling methods in which a research flyer was posted on the university’s Facebook page and sent directly via email to occupational therapists who advertised field-specific work on public websites. Inclusion criteria were licensed occupational therapists, English speaking, who provided at least 1 year of direct service to mothers who breastfed, and worked in a setting where they provided either lactation support or early intervention services. No identifiers were collected beyond the informed consent to protect the confidentiality of the participants.
Instruments

A demographic questionnaire was developed to collect information that included specialty certifications, employment type, practice area, practice setting, years as an occupational therapist, and years working in infant/maternal health. The Person Environment Occupation (PEO) model (Law et al., 1996) was used to formulate 16 semi-structured interview questions related to the person, environment, and occupation, specifically the co-occupation of breastfeeding. The participants were also asked environment-related questions such as, “How do you address concerns the client has with the physical or social environment? In addition, the occupational therapists were asked questions about co-occupation for the occupation-related questions, such as, “As you consider the mother/infant dyad in feeding, do you believe the co-occupational experience helps facilitate optimal bonding/attachment?”

For person-related questions, the MOHO was used to formulate semi-structured interview questions that examined volition, habituation, and performance capacity (Kielhofner, 2008). Example questions included: “How do you address the choice a mother has to breastfeed?” and “How do you help mothers develop habits that help them reach their goals for breastfeeding?” The Model of Human Occupation Screening Tool (MOHOST) was reviewed to help guide the development of semi-structured interview study questions (Parkinson et al., 2004).

Data Collection

The participants were sent a link via email to complete the demographic questionnaire online via Qualtrics. Once the initial demographic questionnaire was completed, the participants engaged in a semi-structured interview with the first author via Zoom. The interviews were audio-recorded and transcribed before data analysis. The participants were provided with a pseudonym during the data collection and analysis process to protect their identity. Any unintentionally disclosed identifiers shared by the participants during the interview were removed during the transcription process. During data collection and analysis, data was stored on a password-protected HIPPA-compliant network.

Data Analysis

The verbatim interview transcripts were uploaded to Dedoose, a cross-platform application (Dedoose, 2021). The first author initially coded transcripts using descriptive coding and categorized codes with feedback and guidance from the research team (Creswell & Creswell, 2018). Regular research team meetings were held to support data analysis. Throughout this process, 832 transcript excerpts were coded. After an initial codebook was established, all members of the research team engaged in revisions to the codebook to determine the best fit within major code and sub-code categories. The final codebook consisted of four themes and 19 sub-code categories (DePoy & Gitlin, 2016). Regular research team meetings were held to support data analysis and interpretation. Extensive discussion regarding thematic organization provided a clear interpretation of the emerging data (Creswell & Creswell, 2018). The presence of investigator bias was expected; therefore, reflexivity in the data analysis process was employed (DePoy & Gitlin, 2016). Consideration was given to the perspectives and voices of the participants and persons to whom this research is being disseminated. Intelligent transcription was used when selecting key quotes in the results section.

Results

All eleven participants in this study were female, registered occupational therapists. Ten of the participants held specialty certifications in lactation, including Certified Lactation Educator (CLE), Certified Lactation Counselor (CLC), and International Board Certified Lactation Consultant (IBCLC).
Interviews ranged from 33 min to 72 min in length. Table 1 contains demographic information about the study participants.

Table 1
Demographic Information (N = 11)

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Education</th>
<th>Specialty Certification</th>
<th>Employment</th>
<th>Practice Area</th>
<th>Practice Setting</th>
<th>Years as Occupational Therapist</th>
<th>Years in Maternal/Infant Health</th>
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</thead>
<tbody>
<tr>
<td>Belle</td>
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<td>CLC</td>
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<td>Early Intervention</td>
<td>Lactation Infants</td>
<td>Private Practice</td>
<td>15+</td>
</tr>
<tr>
<td>Aurora</td>
<td>Master's</td>
<td>CLC</td>
<td>Part-time</td>
<td>Government Agency</td>
<td>NICU</td>
<td>6–10</td>
<td>1–2</td>
</tr>
<tr>
<td>Esmé</td>
<td>Master's</td>
<td>IBCLC</td>
<td>Part-time</td>
<td>Inpatient/ Hospital</td>
<td>NICU</td>
<td>15+</td>
<td>5–10</td>
</tr>
<tr>
<td>Anna</td>
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<td>IBCLC</td>
<td>Part-time</td>
<td>Government Agency</td>
<td>Private Practice</td>
<td>6–10</td>
<td>2–3</td>
</tr>
<tr>
<td>Deb</td>
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<td>Private Practice</td>
<td>15+</td>
<td>10+</td>
</tr>
<tr>
<td>Tia</td>
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<td>Early Intervention</td>
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<td>15+</td>
<td>2–3</td>
</tr>
<tr>
<td>Jasmine</td>
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<td>IBCLC</td>
<td>Part-time</td>
<td>Lactation</td>
<td>Private Practice</td>
<td>3–5</td>
<td>3–5</td>
</tr>
<tr>
<td>Jane</td>
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<td>Infants</td>
<td>NICU Private Practice</td>
<td>6–10</td>
<td>3–5</td>
</tr>
<tr>
<td>Violet</td>
<td>Master's</td>
<td>CLC</td>
<td>Part-time</td>
<td>Lactation</td>
<td>NICU Private Practice</td>
<td>6–10</td>
<td>1–2</td>
</tr>
<tr>
<td>Sally</td>
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<td>IBCLC</td>
<td>Full-time</td>
<td>Pediatrics Lactation</td>
<td>NICU Private Practice</td>
<td>11–15</td>
<td>5–10</td>
</tr>
<tr>
<td>Ariel</td>
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<td>Full-time</td>
<td>Inpatient/ Hospital</td>
<td>NICU</td>
<td>15+</td>
<td>10+</td>
</tr>
</tbody>
</table>

Through the phenomenological exploration of the lived experiences of the occupational therapists in this study, the distinct value of occupational therapy with breastfeeding dyads was magnified. Four themes emerged during data analysis: an occupational therapy approach, patient education and direct intervention, mental health support, and supporting co-occupation through breastfeeding.

An Occupational Therapy Approach

The participants provided insight into the occupational therapy approach and process that occurs with breastfeeding dyads in order to support dyad breastfeeding goals. The occupational therapy approach, described by the occupational therapists, takes into consideration the interplay between mother and infant and addresses complex factors that arise when there is a breakdown in the occupation of breastfeeding. These factors were considered through a comprehensive assessment, beginning with an intake call or “discovery call,” to determine if the services would benefit the breastfeeding dyad. The occupational therapists shared that their approach considered infants’ oral motor coordination and strength, feeding difficulty or difficulty latching, tongue ties, torticollis or asymmetry, positioning for feeding, overall
health, prematurity, tummy time, and sensory and transition to solids. They also shared that their approach takes into account the mothers’ choice to breastfeed, self-efficacy, routine management, mental health, overall health, environmental supports, milk supply, mothers’ abilities, confidence, and roles. Violet demonstrated her client-centered and holistic approach when discussing her primary focus with clients: “I focus on the baby’s oral motor skills and also mom’s mental health. Checking in on her and not overwhelming her, really giving her what realistically she can do.” Similarly, Belle illustrated how an occupational therapy-driven focus considers a wide range of contextual factors for both the mother and infant:

Milk supply, oral motor skills for baby, mom’s self-efficacy, boosting her confidence in her own abilities; a big part of my job is trying to shed some light on what’s really valid and what they need to focus their energies on.

The participants noted specific occupational therapy models or frames of reference they employed to help guide interventions. These included the Developmental Frame of Reference, Mental Health Frame of Reference, Evolutionary Frame of Reference, Biomechanical Frame of Reference, Frame of Reference for Neuro-Developmental Treatment, PEO model, and the MOHO. Five of the participants stated they do not use a specific model. However, the participants described a “blended” or “holistic” approach to client intervention formulation. Jasmine described how the needs of the family often determine how she drew from an appropriate frame of reference: “I guess it depends on the mom’s situation. I’m looking at the family through the lens of the developmental frame of reference, biomechanical frame of reference, and mental health frame of reference.” Violet stated that she used both the PEO model and the MOHO. She stated, “I was thinking about this; actually, I would say I really liked the PEO model. I like that one or the MOHO. Because my interventions, they’re very holistic.” Overall, the participants reported using a specific model or frame of reference, or a combination of models to guide intervention determination and assist mothers in reaching breastfeeding goals.

**Patient Education and Direct Intervention**

The occupational therapists described their role in educating mothers and providing direct interventions with breastfeeding dyads. Education was used more frequently with mothers, and direct interventions were used more frequently with infants. The occupational therapists made an effort to support a mother’s right to choose to breastfeed by providing education, as described by Ariel:

They (mothers) need to be informed so that they can make an educated decision for their family. I tell them my job is to give them information in a way that it makes sense to them, so that they feel that they had the information they needed to make a decision for their baby.

Esmé discussed that the choice to breastfeed is always accompanied by “education, provide lots of education, information, and support.” While the occupational therapists provided breastfeeding education, they also recognized that the choice to breastfeed is not always a choice for everyone, as described by Deb: “You know that people just choose to breastfeed or not, discounts the fact that it’s not always the things you know, that choice is not a choice for everybody.”

Anna discussed that patient education is often about trying to educate mothers on what’s normal:

“That way, moms can know that they are normal, like, that’s typical normal infant development. It’s not baby’s fault. It’s just developmental. And so we talk a lot about development as well.” Sally explained that
she often tailors the education she provides based on needs: “What kind of systems and routines and patterns you need to do to support successful breastfeeding? Whether that’s teaching about frequency of infant feeding, in hunger cues, milk removal, and frequency.”

The occupational therapists commonly provide direct interventions with breastfeeding dyads to establish home programs, pumping, returning to work, ergonomics, family dynamics, benefits for babies, and the Tummy Time!™ Method. In discussing the importance of home programs, Ariel noted that she supported mothers with appropriate patient education and provided “handouts about the benefits of bonding, skin-to-skin care, nuzzling and holding their infant” and the “psychological maternal benefits.”

One of the most significant baby factors that surfaced in the interviews was oral motor coordination and strength issues. Sally provided the parents with strategies, exercises, and things that they could do with their baby “to help them be in a better place.” Belle stated: “A huge part of my practice is teaching and finding home strategies that the families can use and take away. It’s not me there with my magic hands doing.” Aurora described her approach to creating a meaningful home program for her clients: “I equip every mom with a program at home that they can do with the baby that can help with some of those positional things or asymmetry, and that does help improve their feeding outcomes.” Mothers who breastfeed often required knowledge of infant development. Violet noted, “I emphasize that the babies go through different stages. So maybe you'll need me a lot in the beginning, and then, you know, you'll get this down, but then baby’s gonna change in this month.” Esmé noted that her background in “all of the developmental skills that the baby brings to the table or doesn’t bring to the table” allowed her to provide appropriate interventions at the right time for breastfeeding dyads.

**Supporting Mental Health**

The occupational therapists assume an important role in supporting mothers’ mental health, including assessing for signs of postpartum mood disorders, addressing and optimizing environment, social support, future planning, and validation. Esmé described how she often provides “emotional support, giving them some support and tools and knowing that this is not the journey they expected.” The occupational therapists also supported overall mental health for mothers, given their background in mental health and knowledge of community resources. Belle commented, “OTs have this great background in mental health, so I can serve as some of that guide to help moms go to a counselor if necessary.”

The occupational therapists reported addressing signs of postpartum anxiety and depression by paying attention to what the mother is communicating verbally and non-verbally. References to postpartum anxiety and depression occurred in all interviews. Jane spoke of feeling as though “moms in postpartum are very sensitive and you know, very prone to postpartum anxiety and postpartum depression.” Jane continued, “That’s why I feel like the OT has to incorporate more of the psychology.” Ariel noted the clinician often has to be aware and keep “tabs” on the mother “because some people will not be able to verbalize how they’re feeling.” Ariel shared that she often looks at pumping logs or checks in with the support partner. If there is an unexpected change reported in the log, she explained, “then your job is to investigate the why; it’s being aware of all of those factors and then being very in tune to whatever’s being communicated or observed that session.” The occupational therapists also reported that they directly check in with mothers regarding mental health concerns. Tia stated: “So we also screen for depression. We ask questions off of a maternal-infant attachment inventory.”

Addressing socio-cultural and environmental concerns was an area of focus for the occupational therapists working with breastfeeding dyads. The occupational therapists explained that home and workplace environments often influenced breastfeeding dyads. Jane explained, “It’s not just the baby,
parent and the baby, it’s an inner training to look at the whole thing, the whole family dynamics.” Ariel stated she always checks in with the team regarding the social situation. She noted, “I always check in with social work, I check in with an RN, that’s all part of just normal bedside discussion before you’re going to work with a family.” The occupational therapists recognized that social barriers impact the breastfeeding dyad. Belle shared that “social barriers are a big one: your work environment, what’s your schedule going to look like? How comfortable are you talking to your co-workers and your boss about what you’re going to need?”

The occupational therapists also noted they support breastfeeding dyads by navigating issues related to social support. Sally explained how “you need a village, that social support.” The occupational therapists often addressed the needs of the family unit. As Anna noted, “We’re having to educate the grandma and the mom. And, and how that looks different sometimes versus if it was just the mom. And, we actually have handouts that are specifically created for grandparents and partners.” Belle discussed the importance of family support in developing habits that help mothers reach their goals for breastfeeding: “Breastfeeding is pretty intense. In those first couple of weeks, especially if there’s difficulties.” She further explained, “If they don’t have support at home, or they have other kids that they’re managing or taking care of, sometimes that results in a shift of goals, long-term goals for families.” Aurora discussed addressing those “Little red flags sometimes, these moms don’t have that support at home, especially if they’re not in the most ideal relationship. I’ve had moms who make comments where you have concerns with domestic violence.”

The participants described their role in supporting maternal mental health by helping them engage in future planning. The occupational therapists did this by assisting mothers with long-term strategies and by providing anticipatory guidance. Deb discussed anticipatory guidance in reference to pumping and that perhaps at the moment, “You’re pumping all your milk, 8 to 10 times a day while you’re establishing supply, but that’s not forever.” Anna noted she often supported mothers with long-term strategies aimed at maintaining milk supply. She explained that mothers often come to her before “returning to work, and they want to know all about pumping.”

Seven of the eleven participants discussed validation as an important piece in supporting the overall mental health of mothers who breastfeed. Sally explained how validation is a crucial part of supporting mothers. She shared, “First off, I’d like to set the environment by just, you know, acknowledging the big picture and context that you just had a baby, congratulations, this is so exciting.” Belle also discussed how conversations that provided validation of mothers’ feelings led to getting the right support at the right time:

If mom is throwing up red flags for me of excessive anxiety, I’ll just gently ask if, if she’s talked to anybody or talked to her doctor about her feelings, and kind of repeat back, I know, we’re in a really tough time right now, and lots of people are struggling, it’s nothing to be ashamed of, there is help, and I don’t want you to suffer unnecessarily.

The participants reflected on how mothers struggle with role changes and difficulties that arise in breastfeeding. Esmé stated that it is important that she “feel like I really try and give them a sense of purpose.” She explained the complexities of mothers’ experiences, “When you’re a mom in the NICU, you and your baby is [sic.] being cared for by other professionals; that can really impact your sense of self, your definition of mother.” Jane shared: “It’s impressive how much breastfeeding or how much weight they (mothers) put into breastfeeding.” She further explained that it often “influences their identity
and everything.” The participants described how they support mothers’ mental health and role identity as they address the complex needs that often arise for new mothers.

**Supporting Co-Occupation Through Breastfeeding**

The occupational therapists described their unique understanding of co-occupation and its impact on well-being, bonding, and regulation. Esmé noted, “Breastfeeding is such a big occupation for new mothers,” and often other occupations co-exist in proximity to this new occupation. Breastfeeding is also a significant occupation for infants, as it functions for both feeding and communication. Anna described:

I actually have to teach my mothers about how breastfeeding is communication, so they’re gonna do something and you’re gonna respond, and then based on your response, they’re gonna do something. And back and forth between the two.

Sally stated, “I feel like it’s the ultimate co-occupation.” Referring to breastfeeding, Jasmine commented, “I think it is probably one of the best examples of a co-occupation. Because it truly cannot be done without one another, it exists because you’re doing it together.” Tia also described the co-occupation of breastfeeding as “a dance.” Esmé stated it “is really a great metaphor for co-occupation, everyone has to know the steps to the dance.” Jane explained how occupational therapists’ unique understanding enables them to facilitate the co-occupation of breastfeeding. Jane said, “It’s definitely our prime area because it’s all feeding, sleeping, bonding. And there’s so many occupations that we could work on, skin to skin, bonding with your baby, parenting.”

The occupational therapists shared that co-occupation encompasses more than breastfeeding; all eleven of the participants expressed that they believe the co-occupation of breastfeeding facilitates optimal bonding, caregiving, and co-regulation. Esmé noted, “It’s activities of daily living, it’s helping them balance sleep and rest, it’s helping them get a sense of self as a new mother, caregiving.” Tia discussed how co-occupation is just as much about bonding as it is about feeding:

And it’s also about bonding. It’s also about that relationship, the eye gaze, the closeness, there’s that co-regulation piece, so it’s amazing for both of them from a hormonal perspective. And also, from the perspective of the nervous system.

Deb agreed that the co-occupation of breastfeeding facilitated bonding as it “is a really important piece of the nursing relationship and why people breastfeed their babies.” The occupational therapists’ understanding of co-occupation was at the core of the comprehensive care they offered. Through the interview process, the participants were allowed time for personal reflection on the meaning and lived experiences related to supporting dyads through education, intervention, mental health support, and engagement in the co-occupation of breastfeeding.

**Discussion**

The purpose of this phenomenological study was to explore the role occupational therapists have in working with breastfeeding dyads. Learning from the experiences of others through deep engagement in data is a powerful method of inquiry that supports advanced knowledge, an understanding of current health care trends, and an advancement of health care practice (Neubauer et al., 2019). Occupational therapists in this study adopted a client-centered assessment approach that considered the needs of the breastfeeding dyad and provided individualized interventions according to the complex factors that influence difficulties in breastfeeding. They also considered varying models when addressing the needs
of breastfeeding dyads, such as the PEO model, which allowed them to consider the unique interplay between the factors related to the person, the environment, and the co-occupation of breastfeeding. Another model frequently discussed as shaping the co-occupation of breastfeeding was the MOHO, which considered volition, habituation, and performance capacities (Law et al., 1996; Kielhofner, 2008). A study that interviewed occupational therapists about understanding the occupational needs of mothers with perinatal mental illness found that the complex patterns of maternal occupations were best understood through the lens of the MOHO model (Graham, 2020). Occupational therapists are skilled in supporting performance patterns that consist of habits and routines associated with maternal occupations, such as breastfeeding, allowing them a unique advantage in promoting engagement in occupation (AOTA, 2020).

Occupational therapists are well-poised to complement existing lactation support as well as serve as stand-alone providers with unique skills that help mothers form routines and habits that can promote breastfeeding (Sponseller et al., 2021). Although certified lactation consultants play an important role in addressing the needs of nursing mothers, their narrow scope of practice (International Board of Lactation Consultant Examiners, 2018) may limit a holistic understanding of the underlying challenges mothers face that may impact breastfeeding duration (Sponseller et al., 2021). One study found that 10 weeks of group occupational therapy sessions partnered with a lactation consultant that focused on personal wellness goals helped mothers feel more confident in their new roles and supported in their maternal wellness, which helped the mothers continue with breastfeeding (Sponseller et al., 2021).

In our study, the majority of the occupational therapists had obtained advanced lactation training, which may allow them to provide services holistically in a variety of settings. The occupational therapists in this study provided patient education for mothers to address a range of factors that impacted breastfeeding. As Diez-Sampedro (2019) noted, withholding judgment for choices was the safest way to encourage breastfeeding without putting women at risk of undue psychological trauma. Occupational therapists considered the emotional context breastfeeding has for mothers and discussed how they supported a mother’s choice to breastfeed. The occupational therapists also noted that they addressed the mother’s social support system and various client factors that impacted breastfeeding success. Occupational therapists strived for manageable home programs aimed at increasing maternal breastfeeding self-efficacy. This is consistent with Pitonyak’s (2014) assertion that occupational therapists can create valuable home programs that support breastfeeding routines.

The study results emphasized how occupational therapy interventions that include physical, social, and emotional domains for both mother and infant support self-efficacy (Sponseller et al., 2021). Occupational therapists were noted to use their unique background with the neonatal population and to engage in developmental approaches to infant feeding, which increased the therapeutic value of interventions.

Occupational therapists can be a valuable resource for mothers in support of postpartum mental health (Pitonyak, 2014). Findings suggest that aside from performing mental health screenings, occupational therapists possess background and training in mental health and often weave health promotion strategies into their practice. The study also illuminated how occupational therapists support maternal mental health by addressing the socio-cultural environment, engaging in future planning, and providing validation. Postpartum mood disorders negatively impact family relationships, including mother-infant bonding and childhood development, and are associated with behavioral problems for children in the future (Matsuoka, 2021). Occupational therapists have the potential to be a valuable resource in supporting maternal mental health and have the skills to encourage infant bonding through co-
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Our study revealed that occupational therapists made appropriate referrals to mental health professionals and identified when to link mothers with appropriate community resources. Occupational therapists used preventative and health promotion approaches to address barriers to co-occupational engagement in exclusive breastfeeding. Contextual strategies occupational therapists engage in have the potential to reduce postpartum depression risk resulting from breastfeeding difficulties (Pitonyak, 2014). These unique skills set occupational therapy apart from other members of the infant-mother health care team. A qualitative study in Sweden focused on understanding a mother’s perception of breastfeeding support from pediatric nurses found that some mothers felt that their nurses lacked interest in breastfeeding, focused more on bottle feeding, and sometimes gave unhelpful advice (Möller Ranch et al., 2019). Our study demonstrated the important benefit of advanced knowledge of breastfeeding as well as strong listening skills in working with breastfeeding dyads, including addressing the roles of breastfeeding mothers in relation to creating a nurturing environment.

This study identified the distinct value occupational therapists carry in supporting breastfeeding dyads based on clinical understanding of co-occupation. The occupational therapists cited that co-occupation was at the center of their interventions with breastfeeding dyads. This study further explored the integrated perspective of the infant’s occupational engagement in relationship to the mother when examining breastfeeding as a co-occupation (Pitonyak, 2014). Though the term “co-occupation” was not always used to educate mothers regarding value, the importance of mother-infant bonding was central to intervention design. Findings are also in congruence with Sponsellar et al. (2021), which suggested the potential for occupational therapists to have a unique role in helping new mothers achieve greater personal health and well-being while breastfeeding. As occupational therapists promote co-occupation, there is significant potential for improving breastfeeding outcomes by facilitating occupational engagement and optimal bonding.

Occupational therapists are well suited to address the dynamic needs of mothers who breastfeed and provide patient education and appropriate individualized interventions and support mental health (AOTA, 2018). Their understanding of breastfeeding as co-occupation is an asset in providing support to breastfeeding dyads. In addition, occupational therapists have significantly assisted in improving mothers’ self-efficacy and have facilitated improved health and well-being outcomes for the breastfeeding dyad. Finally, occupational therapists support the holistic needs of breastfeeding dyads in varied settings.

Limitations and Future Research

There were limited practice settings represented in this study, and the overall demographics represented in this study do not represent the entire profession of occupational therapy. The results of this study may not be widely applicable, but replication of this study with a larger sample or variety in practice settings would be beneficial. The data in this study may contain an inherent risk of bias related to the subjective nature of qualitative research, despite the team’s efforts to ensure trustworthiness and rigor. Future studies could aim to determine best practices for occupational therapists working with breastfeeding dyads, explore occupational therapy-led community and workplace programs with mothers who breastfeed and their effect on breastfeeding duration, and examine the role of occupational therapy on multidisciplinary teams.

Conclusion

Results demonstrate the unique value the occupational therapy profession contributes to breastfeeding dyads across a wide range of practice areas. The participants depicted their interactions with breastfeeding dyads as supportive, individualized, and co-occupation-focused. The unique skill set of
occupational therapists helps drive an individualized, informed, and well-timed approach. Overall, this study demonstrated that the occupational therapy approach provides a complementary approach to existing models, as well as the potential to create holistic programs to support mothers and infants through the co-occupation of breastfeeding.

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