Two Cases of Difficulties in Breast-Feeding

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Introduction

Whenever we come in contact with pregnancy, childbirth, and infancy we feel deeply moved by the basic processes of the living. We are witnessing the beginning of everything, good and bad, that happens in a person's life:

It never ceases to be a cause of both wonder and amazement how nature in nine months can produce from one sperm and one ovum such a complex but beautifully functioning organism as the human baby When allowed to develop in the uterus of a relaxed and loving mother and born naturally, it becomes immediately an independent and efficient functioning unit (1:310).

The infant's capacity for independence is often overlooked and ba-bies are perceived as being helpless. In reality, the newborn is confronted with tremendous demands to discharge new functions of independence. These functions include breathing and digestion, as well as self-regulation of body temperature, nutrition, and emotional and sexual needs. To satisfy the needs of life the infant must discharge the biosocial function of cooperating with another person (the mother) in a mutually satisfying, pleasurable, highly charged emotional relationship:

When they are not restricted ... babies develop very rapidly in accomplishing movements and control ... The skin is warm and pink, the body a soft and plastic energy system which, out of its own resources, will make contact with its environment and begin to shape it according to its needs. The eyes are open, frank, and serious. The mouth is a remarkable and well developed, functioning organ. One is amazed at the strength and vigor of suckling; if one allows the infant to suck on a finger one finds a strong and rhythmic reflex, which soon starts streamings in the finger, which gradually extend up the arm. It is easy to understand the effect on the mother's nipple; nursing sends energy streaming through the body to the pelvis. With the mother responding to the infant, a deep feeling of love is felt with genital sensations ... (1:312).

Breast-feeding is a central part of the process whereby the baby, in its relationship with the mother, meets its needs in a way that is pleasurable for both. These needs include the need for food, warmth, comforting, contact with the environment and with another person, and expression of emotion (especially

pleasure, which, in the infant, is identical to the expression of love for its mother). In some cases, the newborn can discharge energy in nursing:

The mouth effects its own discharge of energy at its maximum point of intensity by means of a convulsive reaction which can appropriately be called an oral orgasm ... The oral orgasm occurs only in healthy infants who have good contact with a mother whose nipples are sensitive, warm, and alive. The contact is of vital importance to the infant and also to the mother. At the end of nursing one frequently observes a quivering of the lips in the infant. These quiverings spread to the face, finally ending in trembling and soft convulsive movements of the head and throat, sometimes of the whole body. The eyes turn up under the upper lids and the baby gives himself over completely to this pleasurable surrender (1:10, 312-313).

The natural relationship between mother and infant is not widely appreciated. One consequence of this is a lack of understanding of the different functions of breast-feeding. There is a blurring of the distinction between the nutritional, emotional, and sexual functions that the infant, and the mother's own body, are attempting to discharge. The following two case histories illustrate how this blurring of the distinction between functions can have damaging consequences. Helping mothers make contact with their own natural sense of the proper relationship of breast-feeding functions can be crucial in averting unnecessary misery.

Case Presentation

N, a forty two-year-old secretary, married for three years, gave birth to her first child. Prior to her pregnancy, N had been seen for approximately 120 sessions over a period of eight years. Therapy focused on overcoming her timidity and tendency to be placating. She would tiptoe around everything, both in her hesitant and apprehensive manner of speaking on the couch and in her relationships. When this was pointed out to her she gradually developed her capacity to express rage more directly. The more capable she became of expressing rage in therapy, the better she was able to assert her needs in her daily life.

A turning point for her occurred when she described her relationship with her sister's son and how her sister treated her as a servant and babysitter She was very moved, and developed a marked increase in her ability to express rage, when I told her that she would spend the rest of her life as a maiden aunt if she didn't stand up for herself.

N became more responsible about defining and fighting for her needs. She was now more selective in her choice of boyfriends, and more attractive to healthier

men as her self-confidence grew. After about five years of therapy her capacity to tolerate her feelings and engage in mature relationships grew to the point that she began experiencing strong vaginal climaxes with her boyfriend. Shortly after this he proposed marriage.

She soon developed a sense that her marriage would be miserable if she did not learn to fight for herself in a straightforward manner. Her work in therapy focused on this. Her husband was eager to have children and despite some apprehensiveness on her part she became pregnant.

N enjoyed her pregnancy, felt well, and was physically active throughout most of the nine months. She gave birth in a hospital that took an interventionist approach and the delivery and post-partum period were traumatic. N's functioning broke down during the post-partum period and she developed intense agitation and self-blame, with clinging to her husband. She was reluctant to make the trip for therapy, first because of an unwillingness to be separated from her child, and later because of an unwillingness to let her mother learn that she was in treatment. This information came second-hand from her husband, who eventually persuaded her to come for an appointment.

On the couch she appeared exhausted and at the end of her rope. She felt that she was doing a terrible job as a mother and was too distraught to discuss the situation rationally. She was frustrated and angry that she could not satisfy her baby. She hit the couch with the most heart-rending screams I've ever heard (more anguish than rage). This resulted in tremendous relief. She experienced further relief after verbally describing, in a lively and vivid way, her angry thoughts and then her affectionate feelings for the baby.

At this point in the session she was back to her normal self and was able to discuss the difficulties she was facing. Her greatest distress centered around breast-feeding. She did not have enough milk to satisfy the baby. Her own instinct was to supplement breast-feeding with formula and her husband supported this. However, she was torn by feelings of guilt that this would somehow harm the baby. She said her guilt was reinforced by her pediatrician and a breast-feeding support organization, both of whom discouraged her from supplementing with formula. However, there were several episodes when the baby was very content after nursing despite receiving little breast milk. It was during these times that the baby trembled all over with pleasure and fell asleep in her arms with a look of great peace and contentment. She and her husband were very moved by this.

It was clear that blurring the distinction between the sexual (and emotional) and nutritional functions of breast-feeding was interfering with her ability to make rational decisions about the baby's feeding. I explained to her the function of the

oral orgasm in newborns and that if the sexual and emotional needs of the baby were being taken care of, as they were in her case, then the baby's nutritional requirements could be met with formula.

She understood this immediately. She reported that she had the feeling, in her communications with the breast-feeding organization, "that if I give my baby formula, I'm dumping deadly toxic wastes into my baby and depriving her of nutrients that can never be replaced." She understood my explanation that because the organization had an incomplete grasp of the emotional and sexual functions of nursing, they could only focus their attentions, in a mechanical fashion, on chemical factors. N saw clearly how this approach, with its accompanying moralism, made it harder to perceive and understand the emotional needs of babies.

Despite her intuitive grasp of the situation she still had difficulty in overcoming her timidity at contradicting those in authority and taking responsibility for following her own instincts. The rest of the session was spent confronting her tendency to run away from acknowledging, thinking through, and acting on her feelings.

Following her return home she was able, with her husband's help, to face and resolve some of her conflicts about breast-feeding. She decided to use formula to supplement breast-feeding to ensure that the baby's hunger was satisfied. She was able to be content that she was adequately satisfying the baby's need for contact and sexual discharge. Shortly thereafter her production of breast milk increased.

Case Presentation

C is a thirty-seven-year-old housewife who had worked as a computer operator until the second trimester of her pregnancy. She had initially sought treatment ten years ago after a hospitalization for psychosis. Her diagnosis is paranoid schizophrenia. She has functioned relatively free of psychotic symptoms and has been off medication for the last four years, coming for therapy every other week.

Her husband wanted children and she allowed herself to become pregnant because he expected it, even though she was not in contact with a particularly strong desire to have children. She was quite frightened at the prospect of pregnancy, delivery, and the responsibilities of motherhood. During her pregnancy she had a flare up of her paranoia, believing that she was being persecuted at work.

Therapy was successful in clearing her acute paranoia and dealing with her anxieties about delivery. Her pregnancy was otherwise uneventful and she had a routine delivery in the hospital, which she tolerated very well. She immediately

made a strong connection with her baby. She did suffer from fears of being inadequate as a mother. A few months after the baby's birth she began expressing dissatisfaction with breast-feeding, complaining it was too messy. She was not able to clearly describe what she meant by that. When the emotional aspects of breast-feeding were discussed with her, it became clear that she was frightened and disturbed by sexual feelings (particularly feelings of pleasure in her breasts and pelvis) that she was experiencing more and more strongly. She was also disturbed by the intensity of the baby's pleasure during nursing, although she could not be clear about why this disturbed her. She did not describe instances of oral orgasm on the part of the infant, but did describe the baby showing intense pleasure and love toward her during and after nursing. It was explained to her that nursing had a sexual function and that this was important for the baby. She did not intuitively grasp this, but did feel reassured that there was nothing abnormal or perverse in what she was experiencing.

She was able to understand the importance of the feelings of love that she and the baby had for each other. At this particular session her husband had accompanied her and was sitting with the baby in the waiting room. As she walked into the treatment room I could see the baby following her with his eyes and face. His face was beaming in the most beautiful way and his eyes were alive with love for her as he watched her. I described for her what I had just seen and she told of seeing the same thing at home herself and being moved by it. She was reluctant to accept the baby's love because it was so beautiful and she felt she did not deserve it. She was relieved to be told that whatever her thoughts she was allowed to accept his love.

She had been struggling all along with fears about the accuracy of her instincts as a mother (as opposed to the sometimes harsh recommendations of family members; "let him cry so you don't spoil him"). I explained to her that no one but she had this bond with her baby and thus no one else could know as well what the baby needed and how best to treat him. She understood this well but was fearful of accepting the responsibility that went along with it. However, she knew that if she did not take this responsibility, she would repeat her parents' mistakes and neglect the baby's emotional needs as she herself had been neglected. She was able to stand up for her baby's needs.

Notwithstanding how much she was compromised in her own functioning by her schizophrenia, she has done beautifully with her responsibilities as a mother. The baby appears to be doing well.

Discussion

These cases illustrate how, in the course of ongoing therapy, education about the sexual and emotional functions of nursing can be helpful to patients in widely

different circumstances. In the first case, with a relatively healthy mother and an infant with a fully developed oral orgasm reflex, a full explanation of the sexual functions of nursing in the infant was necessary. Without this, the mother had no way of understanding her experiences with her baby and would not have had the strength to deal with the societal pressures that were disrupting their relationship. Anything less than an accurate understanding of the functions involved would have proved inadequate.

There must be many mothers who experience the same torment that N did without ever understanding what is happening to them and their babies. N's case gives some indication how much disruption and tragedy occur in the world as a result of a lack of knowledge of basic, biologic functions in the infant.

The second patient required perspective on the basic emotional functions of contact with her baby and how those functions related to practical decisions that she had to make. She also required reassurance about her own sexual feelings and those of the baby during nursing. Because of her ocular block she could not fully "see" what I was saying and required continued reassurance and perspective from me. Nonetheless, she wanted so very much not to do to her son what her parents did to her when she herself was a child. Being in therapy enabled her to translate this desire into a capacity to do well with her infant.

In both cases there was a great deal of anxiety about assuming the responsibilities and enjoying the satisfactions of motherhood. This anxiety was heightened by the attitudes of those that mothers turn to for support - family, physicians, women's organizations, etc. In this way, with the mechanical application of seemingly good ideas and by increasing the mother's anxiety, they end up promoting inappropriate treatment of the child. Medical orgonomists, having the benefit of practical knowledge of basic energy functions, are in a unique position to assist mothers, infants, and those who wish to help make life better for children.