Maltreatment and NICU Infants: Social Work's Role in Promoting Breastfeeding as a Protective Factor

JaNeen Cross

Abstract: *Child maltreatment is a concern for NICU infants who have special care needs at discharge. Improving mother-infant attachment through breastfeeding in a NICU environment may reduce maltreatment for this high-risk, vulnerable population. Breastfeeding an infant in the NICU is a complicated caretaking task yet provides an opportunity to overcome parenting challenges associated with a medically fragile infant by promoting the development of the maternal-infant attachment bond. Breastfeeding can serve as a prevention strategy for child maltreatment by improving attachment and bonding that is oftentimes disrupted between the NICU infant and mother due to the hospitalization. Social workers serve a pivotal role in preventing child maltreatment through education, promotion, and support of breastfeeding policies. This article highlights the role of social work in enhancing mother-infant attachment and advocating for NICU policies that support attachment therefore preventing maltreatment.*

Keywords: *Maltreatment, NICU infants, attachment, breastfeeding*

Child maltreatment is a public health concern (Department of Health and Human Services [DHHS], 2019). Child maltreatment statistical reports do not stratify the prevalence of abuse/neglect specifically for NICU graduates. However, child maltreatment groups are identified by age with infants representing the highest risk group. The maltreatment rate for infants (under 1 year of age) is the highest in the nation at 25.3 per 1,000 (DHHS, 2019). Infants also have the highest abuse fatality rate (DHHS, 2019). Infants die from abuse and neglect at a rate of 21.9 per 1,000 children, which is three times the death rate for children over the age of one (DHHS, 2019). Annually, child maltreatment costs in the United States (U.S.) are estimated at $80 billion (Gelles & Perlman, 2012). There is heightened concern for medically vulnerable and fragile infants from the newborn intensive care unit (NICU) as they are represented in the highest abuse rate and fatality group (DHHS, 2019).

Owora and colleagues (2016) examined the demographic and clinical characteristics of maltreated NICU graduates to understand the probability of risk. In this group of NICU graduates, 22% were admitted to the NICU for prematurity and 32% for very low birthweight (Owora et al., 2016). In addition, 84% of these infants had a prolonged NICU duration and 55% had high caregiving burdens (Owora et al., 2016). In terms of maternal characteristics, 32% of mothers who maltreated NICU infants were young (less than 21 years of age), 39% were first-time parents, 58% had low income (Medicaid eligible), and 32% had prior histories with child protective services.

Maltreatment probability risk factors increase with NICU duration and caregiving burden poses the highest risk factors, regardless of parenting experience (Owora et al., 2016; Risch et al., 2014). Both high risk infants of first-time and experienced parents have

JaNeen Cross, DSW, LICSW, Assistant Professor, School of Social Work, Howard University Washington, DC.

the highest probability of risk along with infants that have longer NICU stays. Unique risk factors present parenting challenges that lead to maltreatment of NICU infants. Early intervention programs focusing on parenting education and skills training are recommended in the first year of life (Risch et al., 2014) along with enhanced awareness of maltreatment awareness by NICU providers (Owora et al., 2016).

This article adds to the knowledge base by increasing the awareness of maltreatment of NICU infants as a high-risk child maltreatment subgroup. It also highlights breastfeeding as a key area of parenting education and skills training to prevent maltreatment. Breastfeeding is recommended as an intervention to enhance mother-child bonding and attachment prior to discharge improving child maltreatment outcomes. Breastfeeding, as a protective factor against child maltreatment, has special implications for this population based on the context of the NICU that leads to disrupted caregiving and attachment, challenges to parental caregiving, the complexity involved in the provision of human milk to NICU infants, and lack of uniform NICU policies and standards for breastfeeding.

Attachment Theory

Attachment theory promotes the development and safety of infants through maternal-infant attachment. Attachment theory is integrated in this discussion to conceptualize the maternal and infant bonding process in the NICU and subsequent maltreatment outcomes. Child maltreatment of NICU infants occur due to disrupted attachments that may start in the NICU environment. Factors unique to the NICU environment serve to complicate parenting and thus increase infant risk. Although NICU providers transfer medical care at discharge to primary care providers, infant care challenges during the NICU course may create unintentional barriers to maternal-infant bonding leading to negative parenting trajectories that persist post-discharge. For this reason, NICU providers, including social workers, need to adopt heightened awareness of child maltreatment risks during the NICU course and promote care practices that reinforce maternal-infant bonding.

Understanding the association between an infant's early attachment experiences and the subsequent impact on physical, social, and emotional risks to well-being is critical. The attachment relationship between infant and caregiver is critical in determining risk and the capacity for resiliency during infancy and all stages of development. Children with attachment experiences characterized by separation, loss, and inconsistent, neglectful, or abusive caregiving often find their way into the child welfare, medical, and mental health systems (Applegate & Shapiro, 2005).

Attachment involves the parent's capacity to exercise compassion, understanding, warmth, and sympathy in response to the infant's needs (Berzoff et al., 2011). When parents are not able to mirror an infant's emotions optimally, "misattunement" occurs potentially leading to disruption in the attachment/bonding process (Schore, 2012). A mother's "misattunement" (i.e., inappropriate responses and contradicting communications) results in a disorganized attachment (Alexander, 2013). Mothers who do not attune to their infant offer reduced protection to their infants, and this heightens the potential for subsequent trauma (Alexander, 2013). In addition, a maternal history of

trauma and loss, helplessness, and aggressive parenting are additional risk factors for child maltreatment (Alexander, 2013).

The NICU setting itself can disrupt attachments for the mother and infant (Lasiuk et al., 2013). It is difficult for women to learn how to provide optimal nutrition to a medically compromised infant in a stressful environment. This challenge is multiplied when the mother must physically and mentally recover from the delivery process and simultaneously adjust to the NICU setting to successfully provide her own breastmilk to her infant (Hurst et al., 2013; Parker et al., 2013). The position of this paper is that the provision of human milk is a maternal parenting skill that can be developed during the NICU duration.

According to the Centers for Disease Control (CDC, 2020), breastfeeding rates are increasing with 84% of women attempting to breastfeed. Conversely, at 3 months and 6 months, the breastfeeding rates for women who exclusively breastfeed declines significantly to 46.9% and 25.6% respectively (CDC, 2020). The breastfeeding initiation rates for extremely premature, premature, and late preterm infants are lower than term infants at 71.3%, 76.0%, and 77.3% (Chiang et al., 2019). One factor that impacts breastfeeding choices and health decision is the mother's attachment orientation. Women who initiate breastfeeding are more likely to have an attachment-approach orientation and those who do not breastfeed are more likely to have an attachment-avoidance orientation (Scharfe, 2012). Women with either type of attachment orientation equally cited latching, demanding infant, work, and personal health issues as challenges to breastfeeding (Scharfe, 2012). Women who have an approach-orientation are more likely to continue with a care-giving task (breastfeeding) while coping with interpersonal challenges (demanding infant), environmental challenges (work), and medical challenges (Scharfe, 2012). Subsequently, maternal attachment styles may help predict mothers who are more likely to continue care-giving tasks post discharge while coping with similar challenges.

Attachment style may provide an indicator for child maltreatment risk post-NICU discharge. Breastfeeding can serve as a marker to assess attachment and care-giving ability in the NICU. Breastfeeding serves as an in-vivo situation where mothers are supported while coping with high levels of stress and developing parenting skills. Social workers play an important role in understanding the impact of attachment on caregiving outcomes. The National Association of Perinatal Social Workers (NAPSW, 2007) standards for social work services includes that each family with an infant in the NICU should receive social work services. In addition, social work services need to foster information-sharing that is focused on the unique stressors and family's adaptation to the NICU environment (NAPSW, 2007). Furthermore, NICU social work services aim to enhance parenting skills to prevent risk factors (i.e., child maltreatment, failure to thrive) associated with parental separation from the infant (NAPSW, 2007).

The Key Protective Factor

This article asserts that breastfeeding is an important intervention that may help to prevent maltreatment of NICU infants. The provision of a mother's own milk may improve both mother-infant interactions, enhance maternal mental health, and decrease child maltreatment (Callen & Pinelli, 2005). Breastfeeding and the provision of human milk is a

caregiving task that fosters attachment and bonding between the mother-infant dyad, fulfills a biological and physiological need (Hurst et al., 2013), and emphasizes mutuality. In a relationship of mutuality, the mother physiologically responds to infant cues and the infant responds to physiological gratification. The strength of this intervention is its ability to provide positive reinforcement of the relationship between the mother and her infant (Hurst et al., 2013). Subsequently, the provision of human milk and breastfeeding strengthens mother-infant attachment.

Breastfeeding and Parenting

Breastfeeding in the NICU is a challenging process for mothers and their infants (Black, 2012). Breastfeeding is defined as feeding at the breast and the methods used to facilitate the provision of human milk to the infant (AAP, 2012). Also, breastfeeding in the NICU includes the expression of human milk and the use of donor human milk (Davanzo et al., 2012). The clinical instability of the NICU infant hinders the ability to achieve an adequate latch to initiate breastfeeding (Black, 2012). Conversely, healthy full-term infants are better able to latch onto their mother's breast immediately after birth (Black, 2012).

There are also biopsychosocial challenges to breastfeeding. NICU mothers often cite stress, low milk supply (a potential byproduct of stress) and return to work as common reasons for discontinuing pumping and breastfeeding (Rossman et al., 2013). There is a negative association between psychological stress and initiation of lactation, milk volume, and frequency and duration of first feeding (Doulougeri et al., 2013). Maternal stress postpones and compromises the establishment of breastfeeding (Doulougeri et al., 2013). Subsequently, the maternal protective role is altered and benefits to the child are reduced (Doulougeri et al., 2013). Stress and other mental health challenges can disrupt bonding through breastfeeding and ultimately attachment.

Through breastfeeding, NICU mothers expressed increased motivation at seeing the result of weight gain and infant stability (Rossman et al., 2013). Breastfeeding helps develop parenting skills, increases confidence in parenting skills, and supports maternal mental health (Rossman et al., 2013). Similarly, mothers in Rossman and colleagues' (2013) study expressed feelings of reward in helping their infants grow and heal. These mothers could not maintain sufficient milk volume yet continued pumping because they had faith that their infants were healing with the breast milk that they could provide. These positive infant outcomes reinforced the maternal nurturing role, supported bonding, and helped the mothers heal from the trauma of delivery (Rossman et al., 2013). Breastfeeding equally reinforces improved parenting behaviors while improving parenting skills. Martino et al. (2015) credit maternal resiliency, commitment to a demanding pumping regimen, and overcoming hurdles as reasons for increased rates of breastfeeding when medically fragile infants are hospitalized.

NICU infants may refuse the breast, present with fussy and hungry behavior, and have a weak suck response (Black, 2012; Callen & Pinelli, 2005). To breastfeed, infants must be at the appropriate gestational age and be developmentally ready to feed and master anatomic and physiologic barriers, using muscles to coordinate sucking, swallowing, and breathing (Callen & Pinelli, 2005; Sakalidis & Geddes, 2016). They often need to

overcome the challenges of transitioning from gavage (tube) feeding to breast initiation (Ziadi et al., 2016). NICU infants must correctly apply oral latching techniques and sucking patterns to successfully breastfeed and avoid nipple confusion (Callen & Pinelli, 2005). There are challenges to breastfeeding and providing human milk to premature infants, as they are often not able to breastfeed immediately and must learn to breastfeed when they progress to a more physiologically and medically stable level (Maastrup et al., 2012).

Feeding at the breast for preterm NICU infants is further complicated by the medical need of infants during hospitalization. Preterm infants are highly susceptible to health conditions that can impede proper breastfeeding (Greene et al., 2013; Sakalidis & Geedes, 2016). Preterm infants often have comorbidities (i.e., respiratory difficulties, infections, neurological impairments) that significantly reduce their capabilities (Greene et al., 2013; Maastrup et al., 2012). In addition, mechanical devices (extended intubation with nasal or tracheal devices) may lead to the development of feeding aversion in preterm infants (Greene et al., 2013; Sakalidis & Geedes, 2016). As there are safety concerns related to premature infants, Greene et al. (2013) discuss the need to explore breastfeeding methods that focus on the preparedness (i.e., weight, gestational age, oral motor skills, and feeding techniques and experience) of infants to safely feed orally.

The maternal challenges in the NICU environment also complicate successful strategies for breastfeeding. The NICU environment is particularly challenging as it does not always offer privacy for mothers attempting to bond with their infants and initiate breastfeeding (Castrucci et al., 2007). New mothers must bond and maintain lactation progress under the noise and stress of the NICU (Brier et al., 2014). Similarly, maintaining a milk supply during the postpartum period when the health and strength of the mother and infant have been compromised provides an additional physical health barrier (Parker et al., 2013).

Strathearn et al. (2009) examined the association between breastfeeding and child maltreatment reports. They found that 60% of cases (approximately 512 children) with substantiated child abuse reports experienced at least one or more incident of maternal-perpetrated abuse or neglect. An inverse relationship between maltreatment and breastfeeding duration was reported demonstrating an increase in maternal maltreatment with a decrease in breastfeeding duration (Strathearn et al., 2009). In addition, non-breastfed children were 4.8 times more likely to experience child maltreatment than children breastfed for 4 or more months (Strathearn et al., 2009). Maternal neglect was independently associated with breastfeeding duration and increased four-fold for non-breastfed children compared to those breastfed for four months or longer (Strathearn et al., 2009). This study supports the protective factor of breastfeeding duration as it relates to maternal maltreatment.

Kremer and Kremer (2018) conducted a quantitative, longitudinal study examining the odds of child maltreatment by subtypes comparing adolescents who were breastfed to those who were not breastfed. The findings report that adolescents who were breastfed for 9 months or longer have reduced odds of experiencing neglect and sexual abuse (Kremer & Kremer, 2018). In addition, breastfeeding duration is also associated with decreased childhood neglect and sexual abuse (Kremer & Kremer, 2018). While breastfeeding is a

significant consideration for examining the risk of child maltreatment, more research is needed to establish a causal relationship between breastfeeding and the reduction of maltreatment (Kremer & Kremer, 2018).

NICU Challenges

Postpartum depression is another concern that can compromise bonding and attachment. Mothers of infants who are in the NICU are at significant risk of developing postpartum depression due to feelings of failure and guilt for having a premature infant (Hynan et al., 2015; Rossman et al., 2013). These mental health risks are increased for adolescent mothers (Hodgkinson et al., 2014). There is an association between untreated maternal depression and diminished parenting skills, difficult maternal-infant attachment, and behavioral difficulties that develop during childhood (Hodgkinson et al., 2014). Breastfeeding may reduce the risk of postpartum depression and improve infant well-being (AAP, 2012). Breastfeeding women also have lower anxiety scores and improved confidence with interpersonal relationships (Scharfe, 2012). Conversely, women who do not breastfeed or who wean their infants prematurely have increased risk of postpartum depression and an increased rate of abuse and neglect of their infant (AAP, 2012).

Implications for Social Work

Breastfeeding aligns with the core ethical values of social work (Hurst et al., 2018). Health equity and promotion are part of social work's historic roots and is a core value of social work service (Hurst et al., 2018). Breastfeeding is a reproductive right and justice concern for all women (Smith, 2018). However, there are persistent disparities in breastfeeding rates among low-income, African American women (Hurst et al., 2018) therefore improving breastfeeding rates aligns with the social work value of social justice. Similarly, the overrepresentation of infants in child maltreatment rates, and particularly NICU infants, present a public health disparity. The importance of human relationships is a value that is promoted through the bonding and attachment process of breastfeeding (Hurst et al., 2018). The breastfeeding process provides social workers with the opportunity to exemplify the value of dignity and worth of persons through inclusion of breastfeeding practices and breastfeeding choices (Hurst et al., 2018). The ethical value of competence reflects the social workers' need to be educated and familiar with current breastfeeding recommendations and guidelines (Hurst et al., 2018) and to act with integrity as it relates to honest and truthful support of breastfeeding women, especially those with substance use challenges to promote optimal recovery, (Hurst et al., 2018; Trainor, 2022) and advocate for maternal/infant soothing and bonding.

As NICU graduates are represented in the high-risk maltreatment group, it is important that social workers understand that they can influence mother-infant attachment through breastfeeding in the NICU. Lactation support models can help reinforce breastfeeding strategies and support mothers' feeding efforts (Greene et al., 2013). Social workers in the NICU assess mental health needs, child maltreatment risk factors, and social support needs. They also evaluate ongoing mental health needs and provide mental health support and referrals. In addition, social workers motivate and encourage maternal- infant interaction

and bonding. By improving attachment systems between mothers and infants, social workers improve protection against child maltreatment. Social workers encourage parent education and communication by scheduling regular family meetings with NICU providers and endorsing family support policies.

Family-centered care (FCC) is a quality-of-care model that promotes mutually beneficial partnerships between providers and families for the delivery of health care (Kokorelias et al., 2019). The FCC model also encourages full parental access to infants and medical information through family-centered policies and practices (Gooding et al., 2011; Kokorelias et al., 2019). The FCC model urges NICU staff to partner with families and schedule infant care around the parents' schedules to improve parental participation (Gooding et al., 2011). FCC is a model of care that can help reduce a parent's anxiety in the NICU and increase parental competence through involvement in infant care and participation in the decision-making process (Croft, 2012; Gooding et al., 2011). FCC is included in the recommendation for NICU staff education (Hall et al., 2015).

In a study of 59 NICU mothers, Sheeran and colleagues (2013) found that mothers felt that their individual infant's needs were not met based on nursing workflow and assignments in the NICU. Mothers believed that they were not provided with complete, comprehensible, and consistent information about their infants, considered NICU policies and procedures restrictive, and perceived that they were often excluded from the decision-making process (Sheeran et al., 2013). The findings from this study support that NICU nursing behaviors and lack of FCC policies can restrict the ability of parents to provide care to their infants (Sheeran et al., 2013).

Policies are needed that promote lactation practices and remove barriers and constraints to daily activities, opportunity, and location of breastfeeding (Smith, 2018). The FCC model can be used to address NICU parenting concerns and support the unique needs of parents with infants in the NICU (Joint Commission, 2010). Family-Centered Developmental Care (FCDC) extends FCC by involving the family as the necessary contributor of customized, developmentally supportive care of their infants (Craig et al., 2015). FCDC focuses on developing long-term relationships between parents and infants through optimizing physical, cognitive, and psychosocial development and mitigates the negative impact that an infant's illness may have on parent-infant interactions (Craig et al., 2015). Although it is not known how widespread FCC and FCDC policies are implemented in NICU settings, FCDC is recommended as best practice standards with accompanying competencies for interdisciplinary NICU providers (Browne et al., 2020). FCDC is an interprofessional model, however, the emphasis on targeting the psychosocial needs of families in a stressful NICU environment through enhancing individual strengths (Browne et al., 2020) highlights the unique role for social work. Overall, FCDC policies center care around the needs of the family.

FCC policies are also endorsed by the American Academy of Pediatrics (AAP) and other health organizations as a method for standardizing practices and developing NICU environments that support attachment and bonding (AAP, 2012). In addition, the FCC model of practice supports parental involvement in care rounds, which promotes their inclusion in the feedback loop and care planning (Gooding et al., 2011; Joint Commission,

2010). FCC initiatives also support parental needs at discharge to improve their success with caregiving tasks once the baby is discharged (Gooding et al., 2011).

Social workers play a key role in educating NICU staff in efforts to improve maternal bonding experiences for healthy development and to reduce child maltreatment risks. NICU providers can facilitate the necessary skills and techniques to create a clinical environment that supports brain development and aids the infant's brain wiring system (Bader, 2012). Skin-to-skin contact (kangaroo care), infant touch, and oral feeding experiences are recommended options that promote healthy NICU infant development (Craig et al., 2015). FCC is vital in standardizing the optimization of infant development and enhancing the family's long-term relationship with the child (Craig et al., 2015).

Social workers can review NICU policies to address the unique environmental circumstances that compromise attachment and bonding and increase the risk of child maltreatment. In promoting mother-infant attachment, NICU policies and practices should require parenting support efforts by health care providers. Health care practices should center around the needs of the maternal-infant dyad and family. Similarly, opportunities for teaching parenting skills that enhance infant development and bonding can improve the health and safety of NICU infants. NICU staff must emphasize the parental role in all aspects of care to help mothers develop the necessary parenting skills and behaviors to protect and care for their NICU infant during the hospital course and post-discharge.

Conclusion

The unique challenges of parenting and breastfeeding in the NICU provides a support opportunity to build attachment bonds. NICU mothers must be supported in overcoming the challenges of breastfeeding in the NICU environment to successfully deliver needed nutrition to their infants. Mothers who overcome these challenges demonstrate improved attachment and parenting skills. Opportunities are present for social workers to support new mothers facing parenting challenges in the NICU, thus creating a positive parenting interaction and outcome post-discharge. During the NICU course, maintaining the health of infants is paramount; however, from a child maltreatment perspective, it is equally important to maintain and develop babies' attachment and bond with their mothers. Emphasis on maternal-infant bonding and attachment will improve the maternal protective capacity and avoid contributing to poor parenting trajectories that increase risk for maltreatment.

More research is recommended to examine child maltreatment outcomes and interventions for this vulnerable, high-risk population. It is important that NICU providers remain aware and vigilant of child maltreatment and fatality risks for NICU graduates. Social workers can play a pivotal role in supporting positive parenting trajectories during the NICU course to prevent maltreatment outcomes.

References

Alexander, P. (2013). *Treating complex stress disorder in children and adolescents*. Guilford Press.

Applegate, J., & Shapiro, J. (2005). *Neurobiology for clinical social work: Theory and practice*. Norton.

American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, *129*(3), e827-e841. https://doi.org/10.1542/peds.2011-3552

Bader, L. (2012). What snakes taught me about the neonatal intensive care unit. *Journal of Neonatal Nursing*, *18*, 50-53. https://doi.org/10.1016/j.jnn.2012.01.003

Berzoff, J., Flanagan, L. M., & Hertz, P. (2011). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural context* (3rd ed.). Rowman & Littlefield.

Black, A. (2012). Breastfeeding the premature infant and nursing implications. *Advances in Neonatal Care*, *12*(1), 10-14. https://doi.org/10.1097/ANC.0b013e3182425ad6

Briere, C., McGrath, J., Cong, X., & Cusson, R. (2014). An integrative review of factors that influence breastfeeding duration for premature infants after NICU hospitalization. *Journal of Obstetrics and Gynecology & Neonatal Nursing*, *43*(3), 272-281. https://doi.org/10.1111/1552-6909.12297

Browne, J., Jaeger, C., Kenner, C., & Gravens Consensus Committee on Infant and Family Centered Development Care. (2020). Executive summary: Standards, competencies, and recommended best practices s for infant- and family-centered developmental care in the intensive care unit. *Journal of Perinatology*, *40*, 5-10. https://doi.org/10.1038/s41372-020-0767-1

Callen, J., & Pinelli, J. (2005). A review of the literature examining the benefits and challenges, incidence and duration, and barriers to breastfeeding preterm infants. *Advances in Neonatal Care, 5*(2), 72-88. https://doi.org/10.1016/j.adnc.2004.12.003

Castrucci, B., Hoover, K., Lim, S., & Maus, K. (2007). Availability of lactation counseling services influence breastfeeding among infants admitted to neonatal intensive care units. *American Journal of Health Promotion, 21*(5), 410-415. https://doi.org/10.4278/0890-1171-21.5.410

Centers for Disease Control. (2020). *Breastfeeding report card.* https://www.cdc.gov/breastfeeding/data/reportcard.htm

Chiang, K., Sharma, A., Nelson, J., Olson, C., & Perrine, C. (2019). Receipt of breastmilk by gestational age-United States 2017. *Morbidity & Mortality Weekly Report*, *68*(22), 489-493. https://doi.org/10.15585/mmwr.mm6822a1

Craig, J., Glick, C., Phillips, R., Hall, S., Smith, J., & Browne, J. (2015). Recommendations for involving the family in developmental care of the NICU baby. *Journal of Perinatology*, *35*(S1), S5-S8. https://doi.org/10.1038/jp.2015.142

Croft, S. (2012). How can family-centered care be improved to meet the needs of parents with a premature baby in the neonatal intensive care? *Journal of Neonatal Nursing*, *18*, 105-110. https://doi.org/10.1016/j.jnn.2011.07.008

Davanzo, R., Monasta, L., Ronfani, L., Brovedani, P., & Demarini, S. (2012). Breastfeeding at NICU discharge: A multicenter Italian study. *Journal of Human Lactation, 29*(3), 374-380. https://doi.org/10.1177/0890334412451055

Department of Health and Human Services. (2019). Child Maltreatment 2019. Children's Bureau. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf

Doulougeri, K., Panagopoulou, E., & Montgomery, A. (2013). The impact of maternal stress on initiation and establishment of breastfeeding. *Journal of Neonatal Nursing, 19*, 162-167. https://doi.org/10.1016/j.jnn.2013.02.003

Gelles, R., & Perlman, S. (2012). *Estimated annual cost of child abuse and neglect*. Prevent Child Abuse America. http://preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf

Gooding, J., Cooper, L., Blaine, A., Franck, L., Howse, J., & Berns, S. (2011). Family support and family-centered care in the neonatal intensive care unit: Origins, advances, impact. *Seminars in Perinatology*, *35*, 20-28. https://doi.org/10.1053/j.semperi.2010.10.004

Greene, Z., O'Donnell, C., & Walshe, M. (2013). Oral stimulation techniques in preterm infants-International research challenges. *Journal of Neonatal Nursing, 19*, 168-174. https://doi.org/10.1016/j.jnn.2013.03.005

Hall, S., Cross, J., Selix, N., Patterson, C., Segre, L., Chuffo-Siewart, R., Geller, P., & Martin, M. (2015). Recommendation for enhancing psychosocial support of NICU parents through staff education and support. *Journal of Perinatology*, *35*, S29-S36. https://doi.org/10.1038/jp.2015.147

Hodgkinson, S., Beers, L., Southammakosane, & Lewin, A. (2014). Addressing the mental health needs of pregnant and parenting adolescents. *Pediatrics*, *133*(1), 114-122. https://doi.org/10.1542/peds.2013-0927

Hurst, N., Engebreston, J., & Mahoney, J. (2013). Providing mother's own milk in the context of the NICU: A paradoxical experience. *Journal of Human Lactation*, *29*(3), 366-373. https://doi.org/10.1177/0890334413485640

Hurst, C. G., Reno, R., & Lefmann, T. (2018). Committing to breastfeeding in social work. *Social Work*, *63*(3), 252-260. https://doi.org/10.1093/sw/swy028

Hynan, N., Steinberg, Z., Baker, L., Cicco, R., Geller, P., Lassen, S., Milford, C., Mounts, K., Patterson, C., Saxton, S., Segre, L., & Stuebe, A. (2015). Recommendations for mental health support in the NICU. *Journal of Perinatology*, *35*, S14-S15. https://doi.org/10.1038/jp.2015.144

Joint Commission. (2010). Advancing effective communication, cultural competence, patient and family centered care: A roadmap for hospitals. https://psnet.ahrq.gov/issue/advancing-effective-communication-cultural-competence-and-patient-and-family-centered-care

Kokorelias, K., Gignac, M., Naglie, G., & Cameron, J. (2019). Towards a universal model of family centered care: A scoping review. *BMC Health Services Research*, *19*, 1-11. https://doi.org/10.1186/s12913-019-4394-5

Kremer, K. P., & Kremer, T. R. (2018). Breastfeeding is associated with decreased childhood maltreatment. *Breastfeeding Medicine*, *13*(1), 18-22. https://doi.org/10.1089/bfm.2017.0105

Lasiuk, G., Comeau, T., & Newburn-Cook, C. (2013). Unexpected: An interpretive description parental traumas' associated with preterm birth. *BMC Pregnancy and Childbirth, 13*(Supplemental 1), 1-10. https://doi.org/10.1186/1471-2393-13-S1-S13

Maastrup, R., Bojesen, S., Kronborg, H., & Hallstrom, I. (2012). Breastfeeding support in Neonatal intensive care: A National Survey. *Journal of Human Lactation*, *28*(3), 370-379. https://doi.org/10.1177/0890334412440846

Martino, K., Wanger, M., Froh, E., Hanlon, A., & Spatz, D. (2015). Postdischarge breastfeeding outcomes of infants with complex surgical anomalies that require surgery. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 44(3), 450-457. https://doi.org/10.1111/1552-6909.12568

National Association of Perinatal Social Workers. (2007). *Standards for social work services in the newborn intensive care unit.* https://www.napsw.org/assets/docs/NICU-standards.pdf

Owora, A., Chaffin, M., Nandyal, R., Risch, E., Bonner, B., & Carabin, H. (2016). Medical surveillance and child maltreatment incidence reporting among NICU graduates. *Social Work in Public Health*, *31*(7), 607-616. https://doi.org/10.1080/19371918.2016.1160348

Parker, M., Burnham, L., Cook, J., Sanchez, E., Philipp, B., & Merewood, A. (2013). 10 years after baby-friendly designation: Breastfeeding rates continue to increase in a US neonatal care unit. *Journal of Human Lactation, 29*(3), 354-358. https://doi.org/10.1177/0890334413489374

Risch, E., Owora, A., Nandyal, R., Chaffin, M., & Bonner, B. (2014). Risk for child maltreatment among infants discharged from a Neonatal Intensive Care Unit: A sibling comparison. *Child Maltreatment* 19(2), 92-100.

Rossman, B., Kratovil, A., Greene, M., Engstrom, J., & Meier, P. (2013). "I have faith in my milk:" The meaning of milk for mothers of very low birth weight infants hospitalized in neonatal intensive care unit. *Journal of Human Lactation, 29*(3), 359-365. https://doi.org/10.1177/0890334413484552

Sakalidis, V., & Geddes, D. (2016). Suck-swallow-breathe dynamics in breastfed infants. *Journal of Human Lactation*, *32*(2), 201-211. https://doi.org/10.1177/0890334415601093

Scharfe, E. (2012). Maternal attachment representation and initiation and duration of breastfeeding. *Journal of Human Lactation*, *28*(2), 218-225. https://doi.org/10.1177/0890334411429111

Schore, A. (2012). *Treating complex stress disorder in children and adolescents*. Guilford Press.

Sheeran, N., Jones, L., & Rowe, J. (2013). The relationship between maternal age, communication and supportive relationships in the neonatal nursery for mothers of preterm infants. *Journal of Neonatal Nursing*, *19*, 327-336. https://doi.org/10.1016/j.jnn.2013.01.006

Smith, P. H. (2018). Social justice at the core of breastfeeding protection, promotion and support: A conceptualization. *Journal of Human Lactation*, *34*(2), 220-225. https://doi.org/10.1177/0890334418758660

Strathearn, L., Mamun, A., Najman, J., & O'Callaghan, M. (2009). Does breastfeeding protect against substantiated child abuse and neglect? A 15-year cohort study. *Pediatrics, 123*(2), 483-493. https://doi.org/10.1542/peds.2007-3546

Trainor, K. (2022). Maternal substance use disorder: A look at provider stigma, attitudes, and beliefs. *Advances in Social Work, 22,* 1, 67-90. https://doi.org/10.18060/24282

Ziadi, M., Heon, M., & Aita, M. (2016). A critical review of interventions supporting transition from gavage to direct breastfeeding in hospitalized preterm infants. *Newborn & Infant Nursing Reviews*, *16*(2), 78-91. https://doi.org/10.1053/j.nainr.2016.03.013

Author note: Address correspondence to JaNeen Cross, School of Social Work, Howard University, Washington, DC, 20059. Email: janeen.cross@howard.edu