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## Against all odds: a retrospective case-controlled study of women who experienced extraordinary breastfeeding problems

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## Abstract

### Aims

The study investigated factors empowering women to continue breastfeeding despite experiencing extraordinary difficulties. The study documented the experiences and characteristics of women who continued to breastfeed (continuing cohort) and those who weaned (non-continuing cohort) despite extraordinary difficulties.

### Design

Retrospective case control.

### Methods

The study was undertaken in south-east Queensland, Australia in 2004. Forty women (20 in each cohort) were recruited over six months. Both quantitative (breastfeeding knowledge questionnaire) and qualitative (semi-structured interviews) data were collected. This paper describes the qualitative data.

## Results

Women from both cohorts expressed idealistic expectations about breastfeeding and experienced psychological distress due to their breastfeeding problems. Those who continued breastfeeding used coping strategies and exhibited personal qualities that assisted them to overcome the difficulties experienced. Women who continued to breastfeed were more likely to report relying on a health professional they could trust for support. This latter cohort were also more likely to report having peers with which they shared their experiences. Non-continuing women expressed feelings of guilt and inadequacy following weaning and were more likely to feel isolated.

## Conclusions

This study has highlighted the methods women use to deal with breastfeeding problems. It has also revealed modifiable factors that can improve breastfeeding duration.

## Relevance to clinical practice

The findings indicate that clinicians should:

- ♦ • Provide information which accurately reflects the breastfeeding experience;
- ♦ • Ensure systems are in place so that effective postnatal support for breastfeeding difficulties is available;
- ♦ • Consider screening to ascertain levels of psychological distress, sadness and disillusionment among breastfeeding women;
- ♦ • Design educational interventions with elements of cognitive skills, problem-solving and self-efficacy training to equip women with the skills to overcome any experienced difficulties.

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**Key words:** breastfeeding, nurses, nursing, post-natal support, psychological distress

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## Introduction

Breastfeeding has physical and psychological benefits for mother and child, along with social and environmental advantages. The nutritional and immunological properties of breastmilk have been shown to protect infants against numerous health threats (Mayer *et al.* 1988, Ford & Labbok 1993, Raisler *et al.* 1999, Gillman *et al.* 2001). Evidence supports the assertion that breastfed infants are more developmentally advanced than formula-fed counterparts (Reynolds 2001, Mortensen *et al.* 2002). There are also numerous health benefits to the breastfeeding mother (Labbok 1999, 2001, Hollander 2002); economic benefits in terms of health expenditure; the economic cost of formula to individual families; and costs to the environment (Minchin 1989, Smith *et al.* 2002).

The recommended duration of exclusive breastfeeding is six months, with complementary foods introduced thereafter (World Health Organization 2001). In Australia, as many as 93% of women currently have initiated breastfeeding at hospital discharge (Fallon *et al.* 2005). Exclusive breastfeeding rates at six months, however, have been as low as 7% (Donath & Amir 2000, Hegney *et al.* 2003).

Several sociodemographic factors (e.g. age and socioeconomic status), social support factors (e.g. partner support) and mothering factors (e.g. scheduled vs. demand feeding and pacifier use) have been observed to exert an influence on breastfeeding duration (Scott & Binns 1999). Psychological factors (e.g. the woman's attitude to breastfeeding, expectations of breastfeeding, postnatal depression, confidence in breastfeeding ability, self-esteem, achievement motivation, locus of control and adjustments to pregnancy and motherhood) also influenced breastfeeding duration (Allison 1994, Isabella & Isabella 1994, Janke 1998, Landers *et al.* 1998, Dennis & Faux 1999, Tarkka *et al.* 1999, Henderson *et al.* 2003).

Women frequently cite breastfeeding problems as a reason for prematurely ceasing breastfeeding. McLeod *et al.* (2002) found mothers with breastfeeding problems less likely to be breastfeeding at four months. However, Fahy and Holschier (1988) observed a higher frequency of breastfeeding problems among successfully breastfeeding women than those who ceased breastfeeding early. Similarly, Voellmy (1987) found all the mothers in his sample had similar numbers of breastfeeding problems regardless of the duration of breast-feeding. However, the women who breastfed longer tended to consider these problems less severe. Fahy and Holschier (1988) suggested that breastfeeding success was the result of the mother's ability to accept and deal with problems rather than a problem-free postnatal period.

In a set of studies conducted in the regional centre of Toowoomba, Australia (Hegney *et al.* 2003, O'Brien & Fallon 2004, Fallon *et al.* 2005), several women were observed to persist with breastfeeding despite extraordinary difficulties. As a result of this observation, the research team formed the following research question for this study: Why is it that some mothers continue to breastfeed successfully to their goals in the face of significant adversity, while others with similar problems do not reach these goals?

## Method

### Study design

A retrospective, matched, case-controlled design was employed to describe the experiences of two cohorts of breastfeeding women. One cohort continued to breastfeed in the face of extraordinary difficulties (the continuing cohort,  $n = 20$ ). The other cohort, with similar experiences, discontinued breastfeeding (the non-continuing cohort,  $n = 20$ ).

A retrospective design is time- and cost-effective and generally the method used when the likelihood of an event occurring is low. They seek to identify predictors of outcome and results and often generate hypotheses for prospective research designs (Mann 2003). The validity of the retrospective technique depends greatly on participant memory. Encouragingly, research has observed accurate recall of birth weights and infant feeding events up to 14 years postpartum (Launer *et al.* 1994). The addition of a matched non-continuing cohort who experienced similar problems allowed a comparison across both groups and cases (Daly *et al.* 1997).

### Defining extraordinary breastfeeding difficulties

An Expert Panel comprised of eight experienced breastfeeding clinicians (i.e. medical doctors, lactation consultants, midwives, child health nurses and an Australian Breastfeeding Association representative) judged which cases could be defined as having experienced extraordinary breastfeeding difficulties. Prior to presenting a case to this panel, the Project Officer collected breastfeeding experience data from each potential participant. The Expert Panel then examined each de-identified case and categorised the potential participant for inclusion in the study in either the continuing ( $n = 20$ ) or non-continuing cohort ( $n = 20$ ). Inclusion criteria were that the woman had experienced difficulties for at least four weeks and experienced problems beyond those normally expected; had completed their most recent breastfeeding experience within the last two years; were capable of providing informed consent; had sufficient English language skills to be able to participate in an interview; and had not experienced a neo-natal death.

A matched 'case-control' from the non-continuing cohort was paired with each continuing woman. Pairs were matched on the following characteristics: hospital type (public or private), parity, age, marital status and breastfeeding difficulties experienced. To facilitate this matching process breastfeeding problems were divided into four categories including supply problems (e.g. galactagogues, low supply); baby illnesses/complications (e.g. suck problems, lactose intolerance); maternal illnesses/complications (e.g. thyroid problems, retained products); and breast and nipple problems (e.g. recurrent mastitis, complications following breast surgery).

Because of difficulty in recruiting in the non-continuing cohort, the inclusion criteria for this cohort were amended and the time they experienced breastfeeding difficulties reduced to two weeks. However, it was agreed that within that time, a woman must have experienced a considerable breastfeeding challenge prior to deciding to wean.

## **Participants**

Participants were recruited over six months in 2004. Recruitment strategies included radio interviews, global e-mails and contact with child care centres, general practices, shopping centres and pharmacies.

## **Materials**

To assist in validating the matching process, a quantitative survey tool used in previous studies (Hegney et al. 2003, O'Brien & Fallon 2004) was used. It included questions on: age, education, breastfeeding experience, infant feeding method, ethnicity, smoking, employment, socio-economic status, prenatal intentions, solids, pacifiers, obstetric experience and support services.

Semi-structured interviews were used to explore the experiences of both cohorts as participants can be questioned about underlying meaning and research questions can be confirmed or disconfirmed (Honey 1987). Its use guarantees some uniformity of topics across the participants, but allows interviewers and participants to enter into in-depth discussion about other issues that arise. The questions included participant's: coping mechanisms, confidence, stressors and stress management, perceptions of breastfeeding problems, commitment to goals, attitudes, interpretation of baby behaviour and the helpfulness of breastfeeding supports. These data are the focus of this paper.

## **Procedure**

Ethical clearance was granted by the University of Southern Queensland Human Research and Ethics committee. Following agreement by the Expert Panel, participants were contacted and an interview arranged. All participants received a Plain Language Statement, a Consent form, a demographic questionnaire. At interview they provided written and verbal consent. All interviews were conducted by the same member of the team. Face-to-face interviews were considered the most appropriate method of data collection (Holbrook *et al.* 2003) and 34 participants residing within a three-hour drive of Toowoomba were interviewed face-to-face, either at the University of Southern Queensland or their own home. To ensure remotely located women could participate in the study, six women who lived more than three hours drive from Toowoomba were interviewed by telephone. The interviews lasted 30–60 minutes and were audio-taped and transcribed verbatim. Participants were sent their transcripts for verification and changes to the transcripts were made if required (Miller & Crabtree 2005). Following this, the transcript was analysed.

## **Data analysis**

Thematic analyses of the data were conducted from a psychosocial perspective. To increase the reliability of emergent themes, independent analyses were conducted by two psychologists on the Research Team (A.F., M.O'B.) who consequently agreed on the themes and sub-themes (Eley 1991). Transcribed data were analysed using six cycles – content analysis; coding of interview texts; comparison through indexing; re-analysis through text search and study of index nodes; re-interpretation of data; and reconfirming preliminary analyses (Leininger 1991, Ekman & Segesten 1995).

# Results

## Demographics

The majority of participants in both cohorts came from rural areas (populations less than 100 000) (Australian Bureau of Statistics 2002). Women in both cohorts were on average 30 years of age when they gave birth. For both cohorts, 70% of women had vaginal births. The remaining 30% gave birth by caesarean section. Sixty-five per cent of continuing women and 55% of non-continuing women had more than 12 years of education. Partners of non-continuing women appeared less likely to be employed in professional (e.g. doctor, lawyer) and associate professional (e.g. soldier, policeman) occupations (Australian Bureau of Statistics 2001) or to have more than 12 years of education than partners of continuing women.

## Themes

A total of six major themes was identified in the continuing cohort and seven major themes in the non-continuing cohort (see Table 1). No apparent differences emerged between data arising from the face-to-face interviews and the telephone interview data in either group. Data presented here are coded according to cohort, with (CC) indicating a quote from a continuing woman and (NCC) indicating a quote from a non-continuing woman.

**Table 1** Major themes and sub-themes from the thematic analysis of continuing and non-continuing cohorts\*

Continuing women	Non-continuing women
Expectations	Expectations
<ul style="list-style-type: none"> <li>♦ Realistic expectations</li> </ul>	<ul style="list-style-type: none"> <li>♦ Idealised expectations</li> </ul>
Idealised expectations	<ul style="list-style-type: none"> <li>♦ Feelings of disillusionment</li> </ul>
<ul style="list-style-type: none"> <li>♦ Feelings of disillusionment</li> </ul>	
Support issues	Early breastfeeding problems
<ul style="list-style-type: none"> <li>♦ Partner support</li> <li>♦ Trusted health professional</li> <li>♦ Peer support</li> </ul>	Reluctance to seek help/ doing it my way
	Support issues
	<ul style="list-style-type: none"> <li>♦ Partner support</li> <li>♦ Feelings of isolation</li> <li>♦ Family culture</li> <li>♦ Social pressure to breastfeed</li> </ul>
Feelings about breastfeeding and the baby	Feelings about breastfeeding and the baby
<ul style="list-style-type: none"> <li>♦ Breast is best</li> <li>♦ Breastfeeding important to bonding</li> <li>♦ Breastfeeding as an automatic decision</li> <li>♦ Faith in natural processes</li> </ul>	<ul style="list-style-type: none"> <li>♦ Breast is best</li> <li>♦ Breastfeeding important to bonding</li> <li>♦ Breastfeeding as an automatic decision</li> <li>♦ The need/desire to feed</li> <li>♦ Supply concerns</li> </ul>
Psychological distress and the breaking point	Psychological distress and the breaking point
Coping Strategies and Personality Factors	
<ul style="list-style-type: none"> <li>♦ Goal setting</li> <li>♦ Positive self-talk</li> <li>♦ Determination</li> <li>♦ Optimism and perserverance</li> <li>♦ Taking the cue from baby/ reflective functioning</li> </ul>	
Pride	Guilt
	<ul style="list-style-type: none"> <li>• Cognitive dissonance and justification</li> </ul>

\* Themes and sub-themes were often raised by individuals in both groups, while the table specifies only which group raised these issues most frequently/strongly

### *Expectations*

This theme existed in the data in both groups. Within this theme, three sub-themes were evident from the continuing women (realistic expectations, idealised expectations and feelings of disillusionment) and two from the non-continuing women (idealised expectations and feelings of disillusionment).

Some women from both groups expected to face difficulties and challenges while breastfeeding their baby, particularly if they had had a previous child:

... it's a real battle, it's a real learning thing and you have to be committed to do it. (CC)

While more prevalent in the non-continuing women, women from both cohorts reported they had held unrealistic expectations about breastfeeding antenatally. Research suggests that many women face early difficulties in establishing breastfeeding (Brodribb 2006), particularly issues such as nipple pain, attachment difficulties and over-or under-supply. However, these women expected breastfeeding to be a simple and natural task that they should be able to manage easily from the beginning:

... it never dawned on me that I would ever have trouble doing it, or that there would be issues. (CC)

I was really upset, sad I think like because I just presumed it would all like happen and I didn't realise how hard it can be. (NCC)

Regardless of expectations, women from both cohorts reported feelings of sadness and disillusionment about their breastfeeding experience. They noted that the experience was fraught with difficulties and disillusionment.

I just burst into tears. I felt like a real failure. (CC)

### *Early breastfeeding problems*

The majority of non-continuing women experienced breast-feeding problems in the days immediately postpartum. These problems were of great concern and often resulted in ongoing breastfeeding difficulties that were not resolved before hospital discharge:

I really don't think I had the whole gist of it before I went home ... I don't think I even got her on the breast by myself ... It felt like I was feeding her all night ... I would dread going to bed at night with the night ahead ... it was painful the whole time. (NCC)

### *Reluctance to seek help/doing it my own way*

Approximately half of the non-continuing women expressed discomfort or embarrassment about seeking help with breastfeeding problems. They preferred to keep their own counsel and deal with problems in their own way:

I thought this is just ridiculous, I can't keep going to the Doctor, its just silly, you know, going to the Doctor all the time...I just thought I'll grit my teeth...it'll be right in a few days, if I feed her off it and...She'll be right, I'll be right, I'm tough. (NCC)

### *Support issues*

There were both similarities and differences in the sub-themes identified within the continuing and non-continuing cohorts. Continuing women were more likely to discuss partner support, the support they had received from a trusted health professional and peer support. Non-continuing women similarly discussed partner support, but raised different issues such as feelings of isolation, family culture and social pressures to breastfeed.

*Partner support.* The majority of women from both cohorts reported receiving positive support from partners. Others indicated that, though partners were supportive of the woman per se, they were either not supportive of breastfeeding or ambivalent:

My partner was very supportive. He wanted me to be happy and not stressed. He thought the breastfeeding was better [but] he didn't push me to keep doing it. He said to do whatever I felt and that he'd be there and support me. (NCC)

When non-continuing women discussed their partners, a lack of knowledge about breastfeeding and the support women required while breastfeeding was evident:

There was only one person who said, 'well I think you should put her on the bottle' and that was my husband. He doesn't know anything so that's all right he kind of didn't understand. (NCC)

*Trusted health care professionals.* The majority of continuing women reported receiving either conflicting or too much advice while attempting to solve their breastfeeding difficulties. They felt overwhelmed and found it difficult to decide between options. Selecting one health professional, whom they could trust, increased their confidence about the advice received. They found this reassuring:

Finally I decide I was going to just stick to one lot of advice, so I decided to go to Doctor [Lactation consultant]. (CC)

*Peer support.* Support from peers, in the form of contact with someone who could relate to their experiences, was valued, sought after by the continuing women and felt to be important. Sharing their concerns with people in their support network was one way of managing problems:

We just knew where we were both at and we would often be going through the same things. (CC)

*Feelings of isolation.* Feelings of isolation were reported by some non-continuing women, in particular, isolation from breastfeeding supports. These women also reported feeling personally isolated due to lifestyle changes brought about by the baby's arrival:

When I came home, I really didn't have anyone, there was only like a few acquaintances that I met through the shop, as in customers that had come in that knew I had the baby, other than that I didn't have anyone, you know its not like I had a buddy or friends who had kids that I could ring up and say like...what do you do, what did you do when this happened. (NCC)

*Family culture.* About half of the non-continuing women discussed their family culture, with the majority reporting that their families had traditionally breastfed and held positive attitudes towards breastfeeding. Previous research (Hoddinott & Pill 1999) indicates that women who regularly see a relative or friend successfully breastfeed are more confident about and committed to breast feeding and also more likely to succeed. However, more non-continuing than continuing women raised this in their interviews, suggesting that growing up in a family which supports and promotes breastfeeding may not have been a protective factor for these women:

Both our families are in the generation where breastfeeding is all there should be. (NCC)

*Social pressure to breastfeed.* Pressure to breastfeed was reported by non-continuing women. It came from many parts of the women's social milieu, including hospital staff, health professionals, families, partners and the general community. Often these pressures added to feelings of guilt and inadequacy. Some reported that the pressure to breastfeed from hospital staff was counter to the bonding process:

'We need to get her on and we need to have her feeding' and then she wouldn't and I never just got to hold her without it being a breastfeeding thing. (NCC)

### *Feelings about breastfeeding*

This theme was evident in both cohorts of the study. There were similarities in the sub-themes raised by the two cohorts (breast is best, breastfeeding important to bonding, breast-feeding as an automatic decision) and differences. The non-continuing women raised issues such as milk supply concerns, while the continuing women talked about their faith in a natural process. These sub-themes are discussed below.

*Breast is best.* Both cohorts acknowledged the benefits and value of breastfeeding. Several continuing women reported that this belief was a primary reason why they breastfed through adversity. Continuing women in particular believed that breastfeeding was the morally correct choice in terms of providing nutrition to their infant:

I believe babies need breast milk. And I really wanted my kids to have the best...there's a reason why we have this milk when we have a baby...I just really am very much a strong believer in breastfeeding. (CC)

*Breastfeeding and bonding.* Breastfeeding was identified by about half of the women in each cohort as an important part of the emotional link between themselves and their babies. Participants described the silent communication between themselves and their baby during breastfeeds and talked of the unique and special nature of this connection:

... he starts looking up at you and you can feel little hands on your side while he's feeding. It's a really big deal ... (CC)

... he finished and he looked up at me with this smile like, mmm, yum. And I thought oh wow – makes your day. That was probably one of the best moments. (NCC)

*Breastfeeding as an automatic decision.* Most women in both cohorts reported that the decision to breastfeed was automatic. For these women, the decision to breastfeed was a foregone conclusion that required no conscious thought:

No, never even had to think about it. It was like circumcision. You know, you either – you're for it or you're against it. It's just how you are I think. It's how you live your life. I did not make a conscious decision. (CC)

*Faith in natural processes.* The implicit belief in breastfeeding providing appropriate nutrients for infant survival was evident in the majority of continuing women's transcripts:

...to me it doesn't make sense that your body wouldn't be able to make enough [milk]. (CC)

While some non-continuing women also expressed this belief, half of the non-continuing women reported faith in artificial feeding. This was not evident in the transcripts of continuing women:

... most of the formulas these days, they're quite good. (NCC)

... I couldn't do it [give baby formula] because ... it was an inferior product (CC)

*Supply concerns.* The perception of insufficient breastmilk was common among non-continuing women (55%). Women in the continuing cohort expressed these concerns less commonly (20%). Supply concerns were perceived as contributing to the decision to wean and the participants expressed frustration at being unable to breastfeed as they had intended:

I was expressing...I was only getting 10 to 20 mls and other mothers in there were expressing 100 mls at a time and I was like, oh why can't I do that? And it was a little bit frustrating and it was very monotonous. (NCC)

*Psychological distress and the breaking point*

Psychological distress expressed in terms of emotional upset, anxiety or depression, was experienced by both cohorts. These feelings impacted upon women's sense of wellbeing, their ability to breastfeed and their perceptions of being a good mother. Feelings of stress were often provided as a reason for weaning by non-continuing women:

... I was at a point where I couldn't keep going with the breastfeeding because it was, it was too upsetting for me and it was too psychologically, well she, she just kept refusing it and I was getting too upset by it. (NCC)

When stress became extreme, women in both cohorts made reference to reaching a breaking point. Breaking point was understood as a point of extreme emotional and physical exhaustion which prompted a decision to either continue or cease breastfeeding:

... towards the end of it though I knew that I couldn't keep going ... my entire life revolved around feeding her, like feeding her, changing her and that was my life ... either we were going to have to go back to normal breastfeeding or we would have to eventually move through to yeah, formula feeding ... (CC)



### *Coping strategies and personality factors*

On reaching this breaking point, continuing women engaged in coping strategies that assisted them to continue breastfeeding. Additionally, several personality factors (e.g. determination, optimism, perseverance), appeared to assist continuing women to overcome this breaking point and reach their goals.

*Goal Setting.* About half the continuing women reported employing the cognitive strategy of goal setting to overcome difficulties. Some focused on setting short-term goals while others tended to focus on more long-term goals:

I made small goals and would think 'I will express till the end of this week'. (CC)

I was not at my [goal of] 12 months and I would not give up – he would be back on the breast. (CC)

*Positive self-talk.* The internal dialogue of continuing women appeared to play an important role in successfully overcoming breastfeeding challenges. Their attitude was there was no point 'moping around'. They preferred to make a decision and move on. They used self-talk to manage their cognitive reactions to difficulties they encountered. With the aid of self-talk, they used positive messages and logical argument to keep their problems in perspective:

.... there was this 'oh, she's trying to wind me up' sort of thing. But I quickly got over that and thought 'no, she's a child, she can only communicate by crying.' (CC)

*Determination.* A sense of determination was evident in the transcripts of the majority of continuing women:

... one of my best friends nicknamed me 'terrier', when I got something into my head, I'd ... would keep going. (CC)

Determination was also demonstrated by the women's actions and their time commitment in the face of difficulties. One woman who suffered recurrent mastitis commented:

I'd express and then I'd sit there for probably 20 minutes ... and use the heat and massage thing on it and then I'd get into the shower and use the hand-held massager to break the lumps up [several times a day] ... (CC)

*Flexibility.* About half the continuing women also demonstrated flexibility in their approach to breastfeeding:

... so as long as she was happy to just go with the flow, then so were we. (CC)

They were willing to change their regular daily routines wherever necessary and develop alternatives to accommodate their changed situation:

If we went to [name of town] or the coast, I would usually have to express in the car on the way. (CC)

*Optimism.* Optimism refers to generalised positive expectancies about the future (Scheier & Carver 1985). Continuing women appeared to be confident their difficulties would improve in the future and looked forward to easier times ahead:

You know that in a few days time it's going to be better or in a couple of weeks it's going to be better. You just know it. (CC)

*Perseverance.* Perseverance, flexibility and determination have been identified as concepts that assist with 'resilience'. Resilience may be viewed as a measure of stress coping ability and refers to personal qualities that enable individuals to thrive despite adversity (Connor & Davidson 2003). The transcripts of the majority of continuing women demonstrated the concept of perseverance. For example, one continuing woman experiencing mastitis up to 12 times and may have also developed breast abscesses during her breastfeeding experience, but continued to breastfeed through severe pain because the problem was not seen as a reason to wean:

... feeling like you have been hit by a lump of wood in the side of the breast and my arm would ache as well and so it was very sore ...but no I just thought,...you have to I don't know, work through it. (CC)

*Taking the cue from the baby.* Transcripts of about half of the continuing women showed evidence of being able to understand their infants' needs from the infant's behaviour:

... if they're healthy enough and they've got wet nappies and they're bright...I don't know, there are little indicators you can look for. (CC)

About half the continuing women also showed understanding of their infants' feelings or desires, a capacity known as reflective functioning (Fonagy et al. 1998):

... [at day care] there would be nowhere quiet where she could go off if she wanted to sit down quietly and have her own space ... (CC)

### *Pride vs. guilt*

The continuing women took pride in their persistence, success and achievements in relation to breastfeeding:

I feel that I have done the best thing that I can possibly do for my kids (CC)

In contrast, the majority of non-continuing women reported feeling guilt and failure in relation to their decision to wean. The level of guilt experienced was disturbing and appeared to stem from not having reached breastfeeding goals despite the knowledge that this was best for the child. Guilt was often experienced for long periods. Women reported letting the baby, others and themselves down and failing as a mother:

Well, to start with I felt guilty because I wanted her to have breast milk. And I felt I was letting other people down as well. Like my hubby and I just thought that was what people expected of me as well. I felt really guilty for giving it up (NCC)

Several non-continuing women experienced dissonance between their actions and intended actions. To reduce this dissonance, they justified their behaviour:

For a long time I couldn't get over the fact that I'd let myself down. That I'd put her on the bottle and that I hadn't breastfed ... a doctor had said ... in six years time are you going to be able to tell in the playground who's breastfed and who's bottle fed? And I thought, well that about sums it up. So, for a long time I had to get over that. I'm definitely over it now.' (NCC)

## **Discussion**

Investigation of these two cohorts of women provides important insights into the experiences, personal qualities and coping strategies of women facing difficult breastfeeding problems.

### **Support issues**

These results are consistent with past studies demonstrating a relationship between partner support and breastfeeding duration (Whelan & Lupton 1998, Scott *et al.* 2001). However, partner knowledge and understanding of breast-feeding women's support requirements differed across cohorts. This is consistent with Susin *et al.* (1999), who observed that partner's breastfeeding knowledge was positively related to breastfeeding duration. Findings are also consistent with previous research showing that peer counselling is effective in enhancing breastfeeding duration (Dennis 2002). The findings suggest that having a pro-breastfeeding family culture does not necessarily protect women with extraordinary difficulties from weaning.

The importance of having a trusted health professional whose opinions and advice regarding breastfeeding issues was followed above all others has not previously been reported. General practitioners would be best

poised to undertake this role in the Australian system, but limitations regarding time, resources and breastfeeding knowledge are barriers. One way to overcome these issues could be the employment of a lactation consultant in general practices. Lawlor-Smith *et al.* (1997) engaged a lactation consultant in general practice to provide a service to breastfeeding women who experienced problems and observed a 25% improvement in breastfeeding rates at six months postpartum. Another possibility is the 'bub-hub', where a multidisciplinary team of professionals provide integrated care to the woman during pregnancy, birth and the postnatal period (Hirst 2005).

### **Unrealistic expectations**

Findings observing that women with unrealistic expectations of breastfeeding are more likely to wean are consistent with past literature (Bottorff 1990, Hauck & Irurita 2003). Women should be fully informed of their breastfeeding experience antenatally (McVeigh 1997). Hauck *et al.* (2002) also note that women who have more realistic expectations regarding breastfeeding may be unprepared for the impact of the difficulties they experience. Interactive methods of imparting information, such as incorporating peers who have experienced breastfeeding difficulties into antenatal classes, may be effective in producing attitude and behaviour change (National Health and Medical Research Council 2000).

### **Understandings of maternal morality**

The inability to breastfeed, for many women, is akin to failure as a mother (McInnes 2003). The study transcripts are full of the sense of failure and guilt experienced when breastfeeding goals are unmet. Clinicians need to be aware of this. Similarly, hospital staff need to make every effort to resolve breastfeeding difficulties prior to the woman's discharge, and ensure appropriate postnatal support mechanisms are in place for women whose difficulties are not resolved.

### **Disillusionment, the breaking point and ways of overcoming**

Disillusionment in response to breastfeeding difficulties is well-documented (Mozingo *et al.* 2000, Hauck *et al.* 2002). The finding that both cohorts experienced a breaking point, however, would appear to be novel. The finding that coping strategies and personal qualities helped continuing women to overcome this breaking point is important. Positive self-talk has been previously discussed in association with the continuation of breastfeeding (Bottorff 1990). However, the relationship between coping successfully with breastfeeding difficulties and goal setting and/or perspective-taking is also novel. All these strategies are integral components of most cognitive-behavioural therapies (Haaga & Davison 1991). While cognitive behavioural therapy has been effective in the treatment of many mental health issues (Chambless & Gillis 1993, Ellis *et al.* 2003), the effectiveness of cognitive behavioural techniques to increase breastfeeding duration is yet to be tested.

Several personal qualities were identified that assisted continuing women to traverse breaking point and continue breastfeeding, including determination, flexibility, optimism and perseverance. Determination and flexibility have been previously associated with persisting with breastfeeding (Bottorff 1990). What is most exciting, though, is that many of the personal qualities identified are potentially modifiable through intervention (Seligman 1991, Oppenheim *et al.* 2001). Interventions designed to enhance the woman's mental health while also preparing her for the challenges of breastfeeding and motherhood may offer an opportunity to increase breastfeeding duration.

### **Guilt, failure and rationalisation**

There is a need to discuss the strong feelings of guilt and failure associated with early weaning experienced by non-continuing women. This has been observed previously (Mozingo *et al.* 2000, Hauck & Irurita 2003). It is important to emphasise how aversive experiences of guilt and failure were for some women who weaned and for how long these feelings lasted.

Some non-continuing women who experienced guilt underwent a rationalisation of their feelings about breast-feeding. This process appeared to be motivated by a need to reduce dissonance between their actions (i.e. ceasing breast-feeding) and their feelings about themselves and breastfeeding (i.e. 'I want to do the best for my child'). This is a common process and is well-documented in social psychology (Stone and Cooper 2001). It represents an important coping mechanism for women who wean to alleviate an aversive mental state, but makes it less likely that breastfeeding will occur in the future.

### **Limitations and considerations**

The inclusion of two matched groups allowed not only an examination of the qualities and characteristics of women who continued to breastfeed, but also a comparison between these women and women with similar breastfeeding experiences who elected to wean. The benefits of the case-controlled design and the fine-grained analysis it affords can easily be observed. For example, Mozingo *et al.* (2000) observed that women who weaned early had idealised expectations of breastfeeding and experienced disillusionment. The design of this study enabled the replication of this finding, but also enabled the observation that at least some continuing women *also* held idealised expectations of breastfeeding and experienced disillusionment.

## **Conclusions**

The benefits of breastfeeding to the infant and mother (WHO/UNICEF 1989) and the economic benefits of breastfeeding to the country and individual families (Minchin 1989, Smith *et al.* 2002) are well-documented. This study has provided an insight into the experiences of continuing and non-continuing women who have experienced extraordinary breastfeeding difficulties. The methods women used to deal with their problems, along with the type of support they received, some of their attitudes and beliefs and certain personal qualities they possess appear to have combined to determine whether or not they continued to breastfeed in the face of extraordinary difficulties. This study has also exposed modifiable factors with the potential to improve breastfeeding duration rates and several coping strategies which may assist breastfeeding women to continue to breastfeed through difficult times. The findings indicate that clinicians should:

- ♦ Provide information which accurately reflects the breast-feeding experience;
- ♦ Ensure systems are in place so that effective postnatal support for breastfeeding difficulties is available;
- ♦ Consider screening to ascertain levels of psychological distress, sadness and disillusionment among breastfeeding women;
- ♦ Design educational interventions with elements of cognitive skills, problem-solving and self-efficacy training to equip women with the skills to overcome any experienced difficulties.

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## Contributions

Study design: DH, MO'B, AF; data collection and analysis: DH, MO'B, AF and manuscript preparation: DH, MO'B, AF

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