

‘You're kinda passing a test’: A phenomenological study of women's experiences of breastfeeding

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ABSTRACT

Objective: To explore the experiences of breastfeeding women.

Design: Interpretive phenomenology.

Setting: Rural county in the United Kingdom.

Participants: 22 primiparous and multiparous women who had all breastfed their youngest baby for at least 11 days.

Methods: data were collected using in-depth interviews when the women's babies were between 3-6 months of age. Thematic analysis was used to analyse findings.

Findings: The women described tensions and mixed messages regarding breastfeeding – feeling scrutinised in their ability to breastfeed their own infants, and contradictions between public health messages promoting breastfeeding and the health care professional support received to facilitate breastfeeding continuation. The women also described how these approaches and messages impacted on their breastfeeding experiences, and how they managed breastfeeding as a result.

Key conclusions and implications for practice: The findings from this study revealed a patriarchal healthcare support system for breastfeeding whereby the women felt under surveillance and expected to perform to a prescribed ideal, but also a lack of support for exclusive breastfeeding after the initial postnatal period. These findings have clear implications for practice and policy.

INTRODUCTION:

Despite an increasing research base about what helps or hinders breastfeeding, there is a dramatic drop in breastfeeding prevalence within the first six weeks (Health and Social Care Information Centre [HSCIC], 2012). The reasons that mothers give for stopping breastfeeding suggest that few mothers **discontinued** because they planned to, particularly those **discontinuing** before four months (Bolling et al, 2007). Most importantly, given that breastfeeding confers short and long term health benefits for both mother and infant (Horta et al, 2007; Ip et al, 2007), and the adverse effects of early discontinuation, particularly to maternal mental health and attachment security between infant and mother (Dennis and McQueen, 2009), it is crucial that more research is directed to capturing, analysing, and seeking to understand this phenomenon from the perspective of those living that experience.

NICE (2006) public health guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS. Evidence supports the provision of a combination of interventions including antenatal education, peer support and education and training for health care professionals (Britton et al, 2007; Renfrew et al, 2005). 'Better Births' states that *'caring for the woman and baby after birth is equally as important as during pregnancy and birth'* (National Maternity Review, 2016 pg. 61). The influence of postnatal care provision on breastfeeding requires further exploration. Results from a randomised controlled trial conducted in the United Kingdom (Winterburn and Fraser, 2000) demonstrated no significant effect on breastfeeding rates at one month. A Cochrane review concurred (Brown et al, 2009). By contrasting and comparing mothers' experiences against the backdrop of the existing breastfeeding literature, this study aimed to move us one step further towards the development of a

comprehensive understanding of the phenomenon of breastfeeding.

METHODOLOGY AND METHODS:

To uncover what meaning women give to their experiences of breastfeeding, interpretive phenomenology informed by Heidegger [1889–1976] was chosen as the research methodology. This approach was chosen seeking to explore and understand mothers' views of breastfeeding their infants, as it is proposed that in order to understand the inherent complexities of successfully promoting and supporting breastfeeding, a woman's breastfeeding experience must be examined within her specific context. Ethics approval to conduct this study was granted by the University Of X Research Ethics Committee and the X Research Ethics Committee. A purposive sample of primiparous and multiparous women who had all breastfed their youngest baby for at least 11 days were provided with information about the study by their health visitor at the primary birth visit. If these women chose to participate in the study, an in-depth face-to-face interview was undertaken when their youngest baby was aged between three and six months.

The approach to data analysis was based on van Manen (1997) and Smith et al (2009). Interview data was transcribed verbatim. The transcripts were read and re-read alongside the first author's field notes to gain a sense of each woman's experience as a whole, rather than as fragments of typed phrase. In accordance with Heideggerian principles, analysis was a continued process of discussions between the two authors.

RESULTS:

The participants in this study were aged between 16 and 37 years at the time of the interview, primiparous and multiparous women (ranging from parity 1 to parity 5); 21 of the participants described themselves as white, British, and one as Asian; 21 were either married or cohabitating, and were in a long term heterosexual relationship with the youngest baby's father, except for one participant, Tanya, who was a single mother living with her parents.

All the participants had given birth in the local hospital. None of the women had returned to employment at the time of data collection except for Michelle who had recommenced her undergraduate study at University when her baby was four weeks of age. All of the women participating in this study began by breastfeeding their youngest infants and breastfed for at least two weeks; 12 were exclusively breastfeeding at the time of the interview.

Quotes from the data are presented in italics. To protect the identity of the participants, all names are pseudonyms which are denoted within square brackets.

Tensions in women's' experiences of breastfeeding

The women described tensions and mixed messages regarding breastfeeding, and how they managed breastfeeding as a result.

Sub theme one: surveillance and scrutiny

The women described feeling scrutinised in their ability to breastfeed, by health care professionals, but also by their family and the wider communities in which they lived. There was an emphasis in the women's narratives around measuring, timing and charting of breastfeeds, of feeding to a prescribed and dictated regime. For some, they felt this put added pressure on their breastfeeding experience and seemed at odds with the unstructured and relational experience of breastfeeding that was not measured or timed, nor in a pattern or routine. In an effort to attain the prescribed amount of breast milk, some of the women were advised to put the baby to the breast for a feed, but then supplement with expressed breast milk as well. Veronica had talked earlier in her interview of the feeding regime that had been instigated as her baby was small and how she had to time how long her baby breastfed for, and ensure she fed within a required amount of hours. This led to Veronica feeling as though she was constantly clock watching. Additionally, she described feeling as if she had to demonstrate performance to the professionals' satisfaction before she would be permitted to be discharged home

On the feeding chart she had to feed every, for, I think it was twenty one minutes out of every three hours, I don't know how they came to that figure, but as long as every individual feed added up to twenty one minutes every three hours we could go home after three days, and we was also charting her wet nappies, the dirty nappies...I think the number of people that watched me feed her was quite amazing, all the various midwives and the feeding team and I think there was someone else, I didn't know who the people were in the end.

Pauline, a first time mother, also described feeling as though her performance as a breastfeeder and as a mother was being judged and assessed by the health care professionals

You feel like you're being checked up on, so you know, you don't wanna say 'oh I'm struggling', because you're kinda passing a test, you feel that you're competent or not.

The women expressed their desire to go home from the postnatal ward as soon after the baby's birth as they were able to, in part because the ward was so busy and noisy it was not felt to be conducive to postnatal rest, but in part so that the women were able to get away from feeling as though they were under surveillance. As a result, the women did not have the competence and confidence in their own abilities with breastfeeding when they got home.

Sub theme two: conflicts and contradictions

Acknowledging that breastfeeding is a key public health concern, efforts have been made internationally, nationally and locally to strengthen breastfeeding support, including ensuring all health care professionals are confident and competent to support breastfeeding. What was surprising from the women's accounts was how they perceived, described and interpreted the support they received from their midwives and health visitors. The women's accounts expressed that they recognised how busy the hospital midwives were:

Midwives obviously they don't have the time, I know that. I know how understaffed they are, completely [Jenny]

The women described a lack of consistency in the advice they were given, which they ascribed to the lack of continuity in carer. This seemed to result in the women not feeling as if they had a rapport with both the hospital-based and community midwives:

Every different midwife had a different thing to tell me and a different idea of how to latch him on and, urm, and one of them would say don't do that, do this and the next shift would come on and I'd say the lady this morning said to do it like this and they'd say well yes, yes, that was the old way, that was how we used to do it but now we find if you try it like this [Rebecca].

The support for breastfeeding the women did experience was not welcomed. The women spoke of an overwhelming dislike of the physical help they received to latch their baby, to the point that women avoided being honest about the help they needed. The women found a health care professional touching their breasts daunting, intrusive and distressing. Georgina described the midwife who latched her son on for a breastfeed on the postnatal ward as 'pawing at me'.

she [midwife] got my nipple [makes squeezing motion between thumb and first finger], squeezing it [made grimace with face], it did not feel good at all ...So they squeezed and got her latched on, and then she'd fall off as soon as they left the room [Denise]

Charlotte, who had disliked the physical help to latch her previous baby on the breast, admitted to pretending she was coping when in hospital after the birth of her third child in order to avoid the physical assistance:

I think I didn't want to feel like I did, because when I was the first time, with Charlie, they kinda took over, and they grabbed me, and grabbed Charlie.

The majority of the women in this study had not been exposed to breastfeeding prior to having their own babies. However, they described both not having confidence or feeling competent at positioning and attachment prior to their discharge from the postnatal ward, or adequate support with breastfeeding when they were at home, from their community midwifery team or their health visitor

I expected them to help me a lot more, because of him, the importance they place on breastfeeding, and knowing that he wasn't breastfeeding... she [health visitor] said I wouldn't see her again and I'd have to go up to the clinic. She gave me a little sticker with the times the clinic was on [Isla]

Baby clinic was described as a conveyer belt that was predominately concerned with weight surveillance rather than a health care professional contact. Some of the women described having their baby's weight called out across the room whilst the baby was being re-dressed, and was therefore audible to everyone else in the room. For some women, this was distressing if their infant had not put on the required weight as they felt their ability to breastfeed was called into question, and they felt further

discouraged by the clinic set-up from asking for support or advice from the health visitor:

it was all very much, here's your number, go, you get them changed, you put them on the scales, they write it in your book, there you go. Thank you. Off you go...You're sort of weighed and shoved out the door...I thought you haven't got time. You haven't got the time to ask me properly, so you didn't want to say I need to speak to somebody [Kelly]

Participants felt that healthcare professionals stipulated a rigid set of rules for breastfeeding methods and techniques. The process of seeking specialist support was constituted in terms of struggle, revealing tensions between expert knowledge and mothers' experiences. A medicalised approach to breastfeeding management was described by many of the women, particularly in the accounts of those women who were no longer breastfeeding at the time of data collection. For these women, their descriptions of their breastfeeding experience were interspersed with accounts of charting their baby's infant feeding patterns, timing breastfeeds (both the time taken actually breastfeeding in addition to feeding at prescribed intervals), and learning 'how to' breastfeed in a step-by-step mechanistic technique that if one component was not adhered to, would result in failure. Health care professionals were described as not taking a woman's experiential knowledge into account. Fiona, mother of three, described how she was advised to supplement breastfeeding with formula when her second baby lost weight in the initial postnatal period. She refused, and described what happened

They were panicking over nothing. My milk came in the next day, thankfully [laughs]...It felt as though I knew more about it than they did.

Health care professionals were perceived to be preoccupied with weight gain, rather than assisting the women to learn the art of breastfeeding, trusting in their body's ability to provide for their growing infant:

Every day, they came every day to weigh him...They're very hung up on weight, obsessed with weights [Sharon]

Several of the women's accounts suggested that they expressed breast milk as a way of being certain about how much milk they were producing or how much the baby was taking. This is evident in Kelly's account of being able to measure five or six ounces of expressed breast milk obtained in five or ten minutes of expressing with a manual pump. Isla equated the amount of expressed breast milk she obtained at each feed (60 millilitres) with the amount she envisaged a formula fed infant would take, and decided that this demonstrated that '*my milk never seemed to come in*'. This seemed in complete contrast to the relational descriptions of breastfeeding apparent in some of the women's descriptions:

I can't believe that I am life sustaining [Denise]

DISCUSSION:

The majority of mothers in this study expressed feeling pressured, judged and scrutinised regarding breastfeeding. These findings lend support to arguments that health care professionals are becoming the primary

authorities and moral gatekeepers of contemporary infant feeding. High breastfeeding initiation rates may therefore be a reflection of compliance with cultural expectations towards breastfeeding. However, the rapid drop in breastfeeding rates in the early postnatal period highlights a dissonance between women's needs and healthcare professional practice in supporting breastfeeding women. Supplementation with formula milk, and emphasis on precise amounts, timings and frequent weight reviews described by the participants in this study reflects a biomedical paradigm of clinical breastfeeding support.

A significant finding is the problem of feeling pressured to perform or judged (to demonstrate capability as a breastfeeding mother, verified by adequate weight gain) by health care professionals. Women described a model of breastfeeding support that was reactive to requests for help rather than proactive. The help they did receive was described by many of the women as rigid and dogmatic, driven by targets and rules, rather than being woman-centred, flexible, and based upon the woman's individual needs. Multiparous women felt their needs were neglected and overlooked. Online discussion groups were accessed by two of the women who valued the 24-hour availability offered, but also the degree of anonymity it afforded, which they felt was conducive to openness and candour amongst the discussion group members. It is unlikely that the negative experiences of support from health care professionals described by the women in our study are unique.

The focus of healthcare professional practice appears to be on reinforcing the notion of expertise, rigidly attending to the 'Ten steps to successful

breastfeeding' (WHO, 1998), and the widespread acceptance of Baby Friendly Hospital Initiative as a panacea to the poor rates of exclusive breastfeeding in the United Kingdom. The Unicef UK Baby Friendly Initiative standards were subsequently updated and expanded in 2013 to include parent-infant relationships in order to reflect the evidence base on delivering care and ensure the best outcomes for mothers and babies in the UK, yet this revised emphasis appears to be slow to be reflected in the practice experienced by the mothers in our study. It is perhaps unsurprising that the hospital where the women gave birth was not BFI accredited, although was working towards accreditation at the time of data collection. Mothers reported uncertainty over the 'rules' and rationale behind the breastfeeding practices they were taught, for example the step-by-step approach to positioning and attachment, being shown how to hand express prior to discharge home from the postnatal ward, but at the same time being informed that expressing breast milk before 8-12 weeks was discouraged, use of nipple shields, and that bottles and teats would confuse the breastfed baby. The women in this study described a tick box approach to breastfeeding practice in which women received care and advice that was prescribed and standardised, rather than individualised and woman-centred.

Midwifery in the UK has become increasingly professionalised, institutionalised and medicalised (Kirkham, 2010; van Teijlingen, 2005). This body of work shows that notions of power, expertise and medicalisation affect the quality of relationships between midwives, medical professionals and women in maternity care. Central to the debate about where the role of health care professionals are positioned in the provision of infant feeding care (mirroring older debates on the

medicalisation of pregnancy and childbirth) is the question of whether or not breastfeeding is a normal physiological process. Ivan Illich used the term iatrogenesis for the harmful epidemic of disabling medical control. Illich (1976) argues that there is no proven benefit of many medical interventions, and thus no proven causal link between increased medicalisation and improved outcomes. We would suggest that this applies to breastfeeding – increased medicalisation and technological approaches by health care professionals has not resulted in increased breastfeeding duration. Dykes (2006) argues that there is a risk in merely changing one dominant culture (medicalisation) for another (rigid implementation of UNICEF standards), without addressing the constraints that are placed upon either the midwives or the women to maintain breastfeeding in contemporary society. Some of the women in our study felt they were either passing or failing, and this led to reduced self-confidence and reduced self-responsibility. The women in our study who felt they were successful in attaining their breastfeeding goals were different in their attitudes towards breastfeeding management and ownership of breastfeeding. These women placed value on their own expertise and confidence rather than unquestioning deferment to professionals. Increased dependency upon the advice and assistance of health care professionals undermines women's confidence in their own embodied knowledge. Consistent with Illich's (1977) disabling professions, it is argued that the medical model forced women into a submissive and passive role in which science and technology dominate over women's trust in their own bodies. Midwifery was ideologically opposed to this obstetric, medically-dominated model of childbirth. However, it would seem as though in relation to the provision of care for breastfeeding women, the philosophy of midwifery, to be 'with woman' has been compromised.

One of the significant factors identified by participants was that midwives were too busy to provide breastfeeding care and support, particularly on the postnatal hospital ward. Staff shortages and lack of staff time is a dominant theme in much of the research concerning postnatal care (National Maternity Review, 2016; Redshaw and Henderson, 2015). It could be suggested that the 'hands-on' approach to positioning and attaching baby to the breast the women in our study described receiving, and disliked so vehemently, was a response to the limited time available for midwives to complete tasks. The main purpose of the revised UNICEF UK Baby Friendly Initiative standards (2012) is to support health professionals, with explicit stages focusing on workforce education and parent's experiences. Education programmes need to focus on enhancing positive communication skills and developing the midwife's ability to provide women-centred care that is relationship-based. Organisational barriers to creating a cultural change in breastfeeding support also need to be addressed. Midwives need support through policy, management and the environment to implement evidence-based care and to build their own knowledge and self confidence in their ability to support women effectively (Ingram et al, 2011).

There are strengths and limitations to most studies. The study presents interpretations of the phenomenon of breastfeeding as experienced by a small number of women from one city in the East Midlands. These data may not be generalisable to the whole of the UK, however findings resonate with those of other studies. There was also a limitation in the demography of the participants. Only one non-white British woman was

recruited to the study. People from ethnic minority groups were not excluded from the study but their absence is a reflection that all the recruitment material was provided in English and that resources did not allow for bilingual researchers or translation of materials.

CONCLUSION

A patriarchal health care support system was described whereby the women felt under surveillance and expected to perform to a prescribed ideal. The women expressed their desire to go home from the postnatal ward as soon after the baby's birth as they were able so that they could get away from this, but as a result the women did not have the competence and confidence in their own abilities with breastfeeding when they got home. Time and workload pressures on midwives and the organisation of postnatal care, both in hospital and in the community, needs to be addressed. Findings from this study further support the call in 'Better Births' for '*an upgrade to postnatal services*' (National Maternity Review, 2016 pg. 62).

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