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Managing the dynamics of shame in breastfeeding support

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This forum seems a really useful opportunity to consider this question together:

SLIDE TWO

What can we learn about supporting breastfeeding women from a literature that I think has been overlooked when it comes to breastfeeding – the literature on shame, and particularly shame management or shame resilience? I am presenting this material rather tentatively and hoping that it will lead to further discussion afterwards about whether and how the theory I'm going to present might inform good practice with breastfeeding women.

Before I move on to looking at what we can learn from recent research and theory on shame management, I'm going to talk about some research findings from my own work and that of others which I think demonstrate that we ought to be paying attention to shame when we think about some women's experiences of breastfeeding. However, what's interesting is that researchers haven't always used the word 'shame' when they've presented these findings. It's only recently that breastfeeding scholars and researchers have turned explicit attention to shame and that may be because we don't talk about shame very much nowadays in western societies.

SLIDE THREE

If you think about conversations you've had with people close to you with whom you might talk about your feelings, I bet you'll find it difficult to remember the last time you talked about feeling ashamed. As Thomas Scheff has argued (1995, 2003), we are ashamed of our shame. Therefore, we tend to avoid 'shame' words and if we get close to acknowledging feelings of shame we might say instead 'I feel a bit useless' or 'I couldn't think straight with everyone looking at me' or 'I feel a bit daft asking you for help with this'. We also tend to work quite hard to avoid shame, in ways that can actually be destructive to relationships with others, as I'm going to talk about later.

Paradoxically, Scheff argues that though relatively invisible, shame is in many ways the 'master emotion of everyday life'. This masculine image might not seem a very suitable way of talking about

women's emotional responses, but it does convey the way that we spend an awful lot of our time avoiding and managing shame by saving face, bolstering our self-image, justifying our actions, seeking affirmation from others or letting it be known that a complete disaster was everyone else's fault but ours etc etc. However, we often do this quite subtly, so that the possibility of shame remains unspoken, unacknowledged and invisible. This relative invisibility of shame means that I think we have to listen quite carefully to what women say and do in relation to breastfeeding if we are going to be sensitive to signs of shame.

Having said all this about the relative invisibility of shame, ironically this is actually the second presentation on shame in this seminar series. So hopefully that means that shame is now a little more visible. Those of you who were here for the first seminar will remember Lisa Smyth's very thought-provoking presentation on some of the sources of shame for breastfeeding mothers. Therefore I'm only going to touch on this briefly and focus more on how we might respond to any issues with shame that breastfeeding women might face.

SLIDE FOUR

As Gill Thomson and colleagues (2015) have pointed out, our society has such a conflicted approach to breastfeeding that women can feel shamed for feeding in public but also shamed for not breastfeeding. Lisa linked this to the idea of conflict between norms. On the one hand we have the issue of public feeding, which as Sally Dowling and colleagues have discussed (2012) can involve not only a sense of shame about exposure that may be viewed by others as sexual, but also feelings of disgust about lactation and hence shame about *being* disgusting. However, my main focus today is on the shame that women can feel about *not* breastfeeding and in particular the sense of failure or inadequacy some women talk about if they struggle to establish breastfeeding.

SLIDE FIVE

To illustrate what I'm talking about, here are a couple of quotes from participants in a UK study that I was involved in where we interviewed new mothers intending to breastfeed and asked them to keep audio-diaries of their feeding experiences in the first few weeks (Williamson et al., 2012). These were comments from a couple of the mothers who were really struggling to establish breastfeeding, for example they were finding it difficult to get a good attachment at the breast, or were experiencing pain, or were finding their baby disinterested in feeding at the breast or the baby seemed unsettled and unsatisfied: See slide

These themes of inadequacy and failure as a mother and woman are particularly poignant, given how common breastfeeding difficulties are in the early weeks. Unfortunately however, similar

themes have been picked up in numerous recent studies (e.g. Burns et al., 2010; Guyer et al., 2012; Mzingo et al., 2000; Shakespeare et al., 2004; Thomson et al., 2015) where women have experienced difficulty breastfeeding, both during the early weeks and later. Erin Taylor and Louise Wallace (2012), two philosophers, have discussed such findings and argue that two issues here are the promotion of a version of breastfeeding which does not match women's embodied experience and also the promotion of unrealistic ideals of motherhood. They suggest that if women are told they should aspire to a version of motherhood where total focus is on optimising children's needs with no space for mothers' own needs or consideration of the constraints placed on optimal parenting, then a sense of failure is difficult to avoid – perfection is demanded.

However, given today's focus on embodiment, what also interests me about the second of these two quotes is that the good mother is seen here as an embodied phenomenon. She doesn't just breastfeed - she lactates, & has a maternal body which produces plenty of milk and sustains her child with ease. Therefore, from the perspective of this participant, a young woman whose baby did not feed at the breast well and did not seem satisfied without top-ups of formula, she was her inadequately lactating body – 'I couldn't produce what she was needing', not 'my body' didn't produce. Some breastfeeding women seem to talk about the breastfeeding body in a more distanced and even mechanical way than this. But in our study several women who were struggling to establish breastfeeding talked more holistically about their body, self and relationships in ways which were very self-denigrating. For example, experiencing pain or difficulties latching the baby to the breast or perceiving that their milk supply was inadequate meant to them that they weren't normal because breastfeeding *was supposed* to be natural. For a couple of mothers, these perceived bodily limitations were taken as possibly indicating a lack of maternal feeling towards their baby.

The difficulty here then is that the sometimes rather idealised cultural narratives about breastfeeding that are available to women – the Madonna and child type image - are not able to account for their individual embodied experience. And so women fill in the gap by locating the problem within themselves as a personal flaw.

SLIDE SIX

Distress about not breastfeeding has previously been discussed as guilt, so it's worth saying a bit about the differences between shame and guilt before we go any further. It's probably best to understand these as quite fuzzy categories of experience which don't necessarily have tightly defined boundaries and which can overlap and be experienced together – part of a family of related feelings including embarrassment and humiliation. None-the-less research shows there seem to be

some quite important differences between experiences which people label as shame and experiences they label as guilt, though theorists have argued over the best way to capture these differences.

The most common distinction made by emotion theorists (e.g. Tangney et al., 2007) is between making a negative judgement of our whole self, versus making a negative judgement about our behaviour. Shame is considered to be the kind of global negative self-judgement where we might see ourselves as a bad mother or failure as a woman, whereas guilt is defined as our response to our negative judgement about a particular behaviour - for example that we've done a bad thing by not breastfeeding. This is rather different from the more global focus of shame on being a bad person. Jessica van Vliet (2008) talks about shame as an attack on the self-concept or 'a shattering of who I am'.

Earlier theorists argued that the more important difference is that shame is much more about how we are seen by others than guilt. When we are ashamed we have a sense not just of a bad or flawed self but of this self being exposed before others – we see ourselves through the eyes of others as if it is a socially shared understanding that we are a bad mother. In contrast, guilt is considered to involve a sense that we have breached our own moral code e.g. for some women, by formula-feeding. Therefore this perspective places more emphasis on the sense that we have lost others' acceptance of us and lost our sense of connection with others – we are simply exposed before them.

A really useful model of the differences between shame and guilt has been developed by Paul Gilbert (1995; 2003) who has drawn together some of these different ideas. He emphasises the different interpersonal processes in shame and guilt and argues the two experiences differ particularly with regard to felt power inequalities.

SLIDE SEVEN

According to Gilbert, when we feel guilt we focus on others as victims of our actions [right hand box], seeing the other (e.g. the baby) as hurt and needy, and ourselves [left hand box] as the one with the power to hurt and the power to put things right. We see ourselves as responsible for the situation and we focus not just on our specific actions or inactions and what was wrong with these, but also on how to put things right.

SLIDE EIGHT

However, when we feel shame we often feel powerless or *unable* [left-hand heading] and incapable of remedying the situation. [right-hand box] It is the other that seems stronger and more able as

we shrink before their scorn and ridicule. [left-hand box] We have a sense of ourselves through others' eyes as 'bad', an object of scorn, or ridicule.

According to Gilbert this 'other' need not necessarily be an actual other. We may feel ashamed in front of an internalised sense of a general other – a sense of being exposed as inadequate with an 'unwanted identity', whoever might see this. We therefore experience ourselves as inferior to others and if shame is intense we might feel paralysed, confused and unable to make much sense of the situation beyond wanting to shrink, flee or hide our 'bad' self from possible exposure and judgement, rather than try to constructively remedy a situation. We might even experience uncontrollable blushing or even rage about being placed in a position in which we feel trapped. Transient feelings of shame may not necessarily be this strong and we are sometimes very good at resisting or deflecting shame because it is so painful. However, any sense of a potentially exposed and flawed self can mean we are much less able to think clearly about how to change a situation. So we can begin to see why shame has generally been seen as a much more toxic and difficult emotion than guilt.

An important feature of Gilbert's model is the attention it pays to shame as an interpersonal process. Shame isn't just a feeling, it is a devalued sense of our position in the world in relation to others – a sense of not being worthy of connection with others. And, even though shame can be experienced without someone present, often our shame is related to others' perceived or anticipated responses. This brings me back to another paper from our study of women's early experiences of breastfeeding that I was talking about earlier (Leeming et al., 2015). Another striking feature of the participants' stories was the way that healthcare professionals were seen as having the expertise to judge what was 'normal' in breastfeeding. They were assumed to have almost X-ray capacities for being able to say what was actually going on in women's and babies bodies and offer reassurance that this was quite 'normal'.

SLIDE NINE

But of course that meant they were also perceived as able to recognise abnormality and were sometimes seen as having kind of an authority to define acceptable standards of mothering. Therefore it is no great surprise that it was in front of perceived expert gaze that shame came to the fore for some women. This is a recording that one of the participants made in her audio diary about her time in hospital following the birth: [slide 9]

Although this participant talked elsewhere about feeling supported by many of the midwives on the ward, she also suggests here that she felt that negative judgement of her competence as a mother was likely.

SLIDE TEN HEADING

While shame is clearly an issue for some breastfeeding women, there's a danger in over-stating the possibility of shame. Not every mother who experiences difficulty with breastfeeding personalises these struggles and not every mother is fazed by someone else's negative judgement. As research by Joyce Marshall and colleagues (2007) has demonstrated, mothers are not passive recipients of cultural representations and may actively resist and renegotiate definitions of good mothering that position them negatively with regard to infant feeding. They weigh up carefully the information given to them and the ideas of those close to them and sometimes actively renegotiate definitions of 'good mothering' in order to resist ideals of mothering that suggest they might be failing in some way. We could consider some of this identity work that women engage in as a form of shame avoidance. However, some women may find it more difficult to avoid a sense of shame than others, and I want to look now at how some of the strategies we use for shame avoidance can become quite problematic in ways that I think are likely to work against breastfeeding and against forming good relationships with those supporting breastfeeding.

SLIDE TEN DIAGRAM

Donald Nathanson (1997), a psychotherapist and emotion theorist, developed a theory about the way in which problematic responses to shame, or to the potential of shame, can actually amplify shame and damage our relationships with others even further. He identifies four possible responses and calls this the Compass of Shame. We can probably ignore the bottom point of the compass for our present purposes as this relates to more chronic, longstanding experiences of shame. However, I think the other compass points have clear implications for breastfeeding support with women who are having difficulties establishing feeding and feel some shame about this. Firstly, we already had some hint from the quotes I've presented, and the wider literature, of how women might attack themselves or put themselves down and castigate themselves for their struggles with breastfeeding [slide - attack self]. Another shame theorist, Gershen Kaufman (1992), expands this idea to talk about a spiral of shame where we become more and more focused on our inadequacies, replaying shaming scenes, and becoming less and less able to connect meaningfully with the external world. Therefore we withdraw and isolate ourselves. This avoids further exposure of perceived inadequacies and limits the possibility of feeling further shame in front of others. Those who find shame very difficult to tolerate might withdraw from others at the first sign of failure or possible

judgement, in order to avoid the experience of shame altogether. It's not difficult to imagine that someone who feels that her difficulties breastfeeding might mean that she's not a 'proper' mother in some way, and who feels a bit inadequate exposing what she sees as her malfunctioning nipples, might prefer to soldier on alone with a few formula top-up bottles or might begin to rely quite heavily on expressing milk, rather than hunt out help with feeding at the breast. Some of our participants talked about wanting to get home away from the ward so that they would not be so visible in their struggle to feed. Others talked about their reluctance when at home to seek out help more proactively. As one woman said when recounting her conversation with a midwife who had asked her to ring if she needed help with positioning at the breast, *'it makes me feel inadequate if I have to ring'*. However, not all women would feel able to be as open as this about their reasons for not ringing.

According to Nathanson, attacking others is a further defensive response to shame or the possibility that we might be shamed. This might involve retaliating by criticising others in order to avoid being criticised ourselves. Shame and humiliated rage have been closely linked by a number of shame theorists and Thomas Scheff and Suzanne Retzinger (e.g. 1991) have pointed out how cycles of unspoken shame and rage can develop between people, where shame is not acknowledged but powerfully present.

SLIDE ELEVEN

They suggest that, starting at number one here, if this person feels exposed as inadequate before this other person, there is the potential for feeling shamed and humiliated, particularly if there is any perception of disrespect or disinterest or implied criticism on the part of this person here. The resulting sense of anger at the perceived humiliation might lead to a kind of passive-aggressive response – a reciprocated insult or criticism that is veiled, a subtle blaming or subtly disrespectful behaviour. This then leads to the other person also feeling disrespected and dealing with the possibility of shame or humiliation by then also responding with veiled insult or blame and criticism, and the cycle of mutual shaming continues.

Scheff and Retzinger analyse interactions in a whole range of contexts, including between therapists and clients and demonstrate the power of this kind of shame dynamic to lead to unsatisfactory relationship or even conflict. They argue that shame cycles can become more entrenched and problematic if the attacks and counter-attacks and sense of shame are not openly acknowledged but veiled, for example subtle blaming, and therefore difficult to address. However, I think that their model has been under-used in looking at what can go wrong between health-care professionals and their clients. A healthcare setting is a professional encounter where neither party might feel

comfortable openly acknowledging their emotional responses to the other. Additionally the patient or client may feel exposed, vulnerable and scrutinised. Lazare (1987) is one of the few to have written about the potential for shame in healthcare consultations due to patients' beliefs that their healthcare problem is a defect or shortcoming in some kind of way, and also because of the requirement for exposure on the part of the patient. Lazare argues that some of the difficult behaviours encountered in healthcare settings can sometimes be understood in terms of unspoken shame-cycles. He talks about examples of behaviour from service users that might seem difficult or disrespectful such as being late, missing appointments, withholding information and even complaining to others about the healthcare professional. He suggests that all these behaviours might result from shame or attempts to deal with shame. Lazare adds that healthcare professionals are not immune to getting caught up in shame cycles - and this also applies to breastfeeding supporters outside of a healthcare context. He argues that a client who withdraws or does not engage with healthcare advice or is even critical and attacking, can leave the healthcare professional herself feeling a sense of failure or inadequacy. He argues that it is important for healthcare professionals to remain aware of shame dynamics and avoid a blaming response to difficult clients, resulting in this loop [slide] getting more and more entrenched.

So, what do we do about all this? Guilt has been seen as the potential unwanted side-effect of breastfeeding promotion, but there are reasons to believe shame might be more problematic. Not only can it derail relationships with those supporting breastfeeding, shame is also recognised now as a more significant challenge to wellbeing and seems to be a component of a number of mental health difficulties, including post-natal depression, particularly where shame is chronic and may relate to many areas of life. Obviously shame is not *necessarily* an issue when seeking support with breastfeeding and many women find breastfeeding a source of contentment, pride, achievement and empowerment. However, where shame does arise it is important to think about how this can be addressed.

SLIDE TWELVE

One of the most obvious issues is how breastfeeding is promoted as a public health issue. We've already discussed some of these issues within previous seminars. The issue of shame is highly relevant to Bernice Hausman's (2012) argument that we need less emphasis on the responsibility placed on individual mothers to make better 'choices' [they already know that breast is best from a health point of view] and greater emphasis on challenging the constraints on women's *right* to breastfeed. As Lisa noted, the first emphasis on the left shames mothers – the second doesn't and also recognises the material realities of women's lives that can work against breastfeeding,

particularly the way that most leisure and work spaces are set up as if the norm is not to have a baby attached to your breast.

SLIDE THIRTEEN

The other important issue for me is making breastfeeding difficulties more visible in promotional literature and hence more normative. Erin Taylor and Lora Wallace (2012) have argued (amongst others) that a greater variety of embodied breastfeeding experiences – including the ‘good, bad & ugly’ – need to be acknowledged as part of what is ‘normal’. They argue that it is the promotion of idyllic and idealised images of breastfeeding that can shame women who don’t find this to be their experience. Pat Hoddinott & colleagues (e.g. 2012) amongst others have argued for a more woman-centred and realistic approach to promoting breastfeeding which acknowledges difficulties and accepts that goals may need to be modified from ideals. This seems a useful approach, though any normalising of breastfeeding difficulties needs careful handling in case this reinforces the idea that breastfeeding is *inherently* difficult and can therefore discourage women from breastfeeding. I don’t think this picture [slide] would encourage much enthusiasm for breastfeeding among pregnant women! However, unless women are forewarned that although breastfeeding is ‘natural’ it is not necessarily immediately obvious to a mother and baby, then some women will continue to make sense of breastfeeding difficulties as if these are a personal shortcoming. Heather Trickey and Mary Newburn (2014) have recently suggested stronger promotion of the idea of an adjustment period in breastfeeding, which seems a useful idea.

SLIDE FOURTEEN

Finally I want to say a few words about the ways in which those supporting breastfeeding women can be more sensitive to and responsive to issues related to shame. To do so I’m going to draw on recent research on repairing or overcoming shame. This research is not specifically related to breastfeeding, but emphasises the importance of interpersonal processes and therefore is useful for thinking about support for breastfeeding women.

Shame resilience is important for mothers’ wellbeing. However, we’re not *just* talking about how to help women feel OK about having difficulties breastfeeding. We’re also talking about how to manage the emotions that sometimes prevent mothers from getting the help and support they need to *overcome* these difficulties – how to reduce the likelihood of shame-related phenomena such as withdrawal, helplessness, hopelessness and hostile interactions.

Shame involves a sense of being disconnected from others and the research studies listed on the slide (Brown, 2006; Dayal et al., 2015; Leeming & Boyle, 2013; van Vliet, 2008) suggest that one of

the key processes in repairing shame is restoring a sense of meaningful connection with others – a sense that you and your experiences *matter* to someone. Closely related to this is a sense of being accepted by others – a sense of validation, regardless of whether you consider yourself to have failed or to be inadequate in some way. These research studies, based on first person accounts of overcoming shame, suggest that we can tolerate and repair shame more easily and expose what we see as shameful aspects of ourselves if we have a sense of validation and connection - a sense that the other person values us as a person.

It's interesting that these kinds of issues – connection, acceptance, validation – have already been picked up in the breastfeeding support literature. In a metasynthesis of women's experiences of breastfeeding support carried out by Virginia Schmied and colleagues (2011), 'authentic presence' was identified as something highly valued. This referred to the way in which women valued a sense of a meaningful relationship with those supporting their breastfeeding. Although many preferred supporters to be able to spend time with them, even brief contact could demonstrate an interest in them, so that their experiences as a mother seemed important. 'Authentic Presence' also included providing reassurance and positive affirmation of aspects of the women's mothering, which is highly relevant to what shame researchers refer to as 'rebuilding the self' or restoring a positive self-concept. Of course we can't be sure how many of the women contributing to Schmied et al's metasynthesis *had* struggled with breastfeeding difficulties and feelings of inadequacy or failure in relation to this. However, it seems reasonable to assume from other research that some of them would have felt this and that 'authentic presence' might have been valued by some *because* it helped them to resist potential feelings of shame.

Connection and validation are also likely to be important factors in determining whether contact with other breastfeeding women is perceived as helpful, or potentially exposing. It's easy to imagine how feeling on the margins of a peer support group where you think everyone else is getting the hang of breastfeeding but you, could be experienced as quite shaming rather than empowering and supportive. This could be an explanation for why research about peer support has produced such inconsistent findings.

Moving on to the next two points below, if someone seems embarrassed, guilty or ashamed about something, we tend to avoid bringing the topic up. However Brene Brown (2006) who has written extensively on shame resilience argues that articulating or 'speaking' shame is often essential for someone to arrive at a position where they can tolerate this less than perfect aspect of themselves and internalise a sense that despite exposure of this, they are still valued by others. Brown argues that without speaking about what we see as shameful aspects of ourselves (whether these are our

capabilities, our bodies or our circumstances) it becomes difficult to see these aspects as quite possibly normal. And speaking about things that shame us can also mean that for the first time we have to examine our assumptions and conclusions and hear alternative views which contextualise the issue differently. For example, one aspect of our data that particularly struck me was the way in which talking about physiology and anatomy related to lactation could be profoundly *de*-shaming for some women. Apart from the fact that this might enable them to manage breastfeeding challenges better, it could also mean that what was seen as 'incompetent mothering' was now transformed into a more embodied understanding of, for example, the difficulties fitting a particular mouth to a particular breast.

I think this is one of the strongest 'take home' messages from the shame management literature – that secrecy and silence never solves shame. I would be interested to hear from some of you how you think support services for breastfeeding women can create spaces where it is possible for women to speak about some of their darker feelings (which might even include for some a sense of shame related to sexual feelings when breastfeeding or to earlier abuse or dislike of physical closeness with their baby), and which aspects of services can work against being able to acknowledge and disclose these feelings. If women feel comfortable enough to articulate any feelings of shame, failure or self-denigration then this places the feelings out there where they can be accepted as valid feelings but also gently examined and challenged. This seems a better way forward than women ruminating privately and being drawn further into a spiral of shame and withdrawal from sources of support. I noticed the other day that the new BFI guidance on having meaningful conversations with mothers seems really useful in this respect – it emphasises asking open questions about feelings, showing empathy, using active listening and avoiding overt direction and judgement. This also fits with the more person-centred approach to breastfeeding support that Fiona Dykes and colleagues have advocated (e.g. Dykes, 2006), which can be helpful because of the way it empowers and values women and minimises the potential for women to feel scrutinised and evaluated.

There is a risk that talking about shame can seem to locate the problem within breastfeeding women. Instead of focusing on the competing and unrealistic expectations placed on mothers and the social and cultural constraints placed on breastfeeding, we instead focus on women's emotional responses to this and can inadvertently reinforce the idea that breastfeeding is somehow shameful. We therefore probably need to be careful about when, how and where we talk about shame in relation to breastfeeding. However, not speaking about shame is unhelpful to the women who feel their identity and self-worth is threatened by issues related to infant feeding.

If we adopt an interpersonal model of shame, however, then I think there is less of a dilemma. We can see then that shame is not just an internal feeling which mothers impose on themselves, it is a position a mother might take up in relation to the actions of others and the wider social context. This then means that it might be possible for those around her to help her position herself less shamefully.

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