Article

Shame if you do, Shame if you don't: Women's experiences of infant feeding

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Abstract:

Emotions such as guilt and blame are frequently reported by non-breastfeeding mothers, and fear and humiliation is experienced by breastfeeding mothers when feeding in a public context. In this paper we present new insights into how shame-related affects, cognitions and actions are evident within breastfeeding *and* non-breastfeeding women's narratives of their experiences. As part of an evaluation study of the implementation of the UNICEF UK Baby Friendly Initiative (BFI) Community Award within two primary (community-based) care trusts in North West England, 63 women with varied infant feeding experiences took part in either a focus group or an individual semi-structured interview to explore their experiences, opinions and perceptions of infant feeding. Using a Framework Analysis approach and drawing on Lazare's categories of shame, we consider how the nature of the event (infant feeding) and the vulnerability of the individual (mother) interact in the social context to create shame responses in some breastfeeding and non-breastfeeding mothers. Three key themes illustrate how shame is experienced and internalised through 'exposure of women's bodies and infant feeding methods', 'undermining and insufficient support' and 'perceptions of inadequate mothering'. The findings of this paper highlight how breastfeeding and non-breastfeeding women may experience judgement and condemnation in interactions with health professionals as well as within community contexts, leading to feelings of failure, inadequacy and isolation. There is a need for strategies and support that address personal, cultural, ideological and structural constraints of infant feeding.

Key terms: breastfeeding, formula feeding, guilt, infant feeding, qualitative, shame, women

Introduction

Breastfeeding is acknowledged as providing health benefits to both mothers and infants. The World Health Organisation (World Health Organization, 2003) recommend that mothers should breastfeed exclusively for the first six months, and thereafter continue to provide their infants with breast milk for up to two years of age or beyond. Despite this recommendation, breastfeeding rates vary widely; in Sweden 83% of all babies are exclusively breastfed at one week of age and 11% at six months (The National Board of Health and Welfare, 2012); in the UK, the corresponding rates are 46% at one week and <1% at six months (McAndrew et al., 2012).

There are numerous accounts of women's emotional responses to infant feeding. Murphy (1999) has suggested that regardless of how women feed their infants, infant feeding becomes a 'moral minefield' and an 'accountable matter' as women are judged or judge themselves on their efforts in being 'not only good mothers but also good partners and good women' (p.187, 205). The message frequently summarised as 'breast is best' reflects scientific knowledge on the nutritional and immunological benefits of breast milk for infants (American Academy of Pediatrics, 2012) as well as carrying moralistic dimensions. In many cultures, breastfeeding is synonymous with 'good mothering' (Dykes & Flacking, 2010; Hauck & Irurita, 2002; Schmied & Barclay, 1999). When mothers make a decision not to breastfeed, they may experience guilt, blame and feelings of failure (Lakshman et al., 2009; Lee, 2007). Taylor and Wallace (2012), in their theoretical framework aimed at understanding maternal responses to infant feeding, argue how formula feeding mothers may experience shame (as opposed to guilt) through 'failure' to live up to ideals of womanhood and motherhood. They also argue that breastfeeding mothers may experience shame through the violation of feminine modesty when breastfeeding in public (Taylor & Wallace, 2012); the real or imagined humiliation, and fear of criticism, associated with public breastfeeding is reported by others (Dykes, 2007; Thomson & Dykes, 2011).

Shame is considered to incorporate affect (e.g. fear, anger, humiliation, self-disgust, anxiety, low self-esteem, depression), cognitions (e.g. feelings of rejection, inferiority and inadequacy) and actions (e.g. withdrawal and isolation or retaliation) (Gilbert & McGuire, 1998; Lewis, 1971; Scheff, 1997). Whilst shame is often used inter-changeably with guilt, these are considered to be two distinct emotions (Lazare, 1987; Scheff, 1997). Shame is believed to occur when there is a breach between the cognitive evaluation of the ideal self

and that of the actual self (Rubin, 1968). The self-evaluation giving rise to shame emerges through an awareness of a deficiency or feelings of not being good or good enough: a global negative feeling about the self in response to a goal not reached, or some short-coming (Lazare, 1987; Niedenthal et al., 1994; Scheff, 1997). Guilt, on the other hand, refers to behaviours or transgressions: a sense of doing a 'bad thing' (or of not having done a good thing) (Niedenthal et al., 1994). Guilt comprises feelings of tension, remorse and regret, but does not incorporate the self-condemnation associated with shame (Lazare, 1987; Lewis, 1971). One of the key problems in the definitions relates to how these emotions co-occur; an act may make the individual feel guilty and, on internalisation, he/she subsequently experiences shame (Lazare, 1987).

Shame is considered to be a universal and fundamental social emotion (Kaufman, 1996). Its emergence is based on the evaluation of 'self' in the form of its real or imagined appearance to the 'other' and the imagined judgement of that appearance (conveyed via facial expressions, gestures, verbal intonations and explicit criticism) by the 'other'(Lazare, 1987; Scheff, 1997). Tangen, Miller, Flicker & Barlow (1996) define shame as:

> *'..both agent and object of observation and disapproval, as shortcomings of the defective self are exposed before an internalized observing "other". Finally shame leads to a desire to escape and hide – to sink into the floor and disappear'*. (p. 1257)

Lynd (1958) argues that the 'whole-self' involvement characteristic of shame is what makes it so potent. People may therefore adopt defence mechanisms such as distancing themselves from whatever/whomever induces the feelings of shame (Lazare, 1987) or through blaming others. Even when we know we have done nothing wrong, shame can be experienced as a consequence of knowing that we have presented a 'negative' and 'unattractive' image of ourselves to others (Gilbert & McGuire, 1998).

Shame may be particularly salient during the development of maternal identity (Rubin, 1984). Positive judgements in relation to infant feeding methods may increase the mother's self-confidence, whereas negative judgements produce reduced confidence and maternal wellbeing (Hoddinott et al., 2012; Taylor & Wallace, 2012; Thomson & Dykes, 2011). In the wider literature, guilt and blame is frequently cited in association with women's experiences of formula feeding, with discomfort, humiliation and fear appearing as descriptors of

experiences of public breastfeeding. The aim of this paper is to provide a unique perspective on infant feeding by describing how discourses of shame are evident within the experiences of breastfeeding and non-breastfeeding women.

Methods

Context & Setting

This paper reports on data collected with women as part of a wider evaluation of the implementation of the UNICEF/WHO Community Baby Friendly Implementation project in two community health facilities in North West England. Focus groups and individual interviews were undertaken with stakeholders, health professionals and mothers. In this paper we report on the consultations undertaken with mothers. The purpose of these consultations was to ascertain their attitudes and experiences as well as barriers to and facilitators of infant feeding, which could subsequently be utilised to help inform the planning and organisation of services.

Ethics

The full evaluation proposal was reviewed and approved by the Research & Development Units at the two hospital trusts and full ethics approval was granted through the Faculty of Health Ethics Committee (proposal 277) at the lead author's University. Ethical issues in relation to informed consent, confidentiality and withdrawal were adhered to throughout this study.

Participants and Recruitment

Following heads of service approval, health professionals and coordinators of various mother and baby groups or clinics (baby massage, mother and baby groups, breastfeeding groups) were asked to approach women to ascertain their willingness to participate. The contact details of all consenting women were forwarded to the first author, and focus groups dates were organised between the first author and coordinators once initial agreement had been sought. A total of 63 women took part. Participant characteristics are presented in Table 1.

Insert Table 1

Whilst socio-economic identifiers were not recorded, care was taken to recruit women from areas of high and low deprivation. This was achieved by professionals being asked to target women from a range of different backgrounds and infant feeding experiences to take part in an interview. The groups targeted for recruitment were also situated in areas of high and low deprivation. There were no specific exclusion criteria for this study or fixed sample size, rather the aim was to elicit a broad range of views in regard to infant feeding experiences and support needs. Data collection ceased when it was considered that a diverse sample and variety of perspectives had been obtained. All of the women had some experience of breastfeeding (with their first and/or subsequent children), with duration ranging from a few days to > 12 months. The routinely collected breastfeeding initiation rates in the geographical areas where these women reside for the periods 2008/2009 and 2009/2010 were between 56-63% and 60-68% and for 6-8 week duration rates (total or partial breastfeeding) between 20-30% and 22-35% respectively. At the time of the interview some 43 (68%) of the women in this study were either fully or partially breastfeeding their infant; these data suggest that the infant feeding rates of our participant group are fairly representative of the local population.

Data collection

A semi-structured interview/focus group schedule was devised based on existing literature and consultation with the project team. Questions were designed to elicit women's current infant feeding status, intentions and motivations regarding infant feeding and barriers and facilitators to support (a summary of the key questions is presented in Table 2). Sixty-three women took part in seven focus groups (n=33) and 28 individual interviews (two interviews involved two participants). Sixteen interviews were undertaken in the participant's homes, with the remaining interviews or focus groups taking place at mother and baby groups/clinics. The interviews/focus groups took between 25 to 80 minutes to complete and were digitally recorded and transcribed in full. All data collection was undertaken during 2008-2010 by the first author.

Insert Table 2

Analysis

Analysis was informed by the Framework Analysis method originally devised by Ritchie & Lewis (2003). A key strength of this approach relates to the way in which inductive (emergent issues) and deductive (application of a theoretically informed framework) analysis

can summarise data into thematic matrices to enable patterns or explanations to be identified (Gale et al., 2013). In this study, Lazare's (1987) categories of shame were used as a theoretical framework. Lazare (1987) postulates that shame in a medical/clinical encounter may be understood as operating from the interaction between three factors: 1) shame-inducing event; 2) vulnerability of the subject and 3) the social context of the shame. We selected this framework due to its capacity to illuminate how shame is experienced through an interaction of personal, cultural, structural and social factors.

Initially, two of the authors (GT, KEB) engaged in a process of immersion and familiarisation of the transcripts to identify key codes and themes against Lazare's three categories of shame. Drafts of the initial analysis were also shared and discussed with RF on an on-going basis. A single tree structure coding index was agreed and applied in MAXQDA and 'descriptive accounts' were subsequently undertaken through refinement of the themes and associations within the data set. Finally, 'explanatory' accounts were produced to illuminate how similar concepts of shame were experienced amongst those with divergent experiences of infant feeding.

Findings

Lazare (1987) considered that shame occurs through a dynamic interaction between the shame inducing event (i.e. infant feeding method), the individual's (mother's) vulnerability and the social context. In the following sections we first consider how infant feeding can be considered a shame-inducing event. We then describe the conditions which exacerbate the vulnerabilities of new motherhood. Within the social context three themes describe how shame is experienced and internalised by both breastfeeding and non-breastfeeding mothers through; 'exposure of women's bodies and infant feeding methods', 'undermining and insufficient support' and 'perceptions of inadequate mothering'. A selection of illuminating quotes is included (with a pseudonym or focus group identifier). Whilst shame comprises negative emotions, it is an experience of the self which goes beyond the emotions it induces and relates to the interaction between perceptions of self and perception by others. Our interpretations of the data illuminate how some breastfeeding and non-breastfeeding women experience shame through feelings of fear, humiliation, inferiority and inadequacy. Our findings also emphasise the potential negative implications of shame responses in terms of social isolation and withdrawal due to the potential for pressure and counter-productive effects emerging from the 'breast is best' discourse, and women's reticence in seeking out

and engaging with health professionals and services due to fear of condemnation or reprisals. These findings are not intended to suggest that *all* breastfeeding and non-breastfeeding women experience shame; rather that shame affects cognitions and/or actions and was experienced by many of the women we consulted.

Infant feeding as a shame-inducing event

According to Lazare (1987), the shame-inducing event is one which involves individuals experiencing physical or psychological limitations that assault self-perceptions of self-control, independence and competence. All of these issues were evident in many of the women's infant feeding narratives, which frequently indicated a sense of feeling out of control and dependent on others through insufficient information and lacking or inappropriate infant feeding support. Furthermore, when mother's infant feeding methods were not experienced as intended (by self and others), this could lead to feelings of incompetence, inadequacy and inferiority.

Whilst Lazare (1987) considered that individuals can feel stigmatized or socially discredited, through anticipated or actual unfavourable reactions by others, he believed that there were specific categories of 'diseases' that were more likely to induce shame. These categories concern 'offending others through their sight'; involve 'sexual or excretory organs' and 'behaviours perceived by others as weak, stupid or immoral manifestations of personal failure' (p. 1654). Whilst we are not suggesting that infant feeding is a 'disease', the medicalization of infant feeding render situations and experiences where the method becomes a 'disease' in terms of how shame is experienced, internalised and enacted-. Breastfeeding, and bottles can all cause 'offence' to others; similarly, due to the cultural sexualisation of women's breasts, infant feeding is perceived to involve sexual organs, and women may internalise their feeding choices as either failure (for those who do not breastfeed) or morally and socially unacceptable (for those who do breastfeed). Certain practices of breastfeeding may also carry their own shame. Breastfeeding outside the home environment is an evident and much-discussed example of this. A further example relates to 'others' judgements on acceptable and unacceptable breastfeeding practices which appear implicitly associated with conceptions of 'good' mothers and 'good' babies.

Vulnerability of the Subject (Mother)

Lazare (1987) considered that when our basic emotional needs of being loved, taken care of and accepted are not met we become susceptible to shame. The narratives highlighted that whilst the women often held ideals of being a 'good mother' or feeling overwhelmed by new motherhood, the cultural influences and the lack of preparation made some mothers feel anxious, fearful and dependent. Mothers, particularly first-time mothers, often felt overwhelmed by new motherhood, an experience exacerbated by the physical and/or psychological implications of childbirth, particularly for those who had a distressing, assisted or operative birth:

> *I had a section and I was completely out. You wake up and your baby is there and you do lose that initial bond really* [. . .] *I could not get out of bed, so someone had to bring me the baby, but then I could not put him back down or anything or change his nappy or anything*. (Teresa)

New mothers were not always aware of what questions to ask, nor what support was needed until faced with the realities of motherhood: *'I needed someone there, I needed support, I had no idea what I was doing'*. The reliance on health professional support also magnified amongst those with limited support networks: '*no one around us apart from friends'*.

Many of the women had little or no vicarious experiences of breastfeeding within their family or personal networks: *'no one I knew had breastfed'*, nor within the wider community: *'you just don't see people breastfeeding when you are out and about'*. A familial history of breastfeeding could positively influence a woman's decision to breastfeed: *'I always wanted to and the reason was because of my mum'*. Others spoke of how negative comments from within their personal networks undermined their confidence and potentially induced shame associated with breastfeeding: *'she (Aunty) said you will be like a cow. She weren't really encouraging'*.

Conversely, many women referred to how they were *'expected'* or felt under *'pressure'* to breastfeed, a pressure transmitted by cultural messages as well as via health professionals. Women often experienced this as an additional burden within the already bewildering state of new motherhood:

> *I think there was too much emphasis on breastfeeding. […] The tone of it needs to be different, the way it's done needs to be different, more sensitivity around it definitely. You have all the pressure and you don't need it. If it's your first, trying to cope with a new baby, nothing that you read prepares you for it.* (Angela)

The discourse around breast being *'best'* and *'natural'* was often so at odds with women's pre-natal ideals and expectations; this led to self-doubt and anxiety: *'I was upset that I didn't carry on like I wanted to - I thought it would come naturally'; 'They* [health professionals] *tell you to breastfeed and they don't tell you how painful it can be'.*

Social Context of Shame

In this section three key themes describe how shame was experienced and internalised by breastfeeding and non-breastfeeding women in a social context: 'exposure of women's bodies and infant feeding methods', 'undermining and insufficient support' and 'perceptions of inadequate mothering'.

Exposure of Women's Bodies and Infant Feeding Methods

Lazare (1987) considers how shame is experienced in medical/clinical encounters through experiences of physical and psychological exposure of defects, inadequacies and shortcomings. These issues were reflected in the narratives in accounts of the manhandling and objectification of women's breasts, and the real or perceived negative reactions, and responses from others.

Health professionals 'handling' of women's breasts in an attempt to facilitate breastfeeding was often negatively internalised by women. Lazare (1987) considered that the potency for shame was related to the level of public exposure, and the significance of those involved. For some women, the objectification and manipulation of their 'sexual' organs in front of professionals and often their partners induced intense distress and humiliation:

> *She* [midwife] *literally just got hold of it* [breast], *squeezed it and went like that* [demonstrating the action] *I was mortified, I was just like that's my breast you've got hold of,* [. . .] *and they did it in front of X* [partner] *and I think I did get a bit …because men do see boobs in a different way don't they and although I could do*

anything in front of X, I could see his face being really supportive but a bit "oh my god". (Lorraine)

The professional's assistance in the performance of a 'natural' activity served to highlight the potential for women to be perceived by implication, and thus to perceive themselves, as deficient in their ability to 'manage breastfeeding', leading to lowered confidence in their capacity to breastfeed:

The one [midwife] who came pulled my gown down, plonked her on, didn't tell me what she was doing or anything, kept rubbing her head dead hard into my boob, made her latch on and then walked off. So I was like thank you, next time I will really know what to do, won't I. (Gail)

As evident within the wider literature (e.g. (Thomson & Dykes, 2011), many women identified real or imagined reactions to public breastfeeding as a key area of difficulty:

I didn't do it [public breastfeeding]. *I was more concerned with people looking and thinking why is she doing that in public she shouldn't be here, she should be doing that somewhere behind doors, inside in privacy.* (Ava)

Only a small number of women interviewed actually breastfed in public. Whilst some of these women spoke of being *'stared at', 'looked at weird', 'frowned at, 'tutted at'* or asked to leave premises, for others it was the imagined fear of receiving these responses that prevented them from feeding outside the family home. Women often associated the social stigma of public breastfeeding with the violation of a societal norm - *'we are a discreet nation'* - with the fact of how women's *'breasts are sort of sexualised now rather than practical'*. A few of the mothers who were still breastfeeding toddlers (12+ months) also referred to how they felt *'uncomfortable'* and *'uneasy'* feeding their infants in front of others, due to perceptions of judgement for this *'not normal'* practice. However, the impact of the woman's social and cultural network in terms of whether 'any' breastfeeding was acceptable was also highlighted; with breastfeeding mothers believing themselves to be castigated as *'hippies', 'weirdos'* or *'naturalists'*:

> '*Sometimes I think it would be easier to have a bottle, you can go anywhere and do anything, Nobody has an issue with a baby having bottled milk'.* (Annabel)

In response to these cultural condemnations, women displayed actions arising from shame such as 'withdrawing from others' (Tantam, 1998, p.172) by staying at home, *'finding somewhere quiet'* and *'out of the way'*, or within specifically designated breastfeeding areas, thereby avoiding situations in which they might have found themselves vulnerable (Lazare, 1987). Women frequently described breastfeeding as a marginalised, invisible activity, with public breastfeeding often only considered acceptable when it had been mastered; skill in breastfeeding was equated with discretion: *'I wouldn't have sat publicly anywhere until I was really good at it, and could hide it'.* In this way, Lazare's definition of shame as relationship is played out in the responsibility felt by the breastfeeding mother not to impact, or to impact in the 'correct' way, on those around her; the sense of shame thereby becomes a determinant of her behaviour.

Similar issues of judgement were also identified amongst non-breastfeeding women through comments made within their social networks, *'people make the odd comment like "why are you not breast feeding", they shouldn't ask questions like that*". However, it was often within the context of women's relationships with health professionals that those who were formula feeding, or even using bottles for expressed milk, felt they were deviants:

> *I don't think they liked that I stopped breastfeeding. They tend to give people who do bottle-feed a bit of a "hmmm you shouldn't be doing that, you should be breastfeeding"* (Bernie)

Many of the non-breastfeeding mothers disclosed shame responses such as having to *'hide'* their bottles and expressed *'feeling scared' 'frightened'* and *'in fear'* of informing professionals of their infant feeding method:

> *I felt so guilty and bad about giving up, but I just couldn't stand the pain. When I was in hospital I had to go and get my own bottles and make them up. I* [. . .] *felt really frowned upon, and made to feel really bad. I was really frightened of saying "I don't want to". I was in fear of telling the midwife.* (Kryshia)

The perceived undesirable nature of their actions was also reinforced by what women considered to be a *'conspiracy'* of silence amongst health professionals through them not discussing or offering support for bottle-feeding.

Undermining and inadequate support

According to Lazare (1987), it is when individuals seek professional help that the interaction between the shame-inducing event and the individual's vulnerability occurs. Across the narratives, shame was experienced by breastfeeding and non-breastfeeding women when undermining or inadequate support was received.

A number of the women spoke of having *'the guts'* and *'confidence'* to seek support and subsequently facing further perceptions of failure when their needs were not met. Some were told to '*stop buzzing'* for staff in hospital, felt too *'frightened'* to pester over-stretched staff and perceived themselves to be *'a pain'* when support was requested. For one breastfeeding woman, a professional's attempts at reassurance only served to intensify her sense of vulnerability and failure. The quote below suggests that what professionals may view as a positive approach may in fact augment the experience of 'shame' due to the inherently judgemental nature of language used:

> *I got fed up of people telling me I was doing a good job.* [. . .] *I wanted somebody to help me and actually find a solution to the problem I was facing. I think it is underestimated how vulnerable you feel and how much of a failure you feel and that is not really the right thing to say to people.* (Focus group 7)

Some of the women who formula fed from the early post-natal period or after a period of breastfeeding also reported marginalisation through a lack of support:

> *When you bottle-feed you don't get as much help. I did try so hard* [to breastfeed] *I kept blaming myself that I couldn't do it.* [. . .] *it was too painful and however much I tried I couldn't get him on, and wasn't feeding properly.* [. . .] *But when you decide "I don't want to do it anymore", it seems the support goes out the window..* [. . .] *It did get me very very down, it felt like they turned against me because I was bottle-feeding.* (Focus group 4)

Restrictions or inhibitions on discussing substitute feeding methods (both on the post-natal ward and in the community) left women feeling dejected and isolated:

> *Bring the choice back for god's sake, when breastfeeding doesn't work, bottle feeding is a good alternative. I didn't have a clue what I should be using.* (Annie)

The enforced dependency of mothers on the medical model was also in evidence when women experienced incapacity to breastfeed, perceived or otherwise:

> *'They wouldn't allow me to cup feed her, so I had to wait for a midwife to be free* [. . .]. *I did ask as it was distressing that I couldn't feed my child'.* (Belinda)

The term 'support' acted as a barrier to help-seeking behaviours due its association with 'problems' and potential negative connotations for a woman's capacity to mother: *'when you say the word support if makes it feel like you need support with a problem'.* These concerns often created additional tension between women's desire to discuss options with professionals and their fears of being perceived as *'unable to cope'*. Avoidance of help-seeking reflected an internalised process of shame through women presenting idealised images of 'coping', with fears of the consequences of 'not coping', whether actual or in terms of self-image, leading to withdrawal and isolation (Lazare, 1987):

> *I think it was the fact that I didn't want to appear that I wasn't coping and I didn't want people thinking that, even though I know at the back of my mind that they wouldn't be thinking that.* (Lorraine)

Perceptions of inadequate mothering

Lazare (1987) states that shame occurs when we are "not the kind of persons we think we are, wish to be, or need to be" (p. 1653). Many mothers felt a degree of exposure of their 'undesirable' selves to others, creating a rupture between the ideal (e.g. the 'good' mother) and actual self (Rubin, 1968).

Non-breastfeeding women frequently referred to how pro-breastfeeding discourses and negative verbal and/or non-verbal responses from others, primarily health professionals, led them to feel *'second best'*, a *'bad mother'* who was *'denying'* and *'depriving'* their child:

> *Breastfeeding* […] *is pushed down your throat and out of guilt you are made to feel if you don't do it, you are doing your child a mis-justice. Everybody everywhere pushes breastfeeding, and* [I] *feel they look down your nose at you if you don't.* (Kryshia)

Reactions from health professionals led some of the non-breastfeeding women to feel inadequate and defective: *'they make you feel there is something wrong with you, a body part or your baby'*. Many non-breastfeeding women made self-depreciating reflections on their characteristics and capabilities and blamed themselves for the negative health and emotional implications of their infant feeding method. One woman described how she took the *'easy option'* when she stopped breastfeeding and blamed herself because her son had developed eczema and other allergies; *'they say if you breast feed they don't get that'*. Other spoke of how they *'gave up too early'* and of the *'guilt'*, *'regret'*, *'disappointment'*, *'shame'* associated with, and subsequent morbidity attributed to, their infant feeding decisions:

> *I ended up suffering from quite severe postnatal depression, I have always wondered whether that was something to do with it, if I could have breastfed would it have happened.* (Jill)

One woman directly referred to how her *'failure'*, her having *'give*[n] *in'*, was a direct affront to her self-perceived identity:

> *I always thought I had a lot of patience and that's what upset me more because I just, I don't really give in.* (Lorraine)

Some of the mothers who had initiated but discontinued breastfeeding described how bottle-feeding had disrupted their *'closeness'* with their infant. These women experienced dejection and a sense of inadequacy as, in their view, the maternal role became de-valued and eroded as '*everyone else could take over then'*.

Conversely, a number of breastfeeding women made reference to the negative judgements received by health professionals when describing the baby's behaviour - *'he's too lazy'* or *'too eager'* - and/or the women's anatomy, e.g. their breasts or nipples being *'too big'* or *'too small'*. The vulnerability of the post-partum state in the following woman's account,

contributed to the effect of what might appear to be blame directed towards the woman or baby, with at least the potential corollary of shame:

> *Quite a lot of comments were negative and when you are in the state you are in, you've had a section and your hormones are all over the place and you're tired, you don't want to hear negative comments and that it's something that you or* he [baby] *is doing. You just want to hear it's just not working at the minute. I know they mean well,* [and don't] *say things to upset you, but that is what will stick in my mind.* (Annie)

Lazare (1987) emphasised the significance of others in our personal networks in the exacerbation or mitigation of shame. A few breastfeeding women described themselves as *'mean'* or *'selfish'* for adopting an infant feeding method that precluded others' involvement in the care of their infant. Other women received condemnations from others' within their personal networks, leading to negative emotions and cognitions indicating the potentially shame-inducing circumstance of being viewed as contravening appropriate mothering practices:

> *My father and my step mother really, really upset me. They would say "I don't know why you are bothering, you put yourself through all this for nothing, just get her on a bottle, she is not happy and you're not happy" and it was constant. I would say "I have got to get home to feed her", and they would say again, "there is something wrong with that child, she is always feeding".* […] *I just wanted them to say we are really proud of you, you are doing a good job […] but […] it was like you are making a rod for your own back, you are making life difficult* (Kathy)

Occasionally, women responded to the criticism by 'others' by withdrawal from the social sphere, leading to potentially destructive emotional and social consequences:

> *I have just shut off from everyone now. I am not listening, I am doing it my way and I just ask when I need help instead of everyone just bombarding me, because I went dead depressed*. (Bernie)

Discussion

This paper illuminates the experience of shame by breastfeeding and non-breastfeeding women. The application of Lazare's (1987) framework uncovers the extent to which infant feeding may reflect a shame-inducing event. The vulnerabilities of new motherhood, such as the physical and psychological implications of childbirth and lack of preparation for infant feeding, may render women susceptible to shame. Our findings highlight how negative reactions and responses to women's bodies, abilities and infant feeding methods, undermining and inappropriate support from 'others' can lead breastfeeding and non-breastfeeding mothers alike to feel inadequate, defective and isolated. We contend, like Taylor & Wallace (2012), that shame, as opposed to guilt or humiliation, is a more appropriate concept through which to consider women's infant feeding experiences, due to its occurrence within social contexts of being perceived and judged by others and to its internalisation and enaction.

Shame is considered to be a normal part of social interactions, social control and social conformity (Barbalet, 1999). However, shame may become disruptive when internalised and enacted in particular ways (Gilbert, 2000). In this study, a number of the breastfeeding and non-breastfeeding women disclosed affective responses of shame, such as feelings of fear, humiliation, inferiority and inadequacy. The potential negative implications of shame responses, e.g. fear of public breastfeeding leading to social isolation and/or breastfeeding discontinuation, the potential for pressure and counter-productive effects emerging from the 'breast is best' discourse, and women's reticence in seeking out and engaging with health professionals and services due to fear of condemnation or reprisals, raise key concerns. The fact that shame is self-internalised and the associated implications of poor maternal mental health on disrupted and dysfunctional infant developmental outcomes and family functioning (Murray & Cooper, 1997; Royal College of Midwives, 2012) needs consideration.

Lazare (1987) offers a number of methods for the mitigation of shame in the clinical environment. These include the creation of 'positive atmospheres' to enable patients to feel cared for and respected; the development of positive relationships in which 'weaknesses' are respected and cherished; the avoidance of emotive language; the provision of validation and praise; and the practice of 'clarifying personal perspectives on the problems' (p.1656-1657).

The current lack of sufficient breastfeeding support is widely acknowledged (Dykes, 2005a, 2005b; Hoddinott et al., 2012; Schmied et al., 2011; Thomson & Dykes, 2011). Other studies argue that the focus on increasing breastfeeding rates has led to bottle-feeding women becoming marginalised (Lakshman et al., 2009; Thomson & Dykes, 2011) and health concerns have been identified in relation to health professionals not conveying appropriate formula feeding procedures to women (Dykes et al., 2012). The insights from our study confirm those of Taylor & Wallace (2012) and Murphy (1999) in terms of how mainstream breastfeeding advocacy and ideologies of the 'good' breastfeeding mother have participated in shaming non-breastfeeding mothers. A recent paper (Gribble & Gallagher, 2014) also indicates how breastfeeding is a human rights concern, a view which might add to the condemnation of non-breastfeeding mothers. However, the findings from this study also emphasise how breastfeeding women feel equally marginalized and shamed, as expressed in their social and clinical encounters and fears about breastfeeding in public spaces. As poor care and negative emotions is experienced by women irrespective of their infant feeding method, these insights highlight how breastfeeding and non-breastfeeding women require targeted, needs-led support throughout the perinatal period.

A recent meta-synthesis of research into women's perceptions of breastfeeding support by Schmied et al (2011) identified how breastfeeding support occurs along a continuum from 'authentic presence' to 'disconnected encounters'. 'Authentic presence' refers to a trusting partnership between the mother and supporter, with information and support tailored towards the values and needs of the woman. 'Disconnected encounters' were characterised by limited or no relationship, with information and advice provided in a didactic style. To illuminate the 'quality' of breastfeeding support further, Burns et al (2013) identified two discourses in language and practices of midwives that led to disconnected encounters, both of which were evident in the current study. One discourse (i.e. "mining for liquid gold") refers to how midwives have the 'obligation' to ensure that babies received enough breast milk. By being 'experts' midwives not only had the 'right' to introduce techniques and technologies to ensure optimal outcomes but also an undisputed right to the women's bodies. The other discourse leading to disconnected encounters (i.e. "not rocket science") was described as women being left to their own resources because breastfeeding was 'natural' and 'easy'. In both these discourses the midwives focused merely on the physical body and held a reductionist approach to breastfeeding support. However, Burns et al (2013) also identified a minority discourse (i.e. "breastfeeding is a relationship") where midwives regarded

breastfeeding as a relationship and therefore acknowledged the mother-baby relationship being central to the breastfeeding experience. These midwives spent time engaging with mothers on a personal level to get to know them and their babies needs and hence had a more 'authentic presence'. We suggest that the findings of these studies (Burns et al., 2013; Schmied et al., 2011) are equally applicable to non-breastfeeding mothers and their relationships with their supporters, which would also benefit decisively from an 'authentic presence'.

Whilst there appears to be a fine line between protecting women from what might appear as hurtful judgement and indirectly undermining the cause of breastfeeding, Taylor & Wallace (2012) emphasise how women should be enabled to provide their own definition of 'good mothers' so that 'they are empowered to incorporate a sense of self-concern' (p.78) into their self-image. Positive 'authentic' relationships based on trust and respect, which may or may not facilitate successful breastfeeding, could encourage maternal-led definitions of 'good motherhood', promote positive maternal health and work against women's reticence in help-seeking behaviours. Furthermore, raising awareness of breastfeeding difficulties, such as through the motivational model of breastfeeding support detailed by Stockdale et al (2011), may help to minimise women's vulnerabilities. The use of an ASSETs based approach (Foot, 2012) in the maternity context that recognises how adoption of behaviours is situated within different personal, family and community environments may also be beneficial to mitigate against perceptions of shame irrespective of the women's infant feeding methods. A further suggestion offered by Lazare to mitigate shame relates to the use of support groups. The social, emotional and practical benefits of breastfeeding support groups have been reported in the literature (e.g. Thomson, Crossland, et al., 2012). The creation of 'infant feeding groups', as opposed to the current model of group ownership being determined by a specific feeding method, could enable these benefits to be available for all.

Whilst Lazare's insights are targeted to a more clinically based context, this study also emphasises the wider social and cultural influences of shame. ~~The moral connotations of breastfeeding are discussed by Blum (2000) who refers to the ways in which breasts signal the 'good' maternal body (i.e. breastfeeding) and the 'bad' sexual body (i.e. public breastfeeding).~~ Taylor & Wallace (2012) amongst others (e.g. Dykes, 2005a; Hoddinott et al., 2012; Schmied et al., 2011) ~~additionally~~ pinpoint a need to address the cultural, ideological and structural constraints that work against breastfeeding. However, the findings from this

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study illuminate ~~also show~~ how these constraints equally apply to non-breastfeeding women. C~~c~~ondemnation and internalisations of failure and adequacy that are experienced amongst breastfeeding and non-breastfeeding mothers ~~are~~ appear to be directly related to social and cultural norms of 'acceptable' infant feeding practices. ~~Taylor & Wallace (2012) amongst others (e.g. Dykes, 2005a; Hoddinott et al., 2012; Schmied et al., 2011) additionally pinpoint a need to address the ideological and structural constraints that work against breastfeeding. For example,~~ While public breastfeeding areas are becoming more commonplace in high-middle income countries to promote the 'normality' of this infant feeding practice (Thomson, Bilson, et al., 2012), ~~yet~~ this is only part of the work required. Labbok argues for 'transdisciplinarity' in terms of different disciplines coming together to define and address the problem being addressed. A transdisciplinary approach could be achieved through third sector organisations and maternity professionals developing professional advocacy services for women in order to address these constraints, prevent against shame responses and ensure that maternal and infant well-being is nurtured and developed.

~~There is both national (Department of Health, 2014) and international (UNICEF) recognition of how early child development lays foundations for lifelong learning, behaviour, and health patterns. It is crucial in this context that women's shame responses are minimised, irrespective of their infant feeding methods. Thus, there is a definite need for professional advocates to acknowledge and enact on the cultural, ideological and structural constraints to ensure that maternal and infant well-being are nurtured and developed.~~

Strengths and limitations

A key strength of this paper is the inclusion of women with a wide range of infant feeding experiences. Analysis was undertaken by three authors, enhancing the trustworthiness of the data. By using Lazare's categories of shame as a conceptual lens we were able to highlight the personal, cultural, structural and social factors that can induce and create shame. The focused and continual consideration of the literature on shame throughout data analysis also enhanced the authenticity of the interpretations generated. Limitations include restricted views from minority ethnic women due to the area in which the study was undertaken. Whilst the recruitment strategy targeted women from different socio-economic backgrounds, an important limitation relates to the lack of information on income or educational status of the included mothers. This is particularly important to assess in future studies due to women who are younger, less educated and more deprived identified as those who are less likely to

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breastfeed (Flacking et al., 2007). As breastfeeding tends to be the norm in many non-western cultures, the shame responses reported in this paper may not be transferable outside of a western context. The focus of data collection was not specifically to elicit shame, but rather more general exploration of women's infant feeding experiences. Whilst on one hand this open approach has enabled more nuanced realities and opportunities for women to identify what mattered most, more specific questioning on shame responses might have enriched the findings. Qualitative research to elicit where, why and for whom shame is experienced (e.g. between high and low income families) as well as the implications of these experiences of shame is worthy of further consideration.

Conclusion

This study has highlighted how breastfeeding and non-breastfeeding mothers experience shame. Breastfeeding mothers may risk shame if they breastfeed, particularly in public, due to exposure of the sexualised maternal body. Those who do not breastfeed may experience shame through 'failing' to give their infant the 'best start'. Breastfeeding and non-breastfeeding mothers may also experience inadequate support, judgement and condemnation, leading to feelings of failure, inadequacy and isolation. Strategies and support that addresses personal, cultural, ideological and structural constraints upon infant feeding are required. Sensitivity to the potential experience of shame in relation to infant feeding and to professional and public discourses which might generate this experience appears crucial in providing mothers with the care and support they need.

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Authorship

GT was the project lead for this study and collected all the data. GT and RF had the original conceptions for the paper. RF significantly contributed to the introduction section on shame and reviewed and provided feedback on analytical decisions on an on-going basis. GT and KEB were involved in the analysis and interpretation of the findings. GT produced the initial draft of the paper and RF and KEB provided feedback and contributions to various sections. All authors critically reviewed and approved the final content.

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771