Mothers' breastfeeding experiences and implications for professionals

Abstract

Twenty percent of babies in the UK are receiving breast milk for the recommended 6 months, suggesting that long-term breastfeeding is untenable for many mothers. This article reviews research on breastfeeding experiences and analyses six mothers' experiences of initiating and ceasing, or continuing breastfeeding. Interpretative phenomenological analysis was used to understand how they made sense of their breastfeeding experiences. All had breastfed in the last year, had similar socioeconomic backgrounds, and varied in their breastfeeding durations from up to 1 month, for 1–6 months and more than 6 months. Three major themes emerged: 1) reality of breastfeeding was highly discrepant from expectations, 2) the role of others in sustaining breastfeeding, and 3) feelings of guilt. Breastfeeding promotions that focus on biological benefits of breastfeeding without regard for psychosocial factors create a moral dilemma for mothers. Educational and counselling interventions using a biopsychosocial perspective can help mothers make informed feeding decisions.

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'Breast is best' is integral to UK infant feeding policy and is also a cultural discourse linked with a good mother prototype. Despite the intimately private nature of breastfeeding, it is otherwise a matter of long-standing moral interest in public health (Lee, 2007; Marshall et al, 2007; Spencer, 2008). The nutritional benefits of breast over formula milk are long established (i.e. prevention of gastrointestinal, respiratory and urinary tract disorders, diabetes, eczema) (Fewtrew, 2004; Van Teijlingen, 2005; Bolling et al, 2007). Maternal health benefits, such as protection from ovarian and endometrial cancers (Heinig and Kathryn, 1997) also consolidate the biomedical argument in favour of breastfeeding. Long-term reduction of the financial burden posed by such diseases on the NHS is also a key public health driver (Fewtrew, 2005). The World Health Organization (WHO) (2002, 2011) recommends exclusive breastfeeding for 6 months, to be continued as an accompaniment to food for 2 years or more, advice which has long been integral to breastfeeding promotion in the UK and international antenatal and postnatal programmes (Malik and Cutting, 1998; UNICEF UK, 2002; Dykes, 2003; Department of Health (DH), 2004, 2007). The same recommendations are made in the US (Grizzard et al, 2006) and Australia (Blyth et al, 2002). Educational interventions designed to promote breastfeeding target women especially in the lower socio-economic bracket, who are found to be significantly less likely to initiate or sustain breastfeeding (Mahon-Daly and Andrews, 2002).

However, it is increasingly recognised that the likelihood of breastfeeding is not simply a matter of improving knowledge and/or technique. Many well informed women across the entire socio-economic spectrum may fully intend to breastfeed but nonetheless struggle to follow through (Gokshen, 2002; Kelleher, 2006; Lee, 2007). While the last 10 years has seen a significant increase in the number of UK mothers who initiate breastfeeding, only around 35% of babies are exclusively breastfed at 1 week (Bolling et al, 2007). Although in 2005 approximately 75% of infants in the UK were breastfed initially (this figure increased to 81% in 2010) (The Information Centre (TIC), 2011) and 70% of mothers intended to breastfeed in the long-term, only approximately 20% of infants were still receiving any breast milk at 6 months and 64% transitioned from breast milk to formula rather than to solids and other liquids (Bolling et al, 2007). This suggests that something about long-term breastfeeding is untenable for most UK mothers.

Increasingly, research is focusing on the embodied experience of breastfeeding in order to understand parents' feeding decisions (Spencer, 2007). Many women find breastfeeding devastatingly different to their expectations (Mozingo et al, 2000; Hauck and Irurita, 2003; Shakespeare et al, 2004) and much more physically and emotionally demanding than they had anticipated (Romito, 1988; Hoddinott and Pill, 1999). The reality of breastfeeding prompts many families to switch to formula milk, particularly in the first month (Dennis, 2006). Bolling et al (2007) found that 73% of mothers who ceased breastfeeding said that they would like to have breastfed for longer. Particular difficulties include anxiety over milk production (Foster et al, 1997), frequency of feeding (Shakespeare et al, 2004), and pain avoidance (Lamontagne et al, 2008; Linton et al, 2000). In feeling largely unprepared for breastfeeding difficulties, mothers also complain

that antenatal classes that promote breastfeeding fail to mention any of the tiredness and discomfort that they could feel (Shakespeare et al, 2004). Unpleasant breastfeeding experiences can be traumatic in their own right, and they can also increase the bodily disconnect and psychological trauma experienced by women who have had difficult or traumatic deliveries (Kitzinger, 2006).

From a detailed observational study of 158 breast-feeding mothers, Marshall et al (2007: 2159) argued that in practice, feeding decisions are a product of 'managing the balance between ensuring a healthy, contented infant and the reality of their everyday lives'. In Lee's (2007) qualitative study of British mothers' experiences of using formula milk, women used the word 'depressed' to explain how they felt about it, struggling to maintain a positive maternal identity against the all-pervasive moral benchmark that breast is best. Patchy information offered about formula milk in antenatal and postnatal forums exacerbated these feelings. Other mothers were angered by the assumption that using formula milk meant that they were uninformed or dysfunctional. These two studies illustrate the difficulties mothers face in making feeding decisions amidst a moral minefield of good mothering ideals and assumptions. It is clear that long-term, mutually fulfilling breastfeeding requires a high initial commitment and sense of efficacy (Kneidel, 1990; Dykes and Williams, 1999; Kuo, 2005) and a strongly supportive peer network (Kearney et al, 2007). Social support from both professional (Lamontagne et al, 2008) and personal (Kaufman and Hall, 1989) sources is particularly important for breastfeeding sustainability.

This study aims to increase understanding of the experiences of breastfeeding mothers who are all well-educated and informed, but who struggle to meet the WHO ideal of 6 months of exclusive breastfeeding. Consistent with Spencer's (2008) call for more research on the hermeneutics of breastfeeding, the current research uses the interviewing approach interpretative phenomenological analysis (IPA) (Smith, 1996; Smith and Eatough, 2007) to understand in depth how mothers who breastfed for varying lengths of time, make sense of their feeding practices. IPA's origins is in health psychology (Smith, 1996), with epistemological roots in phenomenology, hermeneutics and ideography. The symbolic interactionist element of IPA also assumes that the sense made of experiences is commonly shared. To this extent, it is meaningful to integrate individual cases into one overall meta-narrative while also respecting idiosyncratic experiences.

Methods

Participants

Examination of a small number of intensively analysed cases is typical in IPA research (Smith and Eatough, 2007). Selective sampling (Coyne, 1997) through informal networking was used to recruit six mothers (aged 34–42 years) who were currently or had been breastfeeding in the past year. All participants were professional, middle-class women. Although IPA work does not claim generalisability, this demographic is most likely to have the opportunity to breastfeed (Bolling et al, 2007) and thus difficulties highlighted within this sample are likely to affect a range of women. A homogenous sample further increases analytic sensitivity to duration of breastfeeding among participants. Two participants were short-term breastfeeders (up to 1 month), two were intermediate breastfeeders (up to 6 months—the WHO recommended age), and two were long-term breastfeeders (more than 6 months). *Table 1* summarises participants' demographics.

Procedure

All participants consented to confidential tape-recorded interviews in their own homes, with durations ranging from 43 to 58 minutes. Prior to interview, participants were fully informed of the study and their right to withdraw, which was reiterated at the time of interview. The one-to-one interviews were semi-structured as suggested by Smith and Osborn (2008), with open questions used purely to guide the interview rather than dictate it, affording participants maximum opportunity to share their breastfeeding stories as 'experiential experts'. The interview opened with the broad invitation to 'take me through your breastfeeding story from the beginning,' after which experiences were probed in more detail. At the close, participants were asked whether they had any additional thoughts or experiences. The study was performed in compliance with UK laws and institutional guidelines; the study

Table 1. Participant demographics

Pseudonym	Age	1st/2nd child	Length of breastfeeding	Theoretical category
Angela	42	2nd	3 days	Short-term
Rebecca	35	1st	5 weeks	Short-term
Pamela	34	1st	5 months	Intermediate
Samantha	36	1st	5 months	Intermediate
Nicola	39	2nd	9 months	Long-term
Diana	39	1st	15 months (ongoing)	Long-term

was approved by the University of Surrey Ethics Committee.

Results

Three overarching master themes were identified as important to understanding the differing experiences of mothers who breastfed for a short, intermediate or long duration:

- Reality shock
- The role of other people in sustaining breastfeeding
- Guilt in the effort to balance mother and infant needs.

Examples were chosen from cases that typify each aspect of the master themes and sub-themes.

Reality shock

Irrespective of their breastfeeding duration, all mothers felt that breastfeeding did not meet their expectations that breastfeeding should be a natural, easy, and mutually pleasurable experience. Kramer (1974) conceptualised this discrepancy between expectations and lived experience, as reality shock. In this study, reality shock was experienced as disappointment and frustration in relation to two sets of considerations: 1) the extent of their technical struggle in establishing breastfeeding and 2) the extent of their physical pain in the effort to establish breastfeeding.

Technicalities in the struggle to establish breastfeeding

All mothers spoke of being confident that breastfeeding should just 'happen', even the two long-term feeders, Diana and Nicola, who were disappointed that the expected ease of feeding wasn't immediate:

> ***'I just thought that the breastfeeding would happen and it was a natural thing that would happen and my body would do what it was supposed to do.' (Diana)***

For both Diana and Nicola who both experienced tears of frustration, breastfeeding eventually 'clicked'. However, for Samantha disappointment was profound:

> ***'You get all the messages that it's the best bonding experience... so I was really really really looking forward to it and then quite disappointed about the actual experience...I think when you are built up that much then you come crashing down quite rapidly really.' (Samantha)***

For Angela and Rebecca the initial disappointment was so extreme they ceased feeding after 3 days and 5 weeks, respectively. Angela described how suddenly the tension disappeared when she switched to bottle feeding:

> ***'Because then he suddenly became this really predictable infant. He would eat, he would sleep... He became really regular, and he got into a routine, which subsequently relaxed me and the whole house just felt slightly calmer.' (Angela)***

She further explained how she did not realise how stressed she was feeling until she stopped breastfeeding:

> ***'And also it was like an enormous relief to me to be able to see how much he'd eaten...I didn't realise exactly how much I'd worried about that.' (Angela)***

Physical pain in the struggle to establish and sustain breastfeeding

Five of the six mothers experienced physical pain, and for Angela and Rebecca, pain was the main reason that they stopped breastfeeding. They were shocked at the unexpected intensity of the pain:

> ***'I tried him on one side but after about 30 seconds I was just screaming in agony and I looked at my nipple and it was actually bleeding. And I thought oh god, try the other one... And I think I managed about 10 seconds on that one before it was bleeding...And, um I think I just collapsed in floods of tears. I'll probably cry now when I think about it, it was so awful.' (Rebecca)***

Despite being told they were positioned correctly, Angela could not make sense of her pain:

> ***'She said he was in the right place. But it still really hurt. It really hurt. So I just remained confused. If this is right, why does it hurt?' (Angela)***

Rebecca continued by describing her miserable experience:

> ***'It was just too painful and... I thought, [forget] it, and I think at that moment, two weeks in I thought I'm not going to make this for 6 months... it's so awkward, it's depressing me...I can't be doing this***

24 hours a day…then every day was a struggle.' (Rebecca)

Samantha also experienced excruciating pain, but continued to endure it:

'I knew what I was doing but it was excruciatingly painful…and I would say …certainly for the first 2 months every single time I breastfed it hurt …. Excruciatingly hurt like you know an open wound … horrible feeling.' (Samantha)

Samantha came to dread feeding:

'I remember every time it got to the one [side] that was really painful … I would just dread it and I would do anything to sort of get myself another minute before I actually had to do the feed'. (Samantha)

Despite the pain, the emotional bond she felt with her infant provided the impetus to persevere:

'… So the excruciating pain was awful but I did find all the positive benefits like the bonding and feeling that I could do something to help Mary calm down and relax and go to sleep and it was a fairly instant reaction…. made it worth it.' (Samantha)

In contrast, the long term feeders Nicola and Angela spoke of only minor pain, referring to it as a normal, accepted, but only transient part of breastfeeding. Only Pamela, who fed her infant for 5 months, felt no pain either in establishing or sustaining breastfeeding.

The role of other people in sustaining breastfeeding

Mothers variably benefitted from the support of health professionals, romantic partners, and peers, especially in their efforts to sustain breastfeeding. Support from health professionals was experienced as disengaged or presumptive, support from partners was experienced either as engaged or disengaged, and support from peers was experienced as validating or invalidating.

Assistance from health professionals when initiating breastfeeding

All mothers described feeling initially vulnerable and looked for expert support. Unfortunately only Diana (who was still feeding at 15 months) experienced 'expert support'. All of the other mothers (n=5) were greatly disappointed with the quality of professional assistance provided. For example, after giving birth, Pamela felt treated like an object:

'When she was first born the midwife put her on me. She sort of opened her mouth and sort of shoved my nipple in her mouth.' (Pamela)

Samantha (who fed for 5 months) and the two mothers who fed short-term felt strongly let-down, even abandoned, in hospital:

'And the support…it should be specific, people should stay with you for a whole feed and when you've finished a feed, not just at the beginning. And like, "oh that's fine the infant's latched on you'll be alright now." And leave you. They shouldn't leave you.' (Rebecca)

Similarly, Samantha's recalls:

'… And I had an awful experience, probably the second night … ummm … Mary was crying … it seemed like the whole night … and a midwife stormed into the room at about two in the morning and said "you should be feeding her more often" and then just stormed out again and I still didn't really know what I was doing … I was tired and that was her idea of helping me.' (Samantha)

Angela regretted in particular that during her hospital stay, the midwife had, without her consent, given her infant formula milk:

'Looking back…not that I was… bullied into it… but I think you're so exhausted afterwards I think you kind of go with whatever is going to get you through the night basically.' (Angela)

The role of partners

Mother's varied in how important they described the influence of partners in whether they started, continued or stopped breastfeeding. The two mothers who fed beyond 6 months identified partners as their strongest form of support.

'He kept saying to me 'stop asking everybody else… my sister isn't the

pinnacle for bringing up children, or breastfeeding, you know... you're doing really well... She's eating, she's growing, she's happy, you're doing really really well.' (Diana)

The two mothers who fed briefly did not figure their partners as strongly in the picture. Rebecca explains that, although supportive, her partner wouldn't understand what she was going through:

'And I suppose I'm dismissing Mark as well aren't I, the husband. He um handed me whatever I needed. But it's just so personal no-one can really help...' (Rebecca)

Samantha, who breastfed for 5 months and who found breastfeeding a major source of distress in the early stages, describes how partner support came in the form of pressure to give up breastfeeding:

'But by this time I was even getting pressure from Paul really to give it all up and bottle feed. I think he thought I was a bit crazy to ... just ... dig my heels in.' (Samantha)

For Pamela (who also breastfed for 5 months), her partner's reaction was more complex. Although supportive of breastfeeding, she felt that he was slightly envious of her bond with their infant, of which he could not be a part:

'But I know he definitely felt... I was sort of taking something away from him. Um, so, you know, because she was feeding so often as well, um, he definitely, you know, he definitely felt like he missed out on the cuddles.' (Pamela)

In short, partner support was felt either as engaging, dilemmatic (as in Pamela's case) or relatively disengaged emotionally, supportive in a more pragmatic way—in terms of logistics, as in Rebecca's case, or by suggesting they put an end to the struggle and switch to bottle feeding, as in Samantha's case.

The role of peers

Five out of the six mothers enjoyed, and/or actively sought the support of other breastfeeding mothers, not for specific help or advice but to simply share experiences. Of the intermediate feeders, Samantha emphasised how peer support was more useful than anything else, because other breastfeeding mothers truly understood what she was going through:

'They ... probably the people I spoke to the most because we were all going through it together, we were all having similar experiences and similar pains... so I think... other women that are going through it at the same time were the most support for me more than anything else .. Probably more than Paul [partner] as well to be fair ... unless you are going through it at the time it's very hard.' (Samantha)

The two short-term breastfeeders spoke of craving the support of others who understood their difficulties, but who were not available to them:

'My antenatal group actually weren't helpful and I did find that a real shame and I wanted to say, look I'm really having trouble with this...And you know no one else was struggling and I'd look at them and they'd be looking at me like, "what, what's wrong with you?" and I just felt a failure. I actually started to feel intimidated by them.' (Rebecca)

Mothers experienced some self-validation through engaging with others with similar experiences but those who struggled and could not find anyone with similar experiences felt disenfranchised and devalued by mothers whose experiences were a 'success'.

Guilt in the effort to balance mother and infant needs

Guilt was a strong emotion for all mothers irrespective of their breastfeeding duration, and was felt most when perceiving that they had allowed their own needs to predominate over their infant's needs. Four of the six mothers felt that they had put their infant at some medical risk by not feeding for 6 months and their infant's health might therefore 'fall off a cliff tomorrow' (Rebecca). This feeling persisted especially for Angela:

'I guess every time he gets a cold or something I think, there's a tiny weeny little part of me that goes 'I wonder if he'd had that cold if I'd breastfed him." (Angela)

After 5 weeks, Rebecca described her last breastfeeding experience as a tearful apology to her infant:

'I was mortified! I was, I'm crying, sorry. No I was really really really upset. I remember the last feed was one ounce. And I was so upset and I could have mixed it with formula but I thought there's no way I'm diluting it, because if he doesn't drink it all I'm not having it go to waste. I was like 'oh I'm sorry' and I kept apologising to him saying 'I'm really sorry you're not having any more breast milk." (Rebecca)

Both Rebecca and Angela, regarded bottle feeding as a very bad thing to do, evident in Rebecca's term 'plastic milk' for formula. Samantha, who fed for 5 months, explained how she felt that to give her infant the best health advantages possible, she must breastfeed for 6 months:

'... And I think really it`s only the pressure on ... you need to do it for 6 months if you possibly can and wanting to give the best health to your infant ... that made me carry on.' (Samantha)

And finally, although her guilt was less emphatic, Pamela regretted not giving her infant 6 months of breast milk:

'... But I, I, I, I wanted to at least carry on until, you know, for her to have breast milk for at least the recommended 6 months...And I breastfed up to, sort of, 5.5 months.. That's my only, sort of, regret from that, but you know, I don't regret at all, sort of, but yeah, I don't know. I only wish I'd just carried on for a bit longer.' (Pamela)

By contrast, the two long-term mothers worried that by stopping they might upset and confuse their infant now (s)he had become conscious of their breastfeeding. Diana, for example, explained that although she had reasons to stop, such as getting her body back and being able to go out in the evenings, she felt guilty that it would be traumatic for her child when she stopped:

'Now that she's older, I don't know whether I've done the wrong thing, by now feeding her, because now she's so aware, that it's going to be very difficult, not just for me to stop but for her to stop it. And I think it's going to be awful for a few nights, I really do.' (Diana)

All four mothers who stopped breastfeeding before the recommended 6 months spoke several times of needing a health professional's explicit permission to stop breastfeeding:

'At the end of the day ... I am the mum and Mary's my infant ... umm ... but I still felt that I needed her to give me the authority to bottle feed ... which sounds really strange but... it's like she had to approve it because she`s the medical person.' (Samantha)

Discussion

There are three main findings from this study. First, all mothers, irrespective of their breastfeeding duration, felt disappointed during the early stages of trying to establish breastfeeding because of a major discrepancy existed between their expectations and lived experiences. Second, all mothers sought the support of a partner and/or peers, with whom they could seek reassurance or share experiences. Third, all mothers experienced guilt about sacrificing (or potentially sacrificing), their infant's medical or psychological wellbeing when making feeding decisions.

With regards to feeling disappointed, unexpectedly difficult physical (i.e. struggles with breastfeeding technicalities, pain) and psychological experiences (i.e. feeling let down and abandoned by health professionals) when trying to establish breastfeeding created frustration and, for some mothers, intense distress. For two mothers, this distress was instrumental to their decisions to switch to formula milk, and for another two, made it untenable for them to continue breastfeeding for the recommended 6 months despite their intentions. These findings are consistent with previous work showing that mothers may hold totally unrealistic breastfeeding expectations; in particular, technical difficulties and unexpected pain (which played a dramatic part in all of our mothers' stories) have been shown to break breastfeeding ideals (Romito, 1988; Hoddinott and Pill, 1999; Mozingo et al, 2000; Lamontagne et al, 2008; Larsen et al, 2008). The struggles that the mothers in this study had with their infants is consistent with de Lauzon-Guillain et al (2012) who found that at age 3 months, infants who are breastfed are rated as having more challenging temperaments than formula-fed babies. Despite the widespread challenges that breastfeeding

mothers face, some peers may treat their pain and struggles as unusual, which can compound the problems that mothers face.

Those with difficulties establishing breastfeeding found health professionals to be disengaged or presumptive and not 'in tune' with their vulnerability and need for reassurance contrary to Ogden's (2007) recommendations. The mothers in this study craved professional support and even sought the permission of health professionals to stop breastfeeding. Increased professional support could alleviate many of the fundamental problems experienced, e.g. fears that they were not producing enough milk and feeding difficulties. Alleviation of difficult feeds could in turn reduce some psychosocial problems, such as the feeling of being the only mother who has trouble feeding. Some problems, such as reduced milk production, however, may occur in parallel with difficulty accomplishing feeds.

The second key finding was the importance of others in sustaining breastfeeding, this was also consistent with others findings (Kuo, 2005; Swanson and Power, 2005; Kaufman and Hall, 1989). The long-term breastfeeders relied heavily on practical and/or emotional support, not only from their partners but from their peers. Peer validation appeared particularly important to sustaining breastfeeding especially when mothers were experiencing difficulties, consistent with findings reported by Dennis et al (2002) and Byrne and Long (1976). Despite considerable early discomfort, mothers who managed to feed for almost 6 months did so not just because they were determined to do 'the right thing' (Noel-Weiss et al, 2006) but because they benefitted from strong partner and/or peer support as well as a mutually fulfilling mother–infant bond.

The third key finding was that all mothers felt guilty about putting (or potentially putting) their own needs over those of their infants. Mothers who gave up breastfeeding early worried that they had put their infant at some health risk, this was consistent with findings reported by Earle (2002) and Labbock (2008). All four mothers experienced a lingering regret and sense of failure at not having been able to meet the 6 month criterea for exclusive breastfeeding (WHO, 2002). This is an important finding because mothers who perceive that they have failed in their breastfeeding efforts, may also be prone to conclude that they are 'bad mothers' (Lawson and Tulloch, 1995; Murphy, 1999; Schmied and Barclay, 1999; Earle, 2002; Lee, 2007; Labbok, 2008; Crossley, 2009;). This is concerning, because self-depreciating feelings like guilt can seriously undermine maternal wellbeing (Alder and Cox, 1983; Millward, 2006; Stamp and Crowther, 2008) as well as the quality of the mother-infant relationship, and can potentially impact negatively on the quality of the marital relationship (Wrigley and Hutchinson, 1990). However, even long-term feeders felt guilty for stopping breastfeeding after the recommended 6 months, fearing that they would cause psychological harm to their infants by withdrawing a main source of nourishment and comfort.

Theoretical contribution

The mothers in this study made sense of their breastfeeding experiences in relation to culturally prescribed identities (Millward, 2006) integral to which is a moral belief that 'good mothers breastfeed' (Lee, 2007; Marshall et al, 2007; Crossley, 2009). Through censoring the idea of bottle milk as a viable feeding option during antenatal and postnatal care, public health and professional practice consolidates this moral belief, against which mothers then judge their maternal worth (Lee, 2007; Crossley, 2009; Ryan et al, 2010). Indeed, in contemporary UK society there is perhaps no action so personal and also so public than motherhood when it comes to feeding from the breast (Marshall et al, 2007; Crossley, 2009). There are many, sometimes conflicting, behavioural norms and moral role prescriptions attached to the role of motherhood (Millward, 2006). First time mothers are especially vulnerable to adopting idealistic role prescriptions as their benchmarks for self-esteem. This makes them susceptible to judge themselves against unrealistic ideals. It is thus not surprising that many mothers come to experience breastfeeding as psychologically untenable and are further affected by a vicious cycle of reduced (physical) breastfeeding efficacy and self-depreciation (Wrigley and Hutchinson, 1990; Labbok, 2008; Stamp and Crowther, 2008). Moreover, Alder and Cox (1983) found that guilt in relation to 'failure to succeed' as a mother is a factor in postnatal depression, suggesting a major downside to breastfeeding promotion in which motherhood ideals are implicit in the biomedical message (Lee, 2007; Marshall et al, 2007). Breastfeeding difficulties in particular have been linked with postnatal depression (Zauderer and Galea, 2010). The risks that postnatal depression pose to mothers, infants, and families are great, and although some authors advocate mother-focused prevention, recognising issues that are external to the mother is essential to preventing postnatal depression (Hagen, 1999). By maintaining a biopsychosocial approach to breastfeeding promotion, 'failure to succeed'

may be lessened and thereby lessen postnatal depression and associated difficulties.

Implications for practice

Examining the current evidence in combination with previous research, it would appear that in being predominantly underwritten by a biomedical model, the realities of breastfeeding may be inadvertently hidden by health promotion media and health professionals. It is clear that many women are not adequately prepared for breastfeeding in psychological and social terms. The transition to motherhood is itself a complex personal and moral journey (Crossley, 2009), particularly if this has to be reconciled with the world of work (Millward, 2006).

Health professionals need to ensure that mothers are given a 'warts and all' picture of breastfeeding, untangling their maternal identity from their success at breastfeeding. Any breastfeeding, no matter how limited, is beneficial and an achievement, but giving a bottle is not indicative of poor mothering. For those who struggle, access to peer support (such as self-help groups) and professional assistance may be beneficial. Although there are a number of Baby Cafés (http://www.thebabycafe.org) in the UK, where mothers can get help with breastfeeding problems, most are in major towns and cities and not in healthcare settings (Rossman, 2007). Baby Cafés are also operated by a charitable trust that is outside the NHS; mothers may be more comfortable having a breastfeeding appointment with a healthcare provider with whom they have substantial experience. Although such appointments may be available for a number of professionals, mothers could benefit from greater publicity of their availability and the availability of referrals to breastfeeding organisations.

Health professionals need to be aware of how influential they are to vulnerable new mothers and to treat them in a patient-centred way, ensuring that mothers feel their psychological needs are as important as their infant's needs (Raj and Plichta, 1998; McInnes and Chambers, 2008). New mothers in particular require encouragement and validation (Adewale, 2006). Finally, health professionals must acknowledge individuality in the experience of breastfeeding by complimenting the emphasis on the bio-medical benefits on breastfeeding with consideration of more psycho-social concerns such as social support systems, feelings of not being in control of one's own body, and tension with one's infant. Although deeper engagement with new mothers' breastfeeding needs costs staff time, the long-term benefits to public health and resulting reduction in national health costs due to increased breastfeeding are worth the investment.

Limitations and further work

The study sample was limited to professional, 'middle class', white mothers in an age range of 34–42. By having a demographically homogeneous sample, duration of breastfeeding was the main different between participants. This research also addressed this demographic group, because in the UK, breastfeeding is most likely to be their primary infant feeding approach (Bolling et al, 2007). They tend to have strong support networks and use healthcare services more than people with lower socio-economic statuses (Adler and Ostrove, 1999; Adler and Newman, 2002). Although the findings of this small sample cannot necessarily be generalised, the barriers that these women face are likely to be faced by many across a range of socio-economic backgrounds.

Characteristics of good qualitative research include sensitivity to context, commitment and rigour, impact and importance, and reflexivity (Yardley, 2000; Brockli and Wearden, 2006). Sensitivity to context was addressed by following the iterative process of IPA at each level of analysis by regularly revisiting the text to ensure interpretations were grounded in the participants' actual words. Commitment and rigor was addressed by thoroughness in conducting the study and by following recommended IPA methodology. However, the findings align with those reported in other qualitative work on mothers' experiences and perceptions, and the findings converge theoretically with others to inform our understanding of why 'breast' is not always 'best'.

Conclusions

This study has highlighted the importance of considering the psychological and social factors involved in feeding initiation and sustainability. Far from promoting breastfeeding, public health interventions that naturalise breastfeeding without addressing the physical, psychological and social complexity of breastfeeding inadvertently set mothers up to fail. Internalised ideologies of good mothering, especially among new mothers, provide unrealistic benchmarks for self-evaluation that undermine breastfeeding efficacy. Importantly, breastfeeding expectations must be realistic to prevent distress and to prepare mothers for the potential to experience physical and psychological difficulties. The findings show that although 'breast' may be nutritionally (and immunologically) 'best'

Key points

- First time breastfeeders may experience reality shock regarding pain, logistics, and the experience
- Peer and professional support is important to the willingness to breastfeed and experience doing so
- Mothers may feel guilty for using formula or for using multiple feeding methods
- Mothers may feel guilty not only for transitioning to formula but for weaning
- Using a biopsychosocial approach model in breastfeeding promotion could improve frequency and experiences

for the infant, on a psychosocial level it may not always be psychologically the best choice for the mother or the mother-child bond. Future research could focus on ways to more effectively promote breastfeeding by fostering more realistic expectations and providing adequate support. In such an approach, mothers would be enabled to make informed feeding decisions without finding themselves in a moral stranglehold. **BJM**

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