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# **An exploration of infant feeding experiences of women in Lincolnshire in the early postnatal period**

**Report of a Project Commissioned by NHS Lincolnshire**

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This report is the outcome of work commissioned by NHS Lincolnshire and undertaken by the following team from the University of Nottingham:

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## **EXECUTIVE SUMMARY**

Breastfeeding initiation and maintenance rates within Lincolnshire remain lower than the average for the East Midlands and England. Rates of initiation of breastfeeding at birth in 2010/2011 were 72% in Lincolnshire, compared to an initiation rate in England of 74%. The percentage of babies still being either partially or exclusively breastfed at 6 – 8 weeks dropped to 39% in Lincolnshire in comparison to 46% in England (NHS Lincolnshire, 2011).

The purpose of this qualitative research was to gain an understanding of primigravid women's breastfeeding experience in the first 6 – 8 week postpartum period. Whilst valuable audit data is held on infant feeding methods in Lincolnshire, this research focuses on offering insights into the experiences of new mothers in order to better understand their feeding experiences and decisions, with a view to understanding differences in rates.

The objectives of the study were

### **PRIMARY OBJECTIVE**

To describe women's experiences of breastfeeding

### **SECONDARY OBJECTIVES**

To determine women's perceptions of breastfeeding

To identify the factors that influence breastfeeding duration and cessation

The study used phenomenological principles to understand the lived experiences of the women. The study focused on women who were living in the county of Lincolnshire. Ethical approval was granted by the University of Nottingham and the National Research Ethics Committee.

Two methods of data collection were used:

#### Personal diaries

48 primigravid women over 34 weeks gestation were invited to complete detailed daily diaries of their infant feeding experiences in the 6 to 8 week postnatal period. 22 diaries were completed, a response rate of 46%.

#### In-depth interviews

A sub-sample of 13 women participated in a face-to-face interview which explored their infant feeding experiences and factors that affected their decision to continue or to discontinue breastfeeding.

Data analysis utilised phenomenological principles that proceeded from coding to category development to themes.

## **KEY FINDINGS**

- Mothers experience a 'roller coaster' of emotions in relation to trying to establish breastfeeding
- Mothers are unprepared for the realities of looking after a newborn baby and blame the incessant demands on breastfeeding
- Mothers are aware that breast is best but when this is not as easy or as natural as anticipated, they feel guilty for stopping breastfeeding
- Breastfeeding in Lincolnshire is less common than formula feeding so new mothers are very dependent on the advice and support from health care professionals
- Mothers commented how support for breastfeeding from healthcare professionals appeared more about meeting targets
- Mothers were particularly sensitive to negative comments regarding their efforts at establishing breastfeeding
- Mothers identified difficulties with breastfeeding in public, including in front of family and friends
- Postnatal breastfeeding support groups are not being accessed by new mothers in Lincolnshire

## KEY RECOMMENDATIONS

- Antenatal education should focus more on preparing women for the realities of breastfeeding their newborn, rather than an idealised version. This should include education on hand expression and its benefits.
- Antenatal education should include a session with a mother who has recently breastfed.
- Communication about breastfeeding needs to be realistic rather than idealistic, and include newborn behaviour, both in the antenatal period and throughout the early postnatal period.
- Training should be provided for healthcare staff on how to communicate advice and support to new breastfeeding mothers in a way that empowers them.
- Breastfeeding support in hospital postnatally should be proactive rather than reactive to requests for help. Predictable, scheduled, ongoing support, both on the postnatal ward and throughout the early postnatal period when discharged home is recommended.
- After being discharged home, women who are breastfeeding should be contacted by a local peer support group representative and offered advice and support.
- Consideration should be given to setting up specialist infant feeding teams in postnatal and paediatric wards, and the community.
- A local campaign so that breastfeeding in public is less taboo is recommended.
- Consideration should be given around timings and venues of postnatal support groups to encourage attendance.

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## GLOSSARY OF TERMS

**Baby Friendly Hospital Initiative (BFHI):** an approach to transforming maternity practices as recommended by the joint UNICEF / WHO statement on the protection, promotion and support of breastfeeding (WHO, 1991). WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) in 1992. The foundations for the BFHI are the 'Ten Steps to Successful Breastfeeding' described in the *Innocenti Declaration on the protection, promotion and support of breastfeeding* (WHO, 1991), and observe the principles and aim of the International Code of marketing of breast-milk substitutes.

**Bottle feeding:** feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, formula, and water.

**Commercial infant formula:** a breast milk substitute formulated industrially in accordance with applicable *Codex Alimentarius* standards to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

**Cup feeding:** feeding from an open cup without a lid, whatever is in the cup.

**Duration of breastfeeding:** the period beyond the first nutritive breastfeed for which a baby continues to feed at the breast.

**Exclusive breastfeeding:** breastfeeding whilst giving no other food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

**Expressed breast milk:** milk that has been removed from the breasts, either manually or by using a pump.

**Hand expression:** the expression of milk from the breast by hand.

**Primigravida:** a woman who is pregnant for the first time.

**Primiparous:** a woman who has given birth only once.

## LIST OF ABBREVIATIONS

BF (bf)	Breastfeeding
BFI	Baby Friendly Initiative
BFHI	Baby Friendly Hospital Initiative
EBM	Expressed Breast Milk
PCHR	Personal child health record
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

## **INTRODUCTION AND BACKGROUND**

Breastfeeding is a key public health priority. On a population basis, exclusive breastfeeding for the first 6 months of life is the optimal way of feeding infants (World Health Organisation [WHO], 2011; Kramer and Kakuma, 2012). Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond (WHO and United Nation Children's Fund [UNICEF], 2003). A recent evidence-based review (Ip et al., 2007) found that breastfeeding was associated with a reduction in the risk of a wide range of health problems in the neonate including non-specific gastroenteritis, severe lower respiratory tract infections, asthma (in young children), obesity, and sudden infant death syndrome [SIDS). For maternal outcomes, breastfeeding has been associated with a reduced risk of type 2 diabetes, breast, and ovarian cancer (Ip et al., 2007) and early cessation of breastfeeding (or not breastfeeding at all) is associated with an increased risk of maternal postpartum depression (Ip et al., 2007). Improving health outcomes through raising breastfeeding rates has the potential to save NHS funds (Renfrew et al, 2012a).

### **Public Health importance and policy directives**

International initiatives have been instigated over the past twenty-five years in an effort to increase breastfeeding rates, including the WHO code of marketing breast milk substitutes (WHO, 1981), the *Innocenti Declaration on the protection, promotion and support of breastfeeding* (WHO, 1991), the WHO/UNICEF Baby Friendly Initiative and the WHO Global statement on infant feeding (WHO and UNICEF, 2003). WHO and UNICEF launched the Baby-friendly Hospital Initiative [BFHI) in 1992, to strengthen maternity practices to support breastfeeding. The foundations for the BFHI are the 'Ten Steps to Successful Breastfeeding' (appendix 1) described in the Innocenti Declaration on the protection, promotion and support of breastfeeding (WHO, 1991).

The BFHI is a multi-faceted evidence-based intervention and systems approach, including good practice standards for organisations to meet that cover all aspects of service provision and care. The BFHI has been implemented in approximately 15000 hospitals in 171 countries and has been evaluated as contributing to improving the establishment of exclusive breastfeeding worldwide (UNICEF, 2008). Hospitals are awarded Baby Friendly status if they meet the evidence-based 'Ten Steps to Successful Breastfeeding'. A study using data from the Millennium cohort (Bartington et al., 2006.) found that in Baby Friendly accredited hospitals there was a 10% higher rate of breastfeeding initiation compared to unaccredited hospitals, and an increase in breastfeeding that continued up to seven days. However, birth in an accredited unit was not associated with increased breastfeeding rates at 1 month (Bartington et al., 2006.). Evidence from other developed countries has indicated that a combination of both hospital-based and community-based Baby Friendly Initiative [BFI) breastfeeding training and support is effective in increasing breastfeeding duration and exclusivity up to six months of age compared with hospital-based BFI alone (Coutinho et al, 2005).

In England, the *NHS Plan* (Department for Health [DH), 2000) made explicit the Government's support for breastfeeding to ensure a healthy start for children and to address inequalities in healthcare. The Acheson Report (DH, 1998), aimed at improving health and reducing health inequalities, suggested that interventions to promote rates of



breastfeeding should decrease the incidence of infant infection and lead to other health gains for both mother and child. The Infant Feeding Initiative was launched in 1999 in England, as part of the government's commitment to improving health inequalities. The importance of breastfeeding is highlighted by the inclusion of a specific target in the Department of Health's Priorities and Planning Framework 2003-2006 (2002). The Department of Health public health outcomes framework has recently superseded this (DOH, 2012).

The importance of breastfeeding and initiatives that support its initiation and duration have been endorsed in a range of recent policy statements for England (*Choosing Health: making healthy choices easier* (DH, 2004a), *Every Child Matters* (Department for Education and Skills, 2004), *National Service Framework for Children, Young People and Maternity Services* (DH, 2004b), *evidence into practice briefing* (Dyson et al, 2006) and NICE public health guidance 11 (2008)).

These government policies provide a powerful driver for local action to improve public health outcomes for children, young people, and their families. It is therefore a fundamental requirement that health care practitioners can demonstrate the knowledge and skills for breastfeeding to enable mothers to make fully informed choices on infant feeding and therefore fulfil the objectives of these key policy drivers.

### **The local context of infant feeding in Lincolnshire**

Local data obtained from the East Midlands Public Health Observatory indicates the percentage of mothers initiating breastfeeding within each PCT.

Rate of initiation of breastfeeding at birth in 2009/2010:

England 72.7%  
East Midlands 72%  
Lincolnshire 71.8%

For the same time period, the percentage of babies either partially or exclusively breastfed at 6-8 weeks post birth:

England 49%  
East Midlands 45%  
Lincolnshire 40%

The local data for 2010 for Lincolnshire: initiation 70.4%; at 6-8 weeks (any breastfeeding) 39%.

At present (2012), there are 87 UK hospital maternity units and 17 community health-care facilities with full Baby Friendly accreditation (UNICEF, 2012). United Lincolnshire Hospitals Trust has achieved Stage 2 UNICEF Baby Friendly accreditation (in which staff knowledge and skills have been assessed as meeting a specific standard). There are four infant feeding coordinators - two based in the Acute (hospital) Trust and two in community posts. In order to understand these statistics and the inherent complexities of successfully promoting and supporting breastfeeding, Lincolnshire PCT commissioned an examination of women's experiences of breastfeeding to explore the factors facilitating successful breastfeeding as well as those which militate against it. The

circumstances, under which some women opt to discontinue breastfeeding, whilst others choose to continue, need to be identified and understood to facilitate optimum service provision.

## **RESEARCH AIMS**

The aim of this research study was to develop an understanding of primiparous women's experiences of breastfeeding. The study focused on first time mothers living in Lincolnshire and included those who succeeded in establishing and maintaining successful breastfeeding and those who breastfed initially but then discontinued.

The secondary objectives were:

To determine primiparous women's perceptions of infant feeding

To identify the factors that influence breastfeeding duration and cessation

The methodological orientation of this study was that of hermeneutic or interpretive phenomenology (Heidegger, 1962; van Manen, 1990; Greatrex-White, 2008, and Smith et al, 2009), an approach that seeks to understand human experience from the perspective of individuals' experiences of life events, and the meanings these events have for them.

### **Recruitment of participants**

A non-probability purposive sampling technique was used to recruit participants to the diary phase of this study. This was based on the fact that all recruited women would share a commonality of experiences, i.e. as new mothers who planned to breastfeed. Therefore, pregnant primigravid women between 34 and 36 gestation were accessed through community midwives at their antenatal appointments. Posters outlining the infant feeding study were displayed in antenatal clinics at Lincoln County Hospital and Boston Pilgrim Hospital, GP surgeries, health visitor clinics, and Children's centres throughout Lincolnshire. Intensive recruitment was conducted in order to gain a cross section of primigravid women from Lincolnshire. This included repeated visits to community midwife teams, weekly visits to Boston, Lincoln and Grantham maternity units, including antenatal clinics, maternity wards, and children's centres. The participant information sheet and introductory letter provided the purpose of the study. Prospective participants were able to discuss the study further by contacting the research team directly using contact details on the participant information sheet or poster.

Participation was voluntary, and those who decided to take part were free to withdraw at any time and without giving reason. Written consent was required prior to taking part in the study, on the understanding that anonymity and confidentiality was assured. A sub-sample of 13 self-selected women participated in a face-to-face interview at the end of the initial six-week postnatal period in addition to recording their experiences in a diary. This in-depth qualitative interview aimed to explore, in detail, their experiences and to identify the contextual factors that affected their decision to continue or to discontinue breastfeeding in the first 6 – 8 week period after giving birth.

## **Data collection**

Two methods of data collection were used:

### **Personal diaries**

A sample of 48 primigravid women, over 34 weeks gestation, were recruited and invited to complete detailed daily diaries of their infant feeding experiences in the 6 to 8 week postnatal period. Participants were given the option to choose a written diary or audio. The aim of the diary was for mothers to record their infant feeding experiences and they were encouraged to write something daily, although this was not prescriptive and some women wrote a detailed account of their experiences both daily and at the end of the 6-8 week period.

### **In-depth interviews**

A sub-sample of 13 women participated in a face-to-face interview in order to explore, in detail, their experiences and to identify the contextual factors that affected their decision to continue or to discontinue breastfeeding. The in depth interviews asked questions around the following areas: experience of labour and birth, infant feeding experience in hospital and at home, support offered for breastfeeding (hospital and community), contact with healthcare professionals, present infant feeding status, and feelings about the feeding in the first 6- 8 weeks.

All interviews were tape recorded with participant's permission and lasted between 30 and 55 minutes, and, with consent, were held in the women's home with their baby present. Anonymity and confidentiality were assured prior to and after the interview. The interviews were transcribed verbatim. The collected data was analysed utilising phenomenological principles that involve initial coding, category development and distillation of overall themes. All mothers' quotes are indicated by the participant code (i.e. P1).

## **Data analysis**

The text for analysis constituted written and typed daily diaries from the participants, and verbatim transcripts from the interviews of the sub set of participants. The data were managed manually, without the aid of a software package. The interpretive process was guided by the principles of the philosopher Heidegger (1962). The aim of interpretive inquiry is to identify common themes across the participants and form a pattern of understanding. The objective is to reveal and articulate the structure of the lived experience. To meet this objective, it was crucial to search for the commonality as well as diversity of participants' experiences. This involved immersion in the data by reading and re-reading each diary and interview in a search for emerging themes. Individual segments of texts were considered in relation to the overall text, and each sentence was assessed for meaning of the phenomena. This was a cyclical process whereby the researchers moved back and forth between the whole text and segments of text to gain some understanding of the phenomena being explored. Each researcher carried out simultaneous analysis. Collaborative reflective discussion then took place to generate deeper insights and understandings. Themes were then examined, articulated, re-interpreted and reformulated.

### **Ethical and Research Governance Approval**

Ethics approval to conduct this study was granted by the University of Nottingham and the Derby 1 and 2 National Research Ethics Committee. Approval was obtained from the Research Governance Department of United Lincolnshire Hospitals Trust in March 2012.

Confidentiality and data protection principles were strictly observed, for example, the identities of participants were protected by the use of a code that ensures that all data (digital recordings and diaries and interview transcripts) are anonymised. All participants were given pseudonyms to ensure confidentiality. Before data was stored, any identifying features were removed. The digital recorder was stored in a locked cupboard during the period of data collection, and following completion of the study will be cleared of data. Identifiable data has been stored for between 12 months to 3 years to allow participants to request a summary of the study findings. Documents containing anonymised participant data for the study are stored in a locked cupboard at the University where they will be available for scrutiny with permission from ethical review bodies for seven years. All data has been viewed solely by the research team and not exchanged electronically.

## FINDINGS

From the 48 recruited participants, 26 mothers shared their 'lived' experiences of their infant feeding experiences. This represents 54% of those that indicated at recruitment that they were intending to breastfeed and were willing, prior to birth, to share their infant feeding experiences.

During the study period, one mother formally withdrew from the study, and three participants who had volunteered in the antenatal period to participate, were subsequently excluded from taking part once they had given birth to their babies. These women were excluded because of maternal or newborn complications in the initial postnatal period. One further prospective participant was also excluded from commencing data collection as she went into pre term labour at 34 weeks gestation. A further 18 women who consented in the antenatal period and collected the diary pack and instructions for completion once they had given birth failed to maintain contact with the research team or return their diaries within the study period.

The demographic profile of the 26 mothers who shared their infant feeding experiences is provided in Table 1. There was no significant difference between these mothers and the 22 that took no further part in the study.

Table 1 – Demographic profile of participants

<b>Characteristics</b>		<b>Number of participants</b>
<b>Age</b>	<20 years of age	3
	21-30 years	8
	31-40 years	15
<b>Marital status</b>	Cohabiting	12
	Married	12
	And/or living with parents	2
<b>Qualifications</b>	Masters/Degrees	9
	A level/BTEC/Access	8
	GSCE only	8
	No qualifications	1
<b>Employment prior to birth</b>	Employed	23
	Unemployed	3

Of the 48 recruited participants, 3 chose an audio diary with the remaining participants choosing the written diary. Of the 26 mothers, 25 returned hand written diaries, one mother typed up her experiences.

The study aimed to conduct individual interviews with a sub-group of 10 mothers: 5 who were still breastfeeding and 5 who had discontinued at the end of the initial six week postnatal period. However 13 mothers requested to be interviewed at the 6- 8 week point.

The findings indicate that although participants planned to breastfeed, for many, their feeding experience was not as anticipated. Whilst all 26 participants who shared their experience initiated breastfeeding, 7 were providing formula, 1 combination feeding (formula and expressing of breast milk) and 18 (69%) were discharged from hospital as breastfeeding. Hospital discharge varied from 24 hours to five days. By the 6-8 week postpartum period, 10 mothers (38%) were still exclusively breastfeeding as shown in Table 2 below and in more detail in Appendix 3.

Table 2 – Infant feeding outcome of participants

<b>Feeding at hospital discharge</b>		<b>Feeding pattern at 6 weeks</b>
<b>Breastfeeding including EBM</b>	18	10
<b>Formula</b>	7	16
<b>Mixed</b>	1	0
<b>Total</b>	26	26

From the data, three main conceptual themes were identified: (1) Emotional rollercoaster of infant feeding, supported by the subthemes maternal guilt, unpreparedness for breastfeeding, and unrealistic expectations (2) Professionals: expertise, communication and impact, supported by subthemes perceived power of 'experts', breastfeeding communication and support for breastfeeding (3) Dimensions of public feeding includes three aspects: feeding in front of family and relatives, using private facilities in public spaces and feeding 'where ever and when ever'. These themes with their subthemes are detailed in Figure 1. Although presented separately, these themes are inter-related. Whilst women were recruited from both Boston Pilgrim and Lincoln County Hospitals, all the women had similar views and experiences of breastfeeding.

Figure 1 Thematic map showing main themes and sub themes



The following section will discuss in more detail the themes identified from the analysis of the interview and diary data.

## **EMOTIONAL ROLLERCOASTER OF INFANT FEEDING**

A key aspect that emerged from the data was how unprepared the mothers were for the demands and needs of their newborn and how this contributed to a rollercoaster of emotions. Most mothers felt ill prepared for breastfeeding, and how to meet the continual demands whilst carrying on with their lives. The coded data identified three subthemes: maternal guilt, their unpreparedness for their newborn needs including breastfeeding and, unrealistic expectations about the demands of breastfeeding and continual care of the baby. The following section discusses these sub-themes in more detail.

### **Maternal guilt**

Of the 26 mothers, 10 were still exclusively breastfeeding in the early postpartum period (6-8 weeks of data collection). A theme throughout the diaries and interviews was mother's feelings of guilt that they were unable to breastfeed. This emanated from their strong desire and expectation that they would be able to breastfeed.

All the mothers reported a positive experience of skin-to-skin contact with their baby immediately after the birth, and the majority of mothers commented positively about the first breastfeed immediately after the baby's birth. Following their initial success at breastfeeding, mothers perceived their inability to continue this maternal function as failure, manifesting itself as maternal guilt as they were unable to meet their baby's needs:

*I felt a failure and got really upset and not been able to breastfeed but just express... I wanted the closeness, I kept saying I have failed, I have failed (P30)*

The following excerpts from diaries provide a snapshot of their emotions during the postpartum period in relation to this guilt at not breastfeeding:

*You expect it to be natural; I took it for granted it would just happen (P30).*

*You are encouraged breast is best, and yes, you feel guilty as you see all the other mums on the ward breastfeeding (P31)*

*Feeling defeated and upset I cannot feed my daughter the way nature intended (P38)*

This is further compounded by what they understood to be a 'natural' function that all mothers should be able to perform:

*It does not help to be asked all the time how he is feeding. I did feel really bad, as posters everywhere saying breast is best. I tried to ignore them (P22)*

*I felt I was letting myself down more than them (midwives) (P5)*

*I thought - God I must be rubbish (P30)*

Those mothers who stopped breastfeeding justified and rationalised this decision:

*Breastfeeding is lonely and isolating especially if partner wants to help (P11)*

*Breastfeeding, it was not worth the stress looking back now (P30)*

*I just did not get it (breastfeeding). What am I doing, what is she doing (baby). It all got too much so I asked for a bottle (P5)*

*I left the labour ward and we tried again (to latch) he was trying, he was sucking but my milk wasn't coming through so they suggested a bottle with the special teat, so he went on the bottle in the first day (P22)*

These feelings were further justified by explanation of their rationale for changing to formula, as one participant explained:

*With the bottle, I do not have him latched onto me all the time, constantly on my chest (P22)*

### **Unpreparedness for breastfeeding**

Of the 26 mothers, three attended antenatal classes, two in the hospital setting (Lincoln and Boston), and one in a community children's centre (Grantham). Mothers said they gained most of their knowledge about birth and infant feeding, including breastfeeding, from their routine antenatal appointments with their community midwife. Some mothers gained advice via family and friends and using the internet. One mother who was intending to wean her baby at 4 months and provide sugared water to supplement her breastfeeding, on advice from her mother (P9).

This limited preparation and understanding of newborn behaviour was evident when mothers talked about "relentless" feeding, needing to comfort their baby "constantly", and the consequent negative impact on their lives:

*I tried to breastfeed most of today from midnight till midday; xxx has barely left my chest (P19)*

*Day 2 today's' experience was tiring but OK xxx was on my boob every ten minutes. I am hardly getting chance to go to the toilet (P36)*

Whilst these demands are a factor for all new parents, it appears to be more acute for breastfeeding mothers. A breastfeeding mother shared her experience of the changes to her routine:

*Your whole life is planned around him, when he is due a feed, when he is due a nappy change and then before you go anyway where well, you just cannot! I am one for going out as and when I feel like it, just pick up my handbag, get in the car and go. You cannot just nip out anymore (P1)*

and a mother one week after giving birth:

*he feeds every 2 hours and this I find difficult as I'm very tired, gave him a dummy and so give me a bit more of a rest (P42)*

Breastfeeding mothers were aware of looking for feeding cues. However, the baby not settling was seen as the baby needing to be fed which resulted in them offering the breast and therefore perpetuating the feeling of constantly feeding as one mother wrote in her diary on Day 3:



*He was on the breast for about four hours as he would not settle otherwise and this was very stressful (P42)*

They struggled to contextualise these experiences as 'normal' newborn needs and were more likely to interpret them as a failure of breastfeeding.

A Polish breastfeeding mother shared in her diary 2 weeks after her baby's birth how she was feeling about the feeding demands:

*I was not expecting it to be like this (constant feeding). I thought all kinds of stuff. That I was not a good mum because he was crying (P32)*

Therefore, the reasons provided for discontinuing breastfeeding and changing to formula seem to be linked to the mother's limited understanding of the demands of a newborn baby. The elements of emotional attachment and dealing with the demands of a new baby added to the guilt felt by the mothers, especially those that experienced some difficulty in breastfeeding. Mothers appeared unprepared for the feeding and caring demands of their newborn infant. This was apparent for all mothers in the study but was more acute for those that wished to continue breastfeeding. They perceived breastfeeding to be demanding of them as mothers:

*I feel I'm sacrificing time with [baby] in order to give him breast milk.....I feel my relationship and bond with him is been compromised by the time I spend feeding him (P1)*

A sub theme throughout was the mother's apparent lack of understanding of the process of milk production. A lack of knowledge about the physiology of lactation compounded this level of preparedness. Mothers wrote in their diaries that their babies were often sleepy and therefore "were not interested in feeding" (P3 & P5). Mothers grew anxious that this indicated that their baby was dehydrated because they were experiencing breastfeeding difficulties, resulting in one mother asking for formula (P5) and another seeking advice from her midwife on the first day:

*I was so tired that I slept for a few hours and missed the next feed, later I tried to express some milk to give him in the syringe but he had so little (P45)*

On Day 2 she wrote about trying to provide breast milk for her baby:

*I'm still trying to express some milk and I'm collecting it in the syringe - find it quite difficult and have only few ml of sticky, thick milk to feed him (P45)*

Breast milk volume was assumed directly comparable to the amount of formula being offered in the pre-prepared bottles on the postnatal ward. Mothers who were encouraged to hand express their colostrum were surprised by the small amount expressed. They assumed that this was why their baby was unsettled or constantly crying. Two mothers were encouraged to hand express within hours of giving birth (P48) and another after a few hours after an initial feed (P15). Another mother expected her milk to "be gushing", was shocked when she was only leaking a small amount of milk (P22). Breast engorgement was a factor that mothers misunderstood and therefore were not expecting the feeling of fullness to be "so prominent and for some painful" (P11). This lack of awareness meant that they were unprepared, as they had no solutions without contacting health professionals or consulting the internet. For the mothers, this contributed to their sense of being an emotional roller coaster.

## **Unrealistic expectations**

A theme apparent during the first 6 weeks of motherhood was mothers' unexpected level of tiredness and exhaustion. In particular they mentioned the frequency of feeding, the demands of night feeding and effect on sleep patterns:

*In the beginning very long feeds, for a couple of weeks, he would feed for 40 minutes, very long. I was exhausted because it was a lot in the night but in the day he was a comfort sucker, my partner would find me crying because I could not do anything (P32)*

*One night I was up for 7 hours as he kept trying to latch on and obviously that was tiring (P6)*

*In the first week or two he was constantly feeding, it was not what I was anticipating. I knew at the beginning it would be little and often to stimulate the milk but I didn't realise it doesn't stay in the stomach as long with breastfed babies, did not anticipate, I mean I don't think he ever went more than an hour between feeds at night and sometimes less during the day (P25)*

*7 weeks on and its harder than I thought, the last couple of weeks have been hardest (P48)*

Although for one mother, she was more realistic about breastfeeding and the demands on her energies:

*I didn't really think that I wouldn't be able to do it, even at first when he wouldn't, I just thought it would happen so I wasn't overly relieved I thought it was normal (P48)*

Breastfeeding was not always a negative experience. Some mothers were surprised at how easy and convenient they found breastfeeding and were intending to continue:

*Breastfeeding is better than I thought it would be (P3)*

*I can just go out and if he started to want a feed it's all ready and warm and he can have as much as he wants (P1)*

*Breastfeeding is lovely, its brilliant time just the two of us (P15)*

*I didn't want to give him something fake (P9)*

*Breastfeeding is easier than I thought it would be (P10)*

And for one mother the opportunity for her to meet her babies need was evident from her diary entry at 5 weeks:

*Breastfeeding makes me feel empowered, it's only me that can feed him and I find the time we spend together (feeding) enjoyable (P27)*

Some mothers who continued to breastfeed in the 6 – 8 weeks identified that it was much easier than preparing formula:

*I'm basically lazy, the slobbering around sterilising bottles, heating them up and dishing out formula, making sure not too much or too little.....it must cost a fortune (formula) (P3)*

*What a fuff (making bottles), especially in the night, it's so much easier to breastfeed (P15)*

*I don't know if I could be getting up at 3 am and messing about with bottles, temperatures etc, it's just so easy (breastfeeding) (P10)*

One mother who stopped breastfeeding after her son was observed in hospital for 10% weight loss was able to compare formula preparation and breastfeeding:

*It's not only a fuff and the cost, I hate it.....preparing the bottles, making sure I've enough when I got out; it was easier when I fed him (P1)*

For some mothers it was not just their own exhaustion but it related to their inability to continue with their everyday tasks:

*It was so hard; I could not do anything you know I could not even go to the toilet because he made such a fuss (P32)*

*I just could not do anything around the house. I think its worst now as XXX is back at work now...I have some days when I cannot cope. I look around and see the washing and ironing pile ... (P9)*

For some women, these experiences persisted for some weeks, this participant noting in her diary four weeks after the baby's birth:

*I cannot do anything else apart from breastfeeding, no time for bath or shower or even clean the house (P15)*

## **PROFESSIONALS: EXPERTISE, COMMUNICATION AND IMPACT**

This theme relates to what mothers referred to as the 'experts', the healthcare professionals from who mothers sought help and support with their breastfeeding. These professionals were midwives in the hospital and community settings, health visitors, and others (i.e. health care assistants) that mothers might see assisting with breastfeeding on the ward.

Mothers viewed the actions of healthcare professionals as having a fundamental impact on their breastfeeding experience. The mother's sought out their expertise and assistance to provide reassurance and guidance and the data was coded under three sub-themes: perceived power of 'experts', breastfeeding communication, and support for breastfeeding.

### **Perceived power of 'experts'**

All mothers spoke in a very positive way about the contact with healthcare professionals throughout their pregnancy and in particular with staff working on labour suite:

*They were brilliant, I cannot praise them highly enough (P45)*

*The midwifery care was second to none (P31)*

During the early days of breastfeeding, mothers sought validation of the difficulties they were experiencing. They wanted solutions to these difficulties and reassurance when they had successfully attached or fed their baby. One mother wrote in her diary at the end of the first day:

*I did get into paranoid mummy mode when she spent [baby] about 3 hours during the night latching on for about 5 mins at a time. Luckily the midwife came to check she came to check if feeding correctly. The midwife reassured me that some babies cluster feed plus she was latching on fine, I feel loads better (P11)*

In the diaries, the mothers judged success as meeting expected weight gains, 'filling' nappies, and babies been generally content, and not crying.

However some mothers commented how support for breastfeeding from the healthcare professionals appeared more about meeting their targets:

*It struck us they were keen to get a statistic on the labour suite, their 100% pass rate. They were pushy, getting a cup to try to feed him (P22)*

*I did not like the pressure to get him to latch on (P22)*

### **Breastfeeding communication**

In the women's diaries the nature and type of communication with health professions was paramount to how they (the mothers) viewed their breastfeeding abilities. In particular, negative comments and actions by healthcare staff impacted deleteriously on mothers. This is illustrated by their ability to recall verbatim staff comments. Two mothers, who felt their breastfeeding was going well, talked about their experience of care on Day 2:

*She (midwife) came in and said you are doing it wrong, you do not look like you are sat right, and you don't look comfortable. Relatives were there so it made me feel, oh no they are going to think I am not doing very well. She did something similar when we needed to change him. She was more of a busy body than an observer. She made me feel uncomfortable (P10)*

*She (midwife) was not helpful at all. When I was hand expressing she said, that is not worth giving it to him, and she put it in the sharps bin. I was so mad (P30)*

These comments were not just isolated to midwifery staff. One mother, who had been hand expressing and feeding this expressed breast milk to her baby from a bottle due to painful nipples, wrote in her diary after her first home visit from her health visitor at Day 11:

*My health visitor told me off. She said I was confusing him [baby]. I don't know what to do, either try him on my boob again and see how it goes or keep him on a bottle now. I feel so bad (P36).*

One mother whose son was monitored for 10% weight loss at 3 days old found her dealings with paediatric staff unsupportive of her breastfeeding desire:

*I told them I was breastfeeding but the staff brought me a bottle, I did not know why. I told them again and they brought me a breast pump, I felt unsupported to breastfeed (P1)*

What these examples demonstrate is the potential to undermine and discourage mothers. New mothers appear particularly vulnerable to negative feedback.

Some mothers relayed how they felt under pressure to perform breastfeeding in order to be 'released' (P30) by the midwives:

*Then this horrible one came in on the afternoon shift and said look we are not going to let you home until you can prove that you can feed him, I felt under pressure (P30)*

*She told me that she wanted me to be able to breastfeed before going home on day 2 (P3)*

Whilst the message of 'Breast is Best' is well documented (Earle, 2002), mothers had different feelings about the nature of these messages which they viewed as reinforcing their failure to breastfeed. An aspect for those mothers that ceased breastfeeding, either in hospital or within the 6-8 week postnatal period, was how public health messages on breastfeeding suggested it was all positive and 'natural'. In fact, this was not the case for all mothers and reinforced their maternal guilt described earlier in the theme rollercoaster emotional of breastfeed. What mothers were suggesting, in their diaries and in the interviews, was for breastfeeding to be described in terms that are more realistic:

*The breastfeeding messages are all about the negatives what could happen to your baby if you don't do it, there needs to be the other side too... It does not work for everyone and it doesn't work if you are stressed (P30)*

*Mums to be should be aware it takes time, effort, and patience to breastfeed your baby (P27)*

*If it doesn't work out first time, it doesn't mean it won't work with another baby (P9)*

They suggest that the public health messages on breastfeeding need to also state that it is physically demanding, sometimes hard to establish, and requires perseverance by the mothers. Mothers also recommended including practical tips that would help support breastfeeding:

*I knew nothing about hand expressing, there needs to be alternatives to help you get breastfeeding, and having access to a pump in hospital (P30)*

*When the midwives teach you about breastfeeding, they could teach you how to do it discreetly, with muslin so you do not have to figure it out for yourself (P27)*

*There needs to be more about feeding in the antenatal classes we attended (in hospital) (P10)*

The BFI guidelines suggest that mother's are shown how to express either by hand or by use of a pump (UNICEF, 2008:p31). Expressing is the removal of milk from the breast by other means than the baby sucking (Clemons and Amir, 2010). Women included in the diaries, and in the interviews, how they were encouraged to hand express but seemed

confused why they were being taught this skill in the hospital. Whilst mothers commented on being shown the technique, they wondered why:

*I had no knowledge of hand expressing, I was encouraged to express using a syringe and midwives helped me to feed by syringe (P30)*

And in an interview, a mother talked about her experience of hand expressing on Day 2:

*I said I was struggling and they gave me a cup and said have a go at expressing but I did not understand that at all (P5)*

All the women in this study are primigravid and therefore, as shown earlier, rely on the advice and support of healthcare professionals. This includes how and when they communicate messages about breastfeeding. A mother who was encouraged to hand express by hospital midwives and feed by pipette was discharged from hospital exclusively hand expressing. Having received advice she continued to feed her baby this way for another 2 weeks before expressing and feeding by bottle for a further 3 weeks.

Another mother, who attended antenatal classes and so "felt prepared for breastfeeding" but on hospital discharge was formula feeding, saw her lack of milk when hand expressing as the reason why she could not breastfeed successfully:

*I tried (hand) expressing; I could not even get a dribble (P5)*

And another mother who was struggling to breastfeed was asked by a midwife on the ward about breastfeeding:

*She said have you tried hand expressing and I said oh I don't know how to, and she said had no one talked to you about breastfeeding? (P3)*

In the interviews, the aspect of expressing was explored further and few mothers were anticipating using hand pumps but did not relate this to having knowledge or using hand expressing:

*I had no idea about hand expressing; I thought you had to have a pump or something (P30)*

*I bought a manual breast pump and found it very easy to express milk when full, gave my partner a chance to join in feeding (P42)*

And a mother on Day 3 her solution to breast soreness was to use only a pump:

*I hired an electric pump because I want to breastfeed but my breasts are so sore, I will express and feed by a bottle (P15)*

### **Breastfeeding support**

Lincolnshire PCT has gained the BFHI level 2 accreditation (see <http://www.unicef.org.uk/BabyFriendly/BFI>) and there was clear evidence of good practice in supporting primigravid mothers who wish to breastfeed.

Mothers talked about the sources of support they used during their hospital stay and in the first few weeks at home. Surprisingly few mothers talked about the advice and guidance from family and relatives, relying on the advice from 'experts' about breastfeeding,

*Midwife said she had a good latch and the pain should subside as my milk comes in (P38)*

*When the community midwife arrived I was feeding her and she praised me and said oh that's very good, well done and she watched me and I said am I doing in right (P3)*

and for a mother who struggled in the first week at home:

*It is a good thing I had a midwife come over and helped me otherwise that would of my breastfeeding experience over with! (P27)*

Although this was not always seen as positive support as one mother wrote a summary of her breastfeeding experience at 5 weeks:

*I think if I had better support in hospital – maybe a different sized nipple shield I would never have needed to introduce formula. When I have another baby, I will be more prepared. I will also refuse to stay overnight in the hospital (P38)*

Whilst some mothers did turn to their own mother for feeding advice in addition to the 'experts':

*It was confusing (expressing), I got different advice, but when I came out (hospital), I found mum knows best (P30)*

All mothers in the study were able to recall verbatim the widely publicised health benefits to them and their babies of breastfeeding. They were fully aware of these aspects through a number of sources: leaflets collected at antenatal appointments, discussions with their community midwives and through sources they accessed themselves (i.e. YouTube and Google).

*NHS breastfeeding leaflet is the bible on what to do (P11)*

*Discharge information sheets really helpful...midwife was really reassuring and leaflet extremely helpful (P3)*

*I did get loads of leaflets on support groups (P22)*

There are established breastfeeding support groups in Lincolnshire and mothers are provided with this information in leaflets and included in the personal child health record (PCHR) (red book) within their hospital discharge. Although the mothers said they found the leaflets useful, surprisingly, only three mothers turned to these support groups. One located a local internet forum on breastfeeding and one attended her local group, espousing how "*fantastic it was, reassuring, helped to shared our (breastfeeding) experiences*" (P15). Whilst one mother, when probed further, why she did not attend any breastfeeding support groups replied:

*I have had no problems so I have not needed to contact them (P10)*

One breastfeeding mother, who had successfully breastfed for five weeks, wrote in her diary about her feeding difficulties and rather than seek advice from any local breastfeeding support groups turned to her friends for advice:

*Week 5 – where is the milk!?! This week has been horrible for me, few attempts at breastfeeding but he’s not interested but I was reassured by friends (P42)*

## **DIMENSIONS OF PUBLIC FEEDING**

The dilemmas for mothers wishing to breastfeed in the public sphere are well documented in the academic literature and are viewed as societal barriers (maternity leave, lack of facilities, lack of breastfeeding awareness) rather than a maternal failing (Moore and Coty, 2006, Hoddinott and Pill, 1999).

It is important to emphasise that the mothers in this current study were intending to breastfeed regardless of any societal barriers that exist. However, it was evident that difficulties of breastfeeding ‘outside’ of the home environment were not something they had considered prior to giving birth. Since the aim of this study was to explore their feeding experiences rather than their antenatal decisions to breastfeed, we are unable to draw conclusions about how they might have planned to overcome any feeding difficulties but report here the realities for them.

What is clear from the data analysis is that mothers had anxieties around feeding in different environments. These were categorized in three contexts, as each one presents different challenges: feeding in front of family and relatives, using private facilities in public spaces and their ability to feed ‘when ever and where ever’.

### **Feeding in front of family and relatives**

In the UK, there is an acceptance that relatives will visit the parents and meet the newborn whilst they are in the hospital setting. However, what is less clear is how breastfeeding mothers may feel about this, particularly in the early stages of establishing feeding. Some mothers spoke about the anxiety that they felt when they needed to ‘perform’ in front of family members:

*You have to feed her and you aren’t comfortable doing it yet, you are trying to let everyone say hello and have a hold and then she wants feeding, it all got too much, I was dreading my husband going home (P5)*

*I fed in front of my mum and sisters when they came and that was fine coz they had breastfed, but when partners sister and family came I got a blanket out, none of them breastfed, they couldn’t understand why I was doing it (P10)*

*The lack of facilities, like at family functions made it difficult, so I fed in the car (P3)*

In one case, a mother writing in her diary on the first day, talked about her attempts at breastfeeding, using the curtains to create ‘private’ space’ having delivered by caesarean section:



*Hard to find privacy, curtains helped but as unable to walk, had to keep asking someone to shut the curtains (P3)*

And in explaining, in her diary why this was important:

*I did not feel comfortable breastfeeding in front of others so privacy was important (P3)*

The same mother went to great lengths to write the account of how stressful she was feeling about feeding in hospital and her avoidance of feeding in public:

*Finding feeding on ward a bit inconvenient as having to keep closing the curtains (difficult for me to move due to stitches) a couple of times staff (cleaners, coffee makers) have opened them partly back to do things and then left them open – also observed they don't ask if ok to enter. When attempting to breastfeed find this embarrassing and makes me feel conscious of when to feed my baby, avoiding likely times of meal deliveries etc (p3)*

These diary entries not only indicate the mothers discomfort at feeding in front of family but they also indicate high levels of anxiety by the mothers which are known to have an impact on the let-down reflex (Lawrence and Lawrence, 2011).

### **Using private facilities in public spaces**

This sub-theme relates to how breastfeeding mothers manage feeding in public spaces when away from the home environment:

*We went out shopping and he needed feeding so I asked in a clothes shop and used a changing cubicle to do it (P10)*

*As I continue to breastfeed I sometimes wish I had bottle-fed because going out and about is quite difficult as I'm not yet confident enough to do it in public (P27)*

And she writes further:

*It does frustrate me they drum into you about breastfeeding being the thing to do but nobody tells there are not very many places that have separate areas with nice seats for you to sit on! (P27)*

One mother, when asking staff at a newly built doctor's surgery, the location of facilities for breastfeeding mothers was surprised at the response:

*I asked the receptionist where I could go and they looked at me and said erm you can sit down here if you like, it was basically the thoroughfare where everyone walks through – and she said sit down there (P3)*

### **Feeding 'where ever and when ever'**

This sub-theme relates to mothers growing confidence in their breastfeeding. In their diaries, they talked about feeding when away from home but doing "normal everyday thing like shopping (P11). These comments occurred at different times in the 6-week diary. The following accounts are taken verbatim from their diaries:

*I have a muslin square, cover me up and I just get on with it (P25)*

*I found fantastic facilities at Meadowhall, which made the experience much more pleasurable....I felt nervous the first time but managed it felt like a milestone (P11)*

*Done it in a cafe and actually on a park bench because he was hungry (P48)*

*Having a baby sling is fantastic to carry the baby and for breastfeeding (P15)*

And for one mother she was very conscious of others people's views about breastfeeding in public:

*I've done it a couple of times but I try to keep out of the way because I am wary of other people being...It doesn't bother me but I know other people can be funny about it (P48)*

Although some mothers still felt uncomfortable breastfeeding anywhere than their own home and were daunted by the prospect of needing to breastfeed in public at some point in the future:

*At this stage of breastfeeding (week 1) breastfeeding on the go and in public seems very far away (P39)*

*As I continued to breastfeed I did sometimes wish I had bottle-fed (formula) because going out and about is quite difficult and I am not yet confident enough (6 weeks) just to do it in public (P27)*

Although one self-conscious mother, gave her reason for expressing, was to avoid embarrassment of 'public' feeding and to "extend my time away from home" (P3). Her rationale was to avoid the problem of where and how to breastfeed. Her feelings are perhaps a reflection of the need for privacy that was expressed in earlier interview comments on ward privacy.

## DISCUSSION

It should be stressed that the findings relate to women who indicate that they intended to breastfeed and who then shared their actual infant feeding experience from birth and for the 6-8 weeks. Of the 26 mothers, only 18 (62%) mothers were exclusively breastfeeding at hospital discharge (this figure includes two women who were expressing and breast milk feeding). At the 6-week data collection point, ten of these mothers were still exclusively breastfeeding. What is clear from the data is that there are multi-factorial reasons why primigravid women in Lincolnshire decide to cease breastfeeding in the early postpartum period.

Our metaphor of 'emotional rollercoaster' shows what mothers felt about infant feeding in the 6 weeks and highlights how they were unprepared for the realities of caring for a newborn. A strong feature of this in women, who were unable to continue to breastfeed, was their guilt. Qualitative research into mother's experiences of breastfeeding has discovered that breastfeeding is synonymous with the concept of being a 'good mother' (Carter, 1995; Murphy, 1999; Murphy, 2004). Premature cessation has been seen as a personal failure (Lawson & Tulloch, 1995) accompanied by intense and sustained feelings of grief (Battersby, 2000; Mozingo et al, 2000; Ryan & Grace, 2001; Shakespeare et al, 2004). This cycle of self-blame and 'good mother' syndrome is vividly brought to life with the use of the women's written diaries.

Whilst this guilt is well documented in the literature, the experience of an emotional rollercoaster is compounded by the disconnect between their expectations and the unregulated pattern of their newborn behaviour. They interpreted this dissonance as 'my breastfeeding problem'. This interpretation is reinforced by public health education messages around breastfeeding that present it as unproblematic and 'natural'. Women in this study whose babies were unsettled between feeds and frequently crying found this behaviour difficult to manage. They questioned their ability to produce an adequate milk supply to sustain their baby. This perception was reinforced by family members, often grandparents who suggested formula as a solution. This is a consequence of a lack of breastfeeding culture in a woman's social environment, and has been reported elsewhere. Lavender et al (2006) (p153) described how despite many family members having good intentions, their lack of breastfeeding knowledge and inability to interpret the women's needs hindered the support they provided.

The women in this study described their focus on the production of breast milk and a lack of trust in their body's ability to produce efficiently as they were unable to see or measure how much the baby was getting. This reflects their need for reassurance and validation that there is sufficient breast milk (Dykes, 2002; Dykes, 2005). The women seemed preoccupied with quantifying the frequency and duration of breastfeeds. In relation to expressing, they equated this directly to formula milk. Women also became anxious about their ability to breastfeed enough to meet their baby's growing and developing needs if the baby seemed unhappy and unsettled between feeds. This perception of insufficient milk has been reported extensively. Exploring the women's accounts of their breastfeeding patterns in more detail uncovered ineffective patterns of breastfeeding – the women seemed constrained by the rigid, dogmatic doctrine of positioning and latching that they had been taught in by the hospital midwives. They lacked an embodied and owned confidence in their body's ability to develop and adapt

this skill. This is a disembodied perspective that undermines breastfeeding duration but is common in the extant literature "*If she does not gain weight, I will have to give her the bottle*" (Mahon-Daly and Andrews, 2002, p70) "*I wish there was some kind of marker, to say how much she has had you know*" (Marshall et al, 2007, p2154). However, the lived experience of breastfeeding is clearly, from these women's accounts, physically and emotionally challenging and breastfeeding advocates appear to render this aspect invisible.

In this study, all participants demonstrated awareness of the health benefits of breastfeeding to both them and their babies. Indeed, it was noticeable that these benefits were recalled verbatim. It indicates that the national campaigns and local strategies to promote breastfeeding as the 'norm' are visible. A UK qualitative study of 19 primigravid women in the West Midlands (Earle, 2002) also found breastfeeding awareness campaigns effective at promoting the health benefits, indicating that the messages are not just localised in Lincolnshire.

Bates (1996) has suggested that women who stop breastfeeding are either unable or unwilling to articulate why. This may be because many have deep-rooted negative feelings about the adequacy and sufficiency of their breast milk, and a profound lack of confidence in their ability to breastfeed (Dykes, 2005). A study in California, exploring women's reasons for requesting supplementation for healthy breastfed infants were similar to those in this Lincolnshire study. Mothers interpreted every episode of the crying and waking of their baby as an indicator of hunger and were unprepared for the frequency with which that occurred. They concluded that their breast milk was insufficient to meet their baby's needs (DaMota et al, 2012). Formula was seen as the solution to the 'problem' of breastfeeding.

In accordance with UNICEF BFI '10 Steps to Successful Breastfeeding', all the mothers experienced skin to skin contact with their baby shortly after birth, regardless of the type of delivery, following the birth. The findings show that all mothers attempted an initial breastfeed on the labour suite, which has been shown to increase the likelihood of breastfeeding in the long term (Moore et al, 2012; Dabrowski, 2007), in addition to maximising the let-down reflex through the high oxytocin levels in the first hours after the birth (Nissen et al, 1996).

However, the first 24 hours were periods of particular anxiety for the mothers in this study. If their baby slept a lot or showed little interest in feeding, this was interpreted as either abnormal behaviour or dissatisfaction with their efforts to breastfeed. Midwives response tended to reinforce this. Some recommended that the mother hand express, collecting the early milk (colostrum) in a syringe to feed it to the baby later. However, as the volume expressed by this method was very small, mothers viewed this as quantifiable evidence that their milk supply was inadequate. In addition, hand expression felt counter intuitive to some. Other midwives suggested waking the baby at regular intervals, adding to the mothers' concern about the baby's needs. These findings indicate that many mothers did not understand the physiology of lactation and were not aware that perseverance is sometimes required in the early days post birth to establish milk supply.

It was very clear from the findings that new mothers sought out the advice of professionals extensively. This places the professionals in a very privileged position, but with that comes responsibility. What health care professionals said, and how they said it, was highly significant for the women. In particular, negative feedback from the staff made a lasting impression and tended to disempower women. Their recall of exact conversations was detailed when these negative encounters occurred. This has also been shown in the context of the birth experience itself (Simkin, 1992). Longitudinal studies have shown the women's interpretation and memories become more negative with time if the experience was traumatic. Therefore there is an increased likelihood that feeling disempowered may affect subsequent birth and breastfeeding experiences.

Support from professionals was also inconsistent in that women were expected to 'get on with it' in the early postnatal period, probably reflecting the ideal that breastfeeding was natural and instinctive, with clear benefits for both mother and baby. This hands off, non-intervention approach enabled the professionals to meet standards for breastfeeding as a deregulated, feeding on demand ethos. However, when some standards were breached, for example, excessive weight loss in the baby, they became much more interventionist and prescriptive about their support, adopting a protocol driven medical model. For the mothers in this situation, who may have been struggling with building confidence anyway, this dramatic change in approach by the staff undermined what little confidence they had accrued. Their diary entries at this point began chronicling an inevitable spiral towards cessation of breastfeeding. The women in this study described their focus on the production of breast milk and a lack of trust in their body's ability to produce efficiently as they were unable to see or measure how much the baby was getting. This reflects their need for reassurance and validation that there is sufficient breast milk (Dykes, 2002; Dykes, 2005). The women became preoccupied with quantifying the frequency and duration of breastfeeds. In relation to expressing, they equated this directly to formula milk. Women also became anxious about their ability to breastfeed enough to meet their baby's growing and developing needs if the baby seemed unhappy and unsettled between feeds. This perception of insufficient milk has been reported extensively. Exploring the women's accounts of their breastfeeding patterns in more detail uncovered ineffective patterns of breastfeeding – the women seemed constrained by the rigid, dogmatic doctrine of positioning and latching that they had been taught in by the hospital midwives. They lacked an embodied and owned confidence in their body's ability to develop and adapt this skill. This is a disembodied perspective that undermines breastfeeding duration but is common in the extant literature (Shaw, 2004).

The findings indicate that few women attended antenatal classes, even though the benefits of attending are well documented in the literature (Locke, 2009). These include better preparation for birth and the development of supportive social networks postnatally (Locke, 2009). Classes provide an opportunity to discuss infant feeding, including both the positive messages about breastfeeding and the difficulties sometimes of establishing and maintaining exclusive breastfeeding. Women in this study, whose babies were unsettled between feeds and were frequently crying, found this behaviour difficult to manage. They questioned their ability to produce an adequate milk supply to sustain their baby. This perception was reinforced by family members, often grandparents who suggested formula as a solution. This is a consequence of a lack of breastfeeding culture in a woman's social environment, and has been reported

elsewhere. Lavender et al (2006) (p153) described how despite many family members having good intentions, their lack of breastfeeding knowledge and inability to interpret the women's needs hindered the support they provided.

Despite receiving a plethora of written information detailing local breastfeeding support groups or other postnatal support groups, no women in this study utilised them. Very few mothers accessed baby clinics offered at local children's centres around Lincolnshire, and these were attended for the purpose of weighing the baby or checking the baby's developmental progress rather than peer support. The literature demonstrates that women value peer support from mothers with similar experiences who can relate to their own situation through a shared language (Dykes, 2005; Hoddinott et al, 2006). A recent evaluation of a peer support breastfeeding service conducted by Thomson and colleagues (2012) recommended that strategies of realistic and repeated assessments, ongoing development and formulation of plans, flexible access to support, and promotion of support networks and ongoing feedback, praise and reassurance should be integrated into breastfeeding peer support provision. Thomson et al (2012) reaffirm the importance of relating to women, rather than professional agendas (p352). A recent Cochrane Review (Renfrew et al, 2012b) explored whether providing extra support for breastfeeding mothers, whether professionals, trained lay people or both, would help mothers to continue to breastfeed. This review found that all forms of extra support showed an increase in the length of time women continued to breastfeed. Renfrew et al (2012b) also found that support that was only offered if women sought help was unlikely to be effective. This indicates that women should be offered predictable, scheduled, ongoing support visits.

It would appear that there are no quick fix solutions to the societal barriers around breastfeeding, and, in particular, feeding when away from the mother's home. It was clear from the findings that this caused anxiety for most breastfeeding women during the first six weeks, with some resorting to feeding in their cars or in public toilets. Occasionally, mothers conquered their fears and began feeding 'where ever and when ever'. What is evident and is reported in the literature is that women are rarely seen breastfeeding in public in the UK and in other western countries where breastfeeding rates are low (Bolling et al, 2007). Without continued efforts to challenge societal attitudes and pressure on councils and shopping outlets to provide breastfeeding spaces, it is difficult to see how breastfeeding outside of the home can become accepted and normative.

## **STRENGTHS AND LIMITATIONS OF THE STUDY**

One limitation is the relatively low response rate regarding the utilisation of diaries, though this form of data collection was always going to be challenging for new mothers amongst all their other competing priorities. Only 3 non-white British women were recruited to the study. People from ethnic minority groups were not excluded from the study but their absence is a reflection that all the recruitment material was provided in English and that resources did not allow for bilingual researchers or translation of materials. To gain wider sample future studies, in Lincolnshire, should consider this aspect particularly in providing material in Polish and Lithuanian. Their perspective warrants further investigation as these mothers may differ in their expectations of breastfeeding. We were not able to collect data beyond 6-8 weeks so exploring why mothers give up breastfeeding after this was not possible. Clearly our study is not able to be generalised statistically beyond the sample. However, the experiences of women are likely to resonate with other areas of the UK.

The research shows that diaries are a beneficial way of collecting contemporaneous data on the lived experience of research participants. Some women commented on the cathartic effect recording their experiences in diary form had for them. Some made recommendations for how to alter future experiences of women planning to breastfeed and these have contributed to the recommendations at the end of this report.

## **SUGGESTIONS FOR FURTHER RESEARCH**

It was clear that providing a list of postnatal support groups did not result in the women attending such groups. Further research is indicated to explore how to increase women accessing this resource.

Further research should explore the perspectives of midwives and health visitors, both in hospital and community.

## CONCLUSIONS AND RECOMMENDATIONS

This was a small study in which data was generated from a small group of women in a defined cultural context. The findings offer insight into women's lived experiences of breastfeeding in the first 6 to 8 weeks following birth. These insights are not statistically generalizable, although they are likely to resonate with women's experiences in other similar settings.

The purpose of this study was to explore women's experiences of breastfeeding, and to widen the knowledge and understanding of the meaning they ascribe to this experience. This was in order to develop recommendations for infant feeding policy and practice in Lincolnshire. By using phenomenological methods, the lived experience of breastfeeding was explored in-depth to reveal the tensions, incongruence's and rhetoric/reality gap that some women go through when adjusting to breastfeeding for the first time. Our evidence clearly shows complexities and diversities in the experience of breastfeeding. For all the women in this study breastfeeding was an unforgettable experience.

Our evidence clearly shows the complexities that contribute to infant feeding decisions. Women, on the whole, were ill prepared for the realities of breastfeeding. They were expecting breastfeeding to be a natural process, but once they started breastfeeding, most women experienced it as problematic. Many found the demands and onus of responsibility for their newborn infant to be incessant, and at times, overwhelming.

Experiences of breastfeeding initiation in the immediate period after the baby's birth were overwhelming positive, but experiences of breastfeeding support, both in the postnatal ward and on discharge home were mixed. The impact of comments and advice from health care professionals could be misconstrued and damaged women's confidence, leading some to question their ability to breastfeed. Whilst health care professionals are successful in promoting breastfeeding antenatally, they are less successful in supporting breastfeeding postnatally. This seems to be partly because midwives and health visitors routinely withdrew from proactive contact with the woman once breastfeeding was established, leaving her to seek help only if problems arose. In a social environment where formula feeding is the predominant method of infant feeding, there is a lack of peer and social support for breastfeeding, which is not seen as fitting in with normal family life.

This current study indicates that many mothers have a strong desire to breastfeed, and that they need support in order to initiate and establish breastfeeding. Current data indicates that very few women achieve the ideal six months exclusive breastfeeding.

A number of actions are required for real improvements in breastfeeding rates in Lincolnshire to be achieved. This is particularly important, as it has been shown that improved breastfeeding rates have a direct impact on the long-term health of babies and mothers, and a financial saving for the NHS (Renfrew et al, 2012a).

In a social context where formula feeding is ubiquitous, there is a lack of ongoing professional and peer support for breastfeeding.



Antenatal education should focus more on preparing women for the realities of breastfeeding their newborn, rather than an idealised version. This should include education on hand expression and its benefits. Mothers need to understand why hand expression is taught prior to discharge home from hospital after the birth of their baby. Antenatal education should also include a session with a mother who has recently breastfed, and should provide information to women of breastfeeding support groups that they can access postnatally.

Communication about breastfeeding needs to be realistic rather than idealistic, and include newborn behaviour, both in the antenatal period and throughout the early postnatal period.

Training should be provided for health care staff on how to communicate advice and support to new breastfeeding mothers in a way that empowers them. There is a need to emphasise communication skills and techniques in breastfeeding training in addition to teaching positioning and attachment.

Breastfeeding support in hospital postnatally should be proactive rather than reactive to requests for help. Predictable, scheduled, ongoing support, both on the postnatal ward and throughout the early postnatal period when discharged home is recommended. After being discharged home, women should be contacted by their local peer support group representative.

Time and workload pressures on midwives and the organisation of postnatal care, both in hospital and in the community, needs to be addressed. There is a need to explore other options such as breastfeeding peer supporters and other communication media to facilitate support for all mothers in this rural county.

Consideration should be given to setting up specialist infant feeding teams in postnatal and paediatric wards, and the community, to support breastfeeding mothers and ensure consistent advice and high quality interpersonal skills.

A societal shift needs to take place in order for breastfeeding in public spaces to be acceptable. A local campaign so that breastfeeding in public is less taboo is indicated. Breastfeeding in public should be supported by local breastfeeding cafes, for example in Children's Centres. Retail outlets should be encouraged to commit to supporting breastfeeding women, for example by displaying Breastfeeding Friendly stickers.

It was clear that providing a list of postnatal support groups did not result in the women attending such groups. It may be worth considering the timings of support groups to coincide with times and venues of well baby clinics and lactation clinics. Each mother could be given an appointment to meet the community midwife or health visitor at that clinic.

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## **APPENDIX 1 – TEN STEPS TO SUCCESSFUL BREASTFEEDING (WHO, 1998, p5)**

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.
7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

## **APPENDIX 2 – CODED DATA FROM DIARY ENTRIES AND INTERVIEWS**

### **Unrealistic expectations**

- Sleepless nights
- Frequency of feeding
- Inability to perform other roles (i.e. home)
- Care of baby exhausting
- Mother exhausted

### **Mothers un-preparedness for what baby needs**

- Newborns behaviour
- Feeding cues or something else?
- Lack of knowledge from the experts i.e. via ante-natal classes/parent craft (11 didn't attend)

Some knowledge via other media i.e. YouTube

Demand feeding and constant feeding

### **Maternal guilt**

- Baby not settling so must be down to b/f rather than other 'baby' settling issues
- Sense of letting baby down
- High anxiety levels about b/f
- Do not get it right, cannot go home
- Lack of shared experience (partner) – except when swapped to bottle a justification of decision
- Everything is about why it's best not what the reality is
- Not fulfilling public health messages
- More balanced view needed of b/f
- Lack of weight is due to them choosing to b/f
- Painful so not doing it right
- Baby must only be content if b/f right – i.e. baby ill/unsettled must be b/f fault
- Link to expressing: expressing early so not getting much so therefore seen as 'failure' rather than awareness of b/f cycle (i.e. what happens)
- Issue for mums of weighing and link to b/f – a cycle of not doing good experience upsetting

### **Mums experience of b/f**

- Sore nipples (within ½ days and longer)
- Disconnect between literature and what's happening re pain of b/f
- Must be something wrong as it hurts
- Sleepy baby so what next? - Perception of 'forced' to b/f when baby reluctant
- Advantages b/f over bottle: faff (particularly at night, and no cost)
- B/f a stressful experience

Pumps causing a problem (soreness)

- It was scary, no longer enjoying, not how I wanted to feel
- Experience so upsetting,

### **The healthcare 'experts' – power of knowledge – Early support is critical for b/f**

- Not seeking other external help i.e. b/f groups once home
- Their input (midwives, health visitors) seen as vital
- Majority very supportive midwives (ward and community)
- Positive experience of labour suite staff

Mums improved confidence of b/f (by 6 weeks for those continuing) unless undermined by the 'experts' (i.e. told causing nipple confusion, syringe thrown away)

Negotiating with the 'experts' on paediatric ward (Lincoln) re feeding

C section struggling to b/f because no skin to skin or b/f in theatre

10 day community weighing

Lack of any support for b/f after labour

### **Breastfeeding a taught skill**

New Mums need to be taught these skills they are not 'natural'

Natural not necessarily

Expectation it will work

### **Communication between professionals (i.e. hospital and community support)**

Evidence that all received a community midwife visit within 24 hours of discharge

Two cases IFC involvement (one on ward one at home)

Lack of continued support specifically for b/f i.e. no other professionals consulted by mum or midwife

Lack of support for weight loss and continuing to b/f

Asking closed questions of Mums, not inviting further interaction

Weighing issue understanding between children's ward

Mums sensitivity to negative feelings

Inappropriate advice

Communication how mum is doing

### **Baby friendly drivers (BFI)**

Hand expressing is the norm – driven by medical paradigm

Hand expressing - Mums have no knowledge of this prior to birth

Hand expressing used instead of b/f

Early use of hand expressing (i.e. day ½ in some cases)

Using syringes to feed baby (in one case for 4+ weeks)

Topping up with formula (early <1 day)

Nipple confusion confusing for mums

Skin to skin is clearly evidenced – plus husband/father

Complicated birth (i.e. stitches c section) possible b/f compromised because of delivery

First 24 hours an issue for mums with reluctant feeders, leading to resorting to other approaches to feeding (cup/syringe/formula)

Use of cup and expressing on labour suite

### **Public feeding**

Timing feeds to avoid 'public feeding'

Seeking out privacy

Thinking ahead and planning around feeding

Embarrassment of family/relatives feeding

Lack of public facilities

Ease at b/f feeding publically

Lack of establishing normal routine – i.e. going out

Mums own sense of b/f confidence = public feeding not a problem

Sore nipples (within ½ days and longer)

### APPENDIX 3 - DEMOGRAPHIC DETAILS OF PARTICIPANTS

	Education	Working	living arrangements	Discharge feeding	6-8 week data
<b>1</b>	Degree	✓	husband	breastfeeding	bottle (after weight loss 3 & 6 days)
<b>3</b>	Msc	✓	husband	breastfeeding	Breastfeeding
<b>4</b>	NVQ 2	✓	husband	bottle	Bottle
<b>5</b>	HNC	✓	husband	bottle	Bottle
<b>6</b>	A LEVELS	✓	with partner	breastfeeding	bottle (baby tongue tie)
<b>9</b>	Masters	✓	with partner	combined	Bottle
<b>10</b>	AAT	✓	with husband	breastfeeding	breastfeeding
<b>11</b>	Teacher	✓	with partner	breastfeeding (homebirth)	breastfeeding
<b>15</b>	NVQ 3	✓	husband	breastfeeding	Breastfeeding
<b>19</b>	NVQ 3	✓	with partner	bottle	Bottle
<b>20</b>	Degree	✓	with partner	breastfeeding	Breastfeeding
<b>21</b>	Degree	✓	husband	expressed and cup	Bottle
<b>22</b>	NVQ	✓	husband	bottle	bottle
<b>23</b>	BTEC	✓	husband	bottle	bottle
<b>24</b>	BTEC	✓	with partner	breastfeeding	Bottle
<b>25</b>	HND	✓	with partner	breastfeeding	breastfeeding
<b>27</b>	NVQ	X	with partner	breastfeeding	breastfeeding
<b>30</b>	BTEC	✓	with husband at parents	expressing (syringe)	bottle after 5 weeks of continued expressing
<b>31</b>	Diploma	✓	with husband	bottle	Bottle
<b>32</b>	A/Access	✓	with partner	bottle	Breastfeeding
<b>36</b>	GCSE	X	living with parents	breastfeeding	bottle
<b>38</b>	Int. Bac.	✓	with partner	breastfeeding	Bottle
<b>39</b>	Degree	✓	with husband	breastfeeding	Bottle
<b>42</b>	none	X	with partner	breastfeeding	Bottle
<b>45</b>	Masters	✓	with husband	breastfeeding	Breastfeeding
<b>48</b>	NVQ	✓	with partner	breastfeeding	breastfeeding