”I was meant to be able to do this”: women’s experiences of breastfeeding. A phenomenological study

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'I was meant to be able to do this': a phenomenological study of women's experiences of breastfeeding

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Abstract

Introduction. There is strong evidence demonstrating that human breastmilk provides complete nutrition for human infants. While the rate of initiation of breastfeeding in the UK has increased steadily over the last 25 years, rates of exclusive breastfeeding in the early weeks and months over the same time period have shown only marginal increases.

Method. An interpretive phenomenological approach informed by the philosophy of Martin Heidegger was adopted. The aim was to understand women's experience of breastfeeding. Women were recruited from one city in the East Midlands in the UK, where the prevalence of breastfeeding is decreasing. Potential participants were recruited via health visitors at the primary birth visit. Ethical approval was received from the university and NHS research ethics committees. Data were collected between three and six months after the birth of their youngest child and analysis was guided by interpretive phenomenological principles.

Findings. The women were found to be ill-prepared for the realities of breastfeeding and, for most women, the shock of this experience was overwhelming. In particular there was a lack of understanding and preparation for common problems and a lack of awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant-feeding behaviours, such as crying, wakeful states and cluster feeding, on the specific method of infant-feeding. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply.

Discussion. The extent to which inadequate preparation for breastfeeding had a negative impact on the breastfeeding experiences of women in this study was a surprise. Antenatal education should focus more on preparing women for the realities. Education and support for breastfeeding women need to encompass infant-feeding cues and infant behaviours.

Key words: Breastfeeding, infant-feeding, experiences, expectations, qualitative methods, interviews, evidence-based midwifery

Introduction

Research has emphasised the biological nature of infant-feeding and motherhood, and a body of knowledge has developed promoting breastfeeding globally as the optimum method of infant-feeding (Kramer and Kakuma, 2012; WHO, 2011; 2002). Breastfeeding has been suggested to represent both a medical gold standard for infant-feeding and a moral gold standard for mothering (Knaak, 2005). Numerous international, national and local public health policies cite recommendations to increase breastfeeding prevalence. NICE (2006) postnatal care guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum NHS standard. Despite this increasing evidence base, and encouraging rises in breastfeeding year on year, there remains a dramatic drop-off during the early postnatal period (McAndrew et al, 2012). This is in stark contrast to other countries. For example, 80% of Norwegian mothers (Lande et al, 2003) and 68% of Swedish mothers (Sveriges officiella statistik och Socialstyrelsen, 2009) are still breastfeeding at six months. Locally, there was evidence of a higher fall-off rate between initiation and six to eight weeks in Lincolnshire (33%) than in England (28%) and the UK (26%) (McAndrew et al, 2012). A study exploring local women's experiences of breastfeeding was designed to consider similarity or differences with national studies (McAndrew et al, 2012).

Method

The theoretical location of the research was interpretive phenomenology, informed by the philosophy of Heidegger (1962). The study was designed to describe and interpret the phenomena of human experience in the world in relation to the phenomenon of breastfeeding. Heidegger's interpretive phenomenological approach focuses on illuminating details within experience that may be taken for granted, with the goal of creating meaning and a sense of understanding.

The question posed was: 'How do women experience breastfeeding?' This requires an answer formulated in terms of description and interpretation, which recognises that the way one person perceives an apparently similar experience (breastfeeding) is not necessarily the way another may see it. According to Rolfe (2002), the sort of understanding that arises from a phenomenological study is but one possible understanding among potential others, thus the authors' study was an important addition to the body of knowledge regarding breastfeeding. Ethical approval was received from the university and NHS research ethics committees.

Sampling and recruitment

Participants were recruited because they had experienced the phenomenon. Women were recruited via health visitors from one city in the East Midlands in the UK, where there

was evidence of a higher fall-off rate between breastfeeding initiation and six to eight weeks (East Midlands Public Health Observatory, 2012). Health visitors identified women at their first visit (11 to 14 days postnatally) who had initiated breastfeeding at birth and were currently breastfeeding. They provided participant information sheets, and those who were interested contacted the lead researcher (RS). Interviews were conducted when the youngest child was aged between three and six months. The number of participants recruited was a compromise between satisfying ethics committees, allowing for diversity of the phenomenon and being manageable in the time available for the study.

Data collection and analysis

Data were collected by interviews. Verbal and written consent was obtained prior to each interview. In total, 22 in-depth interviews were performed and digitally recorded by RS. Although interpretive phenomenology is concerned with elucidation and interpretation of human phenomena (Heidegger, 1962), it also rules out treating women as mere objects. It was a methodological assumption that the interviews would reflect breastfeeding phenomena: that women would share their breastfeeding experiences. The authors asked one opening question: 'Can you tell me about your experience of feeding your baby?' Prompts were used to keep the conversation flowing but, at all times, the authors were cognisant of the aim: to understand the women's stories. Data were collected between July 2009 and January 2010, from women with a range of infant-feeding experiences – women who were exclusively breastfeeding, women who had initiated breastfeeding and then changed to formula, and any combination in between. The inclusion criteria were to have initiated breastfeeding at birth and continued at least until the health visitor's first visit. Setting the upper limit for data collection at six months provided an opportunity to gain perspectives from women who may have breastfed exclusively for six months, which is the current WHO recommendation (WHO and UNICEF, 2003). Setting the lower limit at three months reflects a point at which early weaning on to solid food may occur (Bolling et al, 2007). Analysis was guided by Heidegger (1962), Ashworth (2003) and Greatrex-White (2008). All authors participated in the analysis, which consisted of dialogic and concurrent processes.

Rigour

To enhance rigour, a decision trail was made evident, which is sound phenomenological practice (Sandelowski, 1986), and several steps were followed. Accuracy was assured by using audio recordings, transcribed verbatim. In addition, RS recorded reflective field notes about each interview immediately after the interview had been conducted. Interpretations were constantly cross-checked with the original transcripts, ensuring that the interpretations presented the participants' voices as clearly as possible. Rigour was also enhanced through discussions between all three authors who read all interview transcripts and agreed the emerging themes.

Findings

Demographic data

The demographic data of the 22 women who participated are outlined in Table 1 (pseudonyms are used to protect their anonymity). All the participants had given birth in the local hospital (an obstetric unit with one antenatal/postnatal ward). None of the women had returned to employment at the time of data collection, except for Michelle who had recommenced her undergraduate study at university when her baby was four weeks old. All of the women participating in the study began by breastfeeding their youngest infants and breastfed for at least two weeks; 12 were exclusively breastfeeding at the time of the interview. This paper presents an overarching theme that emerged from analysis of the data. The phenomena of 'reality shock' that emerged has three interlinked themes. These are explained in detail below.

Idealised expectations

There seemed to be a gap between the women's expectations of breastfeeding and the reality. Most of the women knew very little about breastfeeding prior to becoming pregnant, other than knowing it was best for the baby. A total of 13 of the women in this study described how their expectations of breastfeeding antenatally were different from their actual experiences. 'Shock' was commonly used by the women to express their reaction to breastfeeding. They seemed ill-prepared for the realities of breastfeeding, and for most of these women the shock of this experience was overwhelming. During pregnancy, their awareness of breastfeeding grew, but their expectations and anticipation of breastfeeding centred around breastfeeding being 'natural', which they translated as innate ability. Women like Denise, aged 19 with her first baby, had perceived breastfeeding to be a natural process and was frustrated that neither mother nor baby had an innate ability to breastfeed:

"I was getting a little bit... frustrated with myself. I was like, I ought to be able to do this" (Denise).

Jenny, who had worked as an administrator in a human resources department of a large company prior to taking maternity leave with her first baby, also expected breastfeeding to be intuitive, that she would instinctively know how to breastfeed when her baby was born:

"I also thought that breastfeeding would come naturally to the baby. I didn't think like she would have to learn it as well as me. I thought if I just swung my boob near her mouth, she would know what to do and latch on herself" (Jenny).

The portrayal of breastfeeding in the media, such as television programmes, and in the professional literature provided to women antenatally was described by two of the women as unrealistic. Fiona, mother to three children, commented how breastfeeding was portrayed in the media:

"It's not what people expect though. You don't see it much on the telly, not really. When you do see it, it's sort of extremes really" (Fiona).

One mother discussed how she felt the professional literature provided to women was not clear:

"[It's] confusing... nobody says this is your guide, don't

worry. You don't have to do it like this" (Kelly).

Inadequate preparation for breastfeeding culminated in some of the women not feeling prepared for the discomfort of feeding in the early postnatal period, and for the time commitment required for each and every breastfeed. Amita described the physical pain she experienced, particularly in her attempts to latch her newborn baby on her breast in the early postnatal period. It was so painful that she reiterated a number of times in her interview that determination was needed to continue with breastfeeding. Pauline described the physical pain she experienced as 'crunching'. Breastfeeding was also found to be a tiring and exhausting process:

"I'm too tired and it's too much effort to go out" (Jenny).

The women's accounts of their experiences of breastfeeding were often imbued with complex emotions such as guilt and self-doubt, particularly for those women whose breastfeeding experience did not match up to their expectations of themselves. Prior to breastfeeding, Queenie had perceived it as an easy aspect of motherhood. As a qualified social worker, she had professional experience of supporting families with their infants. However, once she engaged in the act of breastfeeding, she discovered that her assumptions had led to unrealistic expectations. Like Denise, Queenie too expressed disappointment in herself as she expected breastfeeding to be a *"bonding time"* but the reality was *"a nightmare"*:

"I didn't even feel as if it was a bonding time with him, I just felt, because it was painful and urm he wasn't being satisfied by it, I just, it was, I suppose I was anxious which didn't help, so I never quite felt that it was our time to connect with each other. It was a nightmare... It was a nightmare to be honest" (Queenie).

Comments from the women indicated that many struggled with the loss of life as it used to be, and felt that they had lost control over their own lives. Painful and frequent attempts to breastfeed and a fractious baby were a major source of distress. Heidi described herself as an independent woman with a successful career. Despite this, she still spoke of the image of the good mother with the perfect baby who fed and slept between feeds, waking with a smile and able to enjoy going to the park in the pram with his parents. She described how this image had a hold over her, how she strove to mirror the image, noting how disappointed she was with herself that she did not achieve this. In her interview she broke down in tears at describing this:

"I was trying my damned hardest, I just couldn't do it, it's just hard [cries]" (Heidi).

For Heidi, breastfeeding was intertwined with her image of motherhood. Having introduced formula feeds at three weeks, and stopping breastfeeding completely after a month, she felt she had failed to attain this ideal and, when interviewed when her son was six months of age, she found recounting her breastfeeding experience provoked some uncomfortable memories:

"It isn't how motherhood is supposed to be" (Heidi).

Enjoyment of breastfeeding was not a common narrative for the women in this study.

Table 1. Demographic details and breastfeeding duration of participants

Participant	Maternal age (years)	Parity	Occupation	Marital status	Youngest child's age at interview (months)	Duration any bf (weeks)	Duration exclusive bf (weeks)
Amita	27	1	Unemployed	Married	6	24	24
Belinda	31	5	Healthcare assistant	Married	6	24	24
Charlotte	24	3	Housewife	Cohabitating	3	12	12
Denise	19	1	Unemployed	Cohabitating	3	12	0
Elizabeth	34	1	Shop assistant	Married	6	24	22
Fiona	34	3	Housewife	Married	6	24	24
Georgina	29	1	Physiotherapist	Married	6	22	16
Heidi	24	1	Insurance advisor	Married	6	5	3
Isla	26	1	Unemployed	Cohabitating	6	4	1
Jenny	30	1	Administrator	Married	4	16	12
Kelly	29	2	Adult nurse	Married	3	12	12
Lindsay	36	1	Graphic design	Married	4	16	16
Michelle	23	1	Student	Married	3	12	12
Nicola	25	2	Credit analyst	Cohabitating	3	4	3
Octavia	24	2	Sales advisor	Cohabitating	4	16	10
Pauline	37	1	Unemployed	Married	3	12	12
Queenie	36	1	Social worker	Married	6	4	2
Rebecca	34	2	Healthcare assistant	Cohabitating	3	12	12
Sharon	26	2	Youth worker	Married	3	12	12
Tanya	16	1	Student	Single	3	12	12
Ulrica	28	2	Office worker	Married	4	16	16
Veronica	26	1	Marketing manager	Cohabitating	3	12	3

However, for a few, the reality of their breastfeeding experience exceeded their expectations. For these women, breastfeeding was better than they had expected, not as difficult and they continued to breastfeed longer than they had planned initially as a consequence.

Incessant demands

The women's descriptions of breastfeeding, particularly in the early days, were imbued with a sense of constantly needing to be present. For some, this led to frustration that they could not escape or hand over to someone else, even temporarily. These feelings were expressed by both primiparous and multiparous mothers. The demands of breastfeeding an infant in the early postnatal period led to some of the women beginning to dread each feed:

"I thought: 'Oh no another breastfeed, got to do it'" (Pauline).

They also expressed feelings of disappointment in themselves and personal failure when they subsequently stopped breastfeeding. Queenie's baby was small for dates, so she was advised by the hospital midwives to put him to her breast and then supplement with a prescribed amount of milk every few hours. This entailed an 'incessant' regime of either expressing or putting the baby to the breast, which she continued on discharge home on the second postnatal day. She was in tears for much of the first few weeks with little sleep. If she did not manage to express enough breastmilk, the baby was given a top-up of formula milk. As a consequence, she began to view feeding as a vicious circle.

Queenie described her struggle to breastfeed, despite severe discomfort, sore nipples and a relentless regime of either expressing or trying to position and attach her newborn son. Despite persevering for four weeks, the occasional formula milk top-up resulted in the baby sleeping between feeds, which reinforced to her that he was 'happier' on formula milk. By four weeks, he was exclusively formula-feeding. Queenie's experience led her to feel resentment towards the healthcare professionals for advocating and promoting breastfeeding to the exclusivity of alternatives, but, at the same time, not being as supportive and helpful as she had envisaged in order for her to establish breastfeeding. She confided that she also felt guilty after she decided to wean her son completely on to formula feeds. However, she was not the only woman to anticipate each breastfeed with *"dread"*, nor was this feeling confined to first-time mothers.

The women commented that they expected difficulties, such as bleeding and cracked nipples, reinforced by the plethora of creams, ointments and aids for breastfeeding (such as nipple shields) in shops. However, they did not expect that the *"difficulty"* that other mothers talked about to be the incessant demand, which led to the women feeling as if their lives were on hold and they were hemmed in:

"My life is him now. I am not important" (Amita).

Veronica, who was still breastfeeding at the time of her interview, adapted to this lack of routine and pattern to breastfeeds:

"I have stopped trying to plan my life completely round when she's going to want her next feed because it seems a bit random anyway" (Veronica).

But for others, their feelings were quite different:

"It just seemed really constant. I just couldn't do anything at all. I couldn't get out... I'm the one with the boobs stuck to the front of my chest... I barely had time to go to the loo, let alone have a shower or do the washing or pop to the shops or do anything you normally would. Which was a really bizarre experience, going from being really independent, driving, full-time job, doing what I want when I want... stuck indoors for three and a half weeks. I'm going to go mad in these four walls" (Heidi).

Onus of responsibility

Some of the women described feeling scared when they were home from the hospital, as they felt they had no one to ask for help, no one on the end of the buzzer, and that they were not prepared, competent or confident with positioning and attachment. For some, the responsibility of breastfeeding in terms of being the sole provider of nutrition for their baby was overwhelming. This was noted in the descriptions given by both first-time and experienced mothers in the study. Belinda, mother of five, described herself as *"a fridge... a larder"*. Pauline described the responsibility she felt:

"A massive responsibility, you know, to make sure the baby's healthy, because the only source of nutrition they're getting is from you, and I think you do feel that responsibility. 'Cos it's, you know, the only way that they're kinda surviving is through the breastmilk" (Pauline).

Throughout Nicola's interview she described how she felt the burden of responsibility as a mother was overwhelming with her first child:

"I was 24 and I was like: 'Oh my God, just left with this baby' and obviously you're tired you know, like oh I've got this massive responsibility, you know... what have I done, do you know what I mean, can I cope with this responsibility? And there was times when I thought: 'You take him. I can't do it'" (Nicola).

She expressed her breastmilk so that she could both involve her partner in infant-feeding, but also to relieve herself of the sole responsibility for feeding with her second child. Octavia found that the introduction of an occasional formula feed enabled her to have a degree of control in her life and a degree of separation from the onus of the responsibility to breastfeed:

"It's kinda given me back my life a bit now" (Octavia).

Veronica found the responsibility for breastfeeding in the night time physically and mentally *"exhausting"*. As a first-time mother, she described feeling isolated in the first few weeks after her daughter was born, ascribing this isolation to her belief that no one could help. She had no family or friends with experience of breastfeeding, and so turned to her health visitor for advice and support. However, her health visitor had not completed the breastfeeding management course and, despite promising that she would request one of her colleagues to contact Veronica, no one did. Veronica had attended antenatal classes, but she was the first one to birth from her group, and did not have the confidence to attend a postnatal group until her daughter was eight weeks old, as she felt

self-conscious about feeding in public.

Some of the women in this study (such as Denise) who were initially judgemental about women who did not breastfeed, discussed how their prenatal and antenatal attitude had changed having experienced breastfeeding for themselves. They talked about the dedication and commitment needed to continue, and that it was not necessarily solely a choice regarding infant-feeding method in the same vein as choosing between tea and coffee:

"Now I've had the chance to look back, it's every woman's choice to do it how it's best for them. You don't know all their circumstances" (Denise).

Three participants (Rebecca, Sharon and Ulrica) strove to outperform and breastfeed longer than other mothers:

"She [first child, aged 18 months] stopped of her own accord. I was a bit miffed because my friend had gone on until her daughter was two and I thought right we'll beat that [laughs]" [Ulrica].

However, while vocalising their goals to breastfeed until their children self-weaned, they also expressed feeling an onus of responsibility and incessant demands, as illustrated later in Ulrica's interview: *"It would be nice for it not to be me all the time."*

Discussion

It is clear from the data that women's experiences of breastfeeding were generally not what they had anticipated. Most participants did not find breastfeeding a natural process, instead it came as a shock. Breastfeeding was challenging. Most of the women found the phenomenon to be something that concerned them greatly. The findings suggest that preparation for breastfeeding is inadequate and misleading. In this study, a more realistic idea of breastfeeding may have helped the women to prepare more effectively for their breastfeeding role. This concurs with previous research that identified a mismatch between women's expectations and the reality of breastfeeding (Hoddinott et al, 2012; Redshaw and Henderson, 2012). While the existing literature has already highlighted inadequate preparation for breastfeeding, the extent to which this had a negative impact on the breastfeeding experiences of women in the authors' study was a surprise.

It has been argued that the UK has a predominately bottle-feeding culture (Bolling et al, 2007; Cattaneo et al, 2005), with women rarely, if ever, witnessing breastfeeding prior to having their own baby. This results in a limited understanding of breastfeeding, gleaned predominantly from healthcare professionals in the antenatal period. This preparation centres around the health benefits of breastfeeding, with postnatal support centering on teaching and support with positioning and attachment. All the women in this study intended to breastfeed, were aware of the health benefits of breastfeeding, and all initiated breastfeeding following the baby's birth, although the women's intention to breastfeed was not necessarily for any longer than the initial postnatal period. Professional and popular messages that promote breastfeeding have been very successful. Midwives have prepared women to initiate breastfeeding, but not to sustain breastfeeding. Steps three and five of the Baby Friendly Initiative 'Ten steps to successful breastfeeding' (WHO, 1998: 5) stipulate that maternity services should 'inform all pregnant women about the benefits and management of breastfeeding' and 'show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants'. However, findings from this study indicate a gap surrounding a lack of understanding and preparation for common problems, and a lack of awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant-feeding behaviours such as crying, wakeful states and cluster feeding, on the specific method of infant-feeding. The end result was a vicious circle of dreading feeds. There was a drive in the women's descriptions to establish routine and predictable feeding and sleep patterns. The frequent demands made by their breastfed baby were unexpected and worrying. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply. This concurs with a systematic review of evidence on the concept of insufficient milk syndrome (Gatti, 2008). In social cultures where friends and family have not breastfed themselves, this can lead women to question their abilities to breastfeed further, particularly when infant-feeding behaviours are held in direct comparison with the behaviours of formula-fed infants.

Finding the burden of responsibility as overwhelming has not been explored in relation to breastfeeding in the existing literature. However, loss of former identity in the transition to becoming a mother has been reported elsewhere (Mercer, 2004). Many of the participants in the authors' study felt they had lost some of their self-identity due to breastfeeding, while a few felt that breastfeeding helped them develop a positive identity of themselves as mothers. Cultural representations of femininity are of a superwoman who can cope with caring for a new baby while also completing domestic tasks and caring for others (Ussher et al, 2000). Citing lengthy hours breastfeeding, lack of routine, an inability to undertake household tasks and other family duties, breastfeeding was perceived by many of the women in this study as a chore. These feelings were expressed by both primiparous and multiparous women. The anthropologist Raphael refers to cultures where breastfeeding is universal and seen as natural, but where women view breastfeeding as 'not automatic' (Raphael, 1973: 15). Such societies relieve new mothers of routine domestic tasks and provide practical teaching on baby care. While data were not collected on participants' family networks, the increasing geographic distance between generational family members has been extensively commented on in the literature, particularly in relation to the impact on elderly caregiving. When geographical mobility is combined with the lack of knowledge passed through family generations about breastfeeding, it is easy to see how women can feel ill-prepared, inadequate and overwhelmed.

Limitations

The study presents interpretations of the phenomenon of breastfeeding, as experienced by a small number of women from one city in the East Midlands. These data may not be generalisable to the whole of the UK, however, findings resonate with those of other studies. The interviews were undertaken between three and six months after the birth of the youngest child, which may have affected some women's ability to recall infant-feeding experiences (although a review of 11 published studies has shown maternal recall of breastfeeding initiation and duration to be reliable and valid, especially when the duration of breastfeeding is recalled after a short period (≤3 years) (Li et al, 2005).

Conclusion

While the study involved only a small sample, the findings are likely to be relevant to healthcare staff more widely. In particular, antenatal education should focus more on preparing women for the realities of breastfeeding their newborn, rather than an idealised version. This is a complex challenge as the need is to enthuse women to breastfeed alongside discussing strategies to manage their unique personal and family lives. Midwives should explore the earlier infant-feeding experiences of multiparous pregnant women in order to be aware of previous experiences that may influence perceptions of breastfeeding subsequent babies. An aspect of breastfeeding support in the immediate postnatal period that would be appreciated by women is the provision of a healthcare professional sitting through at least one complete breastfeed. This would provide an opportunity not only to advise on positioning and attachment, but also infant-feeding cues and infant behaviours, using the time as an opportunity to talk with the woman about her expectations, support network and perceptions of infant behaviour. However, postnatal care provision has been the subject of heated debate for a number of years, with researchers noting the low priority afforded to this aspect of maternity care (Bick, 2012), despite *Midwifery 2020* (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010) affirming the importance of skilled midwifery support and continuity of midwife-led care throughout this period. Findings from this study add to this growing debate.

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