

ORIGINAL RESEARCH: EMPIRICAL RESEARCH –
QUALITATIVE

‘I thought it would keep them all quiet’. Women’s experiences of breastfeeding as illusions of compliance: an interpretive phenomenological study

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Nottingham, Queen’s Medical Centre, UKSPENCER R.L., GREATREX-WHITE S. & FRASER D.M. (2015) ‘I thought it would keep them all quiet’. Women’s experiences of breastfeeding as illusions of compliance: an interpretive phenomenological study. *Journal of Advanced Nursing* 71(5), 1076–1086. doi: 10.1111/jan.12592**Abstract****Aims.** To explore the experiences of breastfeeding women.**Background.** There is a plethora of data demonstrating that human breast milk provides complete nutrition for human infants. While the rate of initiation of breastfeeding in the United Kingdom has shown a steady increase in the last 25 years, rates of exclusive breastfeeding in the early weeks and months over the same time period have shown only marginal increases. This study was designed to extend current knowledge around breastfeeding experiences, decisions and behaviours.**Design.** Qualitative, interpretive phenomenological approach.**Methods.** Data were collected between July 2009–January 2010 through in-depth interviews with 22 women from a city in the East Midlands where the prevalence of breastfeeding has showed a decreasing trend. Data were collected between 3–6 months after the birth of their youngest baby.**Findings.** Analysis of data uncovered a key theme: illusions of compliance. The findings revealed that women’s breastfeeding behaviours were socially mediated. They adopted a good mother image by conforming to the moral obligation to breastfeed immediately after their babies were born. Those women who struggled to establish breastfeeding tried to hide their difficulties rather than admit that they were not coping.**Conclusion.** This study provides insights into women’s infant feeding decisions and behaviours, building on understandings of ‘good mothering’ in the wider literature. Importantly we highlight some of the previously unknown strategies that women employed to portray themselves as calm, coping and in control when in reality they were struggling and not enjoying breastfeeding.**Keywords:** breastfeeding, experiences, infant feeding, interviews, midwives/healthcare professionals, qualitative approaches

Why is this research needed?

- A body of knowledge has developed promoting breastfeeding globally as the optimum method of infant feeding.
- Despite an increasing evidence base and encouraging rises in breastfeeding initiation over the last few years, there remains a dramatic transition to formula feeding during the early postnatal period in the UK.

What are the key findings?

- Women described how they felt pressured to initiate breastfeeding to comply with societal expectations and those of the healthcare professionals.
- Women prioritized their own needs and the family unit over baby-centred exclusive breastfeeding.

How should the findings be used to influence policy/practice/research/education?

- Women need to be able to make informed choices about infant feeding, from initiation and throughout their infant's life.
- Healthcare professionals need to work in partnership with women and their families to facilitate this decision-making, regardless of feeding method chosen.
- Healthcare professionals need to be cognizant that some women hide the difficulties they are experiencing with breastfeeding rather than admit their vulnerability.
- Midwives and health visitors must emphasize care of the mother as much as care of the baby.

Introduction

A significant body of knowledge concerning breastfeeding has emphasized the public health benefits, including reduced risk of gastrointestinal disease, respiratory disease, otitis media and necrotizing enterocolitis in infants and lower risk of breast cancer in mothers (Ip *et al.* 2007, Hoddinott *et al.* 2008). Numerous international, national and local public health policies cite recommendations and targets in an effort to increase breastfeeding prevalence. Despite rates of breastfeeding initiation steadily increasing yearly in the UK, there remains a dramatic drop in breastfeeding within the first 6 weeks (Health & Social Care Information Centre [HSCIC] 2012). This is in contrast to other countries: for example, in New Zealand 68% of women are exclusively breastfeeding at 4–6 weeks (Cattaneo *et al.* 2005) and 57.7% of women in Japan (Suzuki *et al.* 2013). At 3 months 70.9% of

women in Norway (Häggkvist *et al.* 2010) and 37.7% of women in the USA are exclusively breastfeeding (Centers for Disease Control & Prevention 2013).

Background

Researchers have tried to establish why rates of breastfeeding in the UK are among the lowest in Europe. Social and demographic data from surveys describe attitudes to breastfeeding and issues surrounding the initiation of breastfeeding (Scott *et al.* 2006, Wright *et al.* 2006, Bolling *et al.* 2007, HSCIC 2012). Several researchers have explored factors affecting breastfeeding in postnatal wards. Cloherty *et al.* (2004) explored why healthcare professionals give breastfed babies supplementary feeds of infant formula. The authors concluded it was midwives' desire to protect the mothers from tiredness or distress, although this at times conflicted with their role in promoting breastfeeding. A similar finding was published by Furber and Thomson (2007) in their study of UK midwives' views and experiences of supporting women to breast feed. Midwives said that they did not have enough time to support mothers feeding their baby. The midwives practised rationing the time they spent with mothers, for example assisting the mother to latch the baby at the breast, but then leaving her, relying on the mother to call for additional help using the bedside call bell. Dykes (2005) also explored influences on women's experiences of breastfeeding in the postnatal ward setting. The women conceptualized breastfeeding using metaphors of the industrial production line with its notions of supply and demand. All of these researchers highlight issues in breastfeeding management and support relating to time constraints in hospital-based postnatal practice.

Afoakwah *et al.*'s (2013) review of qualitative studies exploring women's experiences of breastfeeding found that breastfeeding was experienced as a symbol of motherhood, connecting mother and baby. However, they also highlighted a dilemma of expectations vs. reality of breastfeeding and a need for reassurance and support. The theme of expectations vs. reality was also identified by Burns *et al.* (2010) in a meta-ethnographic synthesis of breastfeeding experiences. The findings from both reviews identify the wider importance of breastfeeding experience beyond provision of infant nutrition.

Given the advantages of breastfeeding, it was of concern that locally, in Lincolnshire, that the prevalence of breastfeeding at 6–8 weeks shows a yearly decreasing trend (2008–2012) (East Midlands Public Health Observatory 2012). A research study designed to explore the phenomenon of

breastfeeding as experienced by women in this geographical area was therefore apposite.

The study

Research question

‘How is breastfeeding manifest in the experience of women?’

Design

The research took a qualitative interpretive phenomenological approach (Heidegger 1962) focussing on the experiences of both primiparous and multiparous mothers. Adopting a Heideggerian interpretive phenomenology to explore the phenomenon of breastfeeding provided an in-depth woman-centred understanding of breastfeeding. This approach acknowledges the individual and unique nature of being-in-the-world and the interconnectedness of experiences from the context within which those experiences occur.

Participants

A purposive sampling approach was used to enable the selection of individuals who have knowledge of the phenomena. The inclusion criteria were: women aged 16 years or over, who had given birth to a healthy term baby (greater than 37 completed weeks gestation), initiated breastfeeding at the birth of their youngest baby and breastfed for at least 11 days. Twenty-two women gave consent to be interviewed following the provision of information about the study by their Health Visitor. Data were collected when the participants’ youngest baby was between three and 6 months. This was so that data would be gained 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 (which is undertaken between 11–14 days after the baby’s birth). Setting the upper limit for data collection at 6 months provided an opportunity to gain perspectives from women who may have breastfed exclusively for 6 months – the current World Health Organisation recommendation (WHO & UNICEF 2003). Setting the lower limit at 3 months was a pragmatic decision chosen to reflect a critical point at which early weaning onto solid food may occur (Bolling *et al.* 2007).

Data collection

Data were collected between July 2009–January 2010. In phenomenology, the data collection method aims to elicit phenomena; that is what the participants experience about the phenomenon under study (breastfeeding) (Greatrex-White 2007). Data obtained were based on interviews. One in-depth interview with each participant was undertaken by the first author (RS). Phenomenological research is by its nature temporal. Given Heidegger’s belief in the relevancy of context, to undertake a subsequent interview to explore the experience again may have altered the meaning or interpretation ascribed to that experience. What was felt at that time may well be interpreted or felt differently in another time. Smythe (2011, p. 41) and Ashworth (2003) concur that one interview is enough as it could influence the woman’s infant feeding behaviour.

Interviews in this context were neither structured (with a pre-organized plan or set of questions), nor completely unstructured whereby there would have been no clear sense of why the interview was being undertaken or focus of exploration. In this study, the initial opening question was: ‘Can you tell me about your experience of feeding your baby’. Occasionally, participants required initial prompt questions such as: ‘Is/was breast feeding how you imagined it would be?’

Ethical approval

Ethics approval to conduct this study was granted by the University Of Lincoln School Of Health and Social Care Research Ethics Committee, the Leicestershire, Northamptonshire and Rutland 2 Research Ethics Committee, and the Lincolnshire Primary Care Trust Research and Development department. Pseudonyms were given to each participant.

Data analysis

Data analysis was undertaken following principles identified by Greatrex-White (2008) and van Manen (1997). Audio-taped interviews were transcribed verbatim. Transcripts were read several times to become intimate with each woman’s account. Significant phrases were extracted relating to the phenomenon breastfeeding and meanings formulated. Formulated meanings were clustered into themes. Themes were continually compared with and across transcripts, noting similarities and differences.

Rigour

Rigour was enhanced through discussions between all three authors who read all interview transcripts and agreed the emerging themes. Credibility, fittingness, auditability and confirmability were achieved by using a reflective diary, audio-recorder, field notes, participant quotes, validation of findings by second and third authors and a decision trail so that the research process can be verified by the reader (Sandelowski 1986).

Findings

Analysis of the data resulted in the emergence of an overarching theme: illusions of compliance and four general structures: compliance to healthcare professionals and society, compliance to family and friends, passively acquiescing and active decision-making. Analysis of personal details revealed variation in the sample of women included in the study (Table 1). Ages ranged from 16–37, parity from one to five; 21 women described themselves as white, British and one as Asian; all but Tanya, a single mother living with her parents, were in a long term heterosexual relationship with the youngest baby's father. All the participants had given birth in the same local hospital. With the exception of Michelle, none of the other participants had returned to

employment at the time of data collection. All of the women breastfed their youngest infants for at least 2 weeks; 12 were exclusively breastfeeding at the time of the interview.

Illusions of compliance

Women described how they felt pressured to initiate breastfeeding to comply with societal expectations and those of healthcare professionals. They also maintained a public pretence in relation to how they themselves were feeling about breastfeeding, putting on a brave face to maintain outward appearances and present themselves as in control and coping in their new role, even though they may not have felt in control or as if they were coping.

Compliance to healthcare professionals and society

Women maintained their normative place as a good mother in society, attending outwardly to the good mother image by conforming to the moral obligation to breastfeed in the immediate period after their babies were born. Eleven of the women interviewed expressed an intention to 'try' to breastfeed, in comparison with five who expressed their determination with breastfeeding:

Table 1 Demographic details and breastfeeding duration of participants.

Participant	Maternal age (years)	Parity	Occupation	Marital Status	Youngest baby'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	Cohabiting	3	12	12
Denise	19	1	Unemployed	Cohabiting	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	Cohabiting	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	Cohabiting	3	4	3
Octavia	24	2	Sales Advisor	Cohabiting	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	Cohabiting	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	Cohabiting	3	12	3

people always talk about breast is better and urm, so I just naturally thought well yes I want to try it, it is the right thing to do, urm, it's, I felt it was better for him [Queenie]

Your milk is so good for your baby and the midwives tell you and my mum tells me, that it is so good, such a good start [Amita]

However, the intention to breastfeed for six of the women was not necessarily for any longer than an initial short period:

I thought it would keep them all quiet and I'd do it for a week and then bottle feed...I just thought, to keep everyone quiet, it was what you were supposed to do, I thought oh well I'll do it, but only for a week [Jenny]

Gonna try, because I was gonna do the bottle. So it had to be breastfeeding, then bottle [Elizabeth]

Interestingly, both these women were still breastfeeding at the time of their interviews. 'Breast is best' and the health benefits of breastfeeding was influential in deciding to initiate breastfeeding at birth, but not as a motivator to continue breastfeeding. Those women ($n = 7$) who had bought equipment and formula milk powder prior to the baby's birth articulated a minimal intention to breastfeed, to 'do the right thing', but no intention to continue past the initial hospital and midwifery input:

just to get the first week and a half over and done with. I wouldn't be doing it any longer...we'd got a couple of bottles just to be on the safe side [Heidi]

Yea, I'd bought the formula in before she was even born, I was quite prepared [Nicola]

It appeared that it was acceptable to fail to establish breastfeeding and then switch to formula, rather than make a choice to formula feed from the start:

you've fulfilled your obligation to give him a really good start [Lindsay]

The women described their attempts to maintain an outward appearance of calmness and control, hiding the difficulties and struggles they were experiencing with breastfeeding. This stemmed from a desire not to be seen as a failure. An idealized comparison with other mothers, either real or idealized media images, reinforced the notion of a sense of failure should the ability to breastfeed be compromised. For some, this pressure to conform led to them maintaining a public pretence with breastfeeding, particularly with other mothers:

everything's fine. I daren't say I've got problems because they would go into a whole 'oh breast is best' and 'I breastfed all of mine until the age of four' and and it was very much sort of like oh I daren't say I've got problems [Kelly]

This was expressed by women who were determined to continue breastfeeding and those who only intended to breastfeed for a short initial period of time. Isla avoided attending her local postnatal group for new mothers because she was not breastfeeding exclusively and went instead to baby clinic to get her baby weighed each week:

Because I thought I was going to be this great mum who was going to breastfeed and it would be easy...I didn't go to any of them [local postnatal groups]...I think fear of what peer pressure could be [Isla]

Several of the women who had breastfeeding difficulties talked about how these difficulties implied failure. Those women who struggled to establish breastfeeding did so in silence. They were reluctant to attend postnatal support groups because they feared being judged for being a mother who needed help. The women hid behind a portrayed image of their breastfeeding experience as calm and coping, effortless and enjoyable. In private, their experience was different and evoked negative emotions. Rather like a swan: serene above the water, paddling furiously below:

The other midwives, they were all nice, they was all oh how are you getting on and that and she's putting on weight, all fine all fine and I was thinking, it's not though, she's always not latching on properly...I didn't want to cry and them [health care professionals] to think I wasn't coping [Jenny]

I tried to make it look like I was coping [Nicola]

Many of the women had very high expectations of themselves. Pauline, aged thirty-seven with her first child struggled with breastfeeding in the early postnatal period. She asked the community midwives to check that she was positioning and attaching her baby correctly as she was unsure on discharge from the hospital postnatal ward how it should feel. In front of healthcare professionals, she admitted to portraying herself as more confident than she felt in reality:

there's something kinda, I don't know if it's that you feel like you're being checked up on, so you know, you don't wanna say oh I'm struggling, because you're kinda passing a test, you feel that you're competent or not...But I feel as well that I kinda, I was being perhaps a bit more confident in front of them than I actually felt [Pauline].

Pauline was not the only participant to portray herself as more confident and capable with breastfeeding than she felt:

it was just this sense of it would look as if you weren't coping, as if you weren't in control and I wanted it to look like we were coping and we were doing fine and it was almost as if that was something that I should appear to be. Everything was all sorted and look the baby's fine...I tried to make it look like I was coping [Lindsay].

The women also felt there was a lack of professional support when they wanted to stop breastfeeding, even when their reasons for wanting to stop breastfeeding were articulately rationalized and justified. Georgina breastfed for over 5 months, of which she was exclusively breastfeeding for the first 4 months. She was returning to work full time when her baby was 8 months old and did not want to breastfeed to any extent when she returned to work. She discussed her plans to have her son completely settled on formula milk and weaning foods by the time she had to do her first shift back at work:

the hardest thing I found was stopping...I'm not going back to work for another 6 weeks and I suppose I could have carried on a little longer but I was concerned it might take some time...People don't want you to stop...you know you don't have to stop to go back to work', But I was like well I think I want to stop...if I had only done it for 3 days I could understand people well saying, encouraging you in that sort of way, but I, I had done it for a good old length of time, I had a reason why I wanted to stop, I'm quite a sensible person, so I was slightly disappointed that no one wanted to help me to stop [Georgina]

Compliance to family and friends

In this sub theme were descriptions of women actively making decisions about infant feeding, but also descriptions of women being passive in this role. The women described being 'naughty' [Georgina], in their management of infant feeding because breastfeeding advice given by healthcare professionals was felt to be a rigid set of rules that should be strictly adhered to. The women devised their own methods for integrating breastfeeding into family life, such as mixed feeding (any combination of breastfeeding, breast milk in bottles and formula feeding), prolonged use of nipple shields, early introduction of complementary foods or early cessation of breastfeeding. The construction of breastfeeding by healthcare professionals as rule-based and regimented resulted in the women not seeking out advice or support from them when they had questions or needed support with infant feeding.

Passively acquiescing

The women in this study rarely stated that their decision to stop breastfeeding was solely one of personal choice. In the first few minutes of the interview, Nicola described how she felt guilty when she stopped breastfeeding and talked about needing that decision to be sanctioned:

my mum said she's not getting enough which she clearly wasn't and you're not getting a rest, there's no point in taking it to the point where you're not enjoying her and she's not having enough [Nicola]

At the time of data collection she had two children, having formula fed her first baby from 5 weeks of age, but with her second child she had introduced occasional formula feeds at 3 weeks and was completely formula feeding by 4 weeks old. Nicola also described how she felt more guilty with her second child, emphasizing that not breastfeeding a female child was more guilt-ridden than not breastfeeding a male infant. In this study, Nicola was the only participant to express any comments about the sex of her infant in relation to breastfeeding.

Some of the women described feeling undermined about their breastfeeding ability by family and friends. This was particularly noted of grandmothers (maternal and paternal), who were reported to cite the unsettled behaviour of the infant between feeds as indicative of insufficient milk or poor breastfeeding technique:

she [maternal grandmother] said well maybe your breast milk isn't enough for him, maybe he isn't getting enough sort of thing, why don't you try a bottle [Michelle]

The women also described how the introduction of formula milk feeds would involve their partner in the feeding experience:

so my partner could feed, cos Noah's [eldest child] not his you see, this [baby] is his first, so he could be a part of it [Nicola]

Queenie talked in depth of how her infant's unsettled behaviour between breastfeeds reinforced to her and her partner that their son was not thriving on breast milk. She felt the decision to discontinue breastfeeding needed to be sanctioned, both by healthcare professionals and by her partner. She also emphasized that the brand of formula was the same as that used in the hospital, an attempt to offset her rule breaking and preserve her good mother image:

I kept saying to the health visitor that I didn't mind going the other way if it was better for him. So I bought some, I bought a tub of the same formula as we'd been using in the hospital [Queenie].

Active decision-making

Successful breastfeeding was not necessarily the same definition for women as for healthcare professionals. For some of the women interviewed, breastfeeding was deemed successful even if it was not done exclusively. Breastfeeding plus some formula feeds was deemed an acceptable alternative, despite not being advocated by midwifery or health visiting staff. Jenny, first time mother, introduced occasional formula feeds at 3 months and was still supplementary feeding at the time of data collection when her baby was just over 4 months of age. She described how the occasional formula feed gave her some rest and it was this that she credited with recharging her energy levels to continue breastfeeding. Jenny said that otherwise she may well have stopped breastfeeding altogether. Her experience contradicted what her health visitor and community midwife had implied would be a slippery slope leading to stopping breastfeeding altogether:

I find that because of the bottle she's slept better and I've slept better and I just deal with it a lot better...because I wanted her to keep having a bit of breast but I wanted a bit of freedom...I was thinking that, if she [other mother at postnatal group] hadn't said I could give her one bottle I was going to stop and give her all bottles [Jenny].

Jenny was not the only participant to credit that combining breastfeeds and occasional formula feeds provided respite that enabled them to continue any breastfeeding:

we can deal with the rougher times during the day [Octavia].

Georgina avoided asking her health visitor for feeding advice as she thought they would not approve that she had already started to wean her son onto solids before the Department of Health (2003) recommended introduction from 6 months:

I was naughty and started him on a bit of baby rice I did. I just couldn't physically do the 2 hour feeds...I suppose I pulled back from asking the professionals about it because I thought, they don't want me to do this, so just work it out [Georgina].

Georgina described her actions as 'naughty', whereas Charlotte expressed dissatisfaction that the advice from healthcare professionals was focussed solely on exclusive breastfeeding:

I wish someone could have told me that I could have, um, bottle feed and breast feed...If they are told its tough and on the [internet] forum every two, four, six, eight and twelve weeks women are there, please help me and if they were told, it is possible to combine, I think you would get a lot more women [Charlotte].

Discussion

The aim of the study was to answer the question 'How is breastfeeding manifest in the experience of women?' We found it interesting that women in this study intended only to breastfeed for a short initial period and were acquiescing to what healthcare professionals and others desire. The women also articulated how they portrayed themselves as coping and in control, when in reality they were struggling and not enjoying their role as a breastfeeding mother. It is noted that, given that most of the women only intended to breastfeed for a short time, many continued to 12 or more weeks, which suggests that the lived experience of participants was better than they anticipated.

The women in this study were aware of the health benefits of breastfeeding, but despite this knowledge, not all the women appeared determined to exclusively breastfeed. This concurs with previous research which suggested that knowledge does not necessarily translate into practice and sustained action – continued breastfeeding (Hoddinott & Pill 1999, Lavender *et al.* 2005, Twamley *et al.* 2011). Antenatal feeding intentions broadly predict postnatal practice. Furthermore, satisfaction with actual infant feeding practice is associated with antenatal intention; levels are higher for those meeting their goals, whether formula feeding from birth or breast feeding for longer periods (Symon *et al.* 2013). Societal and professional pressure to breast feed was also commonly experienced. Decisions to breastfeed are generally expressed as an intention to 'try', with formula feeding seen as a reliable backup option (Bailey *et al.* 2004). Callaghan and Lazard (2012) explored the cultural context where infant feeding choices were made. Women defend their switch to formula feeding to care for their children, illness and pressure from their family, a viewpoint that is shared by several authors (Murphy 2000, Marshall *et al.* 2007, Groleau & Rodriguez 2009, Hoddinott *et al.* 2012). Data from this study supports these findings, that women prioritize the family unit over baby-centred infant feeding. Maintaining an illusion of compliance, they did not adhere strictly to the guidance and advice provided by healthcare professionals, which they viewed as intransigent. They articulated the ways they ignored or dismissed advice for example with regards to supplementary feeding. These decisions were justified as pragmatic approaches to infant feeding that met not only the baby's needs but also their own and those of the whole family. A lack of peer and family support for exclusive breastfeeding, combined with the rigid and inflexible approach to breastfeeding espoused by healthcare professionals, led to the perception that exclusive breastfeeding

did not fit with family life and was an unrealistic and unattainable ideal. Those women who articulated taking ownership of infant feeding management were demonstrating resistance to the ideology of motherhood. However, while subversive practices demonstrate individual agency, this was limited as not disclosing these infant feeding behaviours reveals the difficulties women had trying to establish themselves as authoritative experts in the management of their own child's feeding.

Our study indicated that some women portrayed themselves to healthcare professionals as confident and capable with breastfeeding. This was particularly noted in the descriptions of older, primiparous mothers (Pauline and Lindsay). Analysis also showed that rather than being supported to overcome these challenges, the women's social withdrawal further perpetuated this. While this is not a finding that has received attention in published breastfeeding studies, there are examples in studies of women with breast cancer (Gonzalez & Lengacher 2007), mothers with rheumatoid arthritis (Mitton *et al.* 2007) and women with postnatal depression (Letourneau *et al.* 2007). In these studies women were found to put on a brave face to mask or deny the impact of symptoms, to stay in control and project an image that was acceptable to family, friends and healthcare professionals. These findings reflect cultural representations of femininity that are of a superwoman who is able to cope with competing demands (Usher *et al.* 2000).

Participating women appear to fear sanctions or criticism from healthcare professionals and this seems to inhibit them from seeking help. This phenomenon has been reported elsewhere. For example in Barclay *et al.*'s (1997) study of women's experience of motherhood, one participant was said 'to lie' (p. 727) to hide the decision to stop breastfeeding from her healthcare professional. Similarly, Lee (2007) found that women hid from healthcare professionals that they were supplementary feeding, or even giving expressed milk in bottles. This may be related to infant feeding being presented as a dichotomy, breast or bottle and the perception that healthcare professionals are solely focussed on breastfeeding (Fenwick *et al.* 2013). There is a social expectation that mothers will behave favourably (choose to breastfeed) and attend to their child's needs with total disregard to their own (Flacking *et al.* 2006). This has important consequences for the role of healthcare professionals in supporting women with infant feeding in the postnatal period. Healthcare professionals need to work in partnership with women and their families to give needs-led support, irrespective of their chosen infant feeding methods.

Findings from our study build on notions of 'good mothering' in the wider literature. Controversially, researchers from The University of Sheffield (2013) are undertaking a study offering financial incentives to breastfeeding women in an attempt to increase breastfeeding rates. Mothers will be offered shopping vouchers at several time points postnatally if they continue breastfeeding. We would argue that this is added coercion and would be extremely difficult to verify, given that women in both our study and Lee's (2007) study did not reveal their infant feeding behaviour. It also fails to address the lack of support from healthcare professionals and society for women to breastfeed.

Study limitations

This study presents interpretations of the phenomenon of breastfeeding as experienced by only 22 women from one city. While data may not be generalizable findings resonate with those of other studies. Although recall can be flawed in retrospective studies a review of 11 published studies has shown maternal recall of breast-feeding 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). However, undertaking data collection between three and 3–6 months after the baby's birth should have negated a Hawthorne effect, whereby the women may have been motivated to continue breastfeeding had they been recruited soon after their baby's birth.

The women self-selected to participate in this study. While some researchers might consider it better to recruit only primigravid women (with no previous experience of infant feeding), both primigravid and multigravid women participated. This was in accordance with phenomenological principles: to choose participants on the basis that they had experienced the topic under review, to recruit a broad spectrum of participants with a range of infant feeding experiences.

Conclusion

This study makes a significant contribution to the existing literature. It illustrates how women manage infant feeding behaviours to prioritize the health and well-being of the family unit over baby-centric exclusive breastfeeding practices. The study also illustrates how women reposition themselves to influence moral judgement over their infant feeding behaviours.

Fear of sanctions or criticism from healthcare professionals seems to inhibit women from seeking help or

being honest about infant feeding management and plans. This seems to relate to infant feeding communication being presented by healthcare professionals as a dichotomy – breast or formula. Coupled with the prevailing public health messages extolling the virtues of breastfeeding, anything other than exclusive breastfeeding was perceived as deviant. The experience of participants was that healthcare professionals were not necessarily judgemental if women did not breastfeed exclusively. Nevertheless, the women's perceptions were that they would be. Fear of sanctions or criticism from healthcare professionals has received sparse attention in the published literature on the phenomenon of breastfeeding, yet has crucial implications for clinical practice.

Women need to make true informed choices about infant feeding. It was clear from this study that some women felt coerced into initiating breastfeeding and while some of these subsequently continued breastfeeding out of their own choice, many had no intention to continue and preferred to be perceived as failing at breastfeeding rather than choosing to formula feed.

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Conflict of interest

The authors declare that they have no conflicts of interest.

Author contributions

RS conceived the study and study design, undertook the data collection, analysis, interpretation, preparation and drafting of the manuscript. SGW contributed to the analysis, interpretation and drafting of the manuscript. DF contributed to the analysis, interpretation and drafting of the manuscript. RS, SGW and DF have all approved the final version of the paper to be submitted for publication.

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

References

- Afoakwah G., Smyth R. & Lavender T. (2013) 'Women's experiences of breastfeeding: a narrative review of qualitative studies. *African Journal of Midwifery and Women's Health* 7(2), 71–77.
- Ashworth P. (2003) An approach to phenomenological psychology: the contingencies of the lifeworld. *Journal of Phenomenological Psychology* 34(2), 145–156.
- Bailey C., Pain R.H. & Aarvold J.E. (2004) A 'give it a go' breastfeeding culture and early cessation among low-income mothers. *Midwifery* 20(3), 240–250.
- Barclay L., Everitt L., Rogan F., Schmied V. & Wylie A. (1997) Becoming a mother – An analysis of women's experience of early motherhood. *Journal of Advanced Nursing* 25(4), 719–728.
- Bolling K., Grant G., Hamlyn B. & Thornton A. (2007) *Infant Feeding Survey 2005*. TSO, London.
- Burns E., Schmied V., Sheehan A. & Fenwick J. (2010) A meta-ethnographic synthesis of women's experience of breastfeeding. *Maternal and Child Nutrition* 6(3), 201–219.
- Callaghan J. & Lazard L. (2012) Please don't put the whole dang thing out there! A discursive analysis of internet discussions on breastfeeding. *Psychology and Health* 27(8), 938–955.
- Cattaneo A., Yngve A., Koletzko B. & Guzman I.R. (2005) Protection, promotion and support of breast-feeding in Europe: current situation. *Public Health Nutrition* 8(1), 39–46.
- Centers for Disease Control and Prevention (2013) *Breastfeeding Report Card United States 2013*. Centers for Disease Control and Prevention, Atlanta.
- Cloherly M., Alexander J. & Holloway I. (2004) Supplementing breast-fed babies in the UK to protect their mothers from tiredness or distress. *Midwifery* 20(2), 194–204.
- Dykes F. (2005) 'Supply' and 'demand': breastfeeding as labour. *Social Science and Medicine* 60, 2283–2293.
- East Midlands Public Health Observatory (2012) *Breastfeeding in Lincolnshire County by Local Authority*. EMPHO, Leicester.
- Fenwick J., Burns E., Sheehan A. & Schmied V. (2013) We only talk about breast feeding: a discourse analysis of infant feeding messages in antenatal group-based education. *Midwifery* 29(5), 425–433.
- Flacking R., Ewald U., Nyqvist K.H. & Starrin B. (2006) Trustful bonds: a key to 'becoming a mother' and to reciprocal breastfeeding. Stories of mothers of very preterm infants at a neonatal unit. *Social Science and Medicine* 62(1), 70–80.
- Furber C.M. & Thomson A.M. (2007) Midwives in the UK: an exploratory study of providing newborn feeding support for postpartum mothers in the hospital. *Journal of Midwifery and Women's Health* 52(2), 142–147.
- Gonzalez L.O. & Lengacher C.A. (2007) Coping with breast cancer: a qualitative analysis of reflective journals. *Issues in Mental Health Nursing* 28(5), 489–510.
- Greatrex-White S. (2007) A way of seeing study aboard: narratives from nurse education. *Learning in Health and Social Care* 6(3), 134–144.
- Greatrex-White S. (2008) Thinking about the nature of research findings: a hermeneutic phenomenological perspective. *International Journal of Nursing Studies* 45(12), 1842–1849.

- Groleau D. & Rodriguez C. (2009) Breastfeeding and Poverty: negotiating cultural change and symbolic capital of motherhood in Québec, Canada. In *Infant and Young Child Feeding: Cultural Challenges* (Dykes F. & Moran V., eds), Blackwell Publishing, Oxford, pp. 80–98.
- Hägkvist A.P., Brantsæter A.L., Grijbovski A.M., Helsing E., Meltzer H.M. & Haugen M. (2010) Prevalence of breast-feeding in the Norwegian Mother and Child Cohort Study and health services-related correlates of cessation of full breast-feeding. *Public Health Nutrition* 13(12), 2076–2086.
- Health and Social Care Information Centre (2012) *Infant Feeding Survey 2010*. TSO, London.
- Heidegger M. (1962) *Being and Time*. Blackwell Scientific, Oxford.
- Hoddinott P. & Pill R. (1999) Nobody actually tells you: a study of infant feeding. *British Journal of Midwifery* 7(9), 558–565.
- Hoddinott P., Tappin D. & Wright C. (2008) Breast feeding. *British Medical Journal* 336(7649), 881–887.
- Hoddinott P., Craig L.C.A., Britten J. & McInnes R.M. (2012) A serial qualitative interview study of infant feeding experiences: idealism meets realism. *BMJ Open* 2(2), e000504. doi:10.1136/bmjopen-2011-000504
- Ip S., Chung M., Raman G., Chew P., Magula N., DeVine D., Trikalinos T. & Lau J. (2007) Breastfeeding and maternal and infant health outcomes in developed countries. *Evidence Reports/Technology Assessments* (153), 1–186.
- Lavender T., Baker L., Smyth R., Collins S., Spofforth A. & Dey P. (2005) Breastfeeding expectations versus reality: a cluster randomised controlled trial. *BJOG: An International Journal of Obstetrics and Gynaecology* 112(8), 1047–1053.
- Lee E. (2007) Health, morality and infant feeding: British mother's experiences of formula milk use in the early weeks. *Sociology of Health and Illness* 29(7), 1075–1090.
- Letourneau N.L., Duffett-Leger L., Stewart M., Hegadoren K., Dennis C., Rinaldi C. & Stoppard J. (2007) Canadian mothers' perceived support needs during postpartum depression. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 36(5), 441–449.
- Li R., Scanlon K.S. & Serdula M.K. (2005) The validity and reliability of maternal recall of breastfeeding practice. *Nutrition Reviews* 63(4), 103–110.
- van Manen M. (1997) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, 2nd edn. Althouse Press, Ontario.
- Marshall J.L., Godfrey M. & Renfrew M.J. (2007) 'Being a 'good mother': managing breastfeeding and merging identities. *Social Science and Medicine* 65(10), 2147–2159.
- Mitton D.L., Treharne G.J., Hale E.D., Williams R.A. & Kitas G.D. (2007) 'The health and life experiences of mothers with rheumatoid arthritis: a phenomenological study'. *Musculoskeletal Care* 5(4), 191–205.
- Murphy E. (2000) Risk, responsibility and rhetoric in infant feeding. *Journal of Contemporary Ethnography* 29(3), 291–325.
- Sandelowski M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* 8(3), 27–37.
- Scott J., Binns C., Oddy W. & Graham K. (2006) Predictors of breastfeeding duration: evidence from a cohort study. *Pediatrics* 117, e646–e655.
- Smythe E. (2011) From beginning to end. How to do hermeneutic interpretive phenomenology. In *Qualitative Research in Midwifery and Childbirth. Phenomenological Approaches* (Thomson G., Dykes F. & Downe S., eds), Routledge, London, pp. 35–54.
- Suzuki S., Hirohata S., Uriu K., Hutago Y. & Murakami M. (2013) Obstetric factors associated with exclusive breastfeeding in Japanese women who expected exclusive breastfeeding before delivery at term. *Journal of Clinical Gynecology and Obstetrics* 2(1), 15–19.
- Symon A.G., Whitford H. & Dalzell J. (2013) Infant feeding in Eastern Scotland: a longitudinal mixed methods evaluation of antenatal intentions and postnatal satisfaction-the feeding your baby study. *Midwifery* 29(7), e49–e56.
- The University of Sheffield (2013) Financial incentives for breastfeeding mothers [online]. Retrieved from <http://www.sheffield.ac.uk/news/nr/breastfeeding-incentive-for-new-mums-1.325892> on 12 November 2013.
- Twamley K., Puthussery S., Harding S., Baron M. & Macfarlane A. (2011) UK-born ethnic minority women and their experiences of feeding their newborn infant. *Midwifery* 27(5), 595–602.
- Ussher J.M., Hunter M. & Browne S.J. (2000) Good, bad, or dangerous to know: representations of femininity in narrative accounts of PMS. In *Culture in Psychology* (Squire C., ed.), Routledge, London, pp. 87–99.
- World Health Organisation and UNICEF (2003) *Global Strategy for the Infant and Young Child Feeding*. WHO, Geneva.
- Wright C., Parkinson K. & Scott J. (2006) Breast-feeding in a UK urban context: who breast-feeds, for how long and does it matter? *Public Health Nutrition* 9, 686–691.

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