Realities, difficulties, and outcomes for mothers choosing to breastfeed: Primigravid mothers experiences in the early postpartum period (6–8 weeks)

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Abstract

Objective: to develop an understanding of primiparous women's experiences and challenges of breast feeding in the early postpartum period at two BFI accredited hospitals in the East Midlands in the UK that has lower rates of sustained breast feeding.

Design and setting: a hermeneutic or interpretive phenomenology study was conducted across two hospitals in the East Midlands, UK.

Data collection: 22 primigravid women completed a daily written diary maintained for six weeks post birth. In addition, interviews were conducted with 13 women, nine who had completed a diary and four who did not return a diary but wanted to be interviewed, providing 26 different women's perspectives on their breast feeding experiences either from a diary or interview.

Findings: three main themes emerged from the interviews and written diaries: (1) mothers experience a 'roller coaster' of emotions in relation to trying to establish breast feeding, (2) mothers perceive health care professionals as the 'experts' on breast feeding and (3) mothers had difficulties in breast feeding their infants in public, including in front of family and family and when away from their homes.

Conclusions: women were ill prepared for the realities of breast feeding despite their antenatal intention to breast feed. Mothers had a preconceived idea that breast feeding would be 'natural' and without difficulty. When problems occurred, they perceived this to be a breast feeding problem and so choose artificial milk. Mothers require ongoing support to breast feed, especially in the early postpartum period, but more realistic messages about breast feeding need to be included.

Implications for practice: there is a clear need for antenatal education to focus on preparing women for the realities of breast feeding, including newborn behaviour, which may affect women's perceptions of breast feeding. Local health care professionals need to draw upon national breast feeding strategies but develop a localised approach in order to address the regional variance.

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Introduction

Breast feeding is a key public health priority (World Health Organisation (WHO), 2011). On a population basis, exclusive breast feeding for the first six months of life is the optimal way of feeding infants (World Health Organisation (WHO), 2011; Kramer and Kakuma, 2012). International initiatives have been instigated over the past 30 years in an effort to increase breast feeding 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).

The latest UK quinquennial survey results (Health and Social Care Information Centre (HSCIC), 2012) shows that breast feeding prevalence at 6–8 weeks is 55% in the United Kingdom, 46% in England and 42% in the East Midlands. In accordance with NICE (2006) postnatal care guidance, this region is UNICEF UK Baby Friendly Initiative accredited in both local hospitals and community health care services. However, the HSCIC survey data indicates that breast feeding initiation and continuation rates
remain stubbornly low. Whilst there is a plethora of studies exploring breast feeding, many of these studies have been concerned with infant feeding decision-making, attitudes towards breast feeding, initiation, and breast feeding support. There is a relative lack of qualitative research studies focusing on primigravid women's experiences of breast feeding in the first six to eight weeks after the birth of their infant.

Aim

The aim of this study was to develop an understanding of primiparous women's experiences and challenges of breast feeding in the early postpartum period (6–8 weeks) in one geographic location in the East Midlands, UK.

Methods

Analytic approach

The methodological orientation of this study was that of hermeneutic or interpretive phenomenology (Heidegger, 1962), 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. The aim of interpretive enquiry is to identify common themes across the participants and form a pattern of understanding. 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. Each researcher carried out simultaneous analysis (KHS, DW, RS). Collaborative reflective discussion took place between the three researchers to generate deeper insights and understandings.

Participants

A non-probability purposive sampling technique was used to recruit antenatal participants over 34-week gestation who give birth and receive their antenatal and postnatal care in the region and who indicated that they intended to breast feed.

The setting for the study is two UNICEF BFI accredited hospitals in a county located in the East Midlands who have a lower rate of breast feeding at 6–8 weeks than the rest of the East Midlands region and lower than the national picture. The local acute hospital Trust had been awarded Stage 2 accreditation, and the community health service Trust had achieved Stage 1 accreditation of the BFI.

Data collection

Two methods of data collection were used to obtain data immediately following the birth. Twenty-two mothers completed a written diary recording their infant feeding experiences for six weeks. They were encouraged to record something daily, although this was not prescriptive and some women recorded a detailed account of their experiences both daily and at the end of the 6-week period. In addition, in order to triangulate the data interviews were conducted with 13 women, nine who had completed a diary and four who did not return a diary but wanted to be interviewed, providing 26 different women's perspectives on their breast feeding experiences either from a diary or interview. Interviews were conducted in the mother's home between July and September 2012, were tape recorded with participant's permission and lasted between 30 and 55 minutes. The interviews were transcribed verbatim.

Ethics

Ethics approval to conduct this study was granted by the University ethics committee, the National Research Ethics Service (NRES), and the acute hospital Trust Research and Development department. Participants were recruited from the maternity units of two hospitals, one acute hospital and one-community health service maternity units in the East Midlands of England. The study, which took place in 2012, was advertised in local GP surgeries and antenatal clinics. Written consent was in line with NHS REC guidelines. 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 written data are anonymised. The code was allocated once informed consent had been given by the participant.

Findings

The findings indicated that although participants planned to breast feed, for many, their feeding experience was not as they anticipated. Whilst all 26 participants initiated breast feeding, on discharge from hospital seven were providing artificial milk, nine were combination feeding (artificial milk and solely expressing breast milk), 18 (69%) were exclusively breast feeding. By the 6–8 week postpartum period, only 10 mothers (38%) were still exclusively breast feeding as shown on Table 1.

All quotations are referenced by the participant code and source of data (diary or interview) as shown on Table 1.

Emotional roller coaster 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 roller coaster of emotions. Most mothers felt ill prepared for breast feeding, and how to meet the continual demands whilst carrying on with the lives they had prior to giving birth. The coded data identified three subthemes: maternal guilt, their unpreparedness for their newborn needs including breast feeding and, new mothers unrealistic expectations about the demands of breast feeding and continual care of the infant. The following section discusses the themes and subthemes in more detail (Fig. 1).

Maternal guilt

Of the 26 mothers, 10 were still exclusively breast feeding in the early postpartum period, but for the 16 mothers that stopped breast feeding there was a sense of maternal guilt. This emanated...
from their strong desire and expectation that they would be able to breast feed. All the 26 mothers reported a positive experience of skin-to-skin contact with their infant immediately after the birth, and the majority of mothers commented positively about the first breast feed immediately after the infant’s birth. Following what they described as a successful first feed whilst on the labour ward, the women’s diaries then described difficulties with breast feeding. These difficulties were with either an infant who was sleepy and reluctant to try to feed, or an unsettled infant, or difficulties positioning their infant at the breast to feed which they had not experienced or described with their first breast feed after the infant’s birth. These difficulties resulted in feelings of guilt that they could not provide for their newborn’s feeding 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 interview)

The following excerpts from diaries provide a snapshot of their emotions during the 6–8 weeks postpartum period in relation to this guilt at not breast feeding:

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

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

Unpreparedness for breast feeding

Of the 26 mothers, only three attended antenatal classes, two in the hospital setting and one in a community children’s centre. Mothers said they gained most of their knowledge about birth and infant feeding, including breast feeding, from their routine antenatal appointments with their community midwife.

The limited preparation and understanding of newborn behaviour was evident when mothers talked about ‘relentless’ feeding, needing to comfort their infant ‘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 diary)

Breast-feeding mothers were aware of looking for feeding cues. However, the infant not settling was seen as the infant 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 diary)

Mother’s lack of knowledge about newborn behaviour and their feeling of constantly feeding resulted in them changing to artificial milk as a solution to ‘normal’ newborn behaviour. The elements of emotional attachment and dealing with the demands of a new infant added to their maternal guilt, especially those that experienced some difficulty in breast feeding.

Breast milk volume was assumed directly comparable to the amount of artificial milk 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 infant was unsettled or constantly crying. Two mothers were encouraged to hand express within hours of giving birth (P48 diary) and another a few hours after an initial feed (P15 diary). Another mother expected her milk to ‘be gushing’, was shocked when she was only leaking a small amount of milk (P22 diary). Such misunderstanding of milk production and comparing artificial milk volumes led mothers to consider that there was something ‘wrong’ with their breast milk.

Unrealistic expectations

A theme apparent during the first six 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 first week or two he was constantly feeding, it was not what I was anticipating (P25 interview)

However, for some mothers, who were still breast feeding at six weeks, it was not just their physical exhaustion that they were unprepared for but also their inability to continue with their everyday tasks:

I just could not do anything around the house. I look around and see the washing and ironing pile… (P9 interview)

For some women, these experiences persisted for some weeks. Participant noting in her diary four weeks after the infant’s birth:

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

Professionals: notions of expertise, communication and impact

This theme relates to what mothers referred to as the ‘experts’, the health care professionals from who mothers sought help and support with their breast feeding during the six weeks postpartum period. These health care professionals were midwives in the hospital, health care assistants that mothers might see assisting with breast feeding on the ward, community midwives, and health visitors on home visits.
Mothers viewed the actions of health care professionals as having a fundamental impact on their breast feeding experience. Mother’s sought out their expertise and assistance to provide reassurance and guidance and data was coded under two sub-themes: notions of perceived power of ‘experts’, notions of breast feeding communication and support.

**Notions of perceived power of ‘experts’**

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

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

During the early days of breast feeding, mothers sought validation of the difficulties they were experiencing from health professionals. They saw these health care professionals ‘experts’ are offering solutions to any breast feeding difficulties and sought reassurances throughout the 6–8 week post birth period. 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 diary)

However, some mothers commented how support for breast feeding from the health care 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 diary)

**Notions of breast feeding communication and support**

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

She (midwife) came in and said you are doing it wrong (P10 diary)

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 sharpens bin. I was so mad (P30 diary)

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

My health visitor told me off. She said I was confusing him [baby] (P36 diary).

One mother whose son was monitored for 10% weight loss at three days old found her dealings with paediatric staff unsupportive of her breast feeding 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 interview)

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

Whilst the message of ‘Breast is Best’ is well documented, mothers had different feelings about the nature of these messages, which they viewed as reinforcing their failure to breast feed. An aspect for those mothers that ceased breast feeding, either in hospital or within the 6–week postnatal period, was how public health messages on breast feeding suggested it was all positive and ‘natural’. In fact, this was not the case for all mothers and reinforced their maternal guilt described earlier:

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

The BFI guidelines recommend that all mothers have knowledge of hand expressing. However, mothers who were shown how to hand express, soon after birth and whilst in hospital were confused as to why they were been taught this skill when trying to establish breast feeding:

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

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 diary)

The same mother, who attended antenatal classes and so ‘felt prepared for breastfeeding’ (P5 diary) was formula feeding on hospital discharge. She saw her lack of milk when hand expressing as the reason why she could not breast feed successfully:

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

All 26 mothers in the study were able to recall verbatim the widely publicised health benefits to them and their infants of breast feeding. They had gained this knowledge from antenatal appointments, friends, and the internet but surprisingly after the birth did not seek breast feeding advice from established breast feeding support groups in the locality. Mothers did receive support group information with the personal child health record (PCHR) during the hospital discharge process. Although the mothers said they found the leaflets useful, surprisingly, only three of the 26 mothers turned to these local support groups.

One attending her local group wrote:

It was fantastic, reassuring, helped to share our (breastfeeding) experiences (P15 diary).

Although one breast-feeding mother, who had successfully breast fed for five weeks, wrote in her diary about her feeding difficulties and rather than seek advice from any local breast feeding support group she turned to her friends for reassurance at week 5:

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

**Dimensions of public feeding**

It was clear from the diary entries and interviews that most women were anxious about breast feeding in public. These were categorised into three sub themes: feeding in front of family and
relatives, using private facilities in public spaces, and the ability to feed ‘whenever and wherever’.

Feeding in front of family and relatives

In the UK, there is an acceptance that relatives will visit the new parents and meet the newborn whilst they are in the hospital setting. However, what is less clear is how breast-feeding 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 are not comfortable doing it yet, you are trying to let everyone say hello and have a hold and then she wants feeding (P5 interview)

In one case, a mother writing in her diary on the first day, talked about her attempts at breast feeding, using the curtains to create ‘private space’:

Hard to find privacy, curtains helped, had to keep asking someone to shut the curtains (P3 diary)

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 is a factor known to hinder the let-down reflex.

Using private facilities in public spaces

This sub-theme relates to how breast-feeding 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 interview)

In another case, a mother, when enquiring about breast feeding facilities at a newly built doctor’s surgery, was surprised at the response:

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

Mothers breast feeding ‘wherever and whenever’

This sub-theme relates to mothers growing confidence in their breast feeding. In their diaries, they talked about feeding when away from home but doing ‘normal everyday things like shopping’ (P11 diary). These comments occurred at different times in the 6-week diary:

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

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

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 diary)

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 interview). Her feelings are perhaps a reflection of the need for privacy expressed in earlier interview comments on ward privacy.

Discussion

The findings offer insight into lived experiences of breast-feeding women in the first 6–8 weeks following birth. Though the study was based in a specific geographic location, the results are likely to resonate with women’s experiences in other similar settings and widen the knowledge and understanding of the meaning women ascribe to this experience.

The women’s experiences of breast feeding are vividly brought to life in their own words in their daily diaries and in-depth interviews. What is clear from the data is that there are multifactorial reasons why participants decided to cease breast feeding in the early postpartum period. Some of the women justified their early discontinuation of breast feeding on the relative ease of artificial milk. However, they still identified guilt in having made this feeding choice.

The metaphor of ‘emotional roller coaster’ is a useful description identified by the researcher team on the paradox between health care professionals providing mothers with adequate advice and support, enabling them to make informed decisions about their infant feeding decisions, and the realities for them once they give birth. The narratives from the 26 mothers indicate how over the first six weeks they experience a range of emotions. This transient emotional position is influenced by infant feeding decision making, particularly for those women who decided to stop breast feeding before they had planned to, and by their lack of awareness of normal newborn behaviours.

Whilst maternal guilt is well documented in the literature, the emotional experience described by participants in this study was 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 was reinforced by public health education messages that present breast feeding as unproblematic and ‘natural’ (Andrews and Knaak, 2013).

It is suggested that women who stop breast feeding are either unable or unwilling to articulate why (Schmied and Barclay, 1999). This may be because breast feeding is an intimate embodied act and many mothers have deep-rooted negative feelings about the adequacy and sufficiency of their breast milk, and a profound lack of confidence in their ability to breast feed (Dykes, 2005). The first 24 hours were periods of particular anxiety for the mothers in this study. If their infant showed little interest in feeding, or appeared sleepy, or unsettled between feeds, this was interpreted as either abnormal behaviour or dissatisfaction with their efforts to breast feed. Advice from midwives reinforced this interpretation by introducing different aspects of breast feeding, for example recommending that the mother hand express, collecting the early milk (colostrum) in a syringe to feed it to the infant later. However, as the volume expressed by this method was very small, mothers viewed this as quantifiable evidence that their milk supply was inadequate. This finding indicates that many mothers did not understand the physiology of lactation and concurs with a systematic review of evidence surrounding the concept of insufficient milk syndrome (Gatti, 2008).

In this study, all participants demonstrated awareness of the health benefits of breast feeding to both them and their infants. Indeed, it was noticeable that these benefits were recalled verbatim. It
indicates that the national campaigns and local strategies to promote breast feeding as the ‘norm’ are visible (Earle, 2002).

It was also very clear from the findings that new mothers sought out the advice of professionals extensively. This places health care 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 health care professionals made a lasting impression and tended to disempower women. Their recall of conversations was detailed when these negative encounters occurred. Diary entries of statements made by midwives, health visitors, or doctors were written in capital letters or underlined to emphasise the unconstructive impact they had made on the women. This has also been shown in the context of the birth experience itself (Simkin, 1992).

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 breast feeding was natural and instinctive, with clear benefits for both mother and infant. This hands off, non-intervention approach enabled the professionals to meet standards for breast feeding as a deregulated, feeding on demand ethos. However, when some standards were breached, for example, excessive weight loss in the infant, 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 breast feeding. Their descriptions of breast feeding centred around process and production, lacking any ownership or confidence in their body’s ability to develop and adapt. This is a disembodied perspective that undermines breast feeding duration but is common in the extant literature (Shaw, 2004).

The findings indicate that few women attended antenatal classes or breast feeding support groups, even though the benefits of attending are well documented in the literature (Locke, 2009). Breast feeding support groups are shown to be beneficial for encouraging and supporting mothers to overcome breast feeding difficulties, provide an opportunity for mothers to share their experiences and sustain breast feeding rates (Beake et al., 2012). Mothers in this current study and others (Williamson et al., 2012) state they want a more realistic approach to breast feeding and the difficulties they might encounter rather than an idealised version.

It would appear that there are no quick fix solutions to the societal barriers around breast feeding, and, in particular, feeding when away from the home environment. What is evident and is reported in the literature is that women are rarely seen breast feeding in public in the UK (Boyer, 2012). However, the ability to breast feed in public relates directly to breast feeding continuation, and is therefore an issue that needs addressing.

Conclusions and implications for practice

Using phenomenological methods, the lived experience of breast feeding was explored in-depth to reveal the tensions, incongruence’s and rhetoric/reality gap that some women go through when adjusting to breast feeding for the first time. Our evidence shows complexities and diversities in the experience of breast feeding. For all the women in this study breast feeding was an unforgettable experience.

Women, overall, were ill prepared for the realities of breast feeding. They were expecting breast feeding to be a natural process, but once they started breast feeding, most women experienced it as problematic. Mother’s lack of knowledge about newborn behaviour and their feeling of constantly feeding resulted in them changing to artificial milk as a solution. There is a clear need for antenatal education to focus more on preparing women for the realities of breast feeding, rather than an idealised version.

The findings from this study may resonate with the literature on mother’s experiences of breast feeding. However, it has identified that for primigravid women there is still a pressing need to address maternal care provision, including ante and postnatal care for the breast-feeding mother if we are to encourage and support more women to breast feed. As it has been shown that improved breast feeding rates have a direct impact on the long-term health of infants and mothers, and a financial saving for the NHS (Renfrew et al., 2012) it is imperative that localised breast feeding strategies are implemented if we are to address the regional variances in breast feeding rates.

References


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