Talking about breastfeeding: emotion, context and 'good' mothering

please supply pics

By exploring the emotional, social and psychological contexts for breastfeeding, professionals can better support women, say **Heather Elliott** and **Yasmin Gunaratnam**

The benefits of breastfeeding are now recognised and promoted by governments and healthcare services internationally (WHO 2007), with feeding regarded as a significant part of the maternal role: in the words of the World Health Organization: 'no gift is more precious than breastfeeding'. The idea that breastfeeding can be a 'gift' signifies the increasing, heavy cultural and emotional load of feeding for mothers. Feeding practices can be used to differentiate 'good' and 'bad' mothers, 'high' or 'low' social status and can also be associated with feelings of intimacy, estrangement, guilt, joy, failure or success.

In this article we discuss the findings from the Open University's 'Becoming a Mother' study (www.open.ac.uk/socialsciences/identities/findings/Hollway.pdf) in the light of these wider issues and current policy initiatives. The study examined the personal experience of becoming a mother for the first time, among a socio-economically and ethnically diverse sample of women in the London Borough of Tower Hamlets. In drawing upon mothers' own accounts of breastfeeding, we highlight the importance of the role of midwives in three main aspects of early motherhood: antenatal care and the recognition of women's emotional investments in breastfeeding; establishing feeding in the first few hours and days of motherhood; and in home visits where engagement with the role of the wider family and the physical and social environment of households can be used to better understand and support feeding practices.

By examining the significance of psychosocial factors in mothers' decisions about breastfeeding, our research suggests that information-giving to mothers on the benefits of breastfeeding is not enough by itself to improve breastfeeding rates. Such models of health education are based upon assumptions of rational decision making. These can fail to take account of the complex, and sometimes contradictory, emotional dynamics and biographical and material circumstances that can shape choices and can overestimate the ability to make choices at all.

Tower Hamlets, the ethnically diverse London borough where the research was carried out

> Research has found that professionals find it easier to provide services to UK-born mothers from minority ethnic groups than to migrant mothers

Breastfeeding in the UK

Despite global initiatives to increase breastfeeding rates, many mothers in the UK do not breastfeed for four or six months, either at all or exclusively (Griffiths et al 2007). The Office for National Statistics carries out an 'Infant Feeding Survey' every five years. The preliminary findings from the 2005 survey, involving almost 20,000 births, were published in 2007 and show evidence of the continuing sway of socio-demographic factors, with the highest incidences of breastfeeding being found among older women, mothers from managerial and professional occupations, and those with the highest educational levels.

Although policy guidance and initiatives in maternity service provision have given critical attention to the reduction of health inequalities (Department of Health 2005, Department of Health 2007, NICE 2008, SACN 2008), particularly among those who are poor and/or who are from black and minority ethnic groups, the situation is complicated. For example, there are differences in breastfeeding rates between different minority ethnic groups (Kelly et al 2006) and also in how different groups are perceived by professionals. Recent research (Puthussery et al 2008) with maternity care professionals in the UK has found that professionals find it easier to provide

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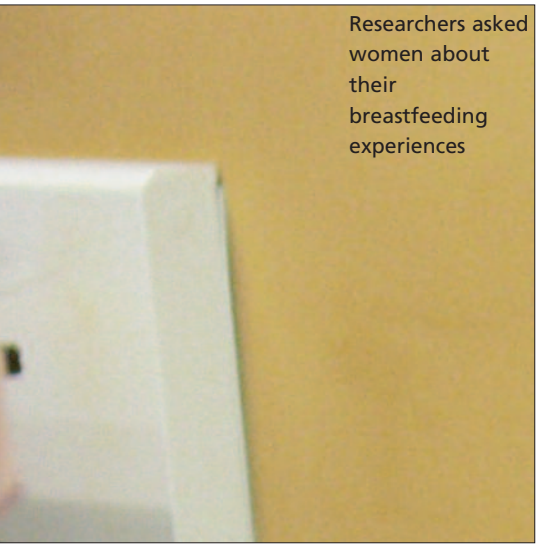

Researchers asked women about their breastfeeding experiences

services to UK-born mothers from minority ethnic groups than to migrant mothers; this echoes the finding that migrant mothers to the UK have relatively poor maternal and neonatal outcomes (Lewis 2007).

Research on ethnicity and breastfeeding also shows complex relations between maternal characteristics and breastfeeding. At a general level, women from minority ethnic backgrounds are less likely to have discussed breastfeeding with a

Midwife; they are, however, significantly more likely to initiate breastfeeding and to exclusively breastfeed after birth (Redshaw et al 2007). Using data from the longitudinal 'Millennium Cohort Study' of nearly 19,000 babies across the UK, Griffiths et al (2007) examined the characteristics of mothers who either discontinued breastfeeding or introduced solids before their infant was aged four months. The results show that:

> *After adjustment for maternal education, socio-economic status, employment, age, parity and lone parenthood, mothers from most ethnic minority groups, including 'other whites' but excluding Pakistani and Bangladeshi mothers, were less likely to stop breastfeeding before four months than white mothers. Mothers who returned to work before four months were more likely to discontinue breast-feeding early, as were lone mothers and those who introduced solids before four months.* (p.959)

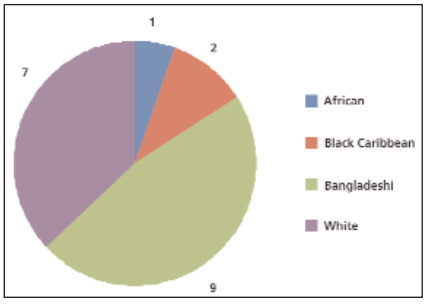

Figure 1: **Ethnicity of the sample mothers (n=19)**

Such findings are valuable because they represent something of the inter-related impact of demographic factors, as well as the individual situations of mothers such as whether they are working or are lone parents. However, there are also experiences that cannot be represented by statistics, such as the trauma of birth, or how social and familial networks can affect feeding. A strength of qualitative research is that it can provide insight into the detail and meaning of such statistically hidden experiences, through a more in-depth engagement with feeding in the context of women's lives.

The study

The 'Becoming a Mother' project was concerned with better understanding how women make sense of the identity transition involved in becoming a mother for the first time. The project was led by Professsors Wendy Hollway and Ann Phoenix, with Dr Cathy Urwin as research consultant, and was based at the Open University. The research was particularly interested in the social and emotional content of maternal identities, and how these are affected by social differences such as ethnicity, culture, socio-economic status and faith. In recruiting women to our sample, we aimed to reflect the ethnic and class mix of Tower Hamlets *(see Figure 1)*. However, because we were using in-depth qualitative interviews and were concerned with the detail of both what women said and how they said it, we did not include women who were not fluent in English. This meant that mothers from newly arrived migrant groups, and those who had migrated on marriage, were not included in the research.

All the women in our sample had given birth in the same hospital within the same six-month period in 2005/06. Each of the

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19 women gave three

Unstructured, in-depth interviews over a 12-month period: the first either in the last trimester of pregnancy (N = 10) or a few weeks after birth (N=9); then twice after the baby was born, at four to six months and 12 months.

The interviews were supplemented by two other methods: psychoanalytically-informed observation of six of the 19 mothers (see Urwin 2007) and two focus groups with Bangladeshi (N=6) and white British (N=3) mothers. When the study had been completed, emerging findings from the project were shared with local health professionals in two discussion groups, consisting of health visitors, midwives, Sure Start workers and family therapists.

Tower Hamlets – the study site

The population of Tower Hamlets is ethnically, culturally and socially diverse. Fifty-one percent of the local population is white, from a variety of ethnic groups, with Bangladeshi people constituting the largest ethnic minority group – 33 per cent (Office for National Statistics 2001). Most Bangladeshis are Muslim by religious background, with 36 per cent of the Tower Hamlets population categorising themselves as Muslim in the 2001 census. Many Bangladeshi young people are British born, as are some of their parents. Bangladeshi populations in the UK are characterised by high levels of ill health, low educational achievement, unemployment and poverty (Salway et al 2007).

During the study period (2005-2008), Tower Hamlets was investing in early-years

services and the specific need to improve local maternity services was recognised (Tower Hamlets PCT and Barts and The London NHS Trust 2007). Breastfeeding support was a core part of the extensive Sure Start programmes in the area. At 81 per cent, the breastfeeding initiation rate is higher than the national average (78 per cent) and there has been a statistically significant shift from mixed to exclusive breastfeeding among Bangladeshi women living in Sure start areas. The UNICEF UK Baby Friendly Initiative co-ordinates consistent support for breastfeeding across community and hospital maternity services in the borough – a key need identified in our fieldwork. By exploring the emotional, social and psychological contexts for breastfeeding, including some women's difficult experiences, our intention is to highlight how professional interventions can be received. Often when breastfeeding was going smoothly it attracted little comment and there was little need for further professional support.

Antenatal support: intentions and imaginings

The importance of antenatal information and advice for breastfeeding is recognised in the UK (SACN 2008), where information is recommended at 10 and 36 weeks (NICE 2008). Our antenatal interviews with women showed that feeding was often a theme in how they imagined themselves as mothers, which suggests that there can be significant emotional investments in feeding. Such emotional investments and their effects can be influenced by the congruence or incongruence between health education literature, social and cultural beliefs and social networks. For example, some of the Bangladeshi Muslim mothers talked about breastfeeding in the context of its value as a part of a mother's role within Islam. However, many younger Bangladeshis are more religious than their parents or grandparents, and there are also intergenerational differences in breastfeeding practices, so that Bangladeshi mothers in our sample also experienced pressure to bottle-feed from older, more experienced mothers who had bottle-fed their children.

For women such as Hannah, a white-British, working-class mother, messages about the health value of breastfeeding were compromised by her social knowledge and experience. Although she was aware of the benefits of breastfeeding from her reading, she told the interviewer: "I don't know anyone who breastfed. My mum's bottle fed everyone." The Infant Feeding Survey (Bolling et al 2008) found that social networks play a significant role in feeding; mothers whose friends mostly formula-fed were more likely to have given up in the first two weeks (29 per cent) than those whose friends mostly breastfed (9 per cent).

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Establishing feeding: the early hours and days

Labour and the immediate postnatal period are times of emotional vulnerability for women, when interventions from midwives and others are particularly significant.

Adowa, a West African mother, described a student midwife as her 'saviour' during her traumatic and bewildering labour because she held Adowa's hand and stayed with her until her son was born. This reminds us that acknowledgement of women's vulnerability and consistency of support can be critical to a positive birthing experience. This was also true of aftercare. Indeed, women reported finding it particularly hard to tolerate inconsistent messages from health professionals about breastfeeding, as Sylvia's story illustrates.

Sylvia had a difficult pregnancy, plagued by health problems, followed by a complicated birth. Her son had difficulty feeding and a consultant had impressed upon her the importance of ensuring that he consumed a specified volume of milk regularly. Exhausted after an emergency caesarean and anxious about her baby, Sylvia describes her encounter with a breastfeeding counsellor:

> *I'd had no sleep for about 24 hours, and she came over and did this whole thing about "You must breastfeed. Do you want me to come over and explain breastfeeding to you, etc.?" And I'd had all that done by someone else, and that was fine, but I felt quite bad because the breastfeeding wasn't working, but I knew that actually the most important thing was that he got enough milk, and that he just got fed. And she said to me, "You do need to be breastfeeding, because that gives you a strong bond with your son." And I really felt like going, "Don't, just don't tell me that I can't have a bond with my child…It is part, but that's not the only reason you are close to your mother".*

Sylvia's words convey some of the difficulty of being in the grip of competing advice. At one level, Sylvia 'knew' from the advice she had received from her antenatal classes, her copious reading and from the hospital breastfeeding counsellor how valuable breastfeeding is for babies. Yet she also 'knew' from her consultant that, without regular feeds, her son could become ill and that her attempts to breastfeed were failing. Her distress was still raw when she talked about this incident six months later, as was her disappointment at the loss of the mother she had wanted to be:

> *I wanted to be that really natural breastfeeding mother. But you find there are so many things that actually you think you can control, but you can't.*

In contrast to information about breastfeeding, Sylvia had not easily been able to find information about bottle-feeding (see also Crossley 2009). This further exacerbated her anxiety about feeding and her guilt about not doing the best for her son. Sylvia's comment reflects how painful it was for some mothers who were not able to give birth or feed their babies in the way they had imagined and how such experiences can colour their ongoing experience of motherhood. Yet the difficult emotions underlying such experiences can remain unrecognised (Crossley 2009).

Conversely, positive birth and/or feeding experiences could galvanise women for future difficulties in motherhood. Liyanna, a Bangladeshi woman, had been determined to breastfeed, despite a chronic illness. Liyanna was convinced of the health benefits for her baby and also saw breastfeeding as a part of her Islamic duties as a mother. Six months after a difficult birth, during a time beset with family tragedies, Liyanna commented that breastfeeding was 'the one thing she felt good about'.

The home context

The data we have presented above illustrate some of the internal conflicts associated with breastfeeding: how a new mother reconciles competing messages, anxiety about her body not performing, letting her baby down, the tensions between doing what is best for her baby and tolerable for herself.

Nonetheless, we found that, despite the emphasis in health policy on the individual women's choices around feeding, decision-making is relational. Breastfeeding is negotiated in the domestic contexts in which new mothers find themselves. These contexts, along with their associated supports and constraints, vary enormously and midwives have to attune themselves quickly to different household circumstances. (This was particularly true of our research site, which was socio-economically and culturally diverse). For some of our sample, the first few weeks were spent alone or with a partner. While representing a chance to get to know the baby, this could also be an isolated and exhausting time. Adowa contrasted the support she would expect in her home country unfavourably with the UK:

> *You have to manage because nobody is ready to help … Back home is not like that; you have a lot of visitors, people are there to help you to do your house things and stuff. But here it is between you and your partner.*

Others returned from hospital to live with, or close to, extended families. This was particularly true of white and African Caribbean working-class women and Bangladeshi women, with the majority of the latter living with their own or their husbands' extended families. Leanne, a white mother who was single, recounted how both her mother and father had taken holiday from work to help her with the baby in the first couple of weeks. The description that Silma, a Bangladeshi women, gives of her homecoming from hospital made it clear how wholeheartedly her daughter was welcomed into the family; she also hints at the claims that extended family members felt in her daughter's upbringing:

> *When I was coming out of the car, they were all at the door… And my sister-in-law, she came and picked the baby up, and they were video recording and taking pictures of her, walking home for the first time.*

In many cases, being part of a large family meant support with everyday care while women rested and breastfeeding was established. However, living in extended families involved negotiating new family and housing situations which were often extremely overcrowded. The domestic labour involved in large households is demanding, and finding time and privacy to feed could be challenging.

Further, when family members were actively involved in childcare and /or sharing a home, they felt they had a legitimate voice in feeding 'choices' that are so often represented as a mother's sole responsibility. This could be particularly difficult when family beliefs about feeding conflicted with official health guidance. Again, women found themselves trying to resolve conflicting advice and recruiting health professionals, friends or other family members to support their position. Fareena, a Bangladeshi mother, commented:

> *I started weaning at SIX months, although I was pressured into weaning at four months by various people… My sisters in law, they're like, "We've raised kids and we've done it" and I said "Well, he's my son I want to raise him how I want to"… I'm glad my husband was on my side, otherwise I would have found it very difficult … I felt as though people were trying to suggest…I wasn't a good mother.*

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Even when the influences of others were less direct, decisions about breastfeeding involved weighing up the impact of feeding choices on other relationships. For example, Sarah, a white mother, described how her relationship with her husband improved when she stopped breastfeeding:

> *When I did stop the breastfeed I went through the usual guilt thing [of] why am I stopping … but I'm sure he'd prefer to have a happy mum and a mum that has a relationship with his dad, rather than a mum that's basically tired.*

The wider world

Initiating feeding takes place in hospital and domestic contexts, but sustaining breastfeeding involves negotiating public spaces. Women expressed embarrassment about feeding outside the home and some took pains to avoid this. Justine, an African Caribbean mother, commented: "I don't like getting my breasts out in public". Practical advice about appropriate clothing for discreet feeding (for example, wearing tops which could be lifted rather than unbuttoned) and local baby-friendly places proved invaluable. Working and institutional spaces were also experienced as inflexible. For example, one mother who was at college gave up breastfeeding after two

months because she found that it was incompatible with taking her A-level examinations.

Conclusions

In this article, we have drawn upon research with first-time mothers to provide insight into the biographical and social contexts in which 'choices' about breastfeeding occur. The research supports existing social policy agendas of personalised, holistic care and demonstrates the importance of midwives taking account of the social and cultural diversity of the mothers that they care for, as well as their changing experiences as new mothers. New mothers need consistent support at the time when they are most vulnerable and unpractised in looking after their baby: immediately after birth. They also need midwives to understand how their domestic arrangements can impact upon feeding in sometimes surprising and contradictory ways. It is equally important that women who do not breastfeed are not left with feelings of guilt or concerns about the quality of relationship with their baby, and have timely access to information about bottle-feeding (Crossley 2009).

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