

***'I felt like I was doing something wrong'* key findings of a qualitative exploration of mothers' experiences breastfeeding beyond a year.**

**Abstract**

Despite its multiple health benefits woman breastfeeding to 2 years and beyond remains significantly low. Tailored interventions are key for supporting breastfeeding. This qualitative study explored the experience local mothers' breastfeeding beyond infancy had with healthcare professionals. Its key finding demonstrate health services are good at supporting breastfeeding in post-natal period. However, beyond the one year review the focus shifts to rapid weaning. A new approach to support breastfeeding continuation alongside the introduction of complimentary foods is needed in line with recommendations. As critical reflective practitioners, Health Visitors are an ideal professional to support woman in context of breastfeeding's wider social complexities. However, commissioners need to recognise the investment in their profession to enable them to fully utilize their skills.

## **Introduction**

### ***Breastfeeding - The continued public health priority***

It is universally acknowledged that breastfeeding has short- and long-term health benefits for mother and child (Horta and Victora 2013a 2013b). Sustained breastfeeding is also associated with continued benefits. Reducing the risks of infectious diseases, hospital admissions and child morbidity (Duijts *et al* 2010, Payne and Quigley 2016, Thompson *et al* 2017). Hence, the global recommendation is to continue breastfeeding for up to two years and beyond (World Health Organisation (WHO, 2018). However, despite this breastfeeding in the UK remains one of the lowest in the world and continues to decline (Victoria *et al* 2016, Public Health England (PHE) 2018a). Beyond the infant age of six weeks breastfeeding data is sporadic, it is thought that just 1% of UK babies are exclusively breastfed to age of six months (McAndrew *et al* 2012, Victoria *et al* 2016, and Department of Health 2018). With such dire statistics even a moderate increase in breastfeeding rates could see a £40 million saving per year to the National Health Service (Renfrew *et al* 2012, Rollins *et al* 2016). Additionally, despite the adoption of the International Code of Marketing of Breastmilk Substitute (WHO 1981) almost forty years ago, the global formula milk industry extensively advertises and is estimated to reach \$70.6 billion profits by 2019 (Mason and Greer 2018). UNICEF (2016) has urged the UK to develop a better national infant feeding strategy, making breastfeeding a continued public health priority (PHE 2016a, 2016b, 2018b).

### ***Supporting breastfeeding in context - Child and Family Public Health Services***

We know effective healthcare interventions play an important role in breastfeeding initiation and prevalence (Sinha *et al* 2015, McFadden *et al* 2017, Brockway, Benzies & Hayden 2017). Quality breastfeeding promotion has the potential to reduce postpartum depression (Chaput *et al* 2016). Establishing meaningful contacts with families to encourage breastfeeding is

recommended (PHE 2016b). However, the transition in commissioning public health services to local governments in 2015 saw rapid cuts to services (Buck 2018). These services are at an increasing risk of being stretched, decommissioned and put out to tender for competing providers (UNITE The Union 2018). This is thought to be having a negative impact on breastfeeding support (Stephenson 2018, UNICEF 2018a). HVs state service cuts have led to higher safeguarding thresholds and increased intensity of need of those families facing multiple adversities (Institute of Health Visiting iHV 2018a). An increasing fragmented service mean providers are decreasing professional contacts to minimum key performance indicators (iHV 2018b). The current five universal contacts include an antenatal health promoting visit, new birth visit and a six-eight week 'check' (PHE 2016b). The remaining two contacts at one year and two and half years are now delegated to less qualified health care practitioners (iHV 2018b). This study explores the mothers' experiences in the context of these issues.

### ***Understanding experiences of breastfeeding***

The objective to understand the breastfeeding mothers' experiences has previously been approached (McInnes & Chambers 2008, Burns *et al* 2010, Williamson & Sacranie 2012, Mangrio, Persson & Bramhagen 2017). Substantial efforts have been made to explore why mothers discontinue (Goncalves 2017). Breastfeeding is an emotive subject with multi-faceted social and cultural complexities. It may be biologically normal but it is not viewed as the normal way to feed an infant in some settings (Thorley 2018). Supporting breastfeeding requires attention to contextual issues and sensitive communication skills. Previously mothers have reported feeling pressured to breastfeed, finding it extremely hard to do so, and then feeling overwhelmingly guilty if they do not succeed (UNICEF 2016). There are a small number of studies which specifically explore the needs of mother's breastfeeding beyond infancy (Dowling and Brown 2013, Tomori, Palmquist and Downing 2016, Dowling &

Pontin 2017). These highlight the divide between the perception of breastfeeding and the realities in which it is practiced. Women breastfeeding for longer periods find themselves outside standard social maternal boundaries in which they are required to balance social disapproval with what they believe is right for their child (Dowling & Pontin 2017). These studies also raise issues around language, disputing the terms 'extended' or 'long term' breastfeeding in toddlerhood due to the connotations it implies. A recent qualitative exploration of eight white women breastfeeding beyond six months offer insights into issues such as stigma, breastfeeding etiquette, media representations and the need for supportive family and friends (Newman and Williamson 2018). It's concluded that HV's could be better trained and educated on benefits of continued breastfeeding, however, what is unclear is the mothers' experiences of these professionals. This study aimed to enhance these insights.

### **Study purpose**

***Aim:** To explore mothers' experiences in response to breastfeeding beyond infancy.*

The study adopted a qualitative approach as this enabled rich data relating to personal experiences to be collected (Willig, 2013). More specifically, the first author facilitated dyadic semi-structured interviews with 24 breastfeeding mothers based in Derbyshire. The interviews invited the women to discuss their breastfeeding journey and address issues that were important to them. The data was analysed using thematic analysis, an established qualitative method which enables data to be systematically analysed and organised through the identification of patterned responses which capture "something important about the data" (Braun & Clarke, 2006 p. 82).

### **Method**

24 mothers (aged 27-48 years, mean age 35.5) (Table 1) were recruited from local parenting groups. Recruitment from these groups enabled focused purposeful sampling in which only women who had been breastfeeding for a minimum of one year were invited to take part. Women who had participated in the interviews went on to tell friends about the study who also went on to participate, thus a snowball technique was also used during recruitment.

Most of the mothers were white and well educated (Figure 1). This reflects the wider literature which reports that white British mothers with a higher maternal age and level of education are more likely to breastfeed for longer (Godbout *et al* 2016, Santorelli *et al* 2013, Dyson *et al* 2010, Mangrio, Persson and Bramhagen 2017). Most mothers had more than one child and had gone on to breastfeed their subsequent child(ren) longer than their first (Figure 2). Two mothers were tandem feeding. In order to ensure that data reflected current experiences all mothers had been breastfeeding for a minimum of one year, the mean duration of breastfeeding was 2 years.

Insert figure 1 here

Insert figure 2 here

Ethics approval was obtained by the University of Derby and informed consent was given by all mothers prior to interviews being conducted via telephone (N=4) or face to face (N=20). All interviews took place between April and June 2018 and lasted between 27- 52 minutes. All the transcribed interviews formed a data corpus which was analysed using thematic analysis. Thematic analysis offers flexibility and therefore it is important to make the theoretical framework and epistemological stance clear (Braun & Clarke, 2006). Given the specific aim of the project themes were identified using a theoretical approach. This enabled a focused reading of the data and facilitated the creation of codes specific to areas of particular interest (Boyatzis, 1998). Following the 6 stages of thematic analysis outlined by

Braun and Clarke (2006) both researchers read and reread the data corpus independently to identify codes relating to the influence of healthcare professionals, friends, family and social media. NVivo 11 was used to collate extracts relating to each code and this process helped to establish their validity. Mind maps were then used by each researcher to cluster codes into themes and it was noted that both researchers were largely in agreement. This gave confidence that the themes identified fairly represented the wider data corpus. Extracts which best represented each theme were analysed by the first author using a realist framework, which assumes that language reflects meaning and experience (Braun & Clarke, 2006). This approach was selected because it enabled claims to be made in relation to the women's thoughts, feelings and motivations. The second author reviewed the analysis to ensure credibility. To maintain confidentiality each participant here has been given a pseudo name.

## **Results**

The overarching themes include: 1) breastfeeding as a continued transition and increased social stigma 2) alternative support beyond infancy and 3) health professional disparities and unmet health needs. Further details of these themes are published elsewhere (authors, under review), for the purpose of this paper the discussion will focus on health professional disparities and unmet health needs.

### **Health Professional Disparities**

A mother's breastfeeding journey was expressed as a continued transition which evolved through investigating (pregnancy), initiating (birth), establishing (infancy) and continuing (toddlerhood). Each stage had its own unique experience. It was evident from this data that the relationship with health professionals radically changed over the course of these transitions. These professionals were in a fundamental position to have both positive and

negative consequences for a mother's breastfeeding practices.

During pregnancy, birth and infancy the majority of the mothers' experiences with health professionals was positive. Breastfeeding at these stages was encouraged. For example, Cathie stated *'The support I got from the midwives was unbelievable'* and Amber felt *'They were absolutely amazing'*. It was highlighted that some staff were more knowledgeable than others but these healthcare professionals were able to provide valuable support. At times their language did not sit well with a breastfeeding mother. For example, Sarah was asked by a midwife *'How much is he drinking'*. This gave Sarah the impression that professionals favour formula for the convenience of measuring volume and weight gain.

The first six weeks of breastfeeding were described as the most difficult *'It never crossed my mind that it was going to be a hard thing to do which was kind of naïve'* Laura. The challenges highlighted included mastitis, thrush, reflux, tongue-tie, bleeding, cracked nipples, allergies, post-natal depression and poor weight gain. A local specialist HV breastfeeding service was praised by Maggie *'I did really depend on the infant feeding team'*. However, Abbie had an incident where she had to assertively insist on getting specialist support for more medical concerns. *'the only reason I got that consultation was because I'd said this is my third baby, I've breastfed both of my other children over a year so there is something medically wrong'*. Abbie felt able to speak out to obtain specialised advice which perhaps only a more experienced mother might do. The local NHS breastfeeding groups were described by Amber as *'brilliant. It's like a clinic appointment without being a clinic appointment'*. Here they were able to access health advice without having to wait for a scheduled appointment. Valerie also appreciated the groups for being able to meet other breastfeeding mothers *'I think that's what kept me going, because it was social'*. There were concerns raised of recent closures to children's centres where the groups took place *'they've lost their funding now but they were*

*absolutely incredible*' Gail. However, the positive experience of these groups was not the case for all mothers. Sharon described them as *'a bit cliquey'*. Laura also believed these groups were for first time mothers only and not for breastfeeding beyond infancy *'it's mainly the new-mums and like the new tiny ones that are under a couple of months old'*.

Once initial barriers of breastfeeding were overcome mothers such as Sarah felt a sense of achievement and determination to continue *'its self-determination and being able to say I did it'*. Laura also felt because her body was still producing milk it was only right to continue *'It's his milk, it's there for him and my body's still producing it for him, he's still entitled to have it'* Laura. However, as breastfeeding continued the responses from health professionals radically changed. *'The HV wasn't very nice at all. When my daughter was one she basically said that she needed to go onto cow's milk and I needed to stop breastfeeding her and she said she will just have to cry herself to sleep'* Catherine. Here breastfeeding was not presented as a choice by the HV as Catherine was told that she needed to stop. Furthermore, there is the sense that wider benefits of continued breastfeeding are completely discounted. Sarah illustrates the impact this had *'Yeah, and then you sit and think about it and then I felt like I was doing something wrong and I didn't have the back up of HVs. At this stage of their breastfeeding it was felt that HVs were focused on weaning. This set up a power dynamic in which the mother was simply expected to follow professional advice. Jessica felt there they need a different approach 'you're coming in to do your weigh in and it's all about right feed them this, this and this, they need a little bit of a re-shift'*. Hazel felt she was completely misinformed *'I went to her two year review and the HV told me that my milk has no nutritional value after six months and this was before she knew I was a breastfeeding support worker'*. Hazel illustrates the role that knowledge has in addressing power imbalance between mothers and health professionals. In this case Hazel's identity as a breastfeeding support worker meant that she

was able to challenge the professional's assertion from an informed position. However, not all women have this knowledge and so this advice could have a negative impact upon breastfeeding practices. Amy also described her issue of the one year review *'In the red book it asks date of last breastfeed which I think is a really loaded question'*. Here Amy felt that this implies breastfeeding should have discontinued by this time.

### **Unmet health needs**

There were a number specific topics the mothers felt services should have provided support or were when they were misinformed. This resulted in them looking for in alternative avenues to find further information. These included:

- Night weaning, Ella felt *'that is where you get fed up of breast feeding, you get tired, and feeding at night is a big hurdle to overcome'*.
- Getting pregnant and fertility whilst breastfeeding, Zoe raised her concern for advice she had following a miscarriage *'We did have a few miscarriages and I can remember the one doctor saying it was because I was breast feeding'*.
- Nursing manners. Janet described needing support with *'how to deal with twiddling and maybe biting, asking politely and stuff like that'*.
- Support with positive self-weaning and ending breastfeeding positively. Ella conveyed *'I don't think I can face the battle of stopping just yet'* believing that when it does end it will be distressing for both her and her child.
- Support around tandem feeding. Gina wanted to know *'how would she react to sharing'*. Zoe stated *'if it was for that group (online forum) I would have no idea'*.
- Support for breastfeeding mothers returning to work. This issue was frequently raised as a critical point for women to give up breastfeeding. Sarah believed specific support is needed because *'you have had a long time away from your child they want more of*

you as well which is very demanding, physically and emotionally demanding at night-time when you have then got to get up and go to work the next day’.

**Discussion:**

These results demonstrate how a professional’s use of language, subtle responses and interaction could encourage, empower and motivate their patient or could cause self-doubt, uncertainty, distrust or disbelief. The mother’s experiences with professionals altered from the mainly positive to negative engagements as they continued breastfeeding into toddlerhood. However, we know the majority of these professionals undertake mandatory breastfeeding training and are fully aware of the current recommendations of two years and beyond. An educated workforce, set out in the *Baby Friendly Initiative Standards*, is recommended as minimum (NICE 2014, UNICEF 2018b). Therefore, it is evident training alone will not resolve this issue. There are a number wider reasons these mothers are experiencing such disparity in services. The most obviously being that due to statistically low breastfeeding uptake, training and healthcare interventions prioritises initiation rather than breastfeeding continuation. Data of a women’s breastfeeding status which is only collected at birth, ten days and eight weeks always reaffirms this priority. The time when mothers’ experiences professional approaches changes also correlates with an increase in social and cultural stigma for breastfeeding an older child (Dowling & Pontin 2017). Therefore, it is also important to consider that these professionals are not exempt from the deeply rooted complexities of breastfeeding. They too are members of society who are likely to have their own personal emotive views of breastfeeding. Particularly if they too are mothers with either positive or negative experiences. With all good intentions to implement evidence-based recommendations there are risks that personal experiences could be reflected through their interpersonal approaches. Raising these points and advising professionals how to speak to

mothers in training could benefit. However, this could only potentially be resolved if professionals were provided time to explore their approach to practice in relation to their own personal experiences. This should be encouraged sensitively in a trusting supervisory environment so the professional is able to gain insightful reflections in a therapeutic way. Additionally, it is the one and two year review when the mothers felt negative connotations towards their breastfeeding. These same contacts which are regularly now delegated to healthcare practitioners. These professionals are great resources to the child and family teams with knowledge around weaning, toileting child development. However, what is evident from these results is that a highly multifaceted and sensitive public health issues such as breastfeeding need complex interpersonal approaches. HV are experienced registered nurses with an additional Specialist Public Health university degree. It could be argued that these professionals are in a far better position to be able to balance a mother's contextual issues with health promotion. What was also evident from these results is that the mothers did not recognise the difference in roles during their contacts and all development checks and health clinics were done by HVs.

## **Conclusion**

This study has raised some important issues for healthcare professional approach to breastfeeding beyond infancy. These women, already the minority, face increased social stigma, combined with misinformed advice. This, worryingly developed into a feeling of distrust and disbelief the health professional's capabilities. Despite this they remain determined to continue with what they felt was right. They had the confidence to obtain alternative advice and seek support from likeminded mothers online. However, not all breastfeeding women would feel able to do this and what we cannot tell from this study is the number of women who had similar experiences and consequently discontinued.

These findings also reaffirm that the way health professional engage with people matters. The language used has consequences and it is essential practitioners have an understanding of the dynamics of professional relationships and language discourse. For this, professionals need to critical thinkers trained at a higher level and be provided with additional support to enable them to reflect on their approaches practice. HVs are ideal practitioners capable of holistic assessments of family needs in context of public health complexities. However, without an increase in investment for these early intervention services, they will not have the opportunity to apply these skills effectively.

Finally, these findings show that the health needs of mothers' breastfeeding beyond infancy differ immensely from pregnancy to toddlerhood. It is important providers deliver a variety of interventions for the different stages of breastfeeding because it is clear here that one approach will not be effective for all. The unmet health needs identified are undoubtedly missed opportunities for public health services.

### **5 key phrases summarising the major themes**

- 1) Despite its multiple health benefits woman breastfeeding to 2 years and beyond remains significantly low
- 2) This qualitative study explored the experience local mothers' breastfeeding beyond infancy had with healthcare professionals.
- 3) Health services are good at supporting breastfeeding in post-natal period. However, beyond the one year review the focus shifts to rapid weaning.
- 4) A new approach to support breastfeeding continuation alongside the introduction of complimentary foods is needed in line with recommendations.
- 5) Health Visitors are an ideal professional to support woman in context of breastfeeding's wider social complexities if the services were able fully utilize their skills.

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### **Conflict of interests**

The authors declare that there is no conflict of interest that may embarrass the author or journal if revealed at a later date.