# What do women lose if they are prevented from meeting their breastfeeding goals?

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*This article explores the complex issue of breastfeeding and maternal mental health. Many women stop breastfeeding before they are ready, leading to feelings of anxiety, guilt and anger. Critics of breastfeeding promotion blame breastfeeding advocates for this impact, claiming that the focus should simply be on feeding the baby, with all methods equally valued and supported. Established health impacts of infant feeding aside, this argument fails to account for maternal intentions, goals, and the physical and emotional rewards breastfeeding can bring. Although some women will take comfort in the message that 'fed is best', others view it as a lack of recognition of their wishes and the loss that they feel when they cannot breastfeed. The purpose of this article is to highlight the importance of recognising and valuing women's individual breastfeeding goals, and not dismissing or invalidating their experience if they don't meet these by telling them that they don't matter. By failing to fully recognise what breastfeeding can mean to women, and what they may have lost if they are unable to breastfeed, feelings of frustration and grief can be exacerbated. To move forward, we must recognise the impact of infant feeding experiences, consider the impact of public messaging, and work to support more women to meet their goals.*

Key words: Breastfeeding; Postnatal depression; Breastfeeding goals; Maternal Identity; Emotions; Pleasure; Bonding; Pride

The relationship between infant feeding experiences and maternal mental health is never far from our thoughts. Between news headlines, social media debates, and our own personal and professional experiences with mothers, we are very aware that infant feeding experiences matter, not just for health but for psychological wellbeing too.

Numerous research studies over the last few decades have shown us that a 'successful' breastfeeding experience is predictive of good mental health[1,2,3] (Kendall-Tackett, Cong & Hale, 2011; Ystrom, 2012; Dennis & McQueen, 2009) – a relationship which is of course complex. Women who have good mental health may find their breastfeeding experience easier to navigate, whilst mothers who are struggling may find breastfeeding, or caring for a baby in general, more challenging. Mothers who are experiencing depression are more likely to perceive their infants as difficult (when independent reviewers do not)[4] and are less likely to be responsive with their infants, missing cues and being less sensitive with attachment and positioning[5], which we know can damage breastfeeding[6].

Of course, the opposite also plays out. A woman's experience of feeding her baby can affect her wellbeing. If a woman plans to breastfeed and is then unable[7] (Borra, Iacovou & Sevilla, 2015), or she cannot meet her breastfeeding goals[8] (Gregry et al), her risk of depression increases. If a woman experiences pain and difficulties, this again is associated with a higher risk of depression[9]. Although some mothers may find peace with their decision to stop, ending a breastfeeding relationship before she is ready can lead to a whole spectrum of emotions including grief, anger, and loss, decreased confidence and feelings of failure as a mother[10-12] (fahlquist; lee; taylor; ). This can be exacerbated by a drop in protective breastfeeding hormones (such as oxytocin and prolactin) which enhance feelings of calm and relaxation[13] (Gallup).

Unfortunately, significant numbers of women are not meeting their breastfeeding goals. In the UK, 80% of women who stop breastfeeding in the first six weeks report that they were not ready to do so, with pain, difficulty and a lack of support given as the most common reasons for doing so[14] (McAndrew et al, 2012). Similar patterns are seen in the USA, Canada and Australia[15-17], leaving many women potentially at risk of these emotions and mental

health difficulties. As a consequence, women often report that they feel significant pressure to breastfeed, whilst support to do so is inadequate[18-20] (Andrews; Craig; Thomson).

Based on this, the argument that we see played out across the media often centres on the suggestion that there is too much pressure on women to breastfeed, and to protect maternal health we should instead take a more mother centred approach, promoting all feeding options as equal. The main focus should be on ensuring a baby is fed, with the proposition that anything is just noise, with minimal real impact upon mother and baby. Criticisms have been made of the lactation field, predominantly by those with a social sciences background, with accusations of 'militant lactivism' destroying women's mental health. Breastfeeding is posed as something that is a moral, identify signalling behaviour as against anything that impacts upon health[21-24] (faircloth; Jung; lee; wolf). The call to stop promoting breastfeeding from certain sectors is strong.

However, taking this approach is akin to treating the symptoms rather than taking a deeper exploration of their cause. Women who have no desire to breastfeed do not experience a negative impact upon their mental health when they do not breastfeed[25]. Instead negative emotions are a consequence of intentions not being met. Simply telling women that their experience does not matter, and to revise and forget their initial goals, may work for some, but for others it may be worsening their grief as they feel that their goals are being brushed aside.

The notion of telling a woman to focus on the positive, rather than what she has lost is a theme that runs throughout pregnancy, birth and mothering. Women who miscarry are often told 'Next time, it wasn't meant to be'. Women who have traumatic births are told 'the main thing that matters is that you have a healthy baby'. Increasingly women are now being told that 'the main thing that matters is your baby is being fed'. Of course, on a bottom line basis these things are true. A healthy, fed baby is at the top of women's wish lists.

But we owe it to women to give them more than the bottom line. It is now accepted that a traumatic birth can have long lasting psychological and physiological impacts upon a woman

and it is important to enhance the experience where possible[26] (Elmir, Schmied, Wilkes & Jackson, 2010), but what about breastfeeding? Telling women that the main thing that matters is that their baby is fed may provide comfort for some but for others, it can feel that their wishes, their expectations, what they perceived to be normal functioning for their body, are being invalidated and dismissed.

**Why do women want to breastfeed so much?**

To understand the importance of not dismissing women's breastfeeding concerns, we must look at what breastfeeding means to many mothers, and why they want to breastfeed. Public health literature would state that women should be encouraged to breastfeed because breastfeeding is protective of infant and maternal health[27,28]. However, this reasoning is actually only a small part of why breastfeeding is so important to women[29,30] (Knaak 2010, brown).

1. ***Breastfeeding is a biologically normal, instinctive behaviour that women expect to be able to do***

Questioning why women want to breastfeed is illogical in as far as we do not question why human beings wish to use any other function that their body was designed for. Women describe an urge to breastfeed as something that is instinctual; physically, in that their body produces milk without their choice, and emotionally, in that women often cannot describe why they so strongly want to breastfeed, they just do[31,32]. loof; Diaz Meneses

Breastfeeding is a natural stage of childbirth. The infant is born, the placenta is delivered, and the infant will expect to be fed. Infants are biologically programmed to manoeuvre themselves to the breast[33], and the breast sends signals – secretions – for the infant to find its way there[34]. At these early stage breast milk production and the infant urge to breastfeed is a normal, hormonally driven bodily function, not a choice that is made[35]. This of course is not to be confused with biological determinism. Just because women are 'designed' to breastfeed their babies after birth does not mean they are required to from a

sociocultural perspective. However, at birth, their body has not recognised wider social context, and prepares for a baby to be fed.

Many women who want to breastfeed describe how they always knew that they would try. They were of course aware of other options, but simply, they never considered any other option for themselves[29,30,36,37]. (Knaak, 2010; Brown & Lee, 2012; Brown et al 2011; Hegney et al). Others describe an indescribable urge that occurred at birth, despite no antenatal intention; evidenced by a small but significant group of women who make their decision to breastfeed at birth[14]. And there is a natural expectation they will be able to breastfeed. One of the biggest emotions women face when they cannot breastfeed is shock that their body did not work as expected[38] (Brown, 2016). Other emotions experienced – grief, anger, loss – all reflect women's desire to engage in a biologically normal behaviour.

We do not present other normal physiological behaviours as an option equal to medical involvement. Take breathing apparatus, kidney dialysis, mobility support – we highly value that option when needed. It can be lifesaving and life enhancing. But we don't question why individuals would want to breathe, filter, or move of their own accord. We recognise the emotional impact that this dysfunction can bring, rather than inferring it doesn't matter. Empowering women to follow this natural, instinctual function, and supporting them if they cannot is therefore vital.

### *2. Breastfeeding is viewed as a central part of becoming a mother*

Breastfeeding and the concept of maternal identity go hand in hand. Breastfeeding is often part of what women envisage themselves doing as a mother. Women report seeing breastfeeding as a way of identifying with a type of mother they wish to be, to fulfil what they see as a maternal physiological role. It is not simply about milk transfer, but a mothering tool, one helping to enhance bonding and closeness. It is a relationship and an experience, rather than simply a nutritional means[38,39] (Brown, Burns). Breastfeeding can be a way of healing after a birth that did not go to plan, or a way of protecting their infant especially if they are sick[31,40] (loof; marshall 2007). This experience can be particularly stark in mothers of preterm infants. Breastfeeding is a fulfilling way of healing, bonding, and part

of claiming maternal 'ownership' of the infant away from machines and staff[41,42] (Flacking et al, 2006; Davim et al, 2010).

However women are increasingly told that formula milk is a comparable substitute for breastfeeding. Formula milk is a safe and sufficient product, which can be lifesaving in the absence of breast milk. But placing any scientific comparison of content of breast and formula milk aside, formula feeding is not a direct substitute for breastfeeding. Although some women may report that they find the process more convenient[43], or that it is reassuring to be able to see how much milk the baby is consuming[44], other women will feel that they lose something through the process of not being able to breastfeed their infant. When women cannot mother in this way they grieve – for the loss of breastfeeding but also who they envisaged themselves to be[45] (Robinson, 2016). Palmer (2012) describes this as an 'existential lostness'[46].

Critics of this relationship have suggested that mothers have become too overly invested in mothering, viewing breastfeeding as a way to signal to others that they are 'good' and 'moral' mothers[47,48] (Faircloth, 2010; ryan et al). This need has been portrayed as disempowering[49] (Crossley) and as symbolic of overall pressure on women to behave in a certain way dictated by societal, gendered and moral norms[50] (Shaw, 2004). However this is in direct contrast to many women's experiences who describe breastfeeding as fulfilling[42] (davim) and empowering[51] (). If women wish for something biologically normal to be part of their identity as a mother, why should this be criticised? It is not saying that *all* mothers should feel this way, or that mothers who do not breastfeed are less of a mother. Where does this feeling come from and how we can prevent it from happening, whilst simultaneously allowing those women who are breastfeeding to hold it as part of their identity?

### *3. Maternal rewards: Pride, pleasure and achievement*

An almost unspoken factor when considering the loss of a breastfeeding experience is the loss of the positive factors breastfeeding can bring to the mother. Breastfeeding is often

posed as for the infant, where in fact it is a mutually beneficial relationship. Physiologically mothers experience reductions in risk across reproductive cancers, heart disease and diabetes if they breastfeed. However, although mothers will often cite these reasons for deciding to breastfeed, a successful breastfeeding experience can bring forth a whole host of positive and personal rewards[29,30] (Knaak 2010; Brown & Lee, 2012).

Breastfeeding can be a source of feeling connected, and intimacy[52,53] (Schmeid, 2001; Battersby 2006). Breastfeeding can be a great source of pride, especially if she has overcome challenges[30,54] (Brown & Lee, 2012; shepherd et al 2017). Breastfeeding can be a pleasurable experience, especially once mothers move past those early days and weeks when the dyad are mastering the skill[31,51] (Schmeid, 1999; loof). Breastfeeding can also bring about a personal sense of achievement, feeling like something mothers have 'got right', especially if they have had a difficult birth[55,56] (Hall et al, 2007; manhire).

Of course all of these connotations give fuel to the common criticism that mothers, especially when they breastfeed past infancy or in public[57] (daglas), are simply 'doing it for themselves'. This is nonsensical, and globally many infants breastfeed into the third year and beyond. However, how much of this disdain is clouded by wider views of women and the female body? In what comparative way would men face the accusation that if they experienced pleasure from a reproductive function, or had a part of their body that wasn't working correctly that they wanted fixed, that they were simply doing it for themselves or being selfish?

Take the comparator of male sexual organ dysfunction, erectile dysfunction. Albeit involving a primary rather than secondary sexual characteristic, the equivalent argument of 'simply doing it for yourself' and a lack of research into dysfunction would not occur. Numerous research studies have explored the impact of erectile dysfunction upon quality of life, depression and anxiety, with specific tools developed to measure its psychological impact[58,59] (Latini et al, 2002) and satisfaction with treatment[60] (Althof et al, 1999). Investment in research and treatment for the condition is vast, with 9 billion dollars spent globally on prescriptions each year[61]. Five times as much research is conducted into erectile dysfunction than research into Premenstrual syndrome and dysphoric disorder, despite this

affecting five times as many women than men[62]. Male bodily dysfunction is recognised as significant, important and worth investing in, rather than persuading men that it does not matter.

***The way forward***

It is established that for many women, aside from being a normal biological function that should not have to be defended, a successful breastfeeding experience can be protective of both physiological and psychological health. However we know that many women are not part of this experience, instead being left with a web of complex negative memories and emotions. Breastfeeding promotion remains a public health priority, but we must do more to understand and protect women who have not been able to meet their breastfeeding goals.

Proponents of the 'fed is best' argument uphold the idea that removing discussion of the importance of breastfeeding (or creating an equal platform for all feeding options) would reduce the number of women negatively affected by their infant feeding experiences. This may work for some, but for others, the literature strongly calls this into question. Not all negative emotions are driven by the concept of 'militant lactivists' supposedly casting shame upon women who not breastfeed; women themselves want to breastfeed for reasons other than health. They talk about the feelings of loss they experience, whilst women who have been able to meet their goals talk about the feelings of connectedness and pride they feel. Many women who wanted to breastfeed but were unable to feel a host of negative emotions precisely because they wanted to. Not because they were told to, but because their experience was important to them. Therefore, to make any real difference, we need to create a better environment for women to breastfeed in,

Breastfeeding decisions, just like emotions, are complex. Physiological impediments to breastfeeding do occur, although most impact upon ability to produce sufficient milk rather than any milk at all[63]. However the proportion of women experiencing breastfeeding challenges is significantly above this expected level. Women's ability to breastfeed is being affected by socio-cultural factors in their environment[64]; a statement supported by vastly

differing durations of breastfeeding around the world[65] (Brown, 2017). Issues such as a disinvestment in health services, negative public attitudes, unsupportive family and friends, financial pressures, and inaccurate beliefs around breastfeeding and normal infant behavior can all cause challenges with breastfeeding that lead mothers to stop before they had planned, removing their choice and volition[66-71] (Meedya, Fahy & Kable, 2010; Renfrew, McCormick, Wade, Quinn & Dowsell, 2012; Brown & Harries, 2015; Rollins et al, 2016).

To move forward we must invest in mothers. We may have breastfeeding promotion messages, but the support available for mothers is still lacking[72,73] (schmied, brown; entwistle). A primary focus of this must be more investment into understanding lactation complications in the first place. As Jennifer Grayson writes in her book Unlatched, 'there are no tests' when it comes to lactation complications. In discussion with Professor Peter Hartmann, she explores how although a typical course of action if you have a physiological health issue is to visit a medic, the solution for many medics to a breastfeeding challenge is to give formula milk[74]. Public health bodies are raising expectations, but failing to support and protect mothers to breastfeed, or to have answers if they cannot. No wonder so much grief, hurt and anger abounds.

We must stop telling women that their breastfeeding expectations, goals and dreams do not matter. Miriam Labbok spoke eloquently about the concept of breastfeeding grief. Women who want to breastfeed but are unable to do so are not simply grieving the loss of a means of providing nutrition to their infant. They are grieving the loss of a relationship, a source of emotional fulfilment, and an identity. When people are grieving we do not tell them that their hopes did not matter. Instead we support them, as Labbok proposed to move through their grief by identifying it, feeling it and working through it[75].

We must stop telling women that their hopes and dreams when it comes to breastfeeding their baby do not matter.

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