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1 **Abstract:**

2 Emotions such as guilt and blame are frequently reported by non-breastfeeding mothers, and  
3 fear and humiliation is experienced by breastfeeding mothers when feeding in a public  
4 context. In this paper we present new insights into how shame-related affects, cognitions and  
5 actions are evident within breastfeeding *and* non-breastfeeding women's narratives of their  
6 experiences. As part of an evaluation study of the implementation of the UNICEF UK Baby  
7 Friendly Initiative (BFI) Community Award within two primary (community-based) care  
8 trusts in North West England, 63 women with varied infant feeding experiences took part in  
9 either a focus group or an individual semi-structured interview to explore their experiences,  
10 opinions and perceptions of infant feeding. Using a Framework Analysis approach and  
11 drawing on Lazare's categories of shame, we consider how the nature of the event (infant  
12 feeding) and the vulnerability of the individual (mother) interact in the social context to  
13 create shame responses in some breastfeeding and non-breastfeeding mothers. Three key  
14 themes illustrate how shame is experienced and internalised through 'exposure of women's  
15 bodies and **infant feeding methods**', 'undermining and insufficient support' and 'perceptions  
16 of inadequate mothering'. The findings of this paper highlight how breastfeeding and non-  
17 breastfeeding women may experience judgement and condemnation in interactions with  
18 health professionals as well as within community contexts, leading to feelings of failure,  
19 inadequacy and isolation. There is a need for strategies and support that address personal,  
20 cultural, ideological and structural constraints of infant feeding.

21  
22 **Key terms:** breastfeeding, formula feeding, guilt, infant feeding, qualitative, shame, women

23  
24

25 **Introduction**

26 **Breastfeeding is acknowledged** as providing health benefits to both mothers and infants. The  
27 World Health Organisation (World Health Organization, 2003) recommend that mothers  
28 should breastfeed exclusively for the first six months, and thereafter continue to provide their  
29 infants with breast milk for up to two years of age or beyond. Despite this recommendation,  
30 breastfeeding rates vary widely; in Sweden 83% of all babies are exclusively breastfed at one  
31 week of age and 11% at six months (The National Board of Health and Welfare, 2012); in the  
32 UK, the corresponding rates are 46% at one week and <1% at six months (McAndrew et al.,  
33 2012).

34  
35 There are numerous accounts of women's emotional responses to infant feeding. Murphy  
36 (1999) has suggested that regardless of how women feed their infants, infant feeding becomes  
37 a 'moral minefield' and an 'accountable matter' as women are judged or judge themselves on  
38 their efforts in being 'not only good mothers but also good partners and good women' (p.187,  
39 205). The message frequently summarised as 'breast is best' reflects scientific knowledge on  
40 the nutritional and immunological benefits of breast milk for infants (American Academy of  
41 Pediatrics, 2012) as well as carrying moralistic dimensions. In many cultures, breastfeeding is  
42 synonymous with 'good mothering' (Dykes & Flacking, 2010; Hauck & Irurita, 2002;  
43 Schmied & Barclay, 1999). When mothers make a decision not to breastfeed, they may  
44 experience guilt, blame and feelings of failure (Lakshman et al., 2009; Lee, 2007). Taylor and  
45 Wallace (2012), in their theoretical framework aimed at understanding maternal responses to  
46 infant feeding, argue how formula feeding mothers may experience shame (as opposed to  
47 guilt) through 'failure' to live up to ideals of womanhood and motherhood. They also argue  
48 that breastfeeding mothers may experience shame through the violation of feminine modesty  
49 when breastfeeding in public (Taylor & Wallace, 2012); the real or imagined humiliation, and  
50 fear of criticism, associated with public breastfeeding is reported by others (Dykes, 2007;  
51 Thomson & Dykes, 2011).

52  
53 Shame is considered to incorporate affect (e.g. fear, anger, humiliation, self-disgust, anxiety,  
54 low self-esteem, depression), cognitions (e.g. feelings of rejection, inferiority and  
55 inadequacy) and actions (e.g. withdrawal and isolation or retaliation) (Gilbert & McGuire,  
56 1998; Lewis, 1971; Scheff, 1997). Whilst shame is often used inter-changeably with guilt,  
57 these are considered to be two distinct emotions (Lazare, 1987; Scheff, 1997). Shame is  
58 believed to occur when there is a breach between the cognitive evaluation of the ideal self

59 and that of the actual self (Rubin, 1968). The self-evaluation giving rise to shame emerges  
60 through an awareness of a deficiency or feelings of not being good or good enough: a global  
61 negative feeling about the self in response to a goal not reached, or some short-coming  
62 (Lazare, 1987; Niedenthal et al., 1994; Scheff, 1997). Guilt, on the other hand, refers to  
63 behaviours or transgressions: a sense of doing a ‘bad thing’ (or of not having done a good  
64 thing) (Niedenthal et al., 1994). Guilt comprises feelings of tension, remorse and regret, but  
65 does not incorporate the self-condemnation associated with shame (Lazare, 1987; Lewis,  
66 1971). One of the key problems in the definitions relates to how these emotions co-occur; an  
67 act may make the individual feel guilty and, on internalisation, he/she subsequently  
68 experiences shame (Lazare, 1987).

69  
70 Shame is considered to be a universal and fundamental social emotion (Kaufman, 1996). Its  
71 emergence is based on the evaluation of ‘self’ in the form of its real or imagined appearance  
72 to the ‘other’ and the imagined judgement of that appearance (conveyed via facial  
73 expressions, gestures, verbal intonations and explicit criticism) by the ‘other’ (Lazare, 1987;  
74 Scheff, 1997). Tangen, Miller, Flicker & Barlow (1996) define shame as:

75  
76 *‘..both agent and object of observation and disapproval, as shortcomings of the*  
77 *defective self are exposed before an internalized observing “other”. Finally shame*  
78 *leads to a desire to escape and hide – to sink into the floor and disappear’.* (p. 1257)

79  
80 Lynd (1958) argues that the ‘whole-self’ involvement characteristic of shame is what makes  
81 it so potent. People may therefore adopt defence mechanisms such as distancing themselves  
82 from whatever/whomever induces the feelings of shame (Lazare, 1987) or through blaming  
83 others. Even when we know we have done nothing wrong, shame can be experienced as a  
84 consequence of knowing that we have presented a ‘negative’ and ‘unattractive’ image of  
85 ourselves to others (Gilbert & McGuire, 1998).

86  
87 Shame may be particularly salient during the development of maternal identity (Rubin, 1984).  
88 Positive judgements in relation to infant feeding methods may increase the mother’s self-  
89 confidence, whereas negative judgements produce reduced confidence and maternal  
90 wellbeing (Hoddinott et al., 2012; Taylor & Wallace, 2012; Thomson & Dykes, 2011). In the  
91 wider literature, guilt and blame is frequently cited in association with women’s experiences  
92 of formula feeding, with discomfort, humiliation and fear appearing as descriptors of

93 experiences of public breastfeeding. The aim of this paper is to provide a unique perspective  
94 on infant feeding by describing how discourses of shame are evident within the experiences  
95 of breastfeeding and non-breastfeeding women.

96

## 97 **Methods**

98

### 99 *Context & Setting*

100 This paper reports on data collected with women as part of a wider evaluation of the  
101 implementation of the UNICEF/WHO Community Baby Friendly Implementation project in  
102 two community health facilities in North West England. Focus groups and individual  
103 interviews were undertaken with stakeholders, health professionals and mothers. In this paper  
104 we report on the consultations undertaken with mothers. The purpose of these consultations  
105 was to ascertain their attitudes and experiences as well as barriers to and facilitators of infant  
106 feeding, which could subsequently be utilised to help inform the planning and organisation of  
107 services.

108

### 109 *Ethics*

110 The full evaluation proposal was reviewed and approved by the Research & Development  
111 Units at the two hospital trusts and full ethics approval was granted through **the Faculty of**  
112 **Health Ethics Committee (proposal 277)** at the lead author's University. Ethical issues in  
113 relation to informed consent, confidentiality and withdrawal were adhered to throughout this  
114 study.

115

### 116 *Participants and Recruitment*

117 Following heads of service approval, health professionals and coordinators of various mother  
118 and baby groups or clinics (baby massage, mother and baby groups, breastfeeding groups)  
119 were asked to approach women to ascertain their willingness to participate. The contact  
120 details of all consenting women were forwarded to the first author, and focus groups dates  
121 were organised between the first author and coordinators once initial agreement had been  
122 sought. **A total of 63 women took part. Participant characteristics are presented in Table 1.**

123

124 **Insert Table 1**

125

126 Whilst socio-economic identifiers were not recorded, care was taken to recruit women from  
127 areas of high and low deprivation. This was achieved by professionals being asked to target  
128 women from a range of different backgrounds and infant feeding experiences to take part in  
129 an interview. The groups targeted for recruitment were also situated in areas of high and low  
130 deprivation. There were no specific exclusion criteria for this study or fixed sample size,  
131 rather the aim was to elicit a broad range of views in regard to infant feeding experiences and  
132 support needs. Data collection ceased when it was considered that a diverse sample and  
133 variety of perspectives had been obtained. All of the women had some experience of  
134 breastfeeding (with their first and/or subsequent children), with duration ranging from a few  
135 days to > 12 months. The routinely collected breastfeeding initiation rates in the geographical  
136 areas where these women reside for the periods 2008/2009 and 2009/2010 were between 56-  
137 63% and 60-68% and for 6-8 week duration rates (total or partial breastfeeding) between 20-  
138 30% and 22-35% respectively. At the time of the interview some 43 (68%) of the women in  
139 this study were either fully or partially breastfeeding their infant; these data suggest that the  
140 infant feeding rates of our participant group are fairly representative of the local population.

141

#### 142 *Data collection*

143 A semi-structured interview/focus group schedule was devised based on existing literature  
144 and consultation with the project team. Questions were designed to elicit women's current  
145 infant feeding status, intentions and motivations regarding infant feeding and barriers and  
146 facilitators to support (a summary of the key questions is presented in Table 2). Sixty-three  
147 women took part in seven focus groups (n=33) and 28 individual interviews (two interviews  
148 involved two participants). Sixteen interviews were undertaken in the participant's homes,  
149 with the remaining interviews or focus groups taking place at mother and baby groups/clinics.  
150 The interviews/focus groups took between 25 to 80 minutes to complete and were digitally  
151 recorded and transcribed in full. All data collection was undertaken during 2008-2010 by the  
152 first author.

153

#### 154 **Insert Table 2**

155

#### 156 *Analysis*

157 Analysis was informed by the Framework Analysis method originally devised by Ritchie &  
158 Lewis (2003). A key strength of this approach relates to the way in which inductive  
159 (emergent issues) and deductive (application of a theoretically informed framework) analysis

160 can summarise data into thematic matrices to enable patterns or explanations to be identified  
161 (Gale et al., 2013). In this study, Lazare's (1987) categories of shame were used as a  
162 theoretical framework. Lazare (1987) postulates that shame in a medical/clinical encounter  
163 may be understood as operating from the interaction between three factors: 1) shame-  
164 inducing event; 2) vulnerability of the subject and 3) the social context of the shame. We  
165 selected this framework due to its capacity to illuminate how shame is experienced through  
166 an interaction of personal, cultural, structural and social factors.

167  
168 Initially, two of the authors (GT, KEB) engaged in a process of immersion and familiarisation  
169 of the transcripts to identify key codes and themes against Lazare's three categories of shame.

170 Drafts of the initial analysis were also shared and discussed with RF on an on-going basis. A  
171 single tree structure coding index was agreed and applied in MAXQDA and 'descriptive  
172 accounts' were subsequently undertaken through refinement of the themes and associations  
173 within the data set. Finally, 'explanatory' accounts were produced to illuminate how similar  
174 concepts of shame were experienced amongst those with divergent experiences of infant  
175 feeding.

176

## 177 **Findings**

178 Lazare (1987) considered that shame occurs through a dynamic interaction between the  
179 shame inducing event (i.e. infant feeding method), the individual's (mother's) vulnerability  
180 and the social context. In the following sections we first consider how infant feeding can be  
181 considered a shame-inducing event. We then describe the conditions which exacerbate the  
182 vulnerabilities of new motherhood. Within the social context three themes describe how  
183 shame is experienced and internalised by both breastfeeding and non-breastfeeding mothers  
184 through; 'exposure of women's bodies and infant feeding methods', 'undermining and  
185 insufficient support' and 'perceptions of inadequate mothering'. A selection of illuminating  
186 quotes is included (with a pseudonym or focus group identifier). Whilst shame comprises  
187 negative emotions, it is an experience of the self which goes beyond the emotions it induces  
188 and relates to the interaction between perceptions of self and perception by others. Our  
189 interpretations of the data illuminate how some breastfeeding and non-breastfeeding women  
190 experience shame through feelings of fear, humiliation, inferiority and inadequacy. Our  
191 findings also emphasise the potential negative implications of shame responses in terms of  
192 social isolation and withdrawal due to the potential for pressure and counter-productive  
193 effects emerging from the 'breast is best' discourse, and women's reticence in seeking out

194 and engaging with health professionals and services due to fear of condemnation or reprisals.  
195 These findings are not intended to suggest that *all* breastfeeding and non-breastfeeding  
196 women experience shame; rather that shame affects cognitions and/or actions and was  
197 experienced by many of the women we consulted.  
198

199 *Infant feeding as a shame-inducing event*

200 According to Lazare (1987), the shame-inducing event is one which involves individuals  
201 experiencing physical or psychological limitations that assault self-perceptions of self-  
202 control, independence and competence. All of these issues were evident in many of the  
203 women's infant feeding narratives, which frequently indicated a sense of feeling out of  
204 control and dependent on others through insufficient information and lacking or inappropriate  
205 infant feeding support. Furthermore, when mother's infant feeding methods were not  
206 experienced as intended (by self and others), this could lead to feelings of incompetence,  
207 inadequacy and inferiority.  
208

209 Whilst Lazare (1987) considered that individuals can feel stigmatized or socially discredited,  
210 through anticipated or actual unfavourable reactions by others, he believed that there were  
211 specific categories of 'diseases' that were more likely to induce shame. These categories  
212 concern 'offending others through their sight'; involve 'sexual or excretory organs' and  
213 'behaviours perceived by others as weak, stupid or immoral manifestations of personal  
214 failure' (p. 1654). Whilst we are not suggesting that infant feeding is a 'disease', the  
215 medicalization of infant feeding render situations and experiences where the method becomes  
216 a 'disease' in terms of how shame is experienced, internalised and enacted-. Breastfeeding,  
217 and bottles can all cause 'offence' to others; similarly, due to the cultural sexualisation of  
218 women's breasts, infant feeding is perceived to involve sexual organs, and women may  
219 internalise their feeding choices as either failure (for those who do not breastfeed) or morally  
220 and socially unacceptable (for those who do breastfeed). Certain practices of breastfeeding  
221 may also carry their own shame. Breastfeeding outside the home environment is an evident  
222 and much-discussed example of this. A further example relates to 'others' judgements on  
223 acceptable and unacceptable breastfeeding practices which appear implicitly associated with  
224 conceptions of 'good' mothers and 'good' babies.  
225  
226  
227

228 Vulnerability of the Subject (Mother)

229 Lazare (1987) considered that when our basic emotional needs of being loved, taken care of  
230 and accepted are not met we become susceptible to shame. The narratives highlighted that  
231 whilst the women often held ideals of being a 'good mother' or feeling overwhelmed by new  
232 motherhood, the cultural influences and the lack of preparation made some mothers feel  
233 anxious, fearful and dependent. Mothers, particularly first-time mothers, often felt  
234 overwhelmed by new motherhood, an experience exacerbated by the physical and/or  
235 psychological implications of childbirth, particularly for those who had a distressing, assisted  
236 or operative birth:

237

238 *I had a section and I was completely out. You wake up and your baby is there and*  
239 *you do lose that initial bond really [ . . . ] I could not get out of bed, so someone had to*  
240 *bring me the baby, but then I could not put him back down or anything or change his*  
241 *nappy or anything. (Teresa)*

242

243 New mothers were not always aware of what questions to ask, nor what support was needed  
244 until faced with the realities of motherhood: *'I needed someone there, I needed support, I had*  
245 *no idea what I was doing'*. The reliance on health professional support also magnified  
246 amongst those with limited support networks: *'no one around us apart from friends'*.

247

248 Many of the women had little or no vicarious experiences of breastfeeding within their family  
249 or personal networks: *'no one I knew had breastfed'*, nor within the wider community: *'you*  
250 *just don't see people breastfeeding when you are out and about'*. A familial history of  
251 breastfeeding could positively influence a woman's decision to breastfeed: *'I always wanted*  
252 *to and the reason was because of my mum'*. Others spoke of how negative comments from  
253 within their personal networks undermined their confidence and potentially induced shame  
254 associated with breastfeeding: *'she (Aunty) said you will be like a cow. She weren't really*  
255 *encouraging'*.

256

257 Conversely, many women referred to how they were *'expected'* or felt under *'pressure'* to  
258 breastfeed, a pressure transmitted by cultural messages as well as via health professionals.  
259 Women often experienced this as an additional burden within the already bewildering state of  
260 new motherhood:

261

262 *I think there was too much emphasis on breastfeeding. [...] The tone of it needs to be*  
263 *different, the way it's done needs to be different, more sensitivity around it definitely.*  
264 *You have all the pressure and you don't need it. If it's your first, trying to cope with a*  
265 *new baby, nothing that you read prepares you for it. (Angela)*

266  
267 *The discourse around breast being 'best' and 'natural' was often so at odds with women's*  
268 *pre-natal ideals and expectations; this led to self-doubt and anxiety: 'I was upset that I didn't*  
269 *carry on like I wanted to - I thought it would come naturally'; 'They [health professionals]*  
270 *tell you to breastfeed and they don't tell you how painful it can be'.*

271  
272 *Social Context of Shame*

273 In this section three key themes describe how shame was experienced and internalised by  
274 breastfeeding and non-breastfeeding women in a social context: 'exposure of women's bodies  
275 and infant feeding methods', 'undermining and insufficient support' and 'perceptions of  
276 inadequate mothering'.

277  
278 *Exposure of Women's Bodies and Infant Feeding Methods*

279 Lazare (1987) considers how shame is experienced in medical/clinical encounters through  
280 experiences of physical and psychological exposure of defects, inadequacies and  
281 shortcomings. These issues were reflected *in the narratives* in accounts of the manhandling  
282 and objectification of women's breasts, and the real or perceived negative reactions, and  
283 responses from others.

284  
285 Health professionals 'handling' of women's breasts in an attempt to facilitate breastfeeding  
286 was often negatively internalised by women. Lazare (1987) considered that the potency for  
287 shame was related to the level of public exposure, and the significance of those involved. For  
288 some women, the objectification and manipulation of their 'sexual' organs in front of  
289 professionals and often their partners induced intense distress and humiliation:

290  
291 *She [midwife] literally just got hold of it [breast], squeezed it and went like that*  
292 *[demonstrating the action] I was mortified, I was just like that's my breast you've got*  
293 *hold of, [. . .] and they did it in front of X [partner] and I think I did get a bit*  
294 *...because men do see boobs in a different way don't they and although I could do*

295           *anything in front of X, I could see his face being really supportive but a bit “oh my*  
296           *god”.* (Lorraine)

297  
298 The professional’s assistance in the performance of a ‘natural’ activity served to highlight the  
299 potential for women to be perceived by implication, and thus to perceive themselves, as  
300 deficient in their ability to ‘manage breastfeeding’, leading to lowered confidence in their  
301 capacity to breastfeed:

302  
303           *The one [midwife] who came pulled my gown down, plonked her on, didn’t tell me*  
304           *what she was doing or anything, kept rubbing her head dead hard into my boob, made*  
305           *her latch on and then walked off. So I was like thank you, next time I will really know*  
306           *what to do, won’t I.* (Gail)

307  
308 As evident within the wider literature (e.g. (Thomson & Dykes, 2011), many women  
309 identified real or imagined reactions to public breastfeeding as a key area of difficulty:

310  
311           *I didn’t do it [public breastfeeding]. I was more concerned with people looking and*  
312           *thinking why is she doing that in public she shouldn’t be here, she should be doing*  
313           *that somewhere behind doors, inside in privacy.* (Ava)

314  
315 Only a small number of women interviewed actually breastfed in public. Whilst some of  
316 these women spoke of being ‘stared at’, ‘looked at weird’, ‘frowned at’, ‘tutted at’ or asked to  
317 leave premises, for others it was the imagined fear of receiving these responses that prevented  
318 them from feeding outside the family home. Women often associated the social stigma of  
319 public breastfeeding with the violation of a societal norm - ‘we are a discreet nation’ - with  
320 the fact of how women’s ‘breasts are sort of sexualised now rather than practical’. A few of  
321 the mothers who were still breastfeeding toddlers (12+ months) also referred to how they felt  
322 ‘uncomfortable’ and ‘uneasy’ feeding their infants in front of others, due to perceptions of  
323 judgement for this ‘not normal’ practice. However, the impact of the woman’s social and  
324 cultural network in terms of whether ‘any’ breastfeeding was acceptable was also  
325 highlighted; with breastfeeding mothers believing themselves to be castigated as ‘hippies’,  
326 ‘weirdos’ or ‘naturalists’:

327

328 *'Sometimes I think it would be easier to have a bottle, you can go anywhere and do*  
329 *anything, Nobody has an issue with a baby having bottled milk'. (Annabel)*

330  
331 In response to these cultural condemnations, women displayed actions arising from shame  
332 such as 'withdrawing from others' (Tantam, 1998, p.172) by staying at home, '*finding*  
333 *somewhere quiet*' and '*out of the way*', or within specifically designated breastfeeding areas,  
334 thereby avoiding situations in which they might have found themselves vulnerable (Lazare,  
335 1987). Women frequently described breastfeeding as a marginalised, invisible activity, with  
336 public breastfeeding often only considered acceptable when it had been mastered; skill in  
337 breastfeeding was equated with discretion: '*I wouldn't have sat publicly anywhere until I was*  
338 *really good at it, and could hide it*'. In this way, Lazare's definition of shame as relationship  
339 is played out in the responsibility felt by the breastfeeding mother not to impact, or to impact  
340 in the 'correct' way, on those around her; the sense of shame thereby becomes a determinant  
341 of her behaviour.

342  
343 Similar issues of judgement were also identified amongst non-breastfeeding women through  
344 comments made within their social networks, '*people make the odd comment like "why are*  
345 *you not breast feeding", they shouldn't ask questions like that*'. However, it was often within  
346 the context of women's relationships with health professionals that those who were formula  
347 feeding, or even using bottles for expressed milk, felt they were deviants:

348  
349 *I don't think they liked that I stopped breastfeeding. They tend to give people who do*  
350 *bottle-feed a bit of a "hmmm you shouldn't be doing that, you should be*  
351 *breastfeeding"* (Bernie)

352  
353 Many of the non-breastfeeding mothers disclosed shame responses such as having to '*hide*'  
354 their bottles and expressed '*feeling scared*' '*frightened*' and '*in fear*' of informing  
355 professionals of their infant feeding method:

356  
357 *I felt so guilty and bad about giving up, but I just couldn't stand the pain. When I was*  
358 *in hospital I had to go and get my own bottles and make them up. I [. . .] felt really*  
359 *frowned upon, and made to feel really bad. I was really frightened of saying "I don't*  
360 *want to". I was in fear of telling the midwife. (Kryshia)*

361

362 The perceived undesirable nature of their actions was also reinforced by what women  
363 considered to be a 'conspiracy' of silence amongst health professionals through them not  
364 discussing or offering support for bottle-feeding.

365

#### 366 Undermining and inadequate support

367 According to Lazare (1987), it is when individuals seek professional help that the interaction  
368 between the shame-inducing event and the individual's vulnerability occurs. Across the  
369 narratives, shame was experienced by breastfeeding and non-breastfeeding women when  
370 undermining or inadequate support was received.

371

372 A number of the women spoke of having 'the guts' and 'confidence' to seek support and  
373 subsequently facing further perceptions of failure when their needs were not met. Some were  
374 told to 'stop buzzing' for staff in hospital, felt too 'frightened' to pester over-stretched staff  
375 and perceived themselves to be 'a pain' when support was requested. For one breastfeeding  
376 woman, a professional's attempts at reassurance only served to intensify her sense of  
377 vulnerability and failure. The quote below suggests that what professionals may view as a  
378 positive approach may in fact augment the experience of 'shame' due to the inherently  
379 judgemental nature of language used:

380

381 *I got fed up of people telling me I was doing a good job. [ . . . ] I wanted somebody to*  
382 *help me and actually find a solution to the problem I was facing. I think it is*  
383 *underestimated how vulnerable you feel and how much of a failure you feel and that*  
384 *is not really the right thing to say to people. (Focus group 7)*

385

386 Some of the women who formula fed from the early post-natal period or after a period of  
387 breastfeeding also reported marginalisation through a lack of support:

388

389 *When you bottle-feed you don't get as much help. I did try so hard [to breastfeed] I*  
390 *kept blaming myself that I couldn't do it. [ . . . ] it was too painful and however much I*  
391 *tried I couldn't get him on, and wasn't feeding properly. [ . . . ] But when you decide "I*  
392 *don't want to do it anymore", it seems the support goes out the window. [ . . . ] It did*  
393 *get me very very down, it felt like they turned against me because I was bottle-feeding.*  
394 *(Focus group 4)*

395

396 Restrictions or inhibitions on discussing substitute feeding methods (both on the post-natal  
397 ward and in the community) left women feeling dejected and isolated:

398

399 *Bring the choice back for god's sake, when breastfeeding doesn't work, bottle feeding*  
400 *is a good alternative. I didn't have a clue what I should be using. (Annie)*

401

402 The enforced dependency of mothers on the medical model was also in evidence when  
403 women experienced incapacity to breastfeed, perceived or otherwise:

404

405 *'They wouldn't allow me to cup feed her, so I had to wait for a midwife to be free [ . .*  
406 *]. I did ask as it was distressing that I couldn't feed my child'. (Belinda)*

407

408 The term 'support' acted as a barrier to help-seeking behaviours due its association with  
409 'problems' and potential negative connotations for a woman's capacity to mother: '*when you*  
410 *say the word support it makes it feel like you need support with a problem*'. These concerns  
411 often created additional tension between women's desire to discuss options with  
412 professionals and their fears of being perceived as '*unable to cope*'. Avoidance of help-  
413 seeking reflected an internalised process of shame through women presenting idealised  
414 images of 'coping', with fears of the consequences of 'not coping', whether actual or in terms  
415 of self-image, leading to withdrawal and isolation (Lazare, 1987):

416

417 *I think it was the fact that I didn't want to appear that I wasn't coping and I didn't*  
418 *want people thinking that, even though I know at the back of my mind that they*  
419 *wouldn't be thinking that. (Lorraine)*

420

#### 421 Perceptions of inadequate mothering

422 Lazare (1987) states that shame occurs when we are "not the kind of persons we think we are,  
423 wish to be, or need to be" (p. 1653). Many mothers felt a degree of exposure of their  
424 'undesirable' selves to others, creating a rupture between the ideal (e.g. the 'good' mother)  
425 and actual self (Rubin, 1968).

426

427 Non-breastfeeding women frequently referred to how pro-breastfeeding discourses and  
428 negative verbal and/or non-verbal responses from others, primarily health professionals, led  
429 them to feel '*second best*', a '*bad mother*' who was '*denying*' and '*depriving*' their child:

430  
431 *Breastfeeding [...] is pushed down your throat and out of guilt you are made to feel if*  
432 *you don't do it, you are doing your child a mis-justice. Everybody everywhere pushes*  
433 *breastfeeding, and [I] feel they look down your nose at you if you don't.* (Kryshia)

434  
435 Reactions from health professionals led some of the non-breastfeeding women to feel  
436 inadequate and defective: *'they make you feel there is something wrong with you, a body part*  
437 *or your baby'*. Many non-breastfeeding women made self-depreciating reflections on their  
438 characteristics and capabilities and blamed themselves for the negative health and emotional  
439 implications of their **infant feeding method**. One woman described how she took the *'easy*  
440 *option'* when she stopped breastfeeding and blamed herself because her son had developed  
441 eczema and other allergies; *'they say if you breast feed they don't get that'*. Other spoke of  
442 how they *'gave up too early'* and of the *'guilt'*, *'regret'*, *'disappointment'*, *'shame'* associated  
443 with, and subsequent morbidity attributed to, their infant feeding decisions:

444  
445 *I ended up suffering from quite severe postnatal depression, I have always wondered*  
446 *whether that was something to do with it, if I could have breastfed would it have*  
447 *happened.* (Jill)

448  
449 One woman directly referred to how her *'failure'*, her having *'give[n] in'*, was a direct affront  
450 to her self-perceived identity:

451  
452 *I always thought I had a lot of patience and that's what upset me more because I just,*  
453 *I don't really give in.* (Lorraine)

454  
455 Some of the mothers who had initiated but discontinued breastfeeding described how bottle-  
456 feeding had disrupted their *'closeness'* with their infant. These women experienced dejection  
457 and a sense of inadequacy as, in their view, the maternal role became de-valued and eroded as  
458 *'everyone else could take over then'*.

459  
460 Conversely, a number of breastfeeding women made reference to the negative judgements  
461 received by health professionals when describing the baby's behaviour - *'he's too lazy'* or  
462 *'too eager'* - and/or the women's anatomy, e.g. their breasts or nipples being *'too big'* or *'too*  
463 *small'*. **The vulnerability of the post-partum state in the following woman's account,**

464 contributed to the effect of what might appear to be blame directed towards the woman or  
465 baby, with at least the potential corollary of shame:

466  
467 *Quite a lot of comments were negative and when you are in the state you are in,*  
468 *you've had a section and your hormones are all over the place and you're tired, you*  
469 *don't want to hear negative comments and that it's something that you or he [baby] is*  
470 *doing. You just want to hear it's just not working at the minute. I know they mean*  
471 *well, [and don't] say things to upset you, but that is what will stick in my mind.*  
472 (Annie)

473  
474 Lazare (1987) emphasised the significance of others in our personal networks in the  
475 exacerbation or mitigation of shame. A few breastfeeding women described themselves as  
476 'mean' or 'selfish' for adopting an infant feeding method that precluded others' involvement  
477 in the care of their infant. Other women received condemnations from others' within their  
478 personal networks, leading to negative emotions and cognitions indicating the potentially  
479 shame-inducing circumstance of being viewed as contravening appropriate mothering  
480 practices:

481  
482 *My father and my step mother really, really upset me. They would say "I don't know*  
483 *why you are bothering, you put yourself through all this for nothing, just get her on a*  
484 *bottle, she is not happy and you're not happy" and it was constant. I would say "I*  
485 *have got to get home to feed her", and they would say again, "there is something*  
486 *wrong with that child, she is always feeding". [...] I just wanted them to say we are*  
487 *really proud of you, you are doing a good job [...] but [...] it was like you are making*  
488 *a rod for your own back, you are making life difficult (Kathy)*

489  
490 Occasionally, women responded to the criticism by 'others' by withdrawal from the social  
491 sphere, leading to potentially destructive emotional and social consequences:

492  
493 *I have just shut off from everyone now. I am not listening, I am doing it my way and I*  
494 *just ask when I need help instead of everyone just bombarding me, because I went*  
495 *dead depressed. (Bernie)*

496  
497

498 **Discussion**

499 This paper illuminates the experience of shame by breastfeeding and non-breastfeeding  
500 women. The application of Lazare's (1987) framework uncovers the extent to which infant  
501 feeding may reflect a shame-inducing event. The vulnerabilities of new motherhood, such as  
502 the physical and psychological implications of childbirth and lack of preparation for infant  
503 feeding, may render women susceptible to shame. Our findings highlight how negative  
504 reactions and responses to women's bodies, abilities and infant feeding methods,  
505 undermining and inappropriate support from 'others' can lead breastfeeding and non-  
506 breastfeeding mothers alike to feel inadequate, defective and isolated. We contend, like  
507 Taylor & Wallace (2012), that shame, as opposed to guilt or humiliation, is a more  
508 appropriate concept through which to consider women's infant feeding experiences, due to  
509 its occurrence within social contexts of being perceived and judged by others and to its  
510 internalisation and enactment.

511  
512 Shame is considered to be a normal part of social interactions, social control and social  
513 conformity (Barbalet, 1999). However, shame may become disruptive when internalised and  
514 enacted in particular ways (Gilbert, 2000). In this study, a number of the breastfeeding and  
515 non-breastfeeding women disclosed affective responses of shame, such as feelings of fear,  
516 humiliation, inferiority and inadequacy. The potential negative implications of shame  
517 responses, e.g. fear of public breastfeeding leading to social isolation and/or breastfeeding  
518 discontinuation, the potential for pressure and counter-productive effects emerging from the  
519 'breast is best' **discourse**, and women's reticence in seeking out and engaging with health  
520 professionals and services due to fear of condemnation or reprisals, raise key concerns. The  
521 fact that shame is self-internalised and the associated implications of poor maternal mental  
522 health on disrupted and dysfunctional infant developmental outcomes and family functioning  
523 (Murray & Cooper, 1997; Royal College of Midwives, 2012) needs consideration.

524  
525 Lazare (1987) offers a number of methods for the mitigation of shame in the clinical  
526 environment. These include the creation of 'positive atmospheres' to enable patients to feel  
527 cared for and respected; the development of positive relationships in which 'weaknesses' are  
528 respected and cherished; the avoidance of emotive language; the provision of validation and  
529 praise; and the practice of 'clarifying personal perspectives on the problems' (p.1656-1657).

530 The current lack of sufficient breastfeeding support is widely acknowledged (Dykes, 2005a,  
531 2005b; Hoddinott et al., 2012; Schmied et al., 2011; Thomson & Dykes, 2011). Other studies  
532 argue that the focus on increasing breastfeeding rates has led to bottle-feeding women  
533 becoming marginalised (Lakshman et al., 2009; Thomson & Dykes, 2011) and health  
534 concerns have been identified in relation to health professionals not conveying appropriate  
535 formula feeding procedures to women (Dykes et al., 2012). The insights from our study  
536 confirm those of Taylor & Wallace (2012) and Murphy (1999) in terms of how mainstream  
537 breastfeeding advocacy and ideologies of the 'good' breastfeeding mother have participated  
538 in shaming non-breastfeeding mothers. A recent paper (Gribble & Gallagher, 2014) also  
539 indicates how breastfeeding is a human rights concern, a view which might add to the  
540 condemnation of non-breastfeeding mothers. However, the findings from this study also  
541 emphasise how breastfeeding women feel equally marginalized and shamed, as expressed in  
542 their social and clinical encounters and fears about breastfeeding in public spaces. As poor  
543 care and negative emotions is experienced by women irrespective of their infant feeding  
544 method, these insights highlight how breastfeeding and non-breastfeeding women require  
545 targeted, needs-led support throughout the perinatal period.

546  
547 A recent meta-synthesis of research into women's perceptions of breastfeeding support by  
548 Schmied et al (2011) identified how breastfeeding support occurs along a continuum from  
549 'authentic presence' to 'disconnected encounters'. 'Authentic presence' refers to a trusting  
550 partnership between the mother and supporter, with information and support tailored towards  
551 the values and needs of the woman. 'Disconnected encounters' were characterised by limited  
552 or no relationship, with information and advice provided in a didactic style. To illuminate the  
553 'quality' of breastfeeding support further, Burns et al (2013) identified two discourses in  
554 language and practices of midwives that led to disconnected encounters, both of which were  
555 evident in the current study. One discourse (i.e. "mining for liquid gold") refers to how  
556 midwives have the 'obligation' to ensure that babies received enough breast milk. By being  
557 'experts' midwives not only had the 'right' to introduce techniques and technologies to  
558 ensure optimal outcomes but also an undisputed right to the women's bodies. The other  
559 discourse leading to disconnected encounters (i.e. "not rocket science") was described as  
560 women being left to their own resources because breastfeeding was 'natural' and 'easy'. In  
561 both these discourses the midwives focused merely on the physical body and held a  
562 reductionist approach to breastfeeding support. However, Burns et al (2013) also identified a  
563 minority discourse (i.e. "breastfeeding is a relationship") where midwives regarded

564 breastfeeding as a relationship and therefore acknowledged the mother-baby relationship  
565 being central to the breastfeeding experience. These midwives spent time engaging with  
566 mothers on a personal level to get to know them and their babies needs and hence had a more  
567 'authentic presence'. We suggest that the findings of these studies (Burns et al., 2013;  
568 Schmied et al., 2011) are equally applicable to non-breastfeeding mothers and their  
569 relationships with their supporters, which would also benefit decisively from an 'authentic  
570 presence'.

571  
572 Whilst there appears to be a fine line between protecting women from what might appear as  
573 hurtful judgement and indirectly undermining the cause of breastfeeding, Taylor & Wallace  
574 (2012) emphasise how women should be enabled to provide their own definition of 'good  
575 mothers' so that 'they are empowered to incorporate a sense of self-concern' (p.78) into their  
576 self-image. Positive 'authentic' relationships based on trust and respect, which may or may  
577 not facilitate successful breastfeeding, could encourage maternal-led definitions of 'good  
578 motherhood', promote positive maternal health and work against women's reticence in help-  
579 seeking behaviours. Furthermore, raising awareness of breastfeeding difficulties, such as  
580 through the motivational model of breastfeeding support detailed by Stockdale et al (2011),  
581 may help to minimise women's vulnerabilities. The use of an ASSETs based approach (Foot,  
582 2012) in the maternity context that recognises how adoption of behaviours is situated within  
583 different personal, family and community environments may also be beneficial to mitigate  
584 against perceptions of shame irrespective of the women's infant feeding methods. A further  
585 suggestion offered by Lazare to mitigate shame relates to the use of support groups. The  
586 social, emotional and practical benefits of breastfeeding support groups have been reported in  
587 the literature (e.g. Thomson, Crossland, et al., 2012). The creation of 'infant feeding groups',  
588 as opposed to the current model of group ownership being determined by a specific feeding  
589 method, could enable these benefits to be available for all.

590  
591 Whilst Lazare's insights are targeted to a more clinically based context, this study also  
592 emphasises the wider social and cultural influences of shame. The moral connotations of  
593 breastfeeding are discussed by Blum (2000), who refers to the ways in which breasts signal  
594 the 'good' maternal body (i.e. breastfeeding) and the 'bad' sexual body (i.e. public  
595 breastfeeding). Taylor & Wallace (2012) amongst others (e.g. Dykes, 2005a; Hoddinott et al.,  
596 2012; Schmied et al., 2011) additionally pinpoint a need to address the cultural, ideological  
597 and structural constraints that work against breastfeeding. However, the findings from this

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598 study illuminate also show how these constraints equally apply to non-breastfeeding women.  
599 ~~C~~ondemnation and internalisations of failure and adequacy that are experienced amongst  
600 breastfeeding and non-breastfeeding mothers ~~are~~ appear to be directly related to social and  
601 cultural norms of 'acceptable' infant feeding practices. Taylor & Wallace (2012) amongst  
602 others (e.g. Dykes, 2005a; Hoddinott et al., 2012; Schmied et al., 2011) additionally pinpoint  
603 a need to address the ideological and structural constraints that work against breastfeeding.  
604 For example, While public breastfeeding areas are becoming more commonplace in high-  
605 middle income countries to promote the 'normality' of this infant feeding practice (Thomson,  
606 Bilson, et al., 2012), yet this is only part of the work required. Labbok argues for  
607 'transdisciplinarity' in terms of different disciplines coming together to define and address the  
608 problem being addressed. A transdisciplinary approach could be achieved through third  
609 sector organisations and maternity professionals developing professional advocacy services  
610 for women in order to address these constraints, prevent against shame responses and ensure  
611 that maternal and infant well-being is nurtured and developed.

612  
613 There is both national (Department of Health, 2014) and international (UNICEF) recognition  
614 of how early child development lays foundations for lifelong learning, behaviour, and health  
615 patterns. It is crucial in this context that women's shame responses are minimised,  
616 irrespective of their infant feeding methods. Thus, there is a definite need for professional  
617 advocates to acknowledge and enact on the cultural, ideological and structural constraints to  
618 ensure that maternal and infant well-being are nurtured and developed.

## 620 Strengths and limitations

621 A key strength of this paper is the inclusion of women with a wide range of infant feeding  
622 experiences. Analysis was undertaken by three authors, enhancing the trustworthiness of the  
623 data. By using Lazare's categories of shame as a conceptual lens we were able to highlight  
624 the personal, cultural, structural and social factors that can induce and create shame. The  
625 focused and continual consideration of the literature on shame throughout data analysis also  
626 enhanced the authenticity of the interpretations generated. Limitations include restricted  
627 views from minority ethnic women due to the area in which the study was undertaken. Whilst  
628 the recruitment strategy targeted women from different socio-economic backgrounds, an  
629 important limitation relates to the lack of information on income or educational status of the  
630 included mothers. This is particularly important to assess in future studies due to women who  
631 are younger, less educated and more deprived identified as those who are less likely to

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Commented [GT1]: 1. Labbok MH:  
Transdisciplinary breastfeeding support:  
Creating program and policy synergy across  
the reproductive continuum.  
*International Breastfeeding Journal* 2008, 3:16.

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Commented [GT2]: Two minds as to whether this needs to come up earlier before the last para?

632 breastfeed (Flacking et al., 2007). As breastfeeding tends to be the norm in many non-western  
633 cultures, the shame responses reported in this paper may not be transferable outside of a  
634 western context. The focus of data collection was not specifically to elicit shame, but rather  
635 more general exploration of women's infant feeding experiences. Whilst on one hand this  
636 open approach has enabled more nuanced realities and opportunities for women to identify  
637 what mattered most, more specific questioning on shame responses might have enriched the  
638 findings. Qualitative research to elicit where, why and for whom shame is experienced (e.g.  
639 between high and low income families) as well as the implications of these experiences of  
640 shame is worthy of further consideration.

641

## 642 Conclusion

643 This study has highlighted how breastfeeding and non-breastfeeding mothers experience  
644 shame. Breastfeeding mothers may risk shame if they breastfeed, particularly in public, due  
645 to exposure of the sexualised maternal body. Those who do not breastfeed may experience  
646 shame through 'failing' to give their infant the 'best start'. Breastfeeding and non-  
647 breastfeeding mothers may also experience inadequate support, judgement and  
648 condemnation, leading to feelings of failure, inadequacy and isolation. Strategies and support  
649 that addresses personal, cultural, ideological and structural constraints upon infant feeding are  
650 required. Sensitivity to the potential experience of shame in relation to infant feeding and to  
651 professional and public discourses which might generate this experience appears crucial in  
652 providing mothers with the care and support they need.

653

654

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755

## 756 **Authorship**

757 GT was the project lead for this study and collected all the data. GT and RF had the original  
758 conceptions for the paper. RF significantly contributed to the introduction section on shame  
759 and reviewed and provided feedback on analytical decisions on an on-going basis. GT and  
760 KEB were involved in the analysis and interpretation of the findings. GT produced the initial  
761 draft of the paper and RF and KEB provided feedback and contributions to various sections.  
762 All authors critically reviewed and approved the final content.

763

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767

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769

770 **Conflict of Interest:** The authors declare that they have no conflicts of interest

771