Issue 33 December 2016

perspective

NCT's journal on preparing parents for birth and early parenthood

Infant Feeding: Changing the Conversation

Anyone who works or volunteers in the field of infant feeding knows that a casual mention of their role will elicit a feeding story: frequently personal, sometimes about the experience of a partner, sister, daughter or friend. These narratives can help us understand the different meanings that feeding a baby has for each of us and often lead us to think about the context for women's feeding decisions. How could services be improved? What might 'good policy' look like? Equally compelling, these conversations often have an undercurrent, they include explanations for feeding decisions, can be a form of 'identity work',[1] can involve a subtle mutual checking of positions, *Which side are you on? Are you judging me?*

It is commonplace for volunteer supporters, who freely give their time to listen and be alongside others, to be casually labelled ‘breastfeeding Nazis.’

A level of alertness to being assessed and judged is only natural, considering the inflammatory language often used. It is commonplace for volunteer supporters, who freely give their time to listen and be alongside others, to be casually labelled ‘breastfeeding Nazis’[2] (though not usually by the women they support). Equally, allow your eye to wander below the line of any newspaper or Facebook comment thread about breastfeeding and you risk finding women who use formula milk being subtly, glibly, smugly, overtly accused of not caring about their children.

This context can make it difficult to talk.

Call to Action

We do need to talk. First, because talk can be a driver for mutual understanding, and is a form of mutual support. And second, because through talking we may find common threads in our feeding narratives, common issues which ought to be addressed.

UNICEF UK has launched a Call to Action for breastfeeding in the UK.[3] This call builds on a series of articles published in The Lancet in 2016, which included a message that infant feeding policy should refocus on addressing social and structural causes of low breastfeeding rates.[4] The call includes the plea to shift away from polarised debate and look to ‘**change the conversation**’ about the way that babies are fed:

by stopping laying the responsibility for this major public health issue in the laps of individual women and acknowledging the role that politics and society has to play at every level. The goal of our Call to Action is not to put pressure on women to breastfeed, but to ***remove the barriers*** *that currently stop women who want to breastfeed from doing so.*[3]

It is no small task to translate a call for a national-level policy shift into changes in individual day-to-day conversations. As health professionals, counsellors, peer supporters, parents, grandparents and friends, how might we even begin to do that?

A different sort of conversation

Perhaps we need a few conceptual tools to help us break the ice? The following series of linked articles offer a starter-size portion of ideas drawn from **public health, psychology** and **philosophy**.

The first article, based on my research, crosses the fields of social science and public health. I describe ways in which the ‘ecological thinking’ underpinning UNICEF UK’s Call To Action may help us depolarise our conversations by shifting the focus from women’s individual health behaviours towards a more conducive social context and improved social rights. This way of thinking is congruent with NCT’s infant feeding policy, which emphasises supporting all mothers, however they feed their babies, while promoting and protecting ‘the conditions that make decisions to breastfeed more straightforward’.[5]

In the second article, Dawn Leeming, a psychologist, introduces the concept of ‘shame’ and considers how women’s feeding journeys are made more challenging by unrealistic expectations of breastfeeding, idealised representations of motherhood, and sometimes misunderstood terminology. She argues that an affirming and supportive context will be essential if mothers who are struggling are to feel encouraged to reach out for help.

In the third article, Fiona Woollard views our society's conversations through a philosophy lens. She argues that we commonly make the mistake of confusing having a reason to breastfeed with having a duty to breastfeed. This confusion stems from a wider problem: an underlying perception that mothers have a duty to perform *any* action which might benefit their children, such that each failure to perform requires defence, a notion that has negative consequences for maternal wellbeing. Eliminating underlying philosophical mistakes might help to strengthen the foundation for a more supportive context.

Changing the Conversation: Ecological Thinking

Heather Trickey

Heather is a Research Associate at Cardiff University and is undertaking a PhD in Infant Feeding Policy. She also works part-time as a Senior Research Manager for NCT.

Key Message:

In the UK, difficult experiences of feeding babies are common and decisions are frequently constrained. Mothers often feel pressured and judged. The ecological approach to public health, advocated by UNICEF UK's Call to Action, has potential to improve the ways we think and talk about feeding. This approach means shifting the focus away from mothers' decisions and towards improving facilities, support and services at community level and by addressing socio-economic, cultural, environmental and legislative barriers at national level. It also allows us to explore the common ground between a public health agenda and a broader agenda to improve the experiences and social rights of parents.[6]

I never met a mother whose infant feeding decisions did not make sense in their own narrative context. Sometimes, breastfeeding comes easy, feels natural, even beautiful. Sometimes there are challenges to overcome. For some of us, breastfeeding is inconceivable, 'not for me', incompatible with family circumstances, competing priorities or our own ideas about our bodies; we decide to formula feed from the off. Frequently we plan to breastfeed but the baby won't latch, or we find that we have run out of milk – and then perhaps we feel we are being shamed for that.

Each feeding tale is unique. Every mother a central character, experiencing, deciding, acting. And yet, take a thousand mothers' stories and map the plot-lines, and see how they cluster with aspects of our social ecology, according to the experience within families and social networks, how the patterns match the social and economic conditions within which we live and work.

Mothers are more likely to breastfeed if their own mother breastfed, or if they have friends who breastfeed. Mothers who are older, from higher socio-economic groups, who have had more education, have higher breastfeeding rates and are more likely to delay introduction of formula milk and/ or solid foods.[7] Geographically, low breastfeeding rates correlate with higher indices of deprivation.[8]

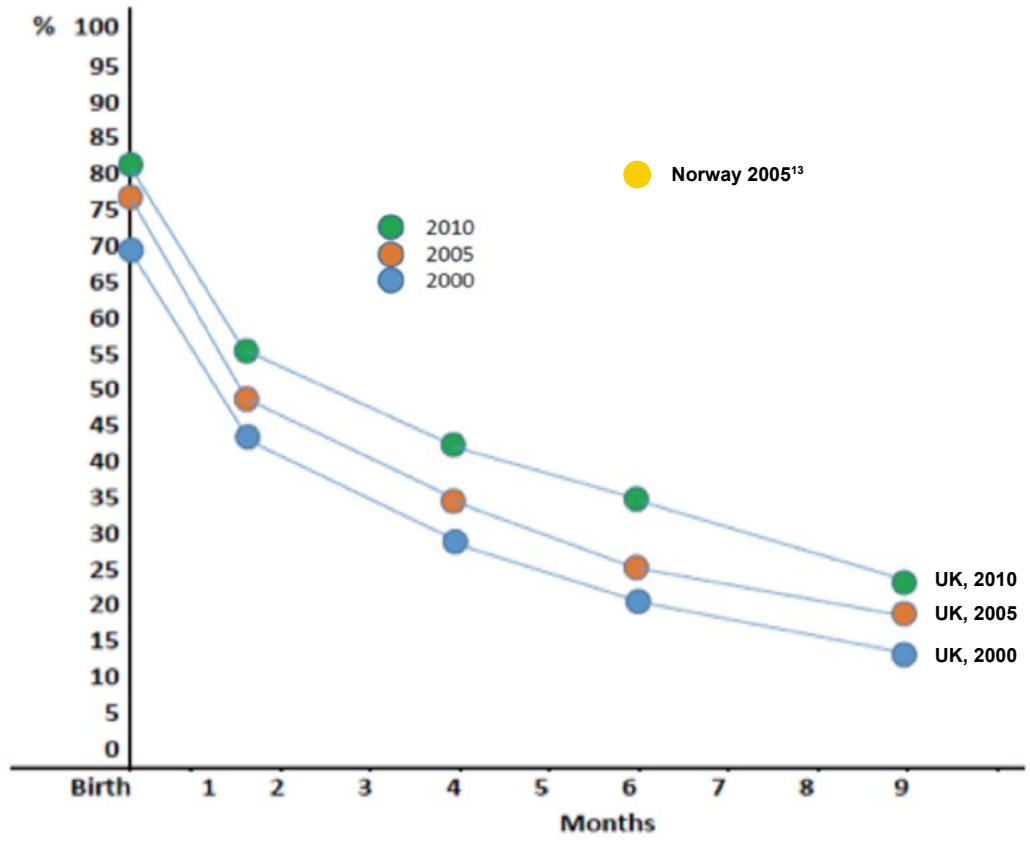
From an international perspective, breastfeeding rates in the UK are exceptionally low.[9] As in the western world generally, the practice of breastfeeding declined in the UK from the late 1800s onwards, with a sharp fall after the Second World War.[10] By the early 1970s only around half of all babies in England and Wales were breastfed even once.[11] There has since been a resurgence of public health concern, as well as a strategic policy development over the past two decades towards the implementation of UNICEF's Baby Friendly Initiative. This is a global programme that aims to reform systems of maternity care to enable breastfeeding. In the UK Baby Friendly standards have been developed around care standards whose aim is to help all mothers build close and loving relationships with their baby, irrespective of their feeding method.[12]

In spite of these developments, formula feeding, either exclusively or in combination with breastfeeding, continues to be the way that most UK mothers feed their babies beyond the early months. By 2010, only around a quarter of all British mothers were still breastfeeding at six months;[7] compared to 80% of Norwegian mothers five years earlier in 2005.[13]

Decisions and disappointment

From a public health planning perspective, breastfeeding initiation and continuation rates are useful measures of progress towards public health goals, including a World Health Organisation recommendation that babies be exclusively breastfed until they are aged around six months, with continuing of breastfeeding until the age of 'two years and beyond'.[14]

Figure 1. Prevalence of breastfeeding in the UK 2000-2010



Over the first nine months, around three quarters of mothers who stopped had intended to continue for longer.

The three curves in Figure 1, based on data from the Infant Feeding Surveys of 2000,[15] 2005,[16] and 2010,[7] indicate that between 2000 and 2010, there were incremental rises in the overall number of women initiating and continuing with breastfeeding at all time points from birth. In 2010 four in five mothers breastfed their babies at least once.[7] However, all three curves display a rapid drop-off in breastfeeding prevalence during the early weeks. In 2010 around a quarter of mothers started and then stopped in the first six weeks – during the '**adjustment period**'[17] when breastfeeding is being established. Few of these mothers are likely to have reached a point at which breastfeeding felt more convenient than using bottles.

A related statistic with a cost in terms of maternal wellbeing is the proportion of mothers who stop breastfeeding before they intend to: the '**breastfeeding disappointment rate**'. In 2010, eight in ten mothers who stopped breastfeeding in the first six weeks did so before they had planned to, while over the first nine months, around three quarters of mothers who stopped had intended to continue for longer.[7] This disappointment rate is just one measure of the emotional temperature in the wider climate of feeding-decisions. There are other indicators. Mothers who use formula milk from birth also experience difficulties, being more likely than others to report problems with colic, vomiting or reflux, and also with their baby being unwell.[7] In the next article, Dawn Leeming explores the psychological impact of breastfeeding problems and of unplanned mixed feeding.

Social and geographical patterning indicate that our feeding journeys are not only matter of biology. Furthermore, the mismatch between feeding intention and outcome demonstrates that they neither are they just a matter of individual '**choice**'. The notion of 'choice' here is problematic, suggesting a consumer decision[18] - selecting an ideal feeding journey from an imaginary shelf. A 'choice' to breastfeed will appear more socially normal in some settings than in others, such as if we are Norwegian rather than British, or if we are rich rather than poor. Because our feeding journeys do not always take us where we plan to go, NCT tends to use the term '**decisions**'[5] to acknowledge these constraints.

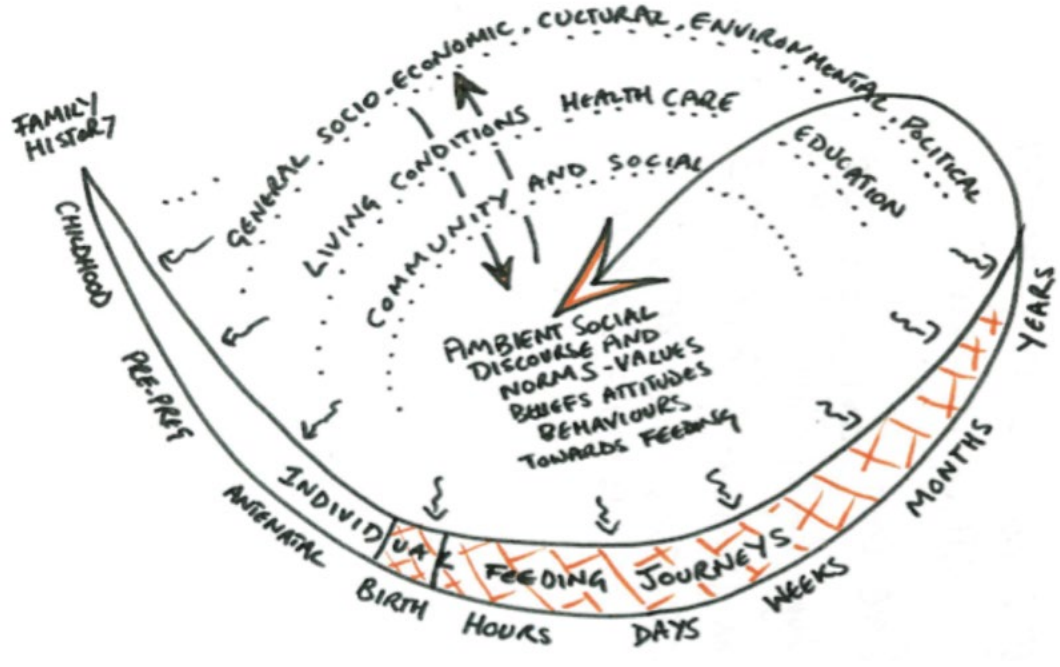
Of course, many mothers have straightforward feeding journeys and even difficult journeys usually include moments of closeness, joy, comfort, relaxation and satisfaction. But, as Dawn Leeming discusses in the next article, a high prevalence of challenging experiences has a considerable impact. On the one hand, women find it difficult to ask for help when they are struggling,[18] while on the other, they may feel reticent about sharing positive or pleasurable feeding experiences of breastfeeding.[19] How can we make it safe for mothers to tell all the parts of their stories, good and bad, without fear of judgment or of treading on each other's toes? Perhaps ecological thinking can help us.

Introducing ecological thinking

An ecological approach to health promotion recognises that interventions directed towards individuals may fail to produce behaviour change in circumstances where there are countervailing forces affecting their decisions. These may be both cultural (for example, through the media) and structural (such as socio-economic conditions). Ecological-based intervention identifies and addresses influences operating at different levels,

often changing physical, legal, economic and social conditions.[20] My own research explores what barriers may exist to taking an ecological approach to infant feeding policy, and has involved interviews with policy makers, health professionals, peer supporters and parents. Pilot interviews confirmed that participants found it difficult not to focus on the immediate experience of individual mothers. To overcome this, I developed a visual thinking tool – Figure 2 – in order to encourage participants to reflect on the ecological context.

Figure 2: Thinking ecologically and dynamically about feeding decisions



The curve along the bottom of Figure 2 describes mothers' journeys running through a layered landscape of influences – based on Dalgren and Whitehead's classic ecological model.[21] The curve ends with a feedback arrow; a prompt for thinking about the ways in which mothers' experiences – positive and negative – become part of the context in which they may influence subsequent cohorts of mothers. Feedback includes stories (positive and negative) and actions such as helping a friend or instigating a campaign. Feedback from personal experience is the engine that drives many voluntary support organisations.

The case for taking an ecological approach to breastfeeding policy is longstanding. The WHO Global Strategy for Infant and Young Child Feeding highlights structural causes for low breastfeeding rates, such as the need for lay support within a community setting, and for legislation to enable working mothers to continue breastfeeding, and the impact of commercial pressure from formula milk manufacturers.[14] NICE guidance recognises that feeding decisions are shaped by the knowledge, skills and experiences within our social networks, by local social norms – for example acceptability of feeding in public places – as well as by availability of skilled support to solve problems, health service policy (including BFI implementation), the legislative context for maternity rights, regulation to restrict unethical marketing of breastmilk substitutes, and by cultural attitudes to the body. In spite of this, governments have been slow to translate this level understanding into strategic policy reach beyond the health service.[4]

The BFI UK programme has successfully raised standards of hospital and community healthcare, providing a minimal foundation for infant feeding support across health services. However, BFI alone cannot change the wider ecology of infant feeding practices in the UK. The UNICEF UK BFI Call to Action recognises this limitation and asks UK Governments to take a more strategic and ecological approach.

Can ecological thinking help us to change the conversation?

The UNICEF UK BFI call is underpinned by growing consensus that an ecological approach to infant feeding is needed. Might ecological thinking also improve our conversations? Well, perhaps, as Figure 3 illustrates.

Figure 3. What difference can ecological thinking make?

Take the left-hand columns as a stand-in for the polarised TV discussions and online threads about infant feeding that a mother might be exposed to – the 'explosion' symbol represents the quality of the debate. The top-left quadrant shows a traditional **health education** position. From this standpoint, the evidence that breastfeeding is associated with improved health outcomes in the UK[22] provides a compelling reason to educate and persuade more women to change their behaviour, for example by making a lifestyle choice to breastfeed for longer. In the bottom-left quadrant is a simplified **social-liberal perspective** in which public health policy is perceived as overly-paternalistic and a threat to maternal experience and autonomy.[23] Messages to 'educate' all too frequently become a form of pressure,[23] compromising the status of the mother as the only person legitimately positioned to decide whether she will (continue to) breastfeed her own baby. Interlocutors in both left-hand quadrants share an assumption that their desired outcomes (improved health vs. maternal autonomy) will be served by changing messages given to individual mothers.

Ecological thinking shifts us into the right-hand side boxes in Figure 3. The top-right quadrant indicates intervention at **higher ecological levels** – assuming that if we change the social, environmental, structural and/or service conditions around people they will become healthier because the context itself improves health outcomes and also because they will be better placed to make healthy decisions. Meanwhile, in the bottom right, is

a position that prioritises improving **maternal experience** and **extending social-rights**. Here, a change to structural and social conditions may improve the experience of parenthood and/or lead to increased equality and opportunity. Interlocutors in the right-hand quadrants assume that their goals (improved health vs. maternal autonomy) will be served by policies that change the context in which mothers live.

Shifting the debate into the right-hand quadrants reduces the focus on individuals and may lessen a concomitant tendency to blame (and to feel judgment or shame), perhaps allowing some depolarisation. This may open up conversational space in which to explore the synergies between public health goals and social rights agendas which include a focus on parent experience. For example, a policy to improve conditions that support breastfeeding at work aligns with public health goals, and potentially improves experiences of feeding and access to employment.

An ecological approach does not exclude health education: informing and educating play a role so long as barriers to taking up advice are also addressed. Similarly, health education is not fundamentally at odds with a rights agenda. Provision of reliable, commercially independent, evidence-based information about breastfeeding and formula feeding is potentially empowering. But an agenda which considers public health outcomes, maternal experience and women's rights together will incorporate an understanding that ultimately mothers are best placed to decide, based on their own values and circumstances. Each mother's decision-making process will encompass factors that extend beyond epidemiological considerations.

Ecological thinking has the potential to help change the conversation and encourages a much-needed focus on maternal experiences of feeding alongside goals to improve health outcomes. But words will begin to ring hollow if policy makers retreat into health messaging and fail to address constraints which lie outside of a health service context. Good words will need to be backed by strategic action.

Issue 33 December 2016

perspective

NCT's journal on preparing parents for birth and early parenthood

Changing the Conversation: Shelving Shame

Dawn Leeming

Key Message:

Some women can experience a sense of shame about breastfeeding difficulties, as they feel they do not measure up to idealised representations of both breastfeeding and motherhood. Antenatal preparation, which anticipates and normalises problems in the early weeks, and provides opportunities to discuss difficulties and associated feelings, may help to dispel shame and mitigate against negative self-evaluation.

Dawn is a Senior Lecturer in Psychology at the University of Huddersfield.

In this article I consider how women's experiences of breastfeeding difficulties interrelate with the concept of 'shame'. Difficulties establishing breastfeeding are frequently interpreted by mothers as a sign that they have failed or are inadequate as a mother,[24,25,26] an emotional experience which has often been described as '**shame**' rather than '**guilt**', though the two are closely related and are often experienced together. I suggest that overcoming shame will be a necessary condition for better conversations.

Shame and guilt

What is shame and how does it differ from guilt? Paul Gilbert[27] argues that when we are ashamed we feel overwhelmed and even paralysed by a sense of a damaged, 'bad' or inadequate self, whereas when we feel guilty we focus negatively on our actions or lack of action. Therefore, we relate to others differently when we are ashamed. Instead of a concern with how we might put things right, we want to flee or hide as we feel exposed before negative scrutiny, or potential scrutiny, and we lose our sense of connectedness or belonging with others. A woman may feel guilty for not giving her baby breast milk, whereas she might feel ashamed in front of another breastfeeding mother or a healthcare professional (or her image of them) for her perceived inadequacy as a mother in not being able to establish breastfeeding. Psychologists have therefore argued that if shame becomes chronic it can be

> Some women interpret their difficulties as a personal shortcoming and sign of inadquacy or abnormality as a mother.

even more problematic than guilt,[28] because our desire to hide from others, and sense of powerlessness and inadequacy, can both affect our mental health and leave us feeling unable to bring about change. We may even become caught in destructive cycles of blaming and shaming others in order to deflect criticism from ourselves.[29] Shame about breastfeeding difficulties can therefore make it challenging for women to engage with breastfeeding supporters – professional or peer – because they may feel defensive or feel that they risk exposing what they see as a deficient self. This may still be the case to some extent even where shame is only fleeting.

Why breastfeeding shame?

How might the current conversation around breastfeeding difficulties and motherhood contribute to women's feelings of inadequacy and shame?

Unanticipated challenges

There is evidence that some women find the reality of breastfeeding (e.g. experiences of discomfort or pain, or difficulty in latching a distressed baby to the breast) at odds with their idealised expectations of breastfeeding,[24,30] and are unsure how to make sense of their struggle without blaming themselves. Difficulties establishing breastfeeding in the early postnatal weeks are common. The last Infant Feeding Survey suggested that around 30% of UK mothers who were exclusively breastfeeding, and 42% who were mixed feeding, experienced some difficulty in the early weeks.[7] However, women often report limited antenatal discussion of potential challenges in establishing breastfeeding[17,31,32] Although in some communities there may be vague negative expectations about the difficulty of breastfeeding,[31] the lack of clear advanced discussion of the 'normality,' and the nature of initial challenges, may mean that some women interpret their difficulties as a personal shortcoming and sign of inadequacy or abnormality as a mother.[32]

Breastfeeding as 'natural'

If we are changing the conversation, we also need to consider the ways in which terminology might contribute to a sense of inadequacy and increase psychological barriers to support-seeking. In particular, my own research suggests that we may need to think about the use of the term 'natural'.

The term 'natural' is not always unhelpful. It can normalise breastfeeding and reinforce women's right to breastfeed in varied places, drawing attention to the misalignment between biology and social norms – the latter, bizarrely, often built on the assumption that babies won't be attached to their mothers' breasts. But we need to guard against women interpreting their breastfeeding difficulties or decisions to use formula milk as 'unnatural'; such an interpretation is likely to lead mothers to shrink away from the exposure that 'support' might bring.

There is a danger that the word 'natural' applied to breastfeeding comes to mean '*I shouldn't need support*', as breastfeeding should be straightforward. If it is natural, perhaps it is also non-negotiable.[34] Such interpretations can cause mothers who struggle with breastfeeding to feel that their identities as women and mothers are being undermined.[24,30] For example, a participant in my own research described her early difficulties in breastfeeding in this way:

I just cried and cried and cried .... I felt like I had failed really, almost as a woman really, you feel like this is a natural thing, why can I not do this?

Another mother added that topping up with formula,

made me feel very, um, just like a really crap mother, to be honest... I just felt that I couldn't um, produce what she was needing... It just made me feel very inadequate.

There may be other terms whose use we need to reflect on. For example, '**poor attachment**', a term used by health professionals and volunteers to describe ineffective feeding from the breast, may be heard by the mother as a global judgment about the quality of psychological attachment between her baby and herself.

Idealised motherhood

Erin Taylor and Louise Wallace suggest that the experience of shame is related to unrealistic ideals of motherhood in general, and not just breastfeeding specifically.[33] They argue that women are often encouraged to aspire to a version of motherhood where the total focus is on optimising children's needs, with no space for their own needs or consideration of the challenges of achieving optimal parenting. Under such conditions, a sense of failure or inadequacy is difficult to avoid. Perfection is demanded, including breastfeeding where breastfeeding is seen as an inextricable part of motherhood, or the consequences are guilt and/or shame.

Opening the conversation

Shame in western societies is taboo – we don't talk about it and we don't like to acknowledge the places where we are vulnerable to feeling shame.[35] Brene Brown, who has written extensively about shame, argues that **shame survives in secrecy and silence**. It can be through articulating our feelings of shame to others that we come to understand that what seemed shameful is in fact quite normal and human, and that we are not rejected as of less worth because of something about ourselves that we deem to be less than perfect.[36]

The new Baby Friendly Initiative (BFI) guidance on having **meaningful conversations** with mothers[37] seems useful in this respect. It places emphasis on using open questions to elicit feelings, showing empathy, using active listening and avoiding overt direction and judgment, all of which may help women to feel more able to disclose some of their concerns and feelings around infant feeding. Alongside this, the concept of an **adjustment period** in the early days of breastfeeding, suggested by Trickey and Newburn,[17] seems a useful way of enhancing antenatal discussion – to **normalise the possibility of initial breastfeeding difficulties** whilst not presenting breastfeeding as something inherently so problematic that it is not worth trying. However, as previous research demonstrates,[38] presenting breastfeeding in this nuanced manner is not a straightforward task and requires careful consideration of what kinds of information would be suitable for which women, and in which antenatal context. Making a space for meaningful conversation and nuanced anticipatory discussion will take time, and will require a creative approach to finding this time, given budgetary constraints and time pressures on fully stretched health professionals.

The concept of shame shows us that we need to focus on starting a new conversation before we can think about changing the existing one.

Conversation itself may be the key to guarding against women viewing their difficulties with breastfeeding as a mark of inadequacy, but support givers need to ensure that this conversation does not inadvertently construct emotional barriers to seeking help by presenting breastfeeding as universally unproblematic, equating decisions to breastfeed with 'good motherhood' and using terminology in an unreflective manner. In particular, it is important that women do not see their breastfeeding difficulties as something deviant, to be hidden from others' scrutiny, and as a result avoid seeking the very help that may enable them to overcome their difficulties.

References are provided at the end of the article by Fiona Woollard.

Issue 33 December 2016

perspective

NCT's journal on preparing parents for birth and early parenthood

Changing the Conversation: reasons not duties

Fiona Woollard

Key Message:

The health benefits of breastfeeding are a reason to breastfeed. Reasons show us why we might want to do something, help us to make sense of the efforts other people make, and sometimes lead us to provide support and encouragement. But having a reason is not the same thing as having a duty. When we confuse reasons with duties we are contributing to a problem of misplaced burden on mothers.

Fiona Woollard is an Associate Professor of Philosophy at the University of Southampton.

As a mother and as an academic working in the Philosophy of Pregnancy, Birth and Early Motherhood, I couldn't agree more that we need to 'change the conversation' about infant feeding. I believe that the difficulties we experience – guilt, shame, blame, polarisation, judgment, pressure, exaggerated claims, feeling unsupported, fearful or silenced, feeling unable to share struggles and triumphs for fear of being perceived as smug or as having failed – are in part due to **philosophical mistakes** in the way we think and talk about mothers and maternal behaviour.

We mistakenly treat mothers as having a '**defeasible duty**' to breastfeed when the benefits of breastfeeding actually give mothers **reason**, but not a duty, to breastfeed (don't panic – all terms will be explained). Recognising that reasons to breastfeed do not give rise to duties allows us to make sense of, support and celebrate, women's considerable efforts to breastfeed without implying criticism of those who do not. It draws the focus off the mother's actions, allowing us to talk about the benefits of breastfeeding and the need for support, and address barriers to breastfeeding without implying judgment of those who do not breastfeed.

> Mothers face negative emotions and perceived judgment whatever decisions they make about infant feeding.

Guilt, Shame and Infant Feeding

Anecdotal evidence of the guilt, blame and shame surrounding infant feeding is easy to find simply by talking to new mothers. There's also plenty of sociological evidence. A systematic review[39] of studies on mothers' experiences of bottle-feeding found,

Mothers who bottle-fed their babies experienced negative emotions such as guilt, anger, worry, uncertainty and a sense of failure. Mothers reported receiving little information on bottle-feeding and did not feel empowered to make decisions.[39]

Indeed, the evidence shows that mothers face negative emotions and perceived judgment whatever decisions they make about infant feeding.[7]

The current conversation surrounding infant feeding decisions is characterised by defensiveness and fear of judgment: women feel required to defend their infant feeding decisions, to defend themselves against the charge of being bad mothers.[40] Insofar as the message about the benefits of breastfeeding is being taken up, it is understood as focused on the choices of individual women: 'breast is best'... and if you do not breastfeed, you'd better have some good excuse.

Defensiveness is a natural response to pressure. It is little surprise to see a pushback, in which any attempt to inform about the benefits of breastfeeding is seen as judgmental and any discussion of breastfeeding is seen as an attempt to be superior. Even online photographs of oneself breastfeeding – or 'brelfies' - are often construed as 'showing off'.[41]

Diagnosis

Part of the problem here is a philosophical mistake in the way people think and talk about maternal behaviour. These discussions often mistakenly assume mothers have a defeasible moral duty to breastfeed. A **moral duty** is something that I am required to do: if I do not do my duty, then I am liable for moral censure - others can blame me and I should feel guilty. If a duty is **defeasible**, that means that some sufficiently strong consideration could override the duty: should I fail to do my duty there are circumstances under which blame and guilt are inappropriate.

I have a defeasible duty to turn up to deliver my lectures. Teaching is part of my job and my students rely on me to be there. But suppose I failed to turn up because I was stopped *en route* to save a child from a burning building. My students wouldn't blame me and feeling guilty would be inappropriate. But if I failed to turn up without a good reason, just because I preferred to spend the day watching telly, then my students would blame me and I would be right to feel bad about it.

So justification is required when I fail in my defeasible duty. Other people are entitled to ask me to account for my failure.

Similarly, there are ways in which our conversations about infant feeding imply that mothers have a defeasible duty to breastfeed. Sometimes we hear mothers justifying their decisions not to breastfeed by citing circumstances,

for example physical conditions or severe trauma. If a mother who doesn't breastfeed fails to produce a justification, she may be (or perceive herself to be) treated as blameworthy, she may feel guilty.

I argue that the idea that women have a defeasible duty to breastfeed stems from a more pervasive belief that mothers have a defeasible duty to perform *any* action that might benefit her child.[42] It follows from this assumption that if it is generally agreed that breastfeeding benefits the child, the mother has a defeasible duty to breastfeed.

The mistake here is to confuse reason with duty. The health benefits of breastfeeding may give mothers a reason to breastfeed. But not all reasons give rise to defeasible duties.

I have a reason to run a marathon. I could raise a lot of sponsorship money for cancer research. But if I decide not to, other people won't be entitled to quiz me, they can't ask me to produce some justification for my failure to run. Even if I don't have any such justification (maybe on balance it would be good for me to run) I don't have to feel guilty. I don't have a defeasible duty to take this opportunity to benefit others.

You might be thinking that my marathon example is not a good analogy for breastfeeding. After all, mothers have special duties to look out for the interests of their children, don't they?

Well, I agree that a mother (a parent) has a **special duty to benefit her child**. But this is a general duty... **it cannot be translated into an endless series of specific defeasible duties** to do each single thing that might benefit her child. Such a duty would be a maximal defeasible duty.

I have a maximal defeasible duty not to lie. There may be times I would like to tell a lie, but I have a duty not to. However, sometimes I have a very good reason to lie. An extreme example, but say I can save my friend's life by lying. That would be okay. In that case you should not blame me and I should not feel guilty. But my duty to lie is still defeasible (I need a justification) and also maximal (I need a justification for each lie I tell).

Placing a parent under **maximal defeasible duty** to benefit a child at every opportunity would be to make the task of child rearing intolerably burdensome and would set the parent up to fail. Pretty much everything a mother does has the potential to harm or benefit her child. A mother operating under a maximal defeasible duty would have to be prepared to defend and justify every decision she makes, managing decisions in a context of uncertainty, and lacking the information she needs to weigh competing risks, let alone time to do the research before the next decision comes along. The mental and emotional energy required to parent under such conditions could be considered Herculean. Sound familiar?

Let’s talk about reasons not duties

Thinking about breastfeeding in terms of reasons instead of duties can help us to change the conversation. If we think in terms of reasons rather than duties we can promote (the good reasons) to breastfeed, without requiring mothers who don’t breastfeed to feel guilt, shame or judgment.

Reasons show us what is good about a certain course of behaviour and help us to make sense of the efforts people make. Others have **reason to help and support us** when we try to act on such reasons, and to admire and celebrate us when we succeed. My friends and family have reason to help me train for my marathon and post celebratory comments on social media afterwards. And we can say all this without implying that there is a duty to run marathons, that anyone who hasn’t run a marathon should feel guilty, or even that the marathon runner is better than people who do not run marathons. After all, we recognise that there are many other ways of being a good person.

Similarly, if we recognise that there are reasons, but no duty to breastfeed, we can say: if you decide to breastfeed it is worthwhile putting up with a good deal of discomfort or inconvenience. Others have reason to help and support women who want to breastfeed and to admire and celebrate them when they succeed. We can say all this without implying that there is a duty to breastfeed, that anyone who doesn’t breastfeed should feel guilty, or even that the breastfeeding mother is better than mothers who do not breastfeed. After all, we recognise that there are many other ways of being a good parent.

UNICEF UK’s Call to Action asserts that a policy approach which places the burden of responsibility on individual mothers to improve breastfeeding rates, rather than addressing social and structural barriers to breastfeeding, is mistaken; when we make the assumption that a mother has a defeasible duty to breastfeed we contribute to this problem of misplaced burden. When we think about maternal duties, we think justifications, guilt and blame. We ignore wider social factors. Moreover, in a climate where a duty to breastfeed is assumed, discussion of health benefits and calls to remove barriers to breastfeeding are difficult to hear above a sense of implied criticism of women who do not breastfeed. A mother who uses formula milk, but who also assumes that if she does not breastfeed she should feel guilty, might take anything that highlights the benefits of breastfeeding as an attempt to induce guilt, even when the message givers are clear that they do think she should feel guilty. Thinking in terms of reasons can help to switch this focus. If potential benefits give mothers sufficient reason to breastfeed, they also give her friends, family, community, and society at large, reasons to support her decision.

References

1. Faircloth CAR. 'If they want to risk the health and well-being of their child, that's up to them': Long-term breastfeeding, risk and maternal identity. *Health Risk Soc* 2010;12(4):357-67.
2. Lock K. 2015. *I'm not a 'Nipple Nazi', I'm a breastfeeding counsellor*. The Guardian, 27 March 2015. Available from http://bit.ly/2eZWbKR [Accessed 31/10/16]
3. UNICEF UK. *Protecting health and saving lives: a call to action*. London: UNICEF UK: the Baby Friendly Initiative; 2016. Available from: http://bit.ly/2h22plo [Accessed 31/10/16]
4. Rollins NC, Bhandari N, Hajeebhoy N, et al. Why invest, and what it will take to improve breastfeeding practices? *The Lancet* 2016;387:491-504.
5. Some ideas presented here appeared in a Cardiff University blog: Trickey H. Allmark H, Dodds R, et al. *NCT values and approaches to infant feeding support: A message framework* London: NCT; 2011.
6. Some ideas presented here appeared in a Cardiff University blog: Trickey H, '*It's not the responsibility of individual mothers to improve breastfeeding rates' – Operationalising an ecological approach*. DECIPHer Blog, July 2016. Cardiff University. Available from: http://bit.ly/2f4tvxH [Accessed 31/10/16]
7. McAndrew F, Thompson J, Fellows L, et al. *Infant Feeding Survey 2010;* London: Health and Social Care Information Centre; 2012. Available from: http://bit.ly/2f8N5l7 [Accessed 31/10/16]
8. Brown A, Raynor P, Benton D, & Lee M. Indices of multiple deprivation predict breastfeeding duration in England and Wales. *Eur J Pub Health* 2010;20(2):231-5.
9. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet* 2016;387:475-90.
10. Wolf, JH. *Don't kill your baby: Public health and the decline of breastfeeding in the nineteenth and twentieth centuries*. Ohio State University Press; 2001.
11. Martin J. *Infant feeding 1975: attitudes and practice in England and Wales, A survey carried out on behalf of the Department of Health and Social Security*. London: HM Stationery Office; 1978.
12. UNICEF UK. *Guide to the Baby Friendly Initiative Standards*. London: UNICEF UK: the Baby Friendly Initiative; 2012. Available from: http://bit.ly/2hbyMUf [Accessed 31/10/16]
13. Lande B, Andersen LF, Baerug A, et al. Infant feeding practices and associated factors in the first six months of life: the Norwegian Infant Nutrition Survey. *Acta Paediatr* 2003;92:152–61.
14. World Health Organization, UNICEF. *Global Strategy for Infant and Young Child Feeding*. Geneva: World Health Organization; 2003.
15. Hamlyn B. *Infant feeding 2000*: *A survey conducted on behalf of the Department of Health, the Scottish Executive, the National Assembly for Wales and the Department of Health, Social Services and Public Safety in Northern Ireland*. TSO; 2002.
16. Bolling K, Grant C, Hamlyn B & Thornton A. *Infant Feeding Survey 2005*. London: Health and Social Care Information Centre; 2007. Available from: http://content.digital.nhs.uk/pubs/ifs2005 [Accessed 31/10/16]
17. Trickey H & Newburn M. Goals, dilemmas and assumptions in infant feeding education and support. Applying theory of constraints thinking tools to develop new priorities for action. *Mat Child Nutr*, 2014, 10, 72-91.
18. Hausman BL. Women's liberation and the rhetoric of "choice" in infant feeding debates. *Int Breastfeed J* 2008;3:10.
19. Brown A, Raynor P, Lee M. Young mothers who choose to breastfeed: the importance of being part of a supportive breast-feeding community. *Midwifery* 2011;27(1):53-9.
20. Rayner G, Lang T. *Ecological public health*: movements and ideas to shift the boundaries between the normal and the desirable. In: Health of people, places and planet: Reflections based on Tony McMichael's four decades of contribution to epidemiological understanding. Canberra: ANU Press; 2015. Available from: http://bit.ly/2f42jj2 [Accessed 31/10/16]

21. Dahlgren G and Whitehead M. *Levelling Up (Part 2): A Discussion Paper on European Strategies for Tackling Social Inequalities in Health*. Copenhagen: World Health Organization; 2006.
22. Renfrew MJ, Pokhrel S, Quigley M, et al. *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*. UNICEF; 2012.
23. Lee E. Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. *Sociol Health Illn* 2007;29(7):1075-90.
24. Burns E, Schmied V, Sheehan A & Fenwick J. A meta-ethnographic synthesis of women's experience of breastfeeding. *Mat Child Nutr* 2010;6:201-19.
25. Guyer J, Millward LJ & Berger I. Mothers' breastfeeding experiences and implications for professionals. *Brit J Midwif* 2012;20(10)724-32.
26. Thomson G, Ebisch-Burton K and Flacking R. Shame if you do – shame if you don't: Women's experiences of infant feeding. *Mat Child Nutr* 2015;11:33-46
27. Gilbert P. Evolution, social roles, and the differences in shame and guilt. *Social Research: an International Quarterly* 2003;70:1205-30.
28. Tangney J, Dearing R. *Shame and Guilt*. New York: Guilford Press;2002.
29. Scheff TJ. Shame in self and society. *Symb Interact* 2003;26:239-62.
30. Larsen JS, Hall EOC, Aargaard H. Shattered expectations: When mothers' confidence in breastfeeding is undermined – a metasynthesis. *Scand J Caring Sci* 2008;22:653-61.
31. Hoddinott P, Craig LCA, Britten J, McInnes RM. A serial qualitative interview study of infant feeding experiences: Idealism meets realism. *BMJ Open* 2012;2:e000504
32. Williamson I, Leeming D, Lyttle S, Johnson S. 'It should be the most natural thing in the world': Exploring first-time mothers' breastfeeding difficulties in the UK using audio-diaries and interviews. *Mat Child Nutr 20*12;8(4):434-47.
33. Taylor EN, Wallace LE. Feminist breastfeeding advocacy and the problem of guilt. In: *Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities* (eds. P. Hall Smith, B. Hausman & M. Labbok). Chapel Hill: Rutgers Press;2012.
34. Wall G. Moral constructions of motherhood in breastfeeding discourse. *Gender and Society* 2001;15:592-610.
35. Scheff TJ. Shame in self and society. *Symb Interact* 2003;26:239-62.
36. Brown B. *I thought it was just me: Making the journey from 'What will people think?' to 'I am enough'*. New York: Gotham Books; 2007.
37. UNICEF UK. Having meaningful conversations with mothers: A guide to using the Baby Friendly signature sheets. UNICEF UK: The Baby Friendly Initiative; 2012. Available from: http://bit.ly/2hbSu1Q [Accessed 31/10/16]
38. Locke A. Preparing women to breastfeed: Teaching breastfeeding in prenatal classes in the United Kingdom. In: *Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities* (eds. P. Hall Smith, B. Hausman & M. Labbok). Chapel Hill: Rutgers Press; 2012.
39. Lakshman R, Ogilvie D, Ong KK. Mothers' experiences of bottle-feeding: a systematic review of qualitative and quantitative studies. *Arch Dis Child* 2009;94(8):596-601.
40. Murphy E. 'Breast is best': infant feeding decisions and maternal deviance. *Sociol Health Illn* 1999;21:187-208.
41. Giles F. *Narcissism gone nuts or 'empowering exhibitionism'? Brelfies, popular culture and breastfeeding's burgeoning publics*. Presented at: Breastfeeding, the media and popular culture. ESRC Seminar Series: Social experiences of breastfeeding: building bridges between research and policy. 9th June 2016, National Museum, Cardiff. Available from: http://bit.ly/2fvXIcm [Accessed 31/10/16]
42. Woollard F. Motherhood and Defeasible Duties to Benefit. *Philos Phenomenol Res*; in press.