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Commentary

Infant feeding and maternal guilt: The application of a feminist phenomenological framework to guide clinician practices in breast feeding promotion

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The World Health Organization's (WHO) *Global Strategy for Infant and Young Child Feeding* recognizes breast feeding as a way of providing optimal nutritional and immunological support for infant growth and development (WHO, 2003). Given this, exclusive provision of human milk to infants in the first six months of life is recommended as nutritionally ideal (American Academy of Pediatrics, 2012; Health Canada, 2014; WHO, 2003). The WHO/United Nations Children's Fund (UNICEF) *Baby Friendly Hospital Initiative* (BFHI) is a worldwide initiative that was launched in 1991 to promote, protect, and support breast feeding (WHO/UNICEF, 2009). The BFHI, an internationally recognized breast feeding promotion program, has been adopted by more than 20,000 maternity care facilities in 156 countries (Saadeh and Casanovas, 2009; WHO/UNICEF, 2009). Considered the 'gold standard' for breast feeding promotion, the BFHI is based on the *Ten Steps to Successful Breastfeeding,* a summary of guidelines for maternity care providers (WHO/UNICEF, 1989). The Ten Steps outline such practices as having an institutional breast feeding policy, teaching all mothers about the benefits of breast feeding, teaching mothers how to initiate and maintain lactation, and giving infants no food or drink other than breast milk (WHO/UNICEF, 2009). To be considered a 'Baby Friendly' hospital, health care providers must demonstrate compliance with these Ten Steps.

Feminist critics of such breast feeding promotion initiatives suggest that breast feeding advocacy as it is currently practiced inappropriately contributes to women's perceptions of feeling guilt and shame (Taylor and Wallace, 2012a, 2012b; Thomson et al., 2015). Recognizing this tension, clinicians often report fear of inducing maternal guilt and shame as a reason for avoiding the promotion of breast feeding (Labbock, 2008; Taylor and Wallace, 2012a). Evidence suggests that breast feeding promotion interventions, such as informal, one-on-one education sessions delivered by health care professionals, are critical in supporting the initiation of breast feeding (Dyson et al., 2005). Consistent with this, compliance with formal breast feeding promotion programs, such as the BFHI, is associated with significantly increased rates of exclusive breast feeding (Abrahams and Labbok, 2009). Such health center policies and compliance with large-scale promotion initiatives have a substantial influence on individual healthcare

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provider attitudes, beliefs, and breast feeding promotion and support practices (Beake et al., 2012; Daniels and Jackson, 2011; Okolo and Ogbonna, 2002) and play a powerful role in informing and supporting infant feeding decisions. Therefore, for the purpose of this paper, breast feeding promotion will broadly refer to all initiatives and practices that aim to enhance and support mothers' exclusive provision of breast milk to infants in the first six months of life. Specifically, it will refer to organizational statements and practice guidelines (e.g., the BFHI), the content of health promotional material targeted at mothers, and the interactions between clinicians and mothers that are related to breast feeding education and support. While exclusive breast feeding is considered nutritionally ideal, the emotional and behavioural development of infants can be negatively impacted by poor maternal mental health (Barnes, 2014; Royal College of Midwives, 2012). Therefore, it is critical that the practices that care providers implement when supporting breast feeding promotion efforts do not negatively influence maternal emotional well-being by fostering feelings of guilt.

Feminist theory and breast feeding

The transition to motherhood is marked by a significant change in roles and relationships (Barnes, 2014; Nelson, 2003; Royal College of Midwives, 2012). Mothers are required to make the decision as to how they want to feed their infant and, if breast feeding, are required to take primary responsibility for nourishing their child (Labbok, 2008; Schmied and Barclay, 1999). Current best evidence supports that breast milk is the optimal form of nutrition for newborns, and thus, healthcare providers promote breast feeding as the 'gold standard' in infant nutrition. Therefore, it is not surprising that mothers report feelings of guilt when choosing not to breast feed. Feminist literature has repeatedly spoken to the ways in which guilt and shame are disproportionately common in women, and how experiencing these emotions play a significant role in women's decisions and experiences around feeding their babies (Taylor and Wallace, 2012b).

Feminism, feminist phenomenology, and health care

Feminist theory proposes that the sexism prevalent in society is a product of social construction, with women and marginalized persons and groups being unjustly oppressed by dominant groups (Bartky, 1990; Campbell and Wasco, 2000; Sherwin, 1992; Wolf, 1996). While feminist theory recognizes that gender oppression is not the sole form of oppression, it places emphasis on the role of gender in creating power imbalances and subordination of women (de Beauvoir, 1989; Sherwin, 1992). As such, changes in legal, economic, and social structure that attempt to minimize the oppression of women cannot be achieved without attending to the issue of gender (Campbell and Wasco, 2000; Sherwin, 1992). The feminist agenda is based in the aim to challenge the structures that perpetuate power imbalances between men and women, thus supporting the development of a social system in which dominance, control, and inequity is not the dominant discourse (Bartky, 1990; Sherwin, 1992).

Under the overarching conceptualization of feminist theory there are several categories of feminism that provide perspectives on the values and social and structural changes necessary to mitigate sexism and oppression (Campbell and Wasco, 2000; Sherwin, 1992). These feminist perspectives include delineations such as liberal, radical, socialist, and cultural feminism (Alcoff, 1988; Campbell and Wasco, 2000). These types of feminisms vary in their conceptualization of how oppression manifests and what changes are necessary to overcome said oppression (Campbell and Wasco, 2000; Sherwin, 1992). However, they are similar in their fundamental values related to recognizing gendered oppression within societal structures and finding ways by which to eliminate it. As such, this paper will not differentiate on the basis of specific feminist perspectives, but will examine the issue of breast feeding and maternal guilt through a broad feminist lens with a particular focus on feminist phenomenological perspectives of women's lived experiences within medical institutions that are inherently patriarchal. It is also important to note that while recent scholarship in queer studies has placed emphasis on the limitations associated with reducing gender identity to the male–female binary, the purpose of this paper is to highlight the benefit of a feminist framework for clinician-led practices to enhance breast feeding and reduce maternal guilt. Thus, this paper will include a discussion specific to women in patriarchy, recognizing that a broader interpretation would be needed to guide clinician practices when caring for populations with more diverse gender identities.

Feminist perspectives of the lived body

An understanding of women's lived body experiences in the context of power inequity and oppression is of critical significance in informing transformation of the social structures that perpetuate such inequities (Grosz, 1994; Kruks, 2001; Young, 2005). Given this, the use of feminist phenomenological frameworks provide invaluable information in understanding how a woman understands herself and how she is understood by others in various contexts (de Beauvoir, 1989; Goldberg, 2002; Goldberg et al., 2009). Heavily influenced by the phenomenological work of Merleau-Ponty (1962), feminist scholar Iris Young places a particular emphasis on the importance of lived experience, and examines how girls and women experience their bodies from positions of disadvantage within the hierarchal structure of masculine institutions (Young, 2005). While originally published in the 1990s, Young's work provides academically rigorous and rich descriptions of the lived female body experience in Western patriarchal societies that continues to be relevant today. In characterizing the nature of female existence in the world, Young (2005) speaks to women being denied the 'subjectivity, autonomy, and creativity that are definitive of being human and that in a patriarchal society are accorded to man' (p. 31). The nature of this existence is captured in Young's work *Breasted Experience*, which outlines women's embodied experience of having breasts within a society whose values are predominantly defined by men (Young, 2005, p. 75–96). While a critical part of self-image, Young describes the appearance of women's breasts as being largely judged by men to objectify women on the basis of attaining a level of 'perfection' that women have no role in defining (Young, 2005). The value that is placed on the appearance of breasts in patriarchal society serves to prevent women from experiencing breasts with a women-centered meaning that is based in feeling (Young, 2005). In addition, Young (2005) describes breasts as 'shattering the border between motherhood and sexuality' (p. 88). In a heteronormative culture that places such emphasis on breasts as sexual objects, a woman who breast feeds her infant is often viewed as de-sexualized in the selfless act of nourishing her infant (Young, 2005). Such division of values highlights the need for clinicians to consider women's lived experiences of breasts and identity when supporting breast feeding decisions.

Medical paternalism and decision-making autonomy

As feminism highlights the patriarchal oppression of women, consideration of the role of the healthcare system in perpetuating power inequity is of importance. As a historically male dominated profession, medical practice has been cited as taking control of the female body (Sherwin, 1992), with the institution of medicine being designed in a way that enforces sexism and disempowerment of

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