

The Social Construction of Stigma Associated with the Normalization of Breastfeeding

An Autoethnography

Jennifer Hemeon

Mount Saint Vincent University

A Thesis

Submitted in partial fulfilment

of the requirements for the degree of

Master of Science in Applied Human Nutrition

April, 2018

Halifax, Nova Scotia

© Jennifer Hemeon

The Social Construction of Stigma Associated with the Normalization of Breastfeeding

An Autoethnography

Jennifer Hemeon

Mount Saint Vincent University

Approved:

Daphne Lordly, Ph.D.
Thesis Supervisor
Professor
Department of Applied Human Nutrition
Mount Saint Vincent University

Deborah Norris, Ph.D.
Associate Professor
Department of Family Studies and Gerontology
Mount Saint Vincent University

Sarah Stahlke, Ph.D.
Associate Professor
Faculty of Nursing
University of Alberta

Abstract

Through autoethnography, I describe, analyze, and interpret my personal and professional experiences related to breastfeeding promotion. I link my experiences to the literature and weave relevant theory throughout. A conceptual framework, the Social Ecological Model (SEM), is used as a sensitizing concept to guide the organization, presentation, and analysis of my experiences. In Part 1, I describe my experiences as a public health dietitian whose role involved breastfeeding promotion and support. I expose my tensions associated with the expert-driven imperative to breastfeed. In Part 2, I describe and interpret my experiences as a mother who “failed” to meet the national public policy’s infant feeding ideal: to exclusively breastfeed for six months and beyond. I expose the dominant discourses that have influenced the stigma associated with the use of infant formula, including health as a duty, intensive motherhood, mother blame, and the quiet coercions used to guide infant feeding decisions. I describe how strategies in place to normalize breastfeeding stigmatize women who do not comply. These strategies do not comply with ethical principles of evidence-based practice, person-centred care, and informed choice.

Keywords: breastfeeding normalization, pressure to breastfeed, stigma

Acknowledgements

I would first like to express my gratitude to my thesis committee. Dr. Lordly, thank you for encouraging me to choose a research method out of my comfort zone. This thesis is as much a critique of a health profession's reliance on science as it is of breastfeeding strategies. I would not have come to the same conclusions with any other method. Dr. Norris, thank you for introducing critical theory to students in the Master of Science in Applied Human Nutrition program. This body of knowledge has had a strong impact on my practice as a dietitian and my ability to think critically. Your influence contributed to the direction of my thesis and my ability to make sense of my experiences. Dr. Stahlke, thank you not only for sharing your expertise in autoethnography, but also for your questions – leading to deep dives to enhance my understanding of my experiences.

I would also like to thank my family. My mother, Freda Hemeon, thank you for proofreading my thesis, and for your support with absolutely everything – even when I know you disagree. I thank “Joseph” for his kind support and understanding during the breastfeeding trials and tribulations, and my cousin, Alex, who is everyone's “go-to” for advice and support.

I acknowledge my boys, “John” and “Tyrone” – the source of the worries and wonders of motherhood.

Dedication

I dedicate my thesis to mothers - who, when it comes to breastfeeding and stigma, are damned if they do and damned if they don't.

Table of Contents

List of Tables and Figures	7
Introduction	8
Thesis Statement, Aim and Objectives	11
Method	
Methodology	12
Conceptual Framework	17
Research Design	19
Data Collection and Analysis	21
Ethical Considerations	22
Part 1: My Tensions with Breastfeeding Promotion Practices	
Introduction	25
Public Policy’s Influence on Breastfeeding Promotion	25
My Tensions with Community-based Breastfeeding Promotion Strategies	29
The Influence of Professional Interpersonal Interactions on My Tensions	32
The Influence of Organizational Culture on My Perspectives	35
A Summary of My Tensions in Practice	38
Part 2: My “Failure” to Breastfeed	
Introduction	43
Early Motherhood	45
Breastfeeding Support is Not Always Supportive	53
The Expert-driven Imperative to Breastfeed	58

Health as a Duty	60
Intensive Motherhood	62
Mother Blame	65
Quiet Coercions	70
My Stigma was Socially Constructed	76
Discussion	78
Evidence-based Practice	80
Person-centred Care	82
Informed Choice	82
Conclusion and Recommendations	85
References	91
Appendices	
Appendix A: Consent and Debriefing Process	99
Appendix B: Collateral Participants Consent Form	100
Appendix C: Collateral Participants Approval of Content Form	103

List of Tables and Figures

Table 1.	Current infant feeding statements	27
Figure 1.	Levels of influence in the Social Ecological Model	18
Figure 2.	Factors that contribute to stigma in an environment that embraces dominant discourses associated with the normalization of breastfeeding in the Social Ecological Model	39
Figure 3.	My tensions in practice associated with a breastfeeding organizational culture	40
Figure 4.	Factors that influenced my decision to breastfeed	44
Figure 5.	Documentation of input and output	48
Figure 6.	Excerpt from <i>An Organizational Guide for New Mothers</i> (July 2004) ..	52
Figure 7.	A Health Canada infant feeding resource that omits reference to infant formula	72
Figure 8.	Region of Peel’s infant feeding resource	72
Figure 9.	“Quick Facts About Breastfeeding” on the Peel Public Health website	74
Figure 10.	A Government of Canada webpage that advises parents to plan wisely	75
Figure 11.	Social media post that stigmatizes celebrity for bottle-feeding baby	75
Figure 12.	The sum of influences on stigma associated with the imperative to breastfeed	77
Figure 13.	Nova Scotia’s breastfeeding pledge	79

The Social Construction of Stigma Associated with the Normalization of Breastfeeding
An Autoethnography

My objective, through autoethnography, is to explore the meaning of my experiences as a health care professional (HCP) and a mother within a breastfeeding culture to expose the dominant discourses associated with the expert-driven imperative to breastfeed, and the stigmatization of mothers who formula-feed. A discourse is a preferred version of the world that disqualifies competing versions [1]. Discourse is also defined as follows:

A dominant discourse comprises a particular language and a distinctive worldview in which some things are regarded as inherently more important or true than others. A discourse is partly a set of concepts that are held in common by those participating in that discourse community. It includes rules for judging what are good or bad, acceptable or inappropriate contributions, and procedures that are applied to determine who may be allowed to join the discourse community. Dominant discourses inevitably reflect and support existing power structures and are vital to them. [2, p. 137]

My aim is to expose the disjuncture between contemporary breastfeeding promotion practices and person-centred practice. I draw on a critical theoretical perspective to explain why I and others have experienced stigma in response to the use of infant formula. In the context of my thesis, the stigma that women experience is a result of the internalization of public attitudes and the recognition that the public holds prejudice against them [3]. Negative consequences include social isolation, low self-esteem and poor self-efficacy, decreased use of healthcare services, poor health outcomes, and poor quality of life [3]. Stigma may result in the avoidance of health care environments, HCPs, and social networks, and may ultimately compromise quality of life, self-esteem, depression, and health outcomes [4].

As an experienced dietitian, my practice focused on nutrition across the lifespan, addressing illness and promoting wellness. Within public health departments, I developed expertise in prenatal nutrition and infant feeding. I provided nutrition education and counselled prenatal women and new mothers. I was a resource to other HCPs on these topics. I developed education resources to address the common questions and concerns relevant to this area of practice. As a professional, I had reservations with organizational practices that seemed to communicate to mothers that they were making a poor or unhealthy choice if they formula-fed their infant. I referred to these reservations as tensions.

As a new mother, my intention was to breastfeed to provide and experience the benefits breastfeeding is touted to offer. I breastfed my children but weaned before they were six weeks of age. Breastfeeding challenges combined with the pressure I experienced to breastfeed impacted my ability to cope. After becoming a mother who “failed” to breastfeed, I became intimately aware of the impact the “breast is best” message has on mothers. I am being ironic and somewhat facetious when I refer to my decision to feed my babies formula as “failure.” Contemporary breastfeeding promotion materials convey that breastfeeding is the only acceptable choice.

According to some viewpoints, I “failed” to breastfeed; however, I made an informed choice to use formula. The decision was not made without mental and physical strife, but it was made with an understanding of what I perceived to be the benefits and risks of my feeding options. I experienced benefits feeding my infants formula, albeit unpublished benefits, and I recognized that there were risks to my and my family’s well-being if I continued to breastfeed (again, a viewpoint not represented in contemporary breastfeeding promotion publications).

In 2012, I applied to complete the Master of Science in Applied Human Nutrition with the intent to study the impact current breastfeeding promotion strategies have on new mothers, whether and why new mothers perceive breastfeeding promotion as pressure to breastfeed, and the impact this perception has on new mothers. I learned that the impact of the “breast is best” message on women was already in the literature. As a practicing dietitian, I wasn’t aware of this body of qualitative evidence.

I suspect that I was not aware of this evidence because I was socialized to the evidence-based discourse that values quantitative research. Under an instrumental/technical paradigm of education [5], I was conditioned to value science-based research. Resources that guide and direct dietetic practice, including national infant feeding guidelines [6] and Practice-based Evidence in Nutrition (PEN) System [7], do not present qualitative research findings to support dietetic practice.

Despite my initial hesitation to pursue qualitative research, which hesitation I attribute to the evidence-based discourse, I considered qualitative methods to expose the stigma women experience. I had a unique perspective from both an HCP’s and mother’s perspective. My unique perspective encompassed an HCP’s tensions related to breastfeeding promotion strategies and a mother’s struggle related to the pressure to breastfeed. Through autoethnography, rather than traditional ethnography, I could analyze, find meaning, and share my professional and personal experiences rather than report and interpret others’ experiences.

I drew upon the Social Ecological Framework (SEM) as a conceptual framework to organize and analyze my personal experiences. In Part 1, I present my experiences as an HCP whose role in a public health environment was to promote and support breastfeeding. I describe how I experienced tensions between the aims to promote, protect and support breastfeeding

while supporting mothers who did not necessarily choose to breastfeed. In Part 2, I present my experiences as a mother who “failed” to breastfeed. I then relate my findings to the principles of evidence-based practice, person-centred care and informed consent, and identify recommendations to address my findings.

Thesis Statement, Aim and Objectives

Thesis statement. Contemporary breastfeeding promotion strategies and messages contribute to the stigmatization of women who feed their babies infant formula. Health care professionals are bound by professional codes of ethics and standards of practice to be person-centred, yet contemporary breastfeeding promotion practices contribute to the psychological and social harm associated with normalizing health behaviours.

Aim. The aim of the thesis is to expose the disjuncture between contemporary breastfeeding promotion practices and client-centred practice to support the thesis statement.

Research Objectives

1. To explore my experiences as both the health care professional and mother within a breastfeeding culture to expose the dominant discourses and their subsequent impact on stigma.
2. To address previous researchers’ recommendations for further research. Shakespeare et al. (2004) indicate that breastfeeding policy may contribute to post-natal stress and that there is a need for further study [8]. Lee (2009) recommends that the effects of breastfeeding promotion be interrogated through a socio-cultural lens, and to explore women’s experiences interacting with other women [9]. Sheehan et al. (2009) indicate that there is a lack of research reporting women’s experiences and expectations pertaining to professional support [10].

Method

Methodology

My research is qualitative in the form of an autoethnography. It is a scholarly account of my personal experiences, drawing upon the literature, and it is analytical and theoretical in a way that links my personal experience to a broader culture. The culture is that in which breastfeeding is promoted, protected, and supported to become a social norm. My research reflects a social constructionist approach.

A qualitative methodology examines social settings and the individuals who inhabit these settings [11] and contributes to understanding social phenomena. Autoethnography is a form of ethnography. My research is an ethnography, in that it involves the investigation (graphy) of cultural processes (ethno) [12]. In autoethnography, a personal experience method [13], the researcher's analysis pertains to the self within a larger social and cultural context [13, 14, 15]. Links are made between the personal and the cultural to advance sociological understanding [13]. Autoethnography draws on the researcher's personal experience to explore substantive social issues [13].

My autoethnography includes characteristics of an organizational autoethnography. An organizational autoethnography studies the relationship between personal experiences with organizational practices, thus illuminating the relationship between culture and the organization [16]. My autoethnography studies the relationship between my personal experiences with broader culture, but also my professional experiences with organizational culture. Dominant discourses from a broader culture have influenced organizational practices. Through autoethnography, my personal experiences within multiple settings are examined. As an HCP,

my education and each practice setting's organizational culture contributed to my evolving viewpoint on infant feeding.

As a mother, the social context, influenced by social norms and dominant discourses, contributed to how and why I experienced the consequences of my infant feeding decision. Through autoethnography, I systematically analyze my personal experiences to understand how and why social and cultural processes and the associated discourses contributed to my stigma. I explain how organizational practices, influenced by dominant discourses, affected my tensions and my experiences as a mother. My analysis of my experiences as an HCP and mother identify the broader political and strategic organizational agendas and their impact on social and cultural practices.

In ethnography, researchers are amid the culture they are studying [11]; thus ethnography involves participant observation. In autoethnography, the author is the participant and describes and analyzes personal experiences intimate in nature [17]. Conventional research (especially in the positivist paradigm) values the separation of researcher from participant, as well as neutrality and objectivity [12]; however an author with personal experience related to an issue, who seeks meaning from personal experience, has an enhanced understanding of a topic [18].

Autoethnography has the power to address unanswered questions, present unique perspectives and ideas [19], and identify implications for practice [20]. Rather than re-telling and interpreting others' experiences, the autoethnographer's personal experience contributes a unique representation of the issue [18].

Researchers in traditional ethnographies may not be able to observe aspects of participants' experience; stigma, guilt, and limited self-awareness, and power differentials may prevent a participant from disclosing details of their experience [21, 22]. My literature review

identified that women were hesitant to disclose that they had been unsuccessful with breastfeeding [23] and had experienced stigma, guilt, and power differentials. These factors would potentially impact the value of ethnography and supported my choice to pursue an autoethnography.

Postmodernism values multiple viewpoints, recognizing that there is no single interpretation [12]. Autoethnography acknowledges “that there is no single truth” [12, p. 227], but one possible perspective within the author’s context. An autoethnography is a valuable source of evidence and enables “voices to be heard in a new way to create new insights and knowledge...” [12, p. 227].

Narratives, particularly those related to illness, often relate to stigma, marginalization, and acceptance [12]. Initially, I considered conducting an ethnography to capture the marginalized voices of mothers who did not breastfeed. I wanted to expose the unintended consequences (from the HCP’s perspective) of the breastfeeding imperative. After conducting a literature review, I learned that mothers’ voices were already apparent in the literature, but that my experience as both an HCP and mother who “failed” to breastfeed would contribute a unique perspective and representation of the issue. I am both the outsider, as an HCP, and the insider, as a mother who “failed” to breastfeed. Unlike other women’s experiences apparent in the literature, I experienced both organizational and social perspectives related to the issue. It is through autoethnography that I offer a unique vantage point from which to contribute to social science [13].

An autoethnography addresses the shifting aspect of self [14] and plays a role in sense making. Through autoethnography, I identify and analyze my tensions and shifting viewpoints as the organizational culture associated with breastfeeding support and promotion changed

throughout my career. I analyze how my professional viewpoints impacted my personal breastfeeding struggle. In autoethnography, sense can be made from painful and difficult experiences, and the authors can express how they made sense of their experience through a reflexive process [16]. My research contributes new insights by making sense of my personal experiences and connecting my personal experiences with the broader social, cultural, and political contexts.

An autoethnography enables the exposure of taboo topics [16]. Breastfeeding promotion materials indicate that breastfeeding is rarely contraindicated. In my autoethnography, I, who delivered the breastfeeding imperative as an HCP, admit to being unsuccessful at breastfeeding, illuminate the stigma and ideologies associated with the imperative, and propose a call for action. It is unusual for an HCP to publicly question breastfeeding promotion strategies because of a risk of contradicting the expert-driven imperative. There are international, national, and regional initiatives, as well as professional-led initiatives, to increase the breastfeeding rate and denormalize the use of formula.

An autoethnography can illuminate ideologies that contribute to marginalization. Health care professionals may unconsciously conform to ideologies as they comply with an instrumental/technical paradigm of education [5] and national infant guidelines. I chose this methodology to illuminate the ideologies and promote effective knowledge translation with policy makers and HCPs. An autoethnography can counter the way things are [1]. It was through autoethnography that I could identify the discourses I wish to challenge [13].

An autoethnography enables HCPs to gain a new cultural understanding from another HCP's experience [12]. Storytelling has potential to influence how learners will approach professional practice [24]. The literature primarily consists of qualitative studies that interpret

mothers' voices. However, according to Muncey (2005), "expert knowledge is socially sanctioned in a way that common sense or personal knowledge is not...how knowledge is produced and who produces it are important in how status is attributed to knowledge" [25, p. 154]. In my research, my voice is also the expert's, thus potentially contributing to enhanced understanding of the issue.

Autoethnography may be effective in explaining a phenomenon because the manner in which it is written may have emotional impact [16], encouraging empathy and contributing to sociological understanding [Sparkes, 2002 cited in 15]. An effective autoethnography can enable a reader to "deeply grasp the experience and interpretation" [17, p. 15] of the experience. When describing my breastfeeding difficulties and the strife that accompanied my "failure" to breastfeed, my aim is to be authentic and lead to empathy, enhanced understanding of the issue, and ultimately to change.

A theoretical approach adds scholarship to the research and contributes to sense-making. In autoethnography, theory may relate to a conjecture that explains the social phenomenon [26]. A critical approach addresses power issues, ruling relations, and marginalization relevant to the thesis [27]. Ruling relations pertain to who has the power to make regulations, but also to how others perceive certain concepts [27]. Ruling relations consist of the activities of individuals and organizations and the discourses they produce and circulate. These relations are organized around a specific function, such as health care or education [Smith, 1987 cited in 28]. Ruling relations interact with people's everyday lives in complex interconnecting ways [27]. A critical approach examines how everyday practices support or resist compliance with prevailing norms [27].

I use a social constructionist approach that emphasizes the role of discourse and power relations when describing my reality [17]. This approach is concerned with social reality, the organization of experience, and is concerned with *what* and *how*, rather than *why* [1]. My research identifies *what* impact the discourse has on a mother, and *how* strategies to normalize breastfeeding contribute to stigma.

Conceptual Framework

Most social phenomena are complex, and a conceptual framework as “an interpretive approach to social reality” [29, p. 51] provides a comprehensive understanding of a phenomena [29]. A conceptual framework is a network of interlinked concepts, where each concept plays an integral role [29]. My conceptual framework is based on sensitizing concepts [30].

Sensitizing concepts are used to create a deeper understanding of social phenomena [30]. They provide a general sense of reference and guidance for the analysis of data [Blumer, 1954 cited in 30]. “Sensitizing concepts offer ways of seeing, organizing, and understanding experiences...” and “provide starting points for building analysis, not ending points for evading it” [Charmaz, 2003 cited in 30, p. 3]. The use of a sensitizing concept, for the organization, presentation, and analysis of my personal experiences, would not constrain my analysis nor prevent finding new meaning from my experiences and identifying emergent concepts.

Sensitizing concepts inform the research problem [30]. The literature provided a basic theoretical argument and identified theoretical ideas, including ideological influences, that supported the use of the Social Ecological Model (SEM) (see Figure 1) as a sensitizing concept. The SEM, as a sensitizing concept, is a theoretical model that set the context for the direction of my study, loosely guided how I organized my data and presented my experiences, and served to

lay the foundation for analysis [30]. The use of the SEM as a sensitizing concept gave me a sense of how my experiences fit within conceptual categories [30].

The SEM is a conceptual framework used in research to describe contextual influences on behaviour [31]. It is a concrete framework to account for a phenomenon or behaviour associated with environment interactions [31]. Since autoethnography is a personal experience method that studies social phenomena, it is fitting that I drew upon the SEM to describe how normalizing a behaviour, namely breastfeeding, impacts stigma.

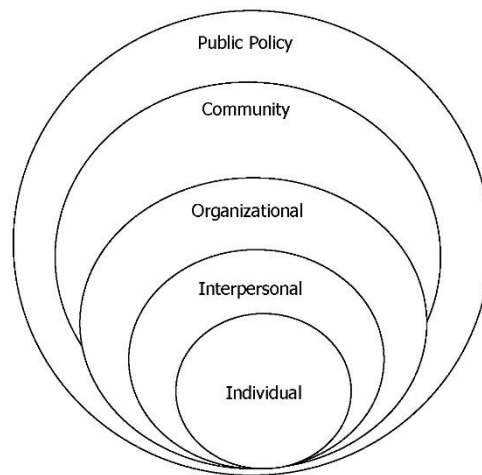


Figure 1. Levels of influence in the Social Ecological Model. Adapted from McLeroy, Bibeau, Steckler and Glanz (1988) [32].

I also drew upon the SEM in my research, in part, because it is also used to normalize breastfeeding. The SEM is a multi-level approach used in health promotion [32,33]. The SEM is used to promote and evaluate behavioral change strategically and intentionally. Health promotion strategies fall within each sphere of influence to promote breastfeeding.

The SEM consists of multiple spheres of influence: public policy, community, organizational, interpersonal, and individual. Within my autoethnography, the public policy

sphere includes international, national, and provincial statements, policies, guidelines, and practices that promote breastfeeding as a social norm. The organizational sphere includes institutional policies and practices. The community sphere includes community-based programs and social networks. The interpersonal sphere includes interactions between HCPs and clients, and social interactions. The individual sphere includes personal characteristics, including knowledge, attitudes, self-efficacy, values, and goals.

A sum of influences impacts a phenomenon or behavior. Stigma is the phenomenon under study. The SEM provides a lens through which to explain the extent to which the environment impacts an individual experiencing stigma [34]. It is important to understand an individual's environment to theoretically understand the factors responsible for the formation of stigma [34]. Not only does each sphere of influence impact stigma independently but the multiple layers are interactive and reinforcing [32].

Research Design

In my autoethnography, I take a scholarly, analytical, and theoretical approach. I add extant literature and weave theoretical content throughout [35]. By citing literature that corroborates my experiences, I demonstrate that my experiences are also relevant to others and that there is a body of research that supports my findings. My intention is to evoke both an emotional and an intellectual response but I am analytic rather than evocative. My approach to autoethnography is moderate and balanced to enable innovation and imagination while sustaining confidence in the quality, rigor, and usefulness of my research [13]. I suspect that an analytic approach would appeal to the intended audience (HCPs) from an intellectual and theoretical perspective because they, like me, have been socialized into a more conventional discipline [20].

I attend to rigor by adhering to published criteria for evaluating autoethnography. I provide abundant detail, including facts and feelings, and present an ethical concern [36]. I use an emotional, engaging, and self-reflexive writing style [37]. I aim to make a substantive contribution to enhancing understanding of the social phenomena, have aesthetic merit, impact the reader on an emotional and intellectual level, and to express a credible lived experience [38].

My aim is to generate an empathetic response to the autoethnography [39]. I use self-explication to effectively demonstrate my transformation [17]. I aim to offer the reader insight into an experience they may never have had or that they experienced but were never able to share [17].

In Part 1 of the autoethnography, I use the SEM as a framework to describe the contextual influences within my practice environment to account for my tensions. I describe how practices potentially influenced stigma associated with formula feeding and subsequently contributed to my tensions associated with breastfeeding promotion strategies. Contemporary breastfeeding strategies influence a mother's choice from multiple levels of influence. The imperative to breastfeed originates within the public policy sphere and is reinforced throughout the other spheres of influence. Therefore, in Part 1, I present my professional experiences from macro (public policy) to micro (individual).

In Part 2, I describe my personal experiences as a mother related to the breastfeeding imperative. My experiences are presented chronologically and thematically. I use the SEM to describe the contextual influences of breastfeeding promotion strategies to account for how a breastfeeding culture impacts stigma.

Analyzing my experiences according to the SEM supported the analysis of the phenomena and illuminated the interactive and reinforcing nature of the influences on stigma. It

is also fitting from a critical theories perspective to use the SEM. According to Brookfield (2005), “Ideology is a central concept in critical theory. It describes the system of beliefs, values, and practices that reflects and reproduces existing social structures, systems, and relations” [2, p. 66]. Ideological behaviours originate at the public policy sphere of influence and are reinforced throughout every level of influence. From a critical perspective, use of the SEM illuminated the complex and interconnecting manner in which ruling relations interact with everyday lives.

Data Collection and Analysis

In an autoethnography, self is the source of data [15]. Data emerges from retrospection and memory as formless data [16]. I used data collection strategies that Chang (2008) [26] presents in *Autoethnography as Method* to collect personal memories and included chronicling to recall personal experiences. Chronicling gave form to the memory data. Chronicling is a strategy used to recall personal and social events and experiences and to give chronological structure to them [26]. I included data that I considered relevant, reflected on why I considered it relevant, and connected the data to either the literature or a theoretical concept. I also used textual artifacts, mainly journal entries written between 2003 and 2006, that described my experiences but also letters to editors of magazines written shortly after my breastfeeding challenges, and personal blog entries.

Textual artifacts stimulated my memory and corroborated my memories of my experiences. Conversations with family and friends also stimulated memory. Data also included cultural artifacts such as images and texts that reflect contemporary breastfeeding imperatives. I collected these artifacts from websites that disseminate breastfeeding promotion information.

The data, consisting of chronicles, letters, and journal entries, was coded and linked to the spheres within the SEM. I was careful not to exclude data that did not link with the spheres of

influence so that I did not limit potential for new insights that could be generated from my analysis. I assembled the data chronologically. I then wrote my narrative as a framework before adding extant literature and analysis. My analysis included systematically linking my experiences associated with environmental interactions to the spheres of influence and drawing on the SEM to illustrate how they fit together to account for the phenomena.

Theoretical explanations for my experiences were a form of interpretation. Transforming the data into text that relays cultural meaning is a form of analysis and interpretation [26]. Analysis of cultural artifacts included describing how the texts impacted my stigma or illustrated ruling relations. Artifacts were labelled according to where they fell on the SEM to influence stigma. Identification of themes within the narrative and organization of the narrative are forms of analysis and interpretation of the data [40].

I was reflexive in keeping with an analytic approach. I connected my personal experiences, thoughts, and feelings to the cultural context, including the broader political and organizational agendas and practices [16]. I was mindful to recognize and address the shifting aspects of self and analyze my experiences within a social and cultural context [14].

Ethical Considerations

When writing my ethics proposal, I referred to the literature [41-44] that discussed ethical issues unique to autoethnography. Issues of paramount concern that required ethical safeguards included privacy and confidentiality and the risk, albeit minimal, of social and psychological harm to myself and those to whom I referred. Mount Saint Vincent University's Ethics Committee approved the ethical components of the study.

The author is the single participant in an autoethnography. I referred to family members and friends in the autoethnography, but did not interview them. Data was not collected directly

from them. They were not a source of data; their interpretations of my experience were not collected nor included in the thesis.

In an autoethnography, there is potential vulnerability for the researcher and those to whom they refer [41]. This risk is especially applicable to authors of autoethnographies that address unpopular opinion [13] and professional practice issues [41]. The author may be vulnerable when writing against a professional practice or stance [41]. As the author, my professional reputation might have been impacted negatively, and I might have experienced a negative response from colleagues who disagreed with the study's findings. As the author, I compromised my privacy. Others to whom I referred might have felt upset or regretful for potentially contributing to my negative experiences.

The autoethnography describes my personal interactions with immediate family and friends, and I refer herein to specific individuals using pseudonyms to protect their anonymity. I also describe experiences with individuals within the community and workplace who were strangers or mere acquaintances. They are nameless and described in a manner that clearly identifies that they are not immediate family or co-workers with whom I directly worked, and that they are un-identifiable.

To reduce the risk of social harm, I obtained consent from and anonymized data from those to whom I refer. Although they were not a source of data, I sought their consent to refer to them in a publicly accessible document. In reading my thesis, they could self-identify. There is risk that individuals might object to the way they are portrayed or fear that they might be recognized. Consent was obtained at the beginning and throughout the writing of the autoethnography to prevent potential harm from the way people are portrayed.

I was in a dual relationship with family and friends. The dual relationship of researcher could be perceived as a conflict of interest because of the competing interests that might arise from the relationship of being a mother and/or partner and/or daughter and researcher. My family members might have felt obligated because of our relationship to give their informed consent. The children who were most vulnerable knew that my reference to them would be as newborn infants and not as adolescents. Intermediaries were used to obtain consent to participate in research to reduce the effect of power in the relationship [42]. An intermediary was present when my children provided informed consent to participate to prevent the potential that I would unduly influence their decision.

As a part of the consent process, family and friends to whom I refer were invited to read relevant excerpts of the text and voice concerns. If they did not consent to the use of the content of the text pertaining to them, changes were made to our mutual satisfaction or the text was deleted. They were also provided the final thesis for review prior to submission. The flowchart in Appendix A illustrates the consent and debriefing process. The consent forms used for initial consent and content consent are found in Appendix B and C respectively.

Part 1: My Tensions with Breastfeeding Promotion Practices

Introduction

Part 1 of my autoethnography includes a description and analysis of my experiences and the tensions I faced when practicing as a dietitian in a public health “breast is best” culture. This culture is characterized by a shared pattern of thoughts [14] related to the “breast is best” imperative. I describe how my viewpoint on the breastfeeding imperative changed based on the culture of my practice environment, organizational practices, and my interactions with clients. Throughout, I refer to relevant studies of women’s experiences associated with their infant feeding decision.

I describe my experiences and my interpretation of how breastfeeding promotion strategies within the spheres of influence, according to the SEM, impacted stigma and my tensions. Public policy had a significant influence on organizational practices that directed my practice. Subsequently, the meaning I found by analyzing my experiences within the community, my practice environment, and interpersonal communications, all overshadowed by the imperative to breastfeed, contributed to my tensions and shaped my beliefs and values related to breastfeeding promotion.

Public Policy’s Influence on Breastfeeding Promotion

In the late 90s, I began my career as a public health dietitian. By that time, I already had had experience in a variety of practice areas. I had been a clinical dietitian in outpatient, small hospital, long-term care, and the homecare settings. I had five years of experience addressing nutrition across the life-span in a variety of settings to apply in the public health role.

I was aware that low breastfeeding rates were of national concern and believed that the promotion of breastfeeding would lead to more positive health outcomes. I led classes, developed educational resources, and counselled mothers in accordance with Health Canada's Nutrition for Healthy Term Infants [6]. This document, based on evidence and expert advisement, was the key resource that guided my practice.

Evidence informs the development of pro-breastfeeding guidelines, statements, and policies. The benefits of breastfeeding are described in national infant guidelines [6]: infants' short and long-term health [Horta, Bahl, Martines, & Victoria (2007); Ip et al. (2007); León-Cava, Lutter, Ross, & Martin, 2002 cited in 6]; enhanced cognitive development, and protection against gastrointestinal infections, acute otitis media, respiratory tract infection, and sudden infant death syndrome [Kramer et al., (2008); Quigley et al (2011); Ip et al. (2007); Hauck, Thompson, Tanabe, Moon, & Vennemann, 2011 cited in 6]; protective effect of breastfeeding against obesity later in life [Arenz, Ruckerl, Koletzko & von Kries, 2004, Ip et al., 2007 cited in 6]; continued protection when infants are exclusively breastfed for six months against gastrointestinal infections and illness [Kramer et al., 2003; Kramer & Kakuma, 2002 cited in 6] and respiratory tract infections [Chantry, Howard, & Auinger, 2006 cited in 6]; maternal weight loss and delayed return of menses [Kramer & Kakuma, 2002 cited in 6].

International, national, and provincial health organizations issue statements (Table 1) that inform breastfeeding promotion guidelines, strategies, and messages. Table 1 presents current statements although these are reflective of the imperatives in place at the time when I was a public health dietitian between 1999 and 2005. Public education materials are based on these statements. Governments also develop policies to influence and support breastfeeding. Public

policy influences entire systems of service delivery and consumer communications, as well as the public opinion process, and serves to regulate healthy actions [34].

Table 1.

Current infant feeding statements

Organization	Infant Feeding Statement
World Health Organization [45]	Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. Review of evidence has shown that on a population basis, exclusive breastfeeding for 6 months is the optimal way of feeding infants. Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond.
Health Canada [46]	Breastfeeding is the normal and unequalled method of feeding infants. Health Canada promotes breastfeeding exclusively for the first six months and sustained for up to two years or longer with appropriate complementary feeding – for the nutrition, immunologic protection, growth, and development of infants and toddlers.
Dietitians of Canada [47]	Dietitians of Canada supports breastfeeding as the best way to feed infants. Breast milk is the only food or drink that babies need until they are six months old.
Infant Feeding Working Group (a collaboration between Health Canada and national organizations, including the Canadian Paediatric Society's Nutrition and Gastroenterology Committee, Dietitians of Canada, the Breastfeeding Committee for Canada, the Public Health Agency of Canada, and Health Canada) [48]	Statements include: <ul style="list-style-type: none"> • Breastfeeding is the normal and unequalled method of feeding infants. • Feeding changes are unnecessary for most common health conditions in infancy. • Breastfeeding is rarely contraindicated.
Nova Scotia Health Promotion and Protection Policy Statement [49]	The Department of Health and the Department of Health Promotion and Protection hold a firm and unequivocal position in favour of breastfeeding and communicates its position both within, the health system, to health system providers as well as the general population. Such affirmation provides fundamental point of reference for all provincial government and health system funded practitioners and staff.

The international, national, and regional guidelines, statements, and policies that direct breastfeeding promotion messages and strategies also direct professional practice. The “breast is best” message becomes an expert-driven imperative to breastfeed. HCPs practice in accordance with public policy.

The public in the region where I practiced had access to the public health program, a telehealth service, on which I worked. People could call and speak with a health care professional to ask health-related questions. Most questions posed were from women about prenatal nutrition, formula feeding, vitamin D supplementation, their baby’s bowel health, picky eaters, and food allergies and intolerances.

It became clear to me that women knew “breast was best” despite their choice not to breastfeed. Women expressed guilt and described the hardship trying to overcome breastfeeding challenges. I witnessed the psychological impact of the “breast is best” message.

Women may not adhere to the expert-driven imperative breastfeed for several reasons. Barriers to breastfeeding include: lack of support, inconsistently informed or unsupportive HCPs, negative support (e.g. grandmothers who did not breastfeed may not support their daughters to breastfeed), and mothers wanting their lives back [50]. Women may stop breastfeeding before six months because the initial adjustment to breastfeeding following birth is one of the most difficult periods of life, and new mothers do not anticipate breastfeeding challenges [8,50]. Challenges are related to a “super-mom phenomenon,” the stress of the overwhelming sense of responsibility to do what is best, sleep deprivation, change in lifestyle, societal expectations, pressure to breastfeed, physical challenges [50], and post-partum blues or depression [8,50]. Confidence [51,52], and the extent and nature of support also impact the

decision to breastfeed [8,10]. Research has identified the consequences associated with a mother's decision to feed their infant formula: a sense of failure [9,53], inadequacy [53], shame [9,53], worry [9], guilt [8,9,53], internalized pressure [53], and self-blame [10]. Women with breastfeeding challenges experience feelings of guilt [8], failure [8,54], anger [54], inadequacy [54], self-blame [54], anxiety [55], powerlessness [54,55] and unhappiness [54].

My Tensions with Community-based Breastfeeding Promotion Strategies

In community settings, I provided education and support to women to promote breastfeeding. I provided in-home prenatal nutrition counselling to women on social assistance and served as a nutrition resource at a local Canada Prenatal Nutrition Program (CPNP). Resource development and dissemination were significant aspects of my role as a public health dietitian.

When I was providing prenatal nutrition counselling to women on social assistance, the women were required to meet with a dietitian for a nutritional assessment to receive a dietary allowance. Women on social assistance were eligible to receive extra financial support to help meet the additional nutritional requirements to support a healthy pregnancy. The additional financial support would continue postnatally to support the nutritional demands of lactation if the mother were to breastfeed. I often entered women's homes unwelcome. I conducted a nutritional assessment, provided education about her nutritional needs during pregnancy, linked her with community resources, and signed the form enabling her to receive the special diet allowance. It didn't take long for me to develop my skills for reading body language and identifying when to adapt my approach. The perfunctory visit became an opportunity to have a friendly chat, offer an ear and my support if she had questions, leave my telephone

number, and ensure she knew who to call to set up a home visit with a public health nurse after having the baby. I met with each woman again after her baby was born to sign the form to verify that she was breastfeeding and needed the extra funds to support lactation. The diet allowance was to enable the mother to meet the higher nutritional needs associated with lactation, but I thought of it as an incentive for the mother to make the right choice: to breastfeed.

I experienced a tension checking up on my postnatal clients to offer support and sign off on their form to enable extra funds for breastfeeding support. A mother's choice is subject to much instruction and scrutiny by experts [56]. This oversight was a form of expert scrutiny that I was expected to perform within provincial policy.

A key aspect of my role in public health was to serve as a nutrition resource at a CPNP. The CPNP is a community-based program. Its current goals are to improve maternal and infant health, increase the rate of healthy birth weights, and to promote and support breastfeeding [57]. Types of support include nutrition counselling, prenatal vitamins, food and food coupons, prenatal health and lifestyle counselling, breastfeeding education and support, food preparation training, education and support on infant care and child development, and referrals to other agencies and services [57].

In a community centre, young mothers met on a weekly basis. There was food, support from peers and professionals, and an education component. A registered nurse led the program and a lactation consultant attended on a regular basis. I provided education and support to the mothers on introducing solid foods, making homemade baby food, and dealing with picky eaters. Education about use of formula was not on the agenda. I

presumed the reason was to prevent the perception that infant formula was something the program endorsed.

Most mothers who attended the program breastfed their babies. I rarely saw a mother feed their baby infant formula. In retrospect, I wonder if mothers who chose to feed their infants formula didn't feel comfortable attending the program.

There is an association between a mother's method of feeding and the impact on the mother's social networks and relationships with HCPs [9]. Mothers may avoid HCPs and lie about their chosen method of feeding. Women may face "interactional challenges" and set boundaries between themselves and the activities of others, including HCPs [23,59]. Prenatal and postnatal programs are publicly funded to support infant and child health and have evaluation processes to measure the outcomes associated with their goals – an indication of a program's success and determinant of further funding. I suspect that the unintended consequences, such as alienating mothers and the subsequent harm, are not evaluated.

I compare the class at the CPNP to the infant feeding class I offered ten years prior - before breastfeeding promotion strategies were as prominent.

During my dietetic internship in an acute-care hospital, a one-year period of practical training after my undergraduate degree, I led nutrition information classes for new mothers. In those days, women stayed in hospital for days if not a week after giving birth. During their hospital admission, they attended a class that the dietitian taught. The class addressed the mother's nutritional requirements during lactation, formula selection and preparation, and the introduction of solid food.

In those classes, mothers were given information about lactation and support. The presentation was not biased. The agenda included giving mothers all the information they might need to inform their infant feeding choice. This experience contrasted with my more recent experiences in a public health setting where there was a pro-breastfeeding culture and silence with regards to alternatives.

The Influence of Professional Interpersonal Interactions on My Tensions

Despite the pro-breastfeeding environment in which I practiced, I rarely observed a professional display blame or judgement toward a woman for not breastfeeding. It would have been disturbing to hear a colleague blame or scorn a mother for her infant feeding decision. Outside of the region where I worked, during a parent education session, I once heard the leader refer to a baby as a “smart baby.” This was in response to a mother expressing her concern that her six-month old wouldn’t accept a bottle. That simple phrase, said to a group of mothers by the group’s leader, was laden with judgement.

In contrast, a colleague whom I met on only one occasion seemed to assume that I would judge her client for feeding her baby infant formula. A public health nurse requested that I visit a mom with a family home visitor to address feeding issues. The home visiting program for new mothers included visits from a public health nurse and/or family home visitor. Family home visitors reinforced the nurse’s messages and implemented their care plan. They were mothers themselves and had training on how to provide support to mothers on a variety of parenting topics. Either the nurse or family home visitor could invite the dietitian to attend visits to assess or provide nutrition education on an issue. The family home visitor abruptly greeted me outside the mother’s

home and very sternly told me not to comment on her client's choice to formula feed, and that the priority was for the baby to be fed. She was clearly trying to prevent her client from being judged for her infant feeding decision. By this time, I had already had my first child, had had my fill of breastfeeding challenges, and had weaned him from the breast by the time he was five weeks old. I quickly clarified that there would be no judgement from me, and why. Her attitude toward me automatically changed.

The family home visitor was protecting her client. She appeared to assume that I would attempt to enforce the breastfeeding imperative, and she must have recognized the negative impact this could have on her client. This experience occurred after I had “failed” to breastfeed my first child, so I was intimately aware of the impact the breastfeeding imperative could have on a woman. Her defense of her client’s infant decision was something I had rarely witnessed. I respected the family home visitor for standing up to “the expert” against the “expert-driven imperative” and practicing in such a person-centred manner.

On the telehealth service, women called to ask questions about infant formula. They commonly preceded their questions with what appeared to be a justification for their decision to formula feed. They preceded their questions by explaining why they chose to wean early and describing their breastfeeding challenges. Their challenges included poor milk supply, sore nipples, bleeding nipples, and not being able to satisfy their baby. Women didn't need to be blamed or scorned for their breastfeeding decision to feel judged.

A longitudinal qualitative study explored how mothers defended their decision to formula feed [59]. Thirty-six women were interviewed before birth and five additional times up until

their child was two years of age. The study demonstrated that a mother's feeding decision is a "a highly accountable matter" [59, p. 205], described infant feeding as a "moral minefield" [59, p. 205], and asserted that "infant feeding decisions are as much about morality as they are about nutrition" [59, p. 206].

Women face "interactional challenges" when they seek to establish themselves as good mothers, good partners, and good women [59]. When mothers called the telehealth service, mothers clearly felt that they made the wrong choice in the eyes of HCPs. I realized that women were defending their decision to me, an HCP, to justify their decision.

I listened to mothers' reasons for choosing infant formula and commonly reassured them that their decision was the best for their baby. I seemed to be contradicting the message I felt accountable to deliver, but it felt like the right thing to do. It was only after mothers were reassured that they wouldn't be scorned or blamed that they felt comfortable to ask questions. I was careful not to imply that they were making or had made the wrong decision, but I felt an obligation to communicate, as WHO states, that there are rarely contraindications for breastfeeding.

As an HCP, I was conditioned to value and base my practice on quantitative evidence and national feeding guidelines. It was also an expectation of practice and a standard of practice to serve as a reliable source of nutrition information. Health care professionals were expected to practice according to national nutrition statements.

I used my judgement on when and how to voice an evidence-based stance to mothers because I realized that an evidence-based rebuttal might imply that a mother's opinion was wrong. I listened to mothers' experiences and drew upon nutrition education resources that stated the "facts" to address mothers' common "misconceptions."

As an example, mothers would supplement breastfeeding with infant formula before settling the infant for the night. Their perception was that it would help the baby to sleep through the night. I would tactfully state or refer her to an educational resource indicating that research did not support this and advise her about the benefits of exclusive breastfeeding.

An HCP's failure to acknowledge mothers' choices leads to alienation and impacts the relationship between HCPs and mother [23]. I recognized that if I were to disrespect a mother's decision, I would negatively impact our relationship and the likelihood that she would continue to draw upon my services for education and support. At that time, to me, person-centred care was more about being respectful during individual interactions than to involve the client in decision-making. I also felt that it was inappropriate for me to question her personal decision.

I felt that it was disrespectful to imply to a mother that she had made the wrong decision, but according to the imperative, she *had* made the unhealthy choice and her decision wasn't consistent with the research that underpins the national feeding guidelines. I felt a tension. I was starting to recognize mothers' experiences as a source of evidence.

The Impact of Organizational Culture on My Perspectives

The organizational cultures of my education and practice settings influenced my perspectives toward breastfeeding. As a graduate dietitian, and early in my career, I held a flexible and person-centred stance toward breastfeeding. I considered breastmilk and infant formula acceptable options for infant feeding. In my role within the context of a public health setting, I began to think of breastfeeding as an imperative.

My education and training took place in the early nineties. In my program, I learned that breastfeeding was ideal, but formula was also an acceptable option. My university textbook presented breast milk as the preferred choice from a nutrition standpoint [60]. The author of the textbook found it problematic that “in some parts of the world, women breastfed without considering alternatives or consciously making a decision” and “...in other parts of the world, women used formula because they knew so little about breastfeeding” [60, p. 150]. The author argued that “in both settings, mothers can benefit from knowledge about both alternatives before deciding which best meets their own needs and the needs of their infants” [60, p. 150]. Although my science-based education led me to value quantitative evidence, when it came to breastfeeding, I was taught to acknowledge a mother’s infant feeding decision. I acknowledge that a degree granted in the nineties and a textbook published in 1990 should not inform current practice, but the concepts of informed choice and person-centred care do not become outdated.

This stance, that both breastmilk and infant formula were acceptable options, was one I applied during my internship and in my first years of practice. I have previously referred to the infant feeding class that I led during my internship (see p. 31). As an intern, I didn’t question or judge the mothers’ choice to formula feed. It didn’t even occur to me to do so because the organization did not expect HCPs to promote breastfeeding as an imperative. Breastfeeding promotion strategies had not yet evolved to normalize breastfeeding and subsequently cause others to judge mothers’ infant feeding choice.

It was ten years after my internship that I began practicing in a public health setting. In this setting, I realized that it was no longer acceptable to advise mothers that breastmilk and iron-fortified formula were acceptable alternatives. It was no longer acceptable to

enable mothers to consider alternatives. The expectation was to advise that “breast is best” with no mention of formula.

When I started working in a pro-breastfeeding environment with an emphasis on breastfeeding promotion, my perception began to shift away from the flexible, person-centred stance held earlier in my career. I came to accept that women had a responsibility to breastfeed or at least try to breastfeed because evidence showed health benefits. Furthermore, breastfeeding an economical choice. I admit, albeit rarely, to feeling an inkling of judgement toward women who didn't intend to breastfeed from the onset or who didn't seem to give breastfeeding ample effort. However, I also felt compassion for the mothers who defended their choice to formula feed, and I respected their decision.

Despite my shifting perspective to embrace the “breast is best” imperative, I experienced tension communicating the imperative to individuals. As a clinical dietitian, I had always recognized the many factors that impact a patient's diet and lifestyle choices and respected their decisions. I continued to do so as a public health dietitian, but I felt as though I was contradicting the infant feeding guidelines that I was expected to enforce.

The following occurrence illustrates the organizational culture that impacted my perspectives. In my practice, new mothers often asked questions about how to choose and prepare infant formula. I served as a resource, but there were no print or web-based educational resources publicly available. I led the development of a resource on infant formula based on a need that I identified in practice. The resource was developed, but it was only available on request or distributed at the HCP's discretion. It certainly was not

distributed at pre-natal classes or included in pre-natal education packages. To do so, I presumed, would convey the message that formula was an acceptable option. The development of the resource included lengthy multi-stakeholder consultation to ensure it was not compromising the pro-breastfeeding message. I experienced a tension because I knew that mothers needed reliable information on the topic, yet it was not publicly available on the website or at community centres. I felt that making the resource available only on request was a subliminal message to mothers that they had not made the right decision.

It was a tension for me to give mothers the impression that their decision to choose formula was unacceptable. The following quote from an HCP captured in a qualitative study by Murphy (2010) reflects my tension: “I remember it was breastfeeding week...and everyone had badges with ‘breast is best’ on, and I used to think to myself, ‘if you were a mother that couldn’t breast feed it must be so traumatic to have so much pressure put on you from the so-called professionals about breast feeding and one must feel an absolute failure” [56, p. 7].

A Summary of My Tensions in Practice

In the 1970s, a movement began to promote breastfeeding [61], but it was in 1990 when the American Academy of Pediatrics took a position against the marketing of infant formula [61]. This was a turning point for how breastfeeding would be promoted, protected, and supported. This movement was in response to a declining breastfeeding rate associated with the marketing of infant formula [61].

I have described the context of the “breast is best” culture and how the “breast is best” imperative, originating from the public policy sphere, is pervasive, and how it interacts and is reinforced in environmental interactions throughout the other spheres of influence. The

imperative to breastfeed influences practices within the community, organizational, interpersonal, and individual spheres that potentially led to stigma, and subsequently to my tensions. Figure 2 illustrates the practices previously identified in my autoethnography that contribute to stigma in a culture that embraces the “breast is best” imperative.

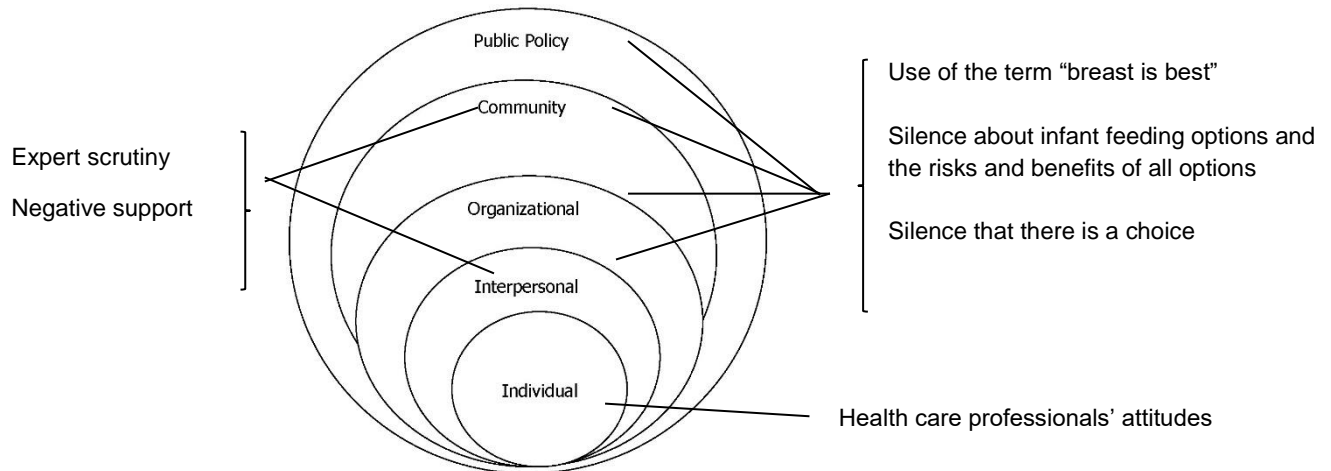


Figure 2. Factors that contribute to stigma in an environment that embraces dominant discourses associated with the normalization of breastfeeding. Adapted from McLeroy et al. (1988) [32].

The “breast is best” message is pervasive, originating from the public policy sphere and reinforced in other practices that promote breastfeeding as a social norm. Negative support, for example, takes place in community programs and counselling, but reflects HCPs’ attitudes that, in turn, are influenced by professional discourse and the breastfeeding imperative.

My analysis exposes the professional discourse, a dominant discourse (defined on p. 5), that led me to value expertise and knowledge generated by science. The discourse, originating from the public policy sphere, influenced the shift in my beliefs about breastfeeding. The inkling of judgement that I felt toward mothers who did not intend to breastfeed (see p. 36) was an outcome of the professional discourse. My professional attitude toward breastfeeding was

influenced by the reinforcing and interactive nature of the public policy, organizational and interpersonal spheres of influence.

Figure 3 illustrates the tensions that I experienced as a public health dietitian while simultaneously conforming to professional discourse and recognizing the stigma that the discourse had on mothers. My analysis exposes the dominant discourse that shifted my reliance on science-based evidence. I began to consider mothers' experiences, silent in professional practice resources and guidelines, as valid sources of evidence. I therefore experienced tension relying on the concept of expertise to guide my practice. Use of the term "breast is best" to communicate the breastfeeding imperative, based on quantitative research and expertise, suggested that the mother who does not breastfeed fails to do what is best for her baby. My tension with the term was further enhanced when I witnessed the self-blame and sense of failure that was so apparent in mothers who did not breastfeed. As the literature suggests [as described on p. 28), those who do not comply with the evidence-based, expert-driven message experience stigma.

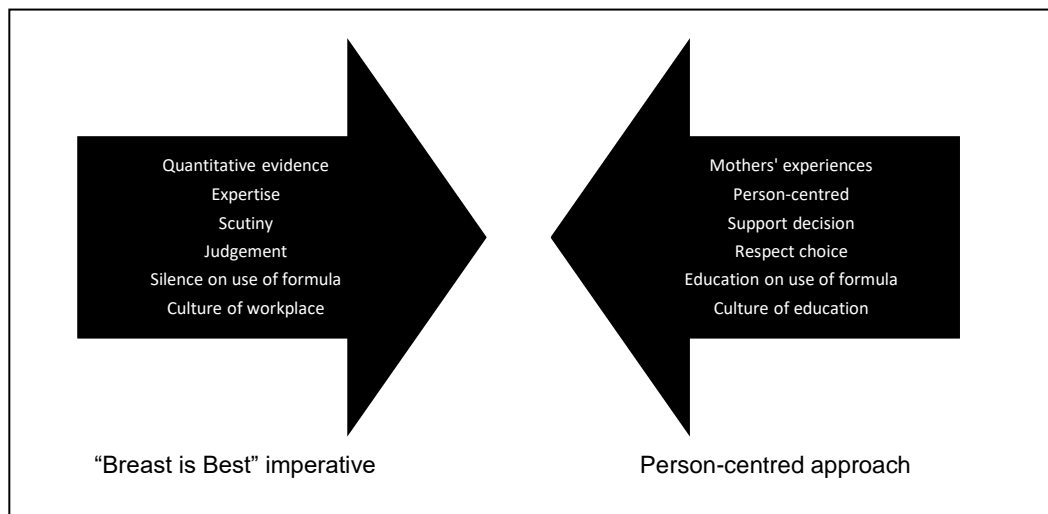


Figure 3. My tensions in practice associated with a breastfeeding organizational culture

Not only is the mother guilty of failing to do what is best for her baby, but of failing to do what is best for herself. The evidence (see p. 25) behind the imperative suggests that there are health benefits for the mother. In an age when individuals are expected to be informed and care for themselves, there is stigma associated with poor self-care. I expand upon “health as a duty” as a dominant discourse in Part 2.

The breastfeeding imperative is reinforced through community education strategies and programs. I struggled when participating in education programs without mentioning infant formula as a potential alternative. The information provided to women prenatally and postnatally was to influence and support the mother to breastfeed. By failing to mention infant formula as an option, I was saying that formula was not an acceptable option. This is a form of negative support that can make a woman feel judged for her decision not to breastfeed. Negative support is further discussed in Part 2.

I felt tension participating in the program that required prenatal women to meet with me to receive funding for a diet allowance. Although I provided a valuable and important service that was often appreciated and led to positive outcomes, I was the expert scrutinizing their actions and rewarding their behaviour with financial aid. It appeared to me, and likely to the mother, that she was receiving payment for making the appropriate choice – to breastfeed. Had she not breastfed, and had I refused to sign the form enabling financial aid, I clearly would have been telling her that she had made an unacceptable decision about the care of her child.

When counselling women about infant feeding, I struggled when fulfilling my role of promoting and supporting them to breastfeed while respecting their choice not to breastfeed. I recognized a contradiction when reassuring women who did not breastfeed that they did what was best for their baby. To do otherwise would have been judgmental. I was contradicting the

imperative, but I was respectful and supportive. I was sincere. I was recognizing the worth of mothers' experiences rather than relying on the evidence that informed the breastfeeding imperative.

The breastfeeding imperative influenced the public health practice environment. When the health system adopted the policy direction to normalize breastfeeding, my flexible, person-centred philosophy toward infant feeding was compromised. I wavered toward the imperative, but felt a tension telling mothers what was best when their potential choice was otherwise. I felt a tension being silent about infant feeding options and the risks and benefits of all options.

In Part 1, I describe a pro-breastfeeding environment (one that is silent about infant formula as an acceptable choice) and the practices that fall within each sphere of influence that contributes to a mother's stigma. In Part 2, I elaborate on the ideological influences that impact stigma which also explicate why I experienced tensions in my practice.

Part 2: My “Failure” to Breastfeed

Introduction

I did not consciously decide to breastfeed. When expecting, I found it puzzling when others asked if I intended to breastfeed. Of course, I would breastfeed: “breast [was] best;” and I was a dietitian. I was not only a dietitian with an understanding of the national infant feeding guidelines, I was a public health dietitian immersed in the breastfeeding imperative. The social norm and what I perceived to be my professional obligation and expectation (to breastfeed) influenced my decision to breastfeed.

I knew ‘breast was best’ and that breastfeeding would likely have become easier after the first six weeks. I understood the challenges associated with breastfeeding from working beside public health nurses who counselled new moms every day on every imaginable breastfeeding challenge. Despite this knowledge, I was unprepared for the breastfeeding challenges I experienced and the emotions that accompanied motherhood. Sleep deprivation, breastfeeding challenges, anxiety, and a plethora of emotions took their toll on me. My professional expertise was irrelevant. My personal challenges clouded my professional knowledge. I didn’t persevere. I “failed” to meet the breastfeeding guidelines that I must follow if I was to do what was best for my baby, be a good mother, and be a respected health care professional.

As I have illustrated in Figure 4, factors from multiple spheres of influence informed my breastfeeding decision: the imperative to breastfeed, the organizational culture of my workplace, society’s expectations to comply with breastfeeding as a social norm, and my personal values related to expertise and science-based knowledge. The reinforcing and interacting nature of these

influences accounted for my decision to breastfeed. By “failing” to breastfeed in accordance with policy, organizational, social, and personal expectations, I experienced stigma.

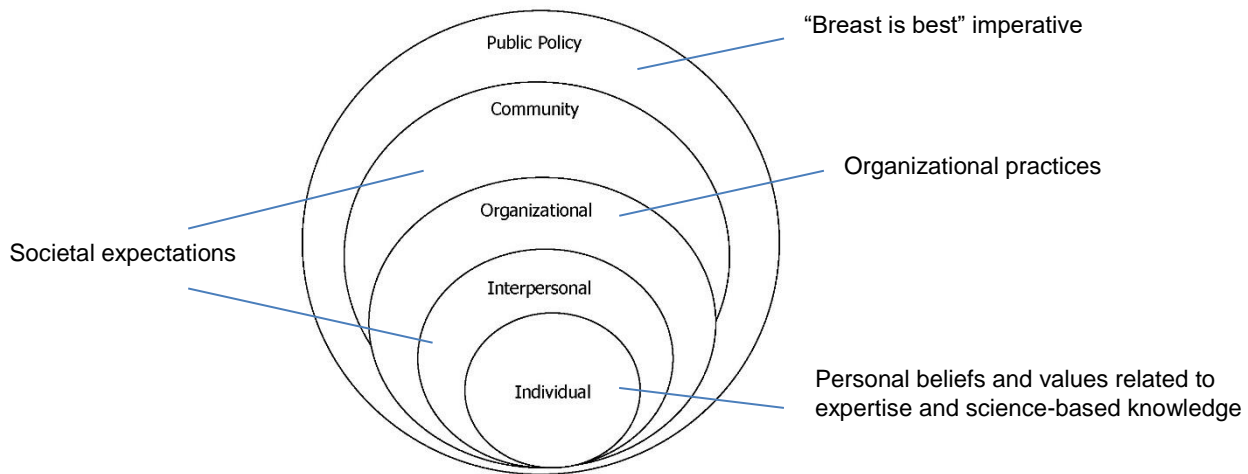


Figure 4: Factors that influenced my decision to breastfeed. Adapted from McLeroy et al. (1988) [32].

My stigma was internalized. No one overtly judged me for formula feeding my children... they didn't have to. It was only *normal* that I felt like a failure, as this autoethnography will illuminate.

There is a hegemonic strategy to cause those who do not conform to an expert-driven imperative to feel as I did. Hegemony is whereby “people learn to embrace as common-sense wisdom certain beliefs ...that work against their interests and serve those of the more powerful.” [2, p. 43] and “the process by which we learn to embrace enthusiastically a system of beliefs and practices that end up harming us and working to support the interests of others who have power of us” [2, p. 93]. This hegemonic strategy is called *normalizing* and originates in the policy sphere of influence. Strategies to support the hegemony fall within the context of each sphere of influence to strategically influence women to breastfeed and normalize breastfeeding. This

autoethnography will reveal that the same intentional, multi-layered mechanism in place to influence women to breastfeed also serves to stigmatize women who do not comply.

The nature of contemporary breastfeeding messages and strategies, those multi-layered influences that normalize breastfeeding, denormalize formula use. These same multi-layered influences that normalize breastfeeding, and in turn denormalize formula use, lead to stigma. A stigmatizing environment is a sum of influences that the surroundings have on stigmatization [34]. Stigma is a consequence of denormalization [4]. According to Burriss (2008) [4], stigmatization is a cruel form of social control. Stigmatization is characterized by negative effects on social networks, quality of life, and self-esteem, and may promote depression, and avoidance of health care environments and providers [Stuber, Meyer & Link, 2008 cited in 4].

In Part 2 of my autoethnography, I illuminate how my stigma, a social phenomenon, was socially constructed. I describe my experiences from the perspective of the mother – the target of the strategies in place to normalize breastfeeding. I describe and explore the meaning of my early motherhood experiences to identify the dominant discourses that impact the stigma women who feed their infants formula may experience.

Early Motherhood

Motherhood began with a difficult labor and breastfeeding challenges. My son was first put to my breast within hours of birth. He had a poor latch; he didn't suckle properly. He was drowsy at the time, but the difficulty was attributed to flat nipples. Another nurse later appeared with a can of infant formula in hand and took a few minutes to help me. She showed me how to use a tube to finger feed with formula and advised me to buy a breast pump. There wasn't a lactation consultant available at the hospital on a Sunday. I

needed support! I called a colleague from the Breastfeeding Team. Over the phone, she gave me advice and arranged a home visit for me the next day.

Despite my professional knowledge, I was psychologically unprepared to encounter breastfeeding challenges. I had only anticipated success. I was aware of the public health imperative to breastfeed, so I was surprised that there was minimal support to breastfeed in the hospital. Women's voices captured in the study by Hall and Hauck (2007) uncannily resembled my own:

I have flat nipples and have had one midwife saying I will always have a dreadful experience breastfeeding because I have 'shit' nipples. [62, p. 791]

I have found the whole experience so far very emotional. Due to the fact that the hospital has been swamped with patients and staff have been incredibly busy I found that with changing shifts I have been unable to obtain assistance and support I need. [62, p. 791]

In Ontario, Canada, 51 in-depth interviews with 17 first-time mothers were conducted to explore how infant feeding is socially constructed in hospital [54]. Women who had breastfeeding difficulties in hospital were offered formula. Mothers' comments were categorized as successful or unsuccessful moments. Unsuccessful moments were characterized by problems latching, insufficient milk, infant weight loss, conflict with healthcare providers, and mothers' pain and discomfort. When mothers felt that they were not successful breastfeeding, they subsequently experienced a sense of failure, inadequacy, and powerlessness.

From the early hours of motherhood and for several weeks, every waking moment seemed to revolve around breastfeeding. On the way home from the hospital, I stopped by the office to borrow a breast pump from a colleague. It didn't work. My husband then rented

a breast pump from a local pharmacy. It wasn't an easy feat on a Sunday afternoon. On that first evening home from the hospital, the day after giving birth, my husband satisfied our son's hunger with formula while I spent hours in the emergency department with edema related to the IV fluids that accompanied my epidural preceding a forcep-delivery.

I pumped to stimulate milk supply, and my son had to be fed formula with a tube until my milk came in, supposedly to prevent nipple confusion. I corrected the latch with the much-needed support from public health nurses and lactation consultants, but I couldn't manage to breastfeed without topping-up with formula to satisfy his hunger. I pumped around the clock to stimulate milk supply and supplement with bottled breastmilk, but my supply was not meeting his demands. By mid-day, my supply had declined, and it was then that my son guzzled formula with obvious preference for the artificial nipple. I was advised to limit the formula. I should have known, but I hadn't realized that the top-ups were contributing to my poor milk supply, as well as to nipple confusion. Feeling overwhelmed clouded my professional judgement to top-up with formula.

I eventually made progress satisfying his hunger with breastmilk until he developed gastrointestinal upset. The upset was associated with a foremilk-hindmilk imbalance. Foremilk is the milk which is low in fat and high in lactose that a nursing baby drinks first. He wasn't getting the hindmilk, which is higher in fat. The high lactose was causing the symptoms. I was advised to pump off the foremilk and feed the baby from what was a very uncomfortable and unnatural angle to decrease the flow. It was complex, and it was stressful. For the first weeks, I recorded every feeding, millilitre of formula fed

to him, wet diaper, bowel movement and my baby's weight (Figure 5). I found the whole process confusing, awkward, and certainly not natural.

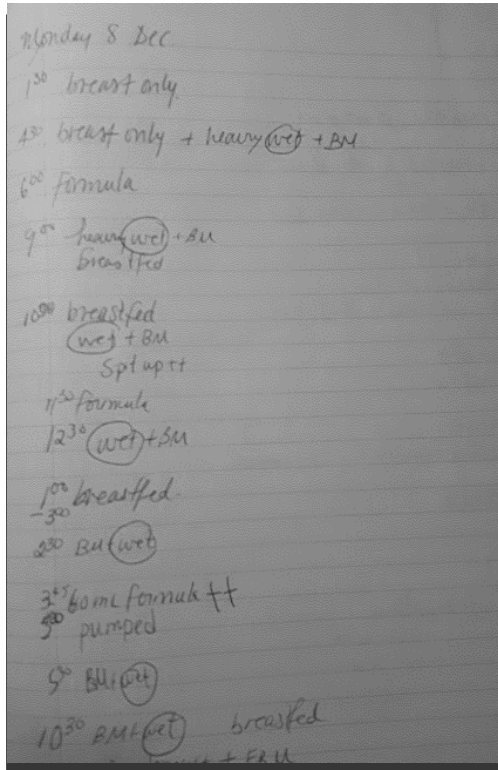


Figure 5. Documentation of input and output

My son wasn't gaining weight as well as expected. Concern about his growth made me anxious. My poor milk supply and the poor latch made me anxious. Cutting his finger nails even made me anxious for fear of clipping his finger! I was overwhelmed with the sense of responsibility for caring for such a tiny being and wasn't confident with much of anything that I had to do to care for him. I weaned him before he was six weeks old.

This image of myself will never leave me: Every afternoon, by 4 o'clock, a dark cloud appeared over my head while I fed my son seated on a black leather couch. I had a dread and fear of the night. I would awaken to his cry in the middle of the night in a

sweat, frantically searching for John in our bed, even though he slept in a crib in his bedroom. I was alone for the night-time feeding routine. I would get up to feed, change diapers, settle baby, pump, get a couple of hours of sleep and then repeat the cycle throughout the night.

It was more than the blues. It was six weeks post-partum. I was prescribed the lowest dose of an antidepressant and referred to a psychologist. I was diagnosed with mild depression. It seemed as if overnight, my mood improved on the medication. I didn't realize that the dose was not considered a therapeutic dose and that I shouldn't have noticed a change in mood for a couple of weeks. I attributed the improvement of mood to the medication, but there were several changes that may have improved my mood: I was out attending mother and baby activities; baby boot camp was over, John was smiling and interacting, and I was bottle feeding. I bonded with John while he was feeding by bottle. He fed on demand. He was held. He was satisfied. I was comfortable. He slept! I slept!

With my second son, Tyrone, again I planned to breastfeed. Again, it was an unconscious decision, and this time I intended to get it right! I had another easy pregnancy, a very short labor that was free from complications, and I didn't have an epidural. Tyrone latched within a half hour of birth. I was so relieved that he had such a strong latch! I thought we were off to a great start! The strong latch led to bleeding nipples and excruciating pain. It wasn't a correct latch after all. He also had thrush. Again, I relied on lactation support.

My son was feeding every two hours around the clock. I was exhausted. I had corrected the latch and milk supply was not an issue. However, I was anxious

anticipating growth spurts and fearing that I would not be able to keep up a supply for his demand.

When my son was only weeks old, my husband was offered a position in another province. My mother was with me for support when Tyrone was born but had returned to her home. I was alone with the children when Joseph traveled out of province to meet his new employer and find us a home. I developed acute anxiety.

Keeping up with breastfeeding demands, sleeplessness and anxiety again took their toll. I decided to wean abruptly. In contrast to John's obvious preference for the bottle, Tyrone experienced nipple confusion with a bottle and would awkwardly suckle the artificial nipple to satisfy his hunger. I felt guilty watching him struggle to latch onto the bottle's nipple. To this day, I feel guilty for abruptly weaning him from my breast. Over the years, I have awoken in a sweat from nightmares of weaning him early. Despite the support from my colleagues, and from my husband and mother, and my intent to breastfeed, I weaned both of my boys before six weeks of age. When I weaned John, I felt despair and failure. When I weaned Tyrone, I felt despair and guilt.

My breastfeeding challenges and the negative consequences associated with my decision to formula-feed correspond with many of those cited in the literature; however, Lee's (2007) finding especially resonates with me: guilt and failure were more profound if the mother had planned to breastfeed, and first-time mothers' responses were most distressful [9].

The normal challenges associated with early parenthood impacted my ability to cope. Post-partum depression and anxiety certainly didn't help. My personality and the adjustment to my role as a mother from that of a professional were also contributing factors.

It is important to me to feel organized. By nature, I am organized but not obsessively so. The hospital bag was packed well in advance. I had sewn gingham curtains and a quilt for the nursery. Baby clothes were bought, washed, and folded in drawers. Supplies were organized. I had insomnia during my first pregnancy and was up for hours every night. I am somewhat embarrassed to admit that I used that time to alphabetize the books on my bookshelf. I organized and prepared for motherhood with excitement. All was in order well before the baby's due date.

In contrast, as a new mother, I felt as though my life was in chaos. I remember feeling obsessed, sweeping crumbs from under the kitchen table when normally they wouldn't have bothered me. Only days after returning from hospital, I sat at the breakfast bar planning menus. Meanwhile I had a toddler and newborn for whom to care. The contradiction in roles between work and home life contributed to my ability to cope. As a professional, I had structure, routine, and purpose. As a new mother, I had a new purpose but one with which I had very little confidence.

*During my maternity leave, I wrote a book entitled, *An Organizational Guide for New Mothers*. Figure 6 contains an example of its contents. The book included templates of lists that parents could use in preparation for parenthood and early childhood. It was a self-help book, not only for others, but for me.*

I attribute the writing of the book to my need to demonstrate my expertise in the areas where I felt confidence. I felt confidence in my ability to plan and organize. The book gave me a purpose that combined my roles as mother and professional on issues in which I felt confidence and success. Breastfeeding had overwhelmed my every waking

moment and despite my knowledge it was a topic about which I was not feeling confident as either a mother or a professional.

I incorporated my professional expertise in the content on meal planning and infant feeding, and in writing a self-help book, I was being the health professional – striving to help others. The book was where I could demonstrate my abilities as a mother and professional whereas I had ‘failed’ as a mother and professional in the breastfeeding department.

During the first six weeks home with my new baby, I cried daily. I felt as though I had no control of my life. I had panic attacks. I couldn't concentrate on anything that didn't involve the baby. Was it the numerous breastfeeding problems I tried to overcome, guilt when I couldn't, lack of sleep (no, I didn't sleep when the baby slept because I was finishing my Christmas shopping and cleaning the house), recovery from a difficult labour (are any pleasant?!), the overwhelming sense of responsibility and tenderness for the little dependent soul, or was it hormonal? Likely, all of the above. As a health care professional, a registered dietitian in the pediatric specialty, I was quite familiar with the signs of post-partum depression. I had several of the symptoms.

At about two months, however, my little one looked up at me from his change pad and gave me his first smile (that did not appear to be gas-related) and cooed. It was uphill from there! In retrospect, all of the above factors triggered my stress, but the underlying cause was the change from a structured, professional lifestyle to a lifestyle governed by the needs of a newborn. It was listing and journaling that helped to introduce some semblance of order in my new role.

Figure 6. Excerpt from An Organizational Guide for New Mothers (July 2004)

The book was not published. I wrote and sent a proposal to editors, but it was not accepted. I was not terribly disappointed. By the time it was ready for publishing, it had already served its purpose. As I said, the book was a self-help book. It was a means for me to cope with and/or compensate for how, in the practice of breastfeeding, I had failed as a mother and dietitian. Through this project, I demonstrated my skills and strengths as a mother and professional.

My early motherhood experiences illustrate the complexity of breastfeeding and indicate that the decision to breastfeed is influenced by a mother's individualized context. Breastfeeding is not only about the act of feeding. Despite the factors that impacted my emotional turmoil, I attribute much of my anxiety, guilt, and feelings of weakness and grief to the pressure I put upon myself to breastfeed. The factors that influenced my initial decision to breastfeed (Figure 4) also influenced the pressure I put upon myself to continue breastfeeding; the suggestion is that the internalized pressure to breastfeed is socially constructed. The literature, however, suggests that women perceive negative support as pressure to breastfeed.

Breastfeeding Support is Not Always Supportive

The emotions that represent my vulnerability; such as weakness, disappointment, self-blame, and inadequacy were interlaced with anger, blame, and resentment. I felt negativity toward those who so caringly provided me with professional support to breastfeed. They did not overtly pressure or judge me. They didn't have to. They supported me to overcome my breastfeeding challenges and persevere, but there was silence as to weaning being a potential or acceptable option.

My anger, resentment, and blame were a result of what I construed as negative support. Programs in place to support mothers to breastfeed failed to communicate an alternative to breastfeeding, and there was silence about alternatives. Although I felt resentment and blame toward health care providers, they were instruments of the organizational sphere.

Through in-depth interviews, researchers [10] explored women's experiences, perceptions, and expectations of professional support for infant feeding in the first six weeks post-birth. The study's finding is that negative support impacted a mother's confidence and subsequent decision to continue breastfeeding. Negative support was characterized as rudeness,

lack of help, being directive, inflexible support, lack of acknowledgement of the women's feelings, lack of honesty, and judgement. According to Sheehan, Schmied and Barclay (2009), "Women felt they could not make the feeding decisions they considered appropriate or best for their baby because any decision apart from breastfeeding was devalued and not tolerated" [10, p. 143].

Hall and Hauck (2007) and Newhook et al. (2013) capture women's voices that describe the pressure that women experience:

I was put under a lot of pressure by the community nurse for the baby to gain weight. She insisted on twice weekly weigh-ins. I felt terribly pressured and on the day of the weigh-ins and felt like a failure if there was only a tiny weight gain. [62, p. 791]

I desperately wanted to breastfeed and when I didn't the amount of guilt I felt and still feel is overwhelming. I have postnatal depression. Not breastfeeding and the stigma I feel are definitively large factors. I have been made to feel a failure that I am not breastfeeding. [62, p. 791]

There's so much pressure put on you about the breastfeeding that, even though that's what I wanted to do, when I knew that . . . I couldn't do it any more I felt guilty . . . I knew I gave her what I could give her and it was better than nothing at all, but I still felt that guilt because of the pressure that was put on me about breastfeeding. I didn't want to admit to caregivers or doctors or the health nurses that I wasn't doing it anymore, because that made me feel inadequate — that made me feel like I was a failure. [58, p. 40]

Qualitative data from a study provide insight into middle class mothers' experiences of perceived pressure to breastfeed by health professionals:

Our women implicated care providers in exerting pressure to breastfeed and undermining their self-esteem by treating them as failures if they were unsuccessful. Messages like, ‘if you really want to breastfeed, you can succeed’ created a climate where women felt personally responsible for problems that resulted in breastfeeding cessation. [62, p. 794]

The study’s findings suggest that women encountered conflicting and unhelpful advice, and feeding pressures from health professionals, community, and family members. I perceived the silence about formula in interpersonal interactions a form of negative support.

When attending community mother-and-baby activities, mothers were often encouraged to breastfeed their child. This was announced to encourage mothers to feel comfortable to breastfeed in public. There was silence, however, as to where mothers who formula-fed their babies could feed. Although well-intentioned, the silence with regards to formula, to me, communicated that formula was not an acceptable option.

A mother’s breastfeeding experience is also influenced by her personal support system via the interpersonal sphere of influence.

*I felt frustration toward my mother who was with me during the early weeks of motherhood to provide me with support. She questioned why I would continue breastfeeding when it was so much trouble and causing such anguish. Initially, I considered her input unsupportive because it contradicted expert advice. Within a couple of weeks of giving birth, I was on PubMed doing a literature search to show Mom the evidence that breast was best and that I **had** to breastfeed.*

She fed me during a time when formula feeding was the norm. Consistent with the 1990 text, she formula fed with very little consideration of the options. She mothered

during a time when there wasn't the same pressure on women to make their children the centre of their universe. My mother supported my choice but didn't appear to understand why I felt the need to breastfeed when it appeared to be causing so much stress.

Now I realize that I wasn't on PubMed to convince my mother. I needed to see the evidence to inform my infant feeding decision. I realized that I hadn't ever actually read the evidence; I had blindly trusted and relied on Health Canada's evidence-based and expert-driven guidelines. I was looking for a choice when I didn't feel as though I had one. The "breast is best" imperative does not present options. My mother presented an option, but it contradicted the expert-driven imperative. Ironically, when I heard the same message from a health care professional, it was a message that I very much needed to hear and allowed me to make the decision I knew I had to make.

The conversation remains vivid in my mind. I was seated on the black leather couch in the living room while my husband was cooking dinner. John was asleep in his bassinet beside me. I was in tears and inconsolable on the phone speaking with my cousin. This conversation was pivotal to support the decision I had already made but had not yet admitted to myself or anyone.

My cousin, a registered nurse who has since exclusively breastfed her three children, was aware of my anguish and the impact it was having on my mental health. She helped me to acknowledge that breastfeeding was not best for me. I could not be the best mom I could be if I continued to breastfeed. It was what I needed to hear. I had permission to wean and validation that stopping was the right thing to do.

It was also ironic that she didn't say anything to me that I hadn't said to my clients when they called to defend their decision to formula feed. There had been tension

in my practice when I valued both the science-based evidence and women's experiences. As a new mother, I was also experiencing this tension. In practice, when mothers called to defend their decision to formula feed, I reassured them that what was best for them was best for their baby. I was sincere. In my practice, I had developed an appreciation for another form of evidence – mothers' experiences to justify not breastfeeding. As a mother, I needed, like my callers, a health care professional to recognize my experience as evidence to support weaning. My cousin, a health care professional, provided the expert-based approval that I and many are conditioned to value rather than to rely on their own experiences.

I have already witnessed how the sharing of my personal breastfeeding challenges has helped others to feel better about their decision to formula feed and share their stories. I believe it is because I am a health care professional who "failed" to breastfeed that they feel less stigmatized. While writing this autoethnography, I have told numerous acquaintances about my thesis. Repeatedly, at the mere mention of the term "pressure to breastfeed," I have been entrusted with their stories or their friends' or relatives' stories. I have heard about experiences with "breastfeeding Nazis", the tremendous pressure applied by health care professionals, and very often, of mothers' justification for formula feeding. It was as though they had finally found a receptive ear who would not judge and could relate. I heard stories which consistently supported my story and the literature. I suspect that when mothers called to ask questions about infant formula, they wouldn't have gone to such lengths defending their decision to formula feed had I told them that I, a dietitian, hadn't breastfed.

Negative support is pervasive throughout the spheres of influence. Tensions that I experienced as a professional, including judgement, silence about formula, and expert scrutiny reappear in Part 2 of my autoethnography as forms of negative support – thus explaining why I felt a tension with these practices.

The Expert-driven Imperative to Breastfeed

The resentment, anger, and blame I experienced during those middle-of-the-night feedings and diaper changes was also directed toward public health – not toward individuals at my workplace, but the institution, the origin of the imperative. I resented feeling pressured to conform without acknowledgement of an alternative.

This imperative was impacting how I perceived myself as a good mother. If I didn't breastfeed, I would place my child's health at risk. If I didn't breastfeed, others would judge me as I was judging myself - as being weak and a bad mother, and without credibility as a health care professional.

A mother's internalized pressure and internalized stigma are societal mechanisms of control, originating from the policy sphere of influence. The expert-driven, evidence-based imperative to breastfeed, also originating from the policy sphere of influence, is a societal mechanism of control. To explain, it is important to recognize that infant nutritional status is a matter of international and national concern, as Table 1 illustrates. Public health problems, such as obesity and heart disease, impact the welfare of the population [56]. An unhealthy population impacts the productivity of the nation, and impacts costs associated with healthcare and social benefits [56]. The nation, therefore, has an interest in infant feeding decisions to promote health and prevent disease.

The breastfeeding imperative also serves the interest of men. A state's leadership predominantly consists of men. Males have an interest in infant feeding decisions, although women bear the responsibility to breastfeed. The imperative to breastfeed for six months and beyond [6] presents a challenge to women in the workforce, especially when having multiple children throughout the span of their careers. A workforce consisting of women who stay home to exclusively breastfeed enables men to progress in the workforce. The breastfeeding imperative may assist men to advance in their careers and maintain positions of power in the workforce. Murphy(2003) states, "Expert discourses that identify certain practices as healthy, and therefore legitimate, and others as unhealthy, and therefore illegitimate, play a crucial role in such systems of domination" [23, p.147].

The work of French social theorist Michel Foucault relates to a paradox involving the relationship between the state and individuals [56]. The state's respect for individual choice and autonomy is in tension with how it influences social and economic factors to promote the welfare of society. Although politicians can legislate some actions to impact health, such as restricting where individuals smoke, they cannot legislate breastfeeding. Doing so would violate a mother's personal freedom of choice. Infant feeding takes place predominantly in the private sphere. According to Murphy (2003), "Telling mothers how they should use their bodies and how their babies should be fed could be interpreted as an illegitimate incursion into the privacy of family life and an assault upon mothers' autonomy and self-determination" [23, p. 435]. Instead, the state "governs from a distance" [56], from the policy sphere of influence, to regulate individuals' behaviours to promote health and prevent disease. From a critical perspective, this form of governance is hegemonic (previously defined on p. 44). The use of this form of hegemonic power prevents the need to employ coercive forms of control to regulate a behaviour [2].

The breastfeeding imperative is a mechanism of control that serves to normalize breastfeeding and enable governance from a distance in a non-coercive manner. According to Foucault, a dominant group recognizes that specific practices have arisen that could become economically advantageous, politically useful, or useful for maintaining the dominant group's position. When a dominant group perceives that certain practices might prove useful to them, mechanisms of control are used to govern a behavior. In Foucault's view, the establishment of societal mechanisms of control is haphazard and accidental rather than deliberately organized [2].

The breastfeeding imperative encompasses two dominant discourses: the evidence-based discourse and expert advice discourse. Both discourses delineate how knowledge is sanctioned. In Foucault's view, there is a relationship between power and knowledge [2]. Those in a position of power can create knowledge supporting a power relationship. Whatever a society accepts as knowledge or truth inevitably ends up strengthening the power of some and limiting the power of others [2], as is seen in women who fail to comply with the imperative to breastfeed.

Foucault's view related to power and knowledge explicates the professional discourse and tensions that I identified in Part 1. These dominant discourses, originating from the public policy sphere, led me to question my personal decision to wean and believe that my personal challenges "clouded my professional judgement" (as described on p. 43 and p. 47). This internalized pressure to breastfeed and subsequent stigma, falling within the individual sphere of influence, was socially constructed.

Health as a Duty

Foucault's 'governing from a distance' paradox, plays out in the medicalization of infant feeding. Experts apply knowledge that demonstrate a link between behaviours and disease (e.g.

smoking and lung cancer) to create health education messages and imperatives. Expertise is important in the creation of power relations between professionals and individuals [Rose, 1993 cited in 63], as is carried out in the interpersonal sphere of influence. The expert-driven imperative warns of risks and states how children *should* be fed. According to Murphy (2010) “While experts are not, in the end, able to control how mothers feed their babies, they do set the standards by which women may be judged by others and, perhaps most importantly, judge themselves” [56, p.12].

According to Murphy (2010), the “breast is best” imperative dominates mothers’ infant feeding decisions and the risks associated with bottle feeding are disseminated through an elaborate “state-sponsored apparatus” through expert advice [56]. From this regard, it is the mother’s moral obligation and duty to adhere to expert-driven imperatives to ensure the health of her child. The “health as a duty” discourse [56] is a term used to refer to the ideology of risk - the expectation that individuals take responsibility for their health or their children’s health by complying with expert-driven recommendations [Leichter, 1997; Murphy, 2004 cited in 9].

In the late 1990s, policy discourse evolved to create an onus on individuals to take responsibility for their health, and to be knowledgeable and improve or maintain their health [28]. This “care of self” discourse is a form of self-surveillance originating from the public policy sphere of influence. Self-surveillance means monitoring one’s own conduct out of fear of being observed or judged [2]. Self-surveillance is referred to as the most important component of disciplinary power because it facilitates self-discipline [2]. Those who conform to managing their health serve as a normative standard with which others compare themselves and may feel deficient [28].

Contemporary breastfeeding promotion approaches reflect the ideology of risk [9] and “health as a duty” discourse [56]. Several authors refer to breastfeeding promotion as an ideological, medicalized discourse [52,59,64]. This expert-driven, evidence-based discourse creates the “breast is best” message as a moral imperative [9,59,65,66].

Intensive Motherhood

To consider herself or be considered by others as “good mother,” a woman may feel morally obligated to comply with expert-driven recommendations derived from the risk paradigm. However, mothers may comply with moral imperatives for reasons beyond the health benefit, for example, to comply with society’s socially and culturally derived expectations. The impact of the risk discourse is intensified when combined with intensive motherhood. Intensive motherhood falls within the public policy sphere of influence and is an ideological phenomenon whereby the baby’s needs are paramount and the mother’s main function is the baby’s welfare [63]. The obligation to comply with the imperative originates from the public sphere of influence.

Previously, I have referred to writing a book during my maternity leaves (p.52). I have explained that this project restored my confidence and helped me to cope with the adjustment to my role as a mother from that of a professional. I also attribute the writing of the book to my need to have a purpose other than to focus solely on the welfare of my children. Just as I did not compromise my health or my family’s well-being by continuing to breastfeed, I did not commit my sole purpose to childcare.

During my second maternity leave, when I cared for an infant and toddler, I spent mornings in activities with the children to stimulate their development. In the afternoons,

I slept when they did, and I went to bed when they did. A sole focus on the children was exhausting and left me drained. Intensive mothering was exhausting.

In the literature, mothers indicate their reason for not breastfeeding was that they wanted their lives back and that early motherhood was the most stressful time of their lives [8,50]. I suspect that it was not childcare that was exhausting but complying with the ideology of intensive motherhood. I was unknowingly contesting the ideology of intensive motherhood by not breastfeeding and not committing my entire purpose to the welfare of my childcare.

Knaak (2010), a Canadian researcher, explored how mothers think about risk when making feeding choices [64]. Thirty-three women were interviewed about their feeding experiences. Thirty-two of the sample breastfed. Results indicated an association between the choice to breastfeed and “good mothering,” and between success and perseverance and the mothers’ identity as a good mother. Many mothers also commented on the culture of pressure, not only related to health promotion, but within the parenting culture. Intensive motherhood, in conjunction with the ideology of risk, impacts a mother’s moral status and identity as a “good mother” [64].

The ideology of intensive motherhood [63], where the baby’s needs are paramount [63], and the responsibility of the baby’s welfare lie solely with the mother [Murphy, 2004 cited in 52], is characterized by the mother prioritizing her child’s needs despite personal inconvenience or distress [59]. The “mothers’ main function is assumed to be maximizing the physical and psychological outcomes for their children” [63, p. 295].

In my practice, I observed mothers going to great lengths to defend their infant feeding decision. They also seemed obsessed with their baby’s bowel habits and whether their

toddler was growing well enough, or eating enough, or drinking too much. At community centres, I watched anxious mothers chase their toddlers with food and beg them to eat. Daily, mothers would call for advice on infant feeding or other parenting issues. I wondered whether mothers, my clients, had lives of their own! They were overwhelmed with the advice from media, friends, mothers, and in-laws, and whether they were doing what was best for their children. Now, as a mother, I realize that those mothers did have lives. Their children were their lives.

In *The Cultural Contradictions of Motherhood*, Hays (1996) describes intensive motherhood as a socially and culturally constructed ideology that defines what socially appropriate mothering entails [67]. Intensive motherhood is “child-centred, expert guided, emotionally absorbing, labour intensive and financially expensive” [67, p.8]. In contrast to stay-at-home mothers of the 1950s and 1960s, mothers today have fewer children, increased technology at their disposal to reduce labour, and work outside the home, yet also mother according to the ideology of intensive mothering. This ideology evolved as more women entered the workforce. It places more demands on women in their mothering role. In intensive motherhood, mothers are the primary caregivers and responsible for their child’s health, even when employed.

There are tensions between expectations of mothers and expectations of working mothers. Motherhood that is intensive, nurturing, and moral is in tension with aspects of a modern capitalist western culture [67]. Society’s expectations of women’s behaviours in the workplace contrast with nurturing, selfless, and moral characteristics of the ideological mother. Society’s expectations of mothers to sacrifice themselves for their children is also in contrast to capitalism’s promotion of self-interest. One would expect intensive motherhood to wane in

response to contemporary mothers' lifestyles, but this discourse enables men to advance in their careers and maintain positions of power in the workforce. This ideology serves the interests of men, capitalism, the state, the middle class, and whites [67].

Instilling a moral obligation to breastfeed is one way the government can govern from a distance (public policy sphere) without overtly violating a mother's personal freedom of choice. With reference to the "health as a duty" and "motherhood as a sacrifice" discourses, Murphy describes the two as "powerful and mutually reinforcing discourses" [56, p.5]. According to Murphy (1999), "...infant feeding decisions are as much about morality as they are about nutrition" and infant feeding is a "moral minefield" [59, p. 206].

Women's breastfeeding experiences were studied within the context of becoming and being a good mother [52]. In this study, 158 observations and the results of 22 in-depth interviews informed the authors' findings: mothers' decisions and mothers' identities are influenced by the ideology of intensive motherhood.

Failure to breastfeed may impact a mother's agency [66] and identity and moral status as a "good mother" [9,52,58,59,64,68]. Crossley (2009) described the "breast is best" discourse as disempowering, especially when there is also a moral imperative and other cultural imperatives [65]. Failure to breastfeed may impact how others perceive her as a "good mother" [64].

Mother Blame

By not conforming to the ideology of intensive motherhood or by not conforming to parenting norms (for example, breastfeeding), the mother "exposes herself to the charge that she is a 'poor mother' who places her own needs, preferences, or convenience above her baby's welfare" [59, p. 187]. Judgement by others may be perceived or explicit. Self-blame may be conscious or unconscious. Blaming complicates the already-complex nature of motherhood and

holds mothers responsible for their actions and for the health and well-being of their children [69].

Mothers have been accused of poor mothering when children are ill [69]. Jackson and Mannix (2004) indicate that there is an “entrenched discourse of mother blaming in health care literature” [69, p. 155]. Health providers are particularly likely to attribute problems to maternal fault [69]. Mother blame and stigma are also evident for single mothers, poverty-affected single mothers, lesbian mothers, working mothers, mothers on welfare, and minority mothers because they are blamed for the country’s social problems [69].

Despite the nature and source of blame, the result is the “internalization of disciplinary power” [70]. Outcomes include feelings of inadequacy and “devastating effects on the women’s self-esteem, health and well-being” [70, p. 154]. Mothers are vulnerable to criticism [63] when they do not adhere to expert recommendations or society’s expectations around mothering responsibilities. An outcome of mother blame is that mothers question themselves, their actions, and their abilities [69].

The following quote from a mother’s narrative illustrates how self-blame occurs in response to a child exhibiting symptoms of allergies and relates to the mother’s self-blame for not breastfeeding: “Poor little thing, he cried all the time...he got it in the first place because I mucked up on the breast feeding” [69, p. 153].

The plethora of emotions that I have described were associated with the normal challenges of baby boot camp, but also self-blame for my breastfeeding challenges. At the time, I blamed myself for not anticipating and being mentally prepared for breastfeeding challenges, for not realizing that topping-up would have affected my milk supply, and for not being stronger and persevering.

In contrast to the emotions associated with self-blame, I felt pride when I breastfed in public and in front of my peers. I felt like a good mother during those successful moments breastfeeding, and I was conscious that people were observing and approving. I didn't feel pride when I bottle fed. In fact, I was self-conscious of my "failure" to breastfeed. When I dropped by my workplace to visit colleagues, a supportive, non-judgmental environment, I would feed my son beforehand. I wanted to hide that I had "failed."

I attended a public health-based community education program with my first son. This was a forum for post-natal education and peer support. I was the only formula-feeding mother in the class. No one expressed any criticism or judgement. Due to my perception that others were questioning and judging, I defended my feeding decision to others.

As the only formula-feeding mother in the class, I suspect that women who formula-fed did not feel comfortable attending the class. I had the resiliency to attend, but others may not have had the confidence due to feeling judged. According to Murphy (2003), women who chose to formula feed their infants faced "interactional challenges" and set boundaries between themselves and the activities of others [23]. Lee (2007) found an association between method of feeding and impact on social networks and relationships with HCPs [9].

With both of my children, I sought community programs to add structure to my day, seek adult companionship, and stimulate their development. I went to library and drop-in programs. I was conscious of my choice to bottle feed, but only once experienced another mother, a stranger, overtly address it. She bragged that her child had never had a bottle.

I suspect she was reassuring herself that she was a good mother, rather than implying that I was a bad mother.

Mother blame is a means for the state to govern from a distance. While the way a mother chooses to feed her baby is her own, her choice is “shaped, guided and molded” [56, p. 3]. Foucault’s notion of “dividing practices,” comes into play. Practices become publicly recognized as “healthy” versus “unhealthy”, and “responsible” versus “non-responsible” behaviours and give rise to expectations and judgements about how individuals should lead their lives. Foucault refers to these judgements as “normalizing judgements” [23], and these expectations and judgements serve as a mechanism of surveillance [2]. Surveillance is an intentional, quiet coercion of the ruling apparatus to “govern from a distance” and influence infant feeding decisions. It gives the public, mere strangers, the right to ask a mother about her choice. Normalizing judgments fall within the interpersonal sphere but originate from the public policy sphere.

While I was expecting, I was amazed when strangers in the lineup or aisle of the grocery store would stop me and ask, “When are you due? Is this your first?” and often proceeded to ask whether I planned to breastfeed. At that time, I found it odd that it would be of interest to so many and that they felt free to ask this of a total stranger or mere acquaintance. They asked whether I planned to breastfeed - not whether I was having a boy or girl, or what would I name him/her, or how I was feeling. During my one-year leave of absence, a familiar greeting was “How old is your baby? Are you still breastfeeding?” Strangers seemed to feel free to ask – as though it was their business. It was as though they were asking if I did the right thing and to deem me a good mother. For me, it reinforced my “failure.”

A stranger's interest in my feeding decision had a profound effect on me the morning after I decided to wean John. The fitness instructor assumed I was breastfeeding and asked me how it was going. Such an innocent question posed by a total stranger was not ill-intentioned. But intentioned it was from the state's perspective.

My son was born late in November, and December had been busy with Christmas, family visiting from out-of-province, and his baptism. In January, my mother went home (she lived out of province). Joseph worked full-time. I was alone.

I braved the winter elements in my desperation to see other mothers and put structure into my day. We went to our first "mommy-and-me" exercise class. John, in his harness facing me and I were the only brave souls to brave the elements to attend the exercise class. One of the first questions from the exercise instructor was "How is the breastfeeding going?" She assumed that I was breastfeeding. I didn't tell her that I wasn't. I struggled fighting back tears during the entire class. This memory continues to have an acute effect on me. I went out in desperation for support and companionship but came home feeling worse than when I had left. What I'm sure was a good-intentioned question left me in tears and feeling like a failure.

It was significant that I did not admit to the exercise instructor that I was not breastfeeding. I did not want to confess to a total stranger that I was not breastfeeding – not fulfilling my duty to prevent health problems and not being a good mother. Normalizing judgements in combination with Foucault's panoptic gaze create a mechanism of control [23]. Judgement by others is social stigma. How individuals judge themselves is internalized stigma and falls within the individual sphere of influence but is socially constructed to serve as a mechanism of control originating from the public policy sphere. Governance from a distance

serves as a mechanism of control and compromises a formula feeding mother's moral identity [63] and puts them in 'moral jeopardy' [23].

Quiet Coercions

While the rules of infant feeding (Table 1) are publicized through an "elaborate state-sponsored apparatus" [23], "quiet coercions" are also used to "govern from a distance" [56]. Quiet coercions, a Foucaultian concept, are used to persuade individuals to voluntarily adopt healthy behaviours [56]. Quiet coercions are intricately linked to Foucault's concept of disciplinary power. In contrast to sovereign power, exercised from above, disciplinary power is "exercised by people on themselves in the specific day-to-day practices of their lives" [2, p. 120]. Foucault views power as something embedded in individuals' everyday life and in everyday activities [2]. Quiet coercions, originating from the public policy sphere, fall within multiple spheres.

Quiet coercions, including the medicalization of breastfeeding, normalizing judgements, and mother-blame, have already been discussed. The idealized image of mothering [70] is another quiet coercion.

It was more than the published benefits of breastfeeding that influenced my intention to breastfeed. I had an image of motherhood in my mind, an image of nurturing and intimacy that involved breastfeeding. I suspect that it is an image that girls have in their minds from childhood of how motherhood will be.

Breastfeeding, an experience that I anticipated with such excitement, was fraught with disappointment and self-blame. I felt like a cow when I pumped and when I breastfed. It was supposed to feel natural. It was a time when I was supposed to bond with the baby. I felt inadequate. I felt misled.

Breastfeeding promotion materials include quiet coercions to influence women to breastfeed. In a critique of childcare educational materials, three dominant constructions contributing to a discursive environment validate breastfeeding through its association with “good” or “moral” mothering [72]. These constructions are described as: medicalization and risk, the ideal maternal individual, and natural versus artificial [72]. These constructions are evident in the images below.

Images of breastfeeding mothers illustrate an infant bonding with a mother and depicts breastfeeding as a peaceful, natural, and comfortable experience. Mothers may blame themselves when they compare themselves to the “pervasive visual and narrative metaphor” of the “good mother” and the “idealized portrait of mothers and mothering characterized by qualities such as understanding, protection, closeness, wisdom, selflessness, and a lack of conflict” [70, p. 1196].

I have already described my tensions associated with the development of a resource on infant formula (p. 37). In my workplace, it was a resource that would be disseminated like the products you would find behind the pharmacy counter that would only be dispensed with a pharmacist’s oversight. It was not to be published on the organization’s website and it was not to be distributed at group sessions or programs.

The omission of language and the failure to provide mothers with options are quiet coercion. Public education resources are silent regarding the option to use formula. Health Canada’s resource (Figure 7) provides infant feeding guidance for breastfed infants. The omission of reference to formula on public health education materials communicates that the use of formula is not an acceptable alternative. Resources (Figure 8) refer to the importance of ensuring that mothers make an informed choice, but information is withheld.

For a young infant (birth to 6 months)

- **Breastfeeding** is the only food or drink your baby will need for the first 6 months.
- Babies who are breastfed should get a **vitamin D supplement** of 10 micrograms (µg) or 400 international units (IU) each day. This will prevent vitamin D deficiency.

If your baby is not breastfed, or is only partially breastfed, commercial infant formulas are an alternative to breast milk. Non-breastfed infants do not require a vitamin D supplement because the commercial infant formula contains vitamin D.

For an older infant (6 to 12 months)

- Continue to breastfeed for up to two years or more, as long as both you and your child want to.
- Continue to give your breastfed infant a vitamin D supplement of 10 µg (400 IU).
- At 6 months, breastfeeding is still your baby's main food source, but it is time to **begin adding solid foods**. Formula-fed infants should also be introduced to solid foods at this time.
- **Start with foods that contain iron and offer them a few times each day.** Iron supports your baby's growth and development. Iron-rich foods include meats such as beef, lamb, game, poultry, and fish. Meal alternatives include eggs, tofu, and legumes such as beans and lentils. Iron-fortified infant cereal is also a common first food.
- Gradually increase the number of times a day that you offer solid foods.
- Offer your baby a range of **nutritious foods from your family meals**. Let them discover different textures and experiment with feeding themselves.
- **Give your baby foods they can eat using their hands.** Offer pieces of soft-cooked vegetables, soft fruit such as banana, grated cheese, bread crusts and toast.
- If you are making the transition to cow milk as your child's main milk source, wait until your baby is between 9 and 12 months old. Start with homogenized cow milk (3.25% M.F.). Do not offer skim or partly skimmed milk (1% or 2% M.F.) before 2 years of age.
- If you are going to make fortified soy beverage your child's main milk source, wait until they are 2 years of age. Rice or nut beverages should not be used as your child's main milk source.

Figure 7. A Health Canada infant feeding resource that omits reference to infant formula.

Retrieved on February 18, 2018 from <https://www.canada.ca/en/health-canada/services/infant-care/infant-nutrition.html#a6>

Region of Peel
Working for you

A-Z List | Accessible Info | Careers | Contact Us | Print this Page

Search go Programs & Services

News/Notices | Regional Government | Health Services | Public Works | Social Services | Housing

Health > Family Health > Breastfeeding > Make an Informed Decision >

Get the Facts

- About obesity
- About ear infections
- About lower respiratory infections
- About diarrheal infections

Revised: Thursday June 15 2017

Get the Facts

Babies don't get to choose whether they are fed breast milk or formula, but you do. And since your choice can affect your child's healthy development you need to get all the facts.

Make an informed decision about infant feeding:

1. Discuss any questions or concerns about feeding baby with your health care provider
2. Know the importance of breastfeeding/providing breast milk for baby, mother, family and community
3. Be aware of health risks for baby and mother of not breastfeeding
4. Risks and costs of formula
5. Difficulty of reversing the decision once breastfeeding is stopped

If you make an informed decision to feed your baby infant formula, the following information can help you prepare infant formula safely.

- About obesity
- About ear infections
- About lower respiratory infections
- About diarrheal infections
- Contact Us

About obesity

Breastfeeding Instructional Videos

Health Services
Peel Public Health
Parenting in Peel
Before Pregnancy
During Pregnancy
After Pregnancy
Caring for Your Newborn
Breastfeeding
Just for Dads
Baby's First Year
Toddlers and Preschoolers
Programs and Services
Contact a Nurse
Your Comments?
Connect 2 Peel
Subscribe to e-Newsletter

Figure 8. Region of Peel's infant feeding resource. Retrieved on February 1, 2018 from:

<https://www.peelregion.ca/health/family-health/breastfeeding/informed-decision/obesity.htm>

Mothers' voices on this subject were captured in studies by Hall and Hauch (2007) and Marshall et al. (2007):

Antenatal classes should have covered options for mothers in the event that they were not able to breastfeed. Very breastfeeding biased. [62, p.791]

There is also quite a strong pressure really there for new mothers who feel that they have to or ought to give it a go because of all this information that's loaded onto you at the classes about how it's so much better for the baby and you just think, well God I really ought to do it for the sake of the baby. [52, p. 2150]

Not only is there a lack of information about infant formula, there is silence on how difficult breastfeeding can be and the impact the difficulties may have on bonding, maternal mental health, and infant growth and development [71].

Breastfeeding promotion materials are also silent about the existence of there being any legitimate reasons not to breastfeed. Breastfeeding information materials emphasize that all mothers, except with HIV, can breastfeed. Nothing justifies an alternative. The reasons that women may not adhere to expert recommendations (page 28) are not cited as valid reasons in published resources. Physical, psychological, and emotional problems should be considered legitimate reasons to stop breastfeeding [71]. According to Fahlquist (2011):

The way breastfeeding is currently promoted by WHO, UNICEF and the national health authorities does not respect mothers as autonomous beings capable of making good decisions for themselves and for their families. Breastfeeding is a very personal matter and women who have physical and emotional problems with it or, for other completely valid reasons, prefer not to breastfeed, are made to feel inadequate as mothers, and perhaps even as women, and made to feel that they are not doing what is in their child's

best interest. This is a powerful message to vulnerable mothers, especially first-time mothers [71, p. 199].

The language used in health promotion messages reinforces dividing practices. Messages on an Ontario public health department's website (Figure 9) illustrates how language serves to influence a mother's infant decision. A post on Health Canada's website (Figure 10) advises mothers to "plan wisely." The dictionary defines "wisely" as "in a way that shows experience, knowledge, and good judgement" [73].

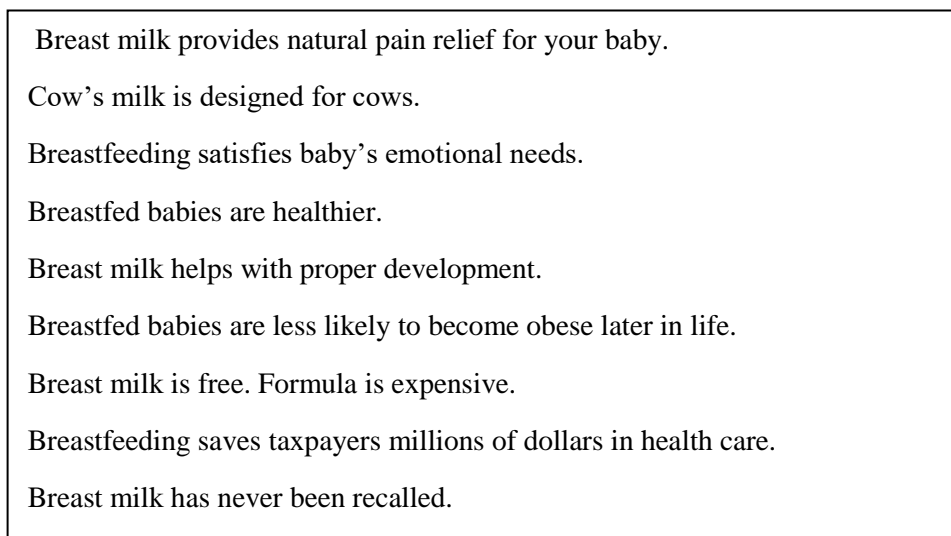


Figure 9: "Quick Facts About Breastfeeding" on the Peel Public Health website. Retrieved on February 1, 2018 from: <https://www.peelregion.ca/health/family-health/breastfeeding/>

A social media post (Figure 11) illustrates expert organizations' and HCPs' reactions to a celebrity photographed bottle feeding. Images posted of Piri Weepu bottle-feeding his infant within an anti-smoking advertisement were removed. This incident illustrates the impetus for silence on formula as an acceptable option because, from the experts' and policy makers' perspectives, it is not. The incidence reinforces dividing practices.

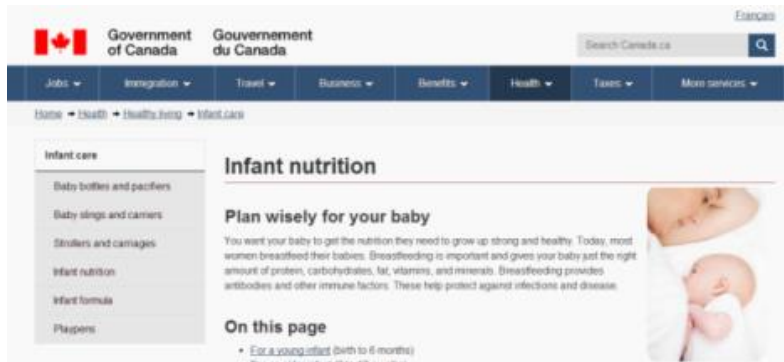


Figure 10. A Government of Canada webpage that advises parents to plan wisely. Retrieved on February 18, 2018 from <https://www.canada.ca/en/health-canada/services/infant-care/infant-nutrition.html#a6>



Figure 11. Social media post that stigmatizes celebrity for bottle-feeding baby. Retrieved on February 18, 2018 from www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10783518

My Stigma was Socially Constructed

I have identified the ideological concepts and described the contextual influences associated with the stigma I experienced during early motherhood. Figure 12 illustrates the complexity in how the ideological concepts, originating at the public policy sphere of influence, are reinforced throughout other spheres. The hegemonic strategy in place to promote, protect, and support breastfeeding, is implemented through ruling relations. According to Taber (2010), “ruling relations are not just about who has the power to make regulations, they are about how people implicated in a system perceive certain concepts” [27, p.10]. Ruling relations influence how health care professionals embrace the expert and evidence-based dominant discourses (to scrutinize and judge), the public embrace the “breast is best” imperative to impose normalizing judgements, and mothers internalize pressure. The public policy influences are reinforced in organizational policies and practices and further reinforced in the manner in which HCPs interact with mothers and they impact HCPs’ professional attitudes.

An understanding of the pervasive ways ideological concepts influence breastfeeding promotion practices has enabled me to make sense of my experiences and understand why my stigma was socially constructed. I now understand that stigma itself is integral to ruling relations to promote perseverance to breastfeed. My understanding of the ideological concepts has also helped me to understand why I felt tensions in practice (see Figure 3). My tensions with expert-scrutiny, reliance on science-based research findings, etc. were a result of my tensions between the socially constructed expert and evidence-based discourses and my recognition of mothers’ values, culture, and experiences. The sense-making that my autoethnography has achieved has contributed to an understanding of the ways in which contemporary breastfeeding promotion strategies are problematic.

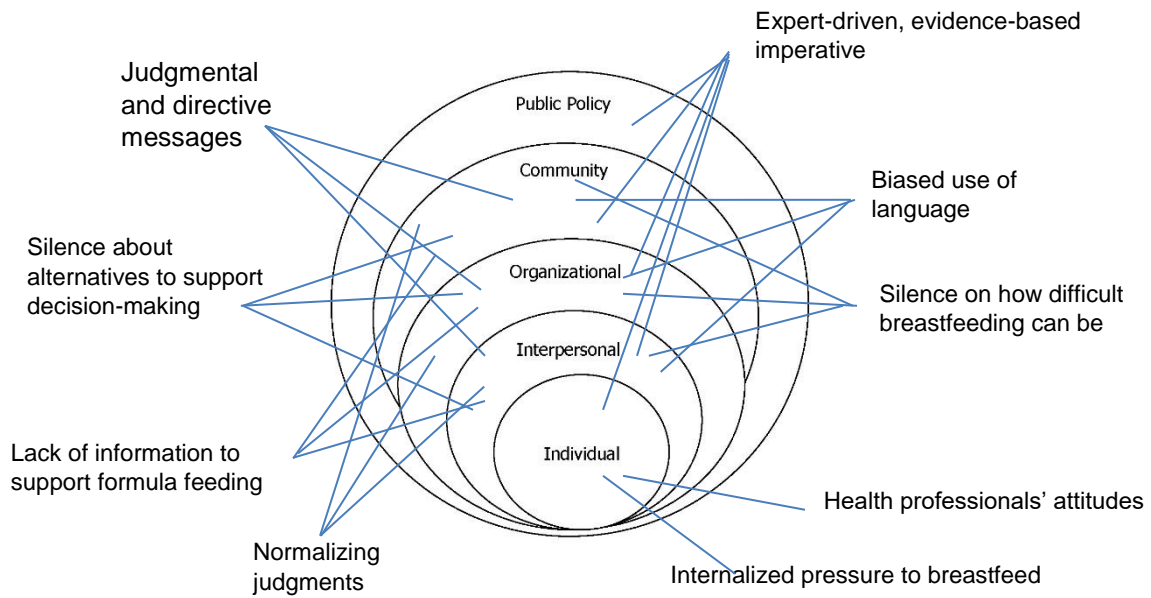


Figure 12. The sum of influences on stigma associated with the imperative to breastfeed.

Adapted from McLeroy et al. (1988) [32].

Discussion

Breastfeeding statements and guidelines, based on scientific evidence and expert advisement, inform population and community health initiatives. Mothers are advised and supported to breastfeed via initiatives that include the publication of national infant feeding guidelines, education strategies, and support programs. The creation of social norms is a strategy used to change health behaviours. The denormalization of smoking is an example of how individuals come to accept norms and illustrates how powerful the creation of social norms is in changing health behaviours.

A desired outcome of normalizing behaviours is for the behaviour to become automatic. For me and 32 of the 33 women in Knaak's (2010) study, the intention not to breastfeed was not an option [64]. A mother's voice in a qualitative study reflected the norm: "I don't think I ever thought, 'oh I'm not breastfeeding.' Along with the baby came breastfeeding – that was just the way it was" [52, p. 2150]. For me, to stop breastfeeding, on the other hand, was a conscious decision fraught with stigma.

The breastfeeding imperative has led to the development of messages, practices, and policies to promote, support, and protect breastfeeding. In turn, these practices denormalize infant formula. Health care professionals have a role in setting social norms [56], but norms are the result of an "elaborate state-sponsored apparatus" [23]. Bayer (2008) [cited in 4] refers to the process of normalizing behaviours as a "barbaric form of social control."

Nova Scotia's breastfeeding pledge (Figure 13) is an example of marketing material intended for populations to promote breastfeeding but viewed by individuals. By the time I first saw this poster, I had already "failed" to breastfeed. It refers to breastfeeding as the normal, safest, and best way to feed a baby. The messages, in combination with the idealized image of

motherhood, informed me that my challenges were *abnormal*, that I would be to blame for my children's health problems, and that I did not make the best infant feeding decision. This poster reinforced my feelings of "failure."



Figure 13. Nova Scotia's breastfeeding pledge. Reprinted from the Nova Scotia Department of Health and Wellness with permission. Retrieved on February 18, 2018 from: <https://novascotia.ca/dhw/healthy-development/documents/Family-Friendly-Breastfeeding-Pledge.pdf>

Public health-promotion program planners strategically and intentionally use the interactive and reinforcing nature of the SEM to promote behavioural change [32,33]. From a critical theories perspective, these strategies are only a component of an elaborate state-sponsored apparatus to normalize breastfeeding. The layered interactions individuals have with the environment strongly effect stigma [34]. Not only does each sphere of influence impact stigma independently, but the multiple layers are interactive and reinforcing [32].

There are three terms evident in regulated health care professions' codes of ethics that are not mutually exclusive: evidence-based practice, client-centred care, and informed choice. Incorporating these principles into breastfeeding promotion messages and strategies would help to alleviate the stigma associated with the denormalization of infant formula. I experienced tensions (as a professional) and stigma (as a mother) because breastfeeding messages and strategies associated with the "breast is best" imperative are contrary to these principles.

Evidence-based Practice

Evidence-based information is the basis of breastfeeding guidelines, but is based solely on quantitative research and does not reflect the qualitative research findings from social sciences that capture the lived experiences of women's breastfeeding experiences.

Postmodernism acknowledges that "many ways of knowing and inquiring are legitimate and no one way should be privileged" [19, p. 147]. Postmodernism questions the dominance of the traditional scientific method and demonstrates that it is possible to gain and share knowledge in many ways [19]. Health care professionals' education and training, however, is science-based. Health care professionals, therefore, are socialized to value quantitative evidence to inform their practice and subscribe to the evidence-based dominant discourse.

Resources that guide practice on infant feeding, including position statements and guidelines, cite only quantitative studies. The dietetic profession's Practice-based Evidence in Nutrition (PEN) System, a key resource for the profession, uses an hierarchal approach to identify evidence to address practice questions [7]. A rigorous process is used in line with a quantitative methodology to assess and grade the evidence that is used to make recommendations [7]. Although this approach is essential, PEN and organizations' position statements and guidelines (see p. 28) draw solely on quantitative evidence. This devalues the worth of

qualitative findings from the social sciences and compels practitioners to access qualitative findings elsewhere to inform their practice.

There is a tension. The International Confederation of Dietetic Association (ICDA) definition of evidence-based practice, endorsed by Dietitians of Canada, states:

Evidence-based dietetics practice is about asking questions, systematically finding research evidence, and assessing the validity, applicability and importance of that evidence. This evidence-based information is then combined with the dietitian's expertise and judgment and the client's or community's unique values and circumstances to guide decision-making in dietetics. [74]

Although the definition refers to research evidence in a broad manner, a quantitative descriptor (validity) is used to describe the value of the research. The definition and PEN's focus appear to devalue the worth of qualitative research. One can presume, however, from the ICDA's introductory statement, that findings from the social sciences should be integrated into practice. The ICDA statements states: "To be relevant and effective, evidence-based dietetics practice must integrate knowledge of other disciplines." PEN, however, does not integrate qualitative research findings from the social sciences into the tool.

Prior to conducting a literature review for this thesis, I was aware of my clients' experiences (and my own), but oblivious to the qualitative literature that describes mothers' contexts, the complexity of the infant feeding decision and the stigma associated with the "failure" to breastfeed. Practice guidelines and resources are science-based but omit other applicable and important evidence.

It is important to recognize that evidence-based practice is "the integration of the best research evidence with clinical expertise and patient values" [75, p. 1]. This definition places

equal emphasis on the three components: the best available research evidence, the clinical expertise of the practitioner, and the individual's goals, values and wishes. Evidence-based practice incorporates person-centred care. The best available research evidence should be comprehensive and include findings relevant to both breastfeeding and infant formula, and mothers' lived experiences.

Person-centred Care

According to Maclellan and Berenbaum (2006), dietitians "struggled with the notion of recognizing client expertise," and indicated that more research is needed within the dietetics profession to better understand the meaning of a client-centred approach to practice [76, p. 124]. Health care professionals may experience a "contractual obligation" to comply with national nutrition statements [23]. This may prevent an HCP from practicing in a person-centred manner, especially when the client's wishes are contrary to expert-sanctioned knowledge. Dietitians may have difficulty recognizing client expertise because they have been traditionally educated in an instrumental/technical paradigm [5]. They, therefore, willingly subscribe to the science-based evidence discourse potentially unaware of the quiet coercions that impact stigma.

Informed Choice

In the creation of social norms, a desired outcome is for individuals *not* to make a conscious decision to adopt a behavior. As I have illustrated, the quiet coercions in place to influence breastfeeding rates normalize a behaviour. Breastfeeding promotion resources are silent on communicating potential alternatives and are silent regarding risks associated with breastfeeding or benefits associated with infant formula. Risks and benefits of all options are not published to enable an informed decision. This is problematic: "Informed choice is linked to the

principle of informed consent, which is both a legal and ethical concept and considered a fundamental right for people receiving health care” [80, p.377].

An informed choice relates people’s ability to make knowledgeable decisions which reflect their own culture, values, and views. It is also based on access to comprehensive, unbiased, and evidence-based information, about the full range of options [81]. Enabling informed choice is a component of ethical professional practice. To enable an informed choice, infant feeding education and support strategies must communicate that there are acceptable alternatives to breastmilk, and that there are benefits and risks associated with all options. Furthermore, published information must be unbiased [71].

Health Canada publishes advice for HCPs to follow when communicating with prospective parents, and states:

The health professional’s attitude toward this topic is also critical. Inconsistent, unfavourable – or even neutral – attitudes towards breastfeeding on the part of health professionals are negatively associated with breastfeeding duration (Thulier & Mercer, 2009). Discuss concerns and correct misinformation to support fully informed decisions about infant feeding. [82]

This advice is contrary to the principals of informed choice, evidence-based practice, and person centred care. Providing objective, comprehensive, and unbiased information and support enables a mother to make a *fully* informed choice. I have previously described my anger and resentment (see p. 53) related to the unsupportive nature of breastfeeding support programs and messages from the perspective of the mother who chose to formula feed. Recognition of the mother’s context, beliefs, and values as valid, rather than as “misinformation,” is a component of evidence-based practice. An HCP, as a clinician with the ability to appropriately demonstrate

professional judgement, should not be discouraged from demonstrating empathy and understanding, and from supporting the mother's choice to formula feed. My interpretation of Health Canada's advice is that it discourages the display of an attitude inconsistent with "breast is best" and, therefore, would lead a mother to perceive an HCP as unsupportive. I have already discussed the potential implications of negative support on stigma (see p. 53).

Despite experts' and national and international organizations' imperatives, women are not exclusively breastfeeding to the desired standard. Statistics show that there has been a steady increase in breastfeeding initiation, but that women are not continuing to breastfeed exclusively. Breastfeeding initiation rates in Canada have increased considerably in recent decades, from less than 25 percent in 1965 [Millar and Maclean, 2005 cited in 83] to 88.4 percent in 2011 [83]. Yet, of the mothers who initiate breastfeeding, close to 25 percent stop before their infant is one month old [83]. The percentage of Canadian mothers exclusively breastfeeding their infants to six months remains low, at 27.8 percent [83].

The challenges, barriers, and reasons that mothers do not exclusively breastfeed for six months are apparent in the literature (see p. 28). The statistics [83] are also a source of evidence that demonstrate that women are not choosing to breastfeed despite the public health imperative. Organizational messages that state that there are no contraindications to breastfeeding (except HIV), disregard these qualitative findings and minimize the psycho-social indications for not exclusively breastfeeding.

Conclusion and Recommendations

The analysis of my personal experiences, through autoethnography, supports my thesis statement and research objectives (see p. 11). One of my objectives was to explore my experiences as both an HCP and mother within a breastfeeding culture to expose the dominant discourses and their subsequent impact on stigma. Through autoethnography, I have demonstrated how denormalizing infant formula contributes to the stigmatization of women who feed their babies infant formula and subsequently contributes to the psychological and social harm associated with normalizing health behaviours. I have also demonstrated that the “breast is best” imperative embodies an elaborate state-sponsored ruling strategy and dominant discourses. I have identified the expert and evidence-based discourses and the impact these discourses have on power relations and subsequently on stigma.

Another research objective was to address previous researchers’ recommendations for further research. Shakespeare et al. (2004) indicates that breastfeeding policy may contribute to post-natal stress and indicates that there is a need for further study [8]. My autoethnography demonstrates how breastfeeding policy contributed to my stigma. Lee (2007) recommends that the effects of breastfeeding promotion be interrogated through a socio-cultural lens in the context where breastfeeding is strongly promoted, and that women’s experiences interacting with other women be explored [9]. Through autoethnography, a research method that links personal experiences to a broader culture, I analyze my professional and personal experiences that took place within a breastfeeding culture. I describe and analyze my experiences with other women and identified the impact normalizing judgments have on stigma. Sheehan et al. (2009) indicate that there is a lack of research reporting women’s experiences and expectations pertaining to

professional support [10]. I describe and analyze my professional and personal experiences related to negative support.

The extant literature woven throughout my autoethnography corroborates my experiences, but I also contribute new insights and perspectives. Unique to this research, is that I, the marginalized voice, am the researcher, professional, and mother. Also, unique, is that I interrogate how normalization practices compare with professional practice expectations: the principles of evidence-based practice, person-centred care, and informed choice. This autoethnography reinforces another researcher's view [71] that calls into question the ethics of breastfeeding promotion practices.

Autoethnography has also enabled me to learn beyond the stated aim and objective. An autoethnography's purpose may be to seek meaning from difficult situations [Ellis & Bochner, 2006 cited in 13] or to explore an issue of personal importance within a specific social context [Holt, 2001; Sparkes, 1996 cited in 13]. Through autoethnography, I have been able to make sense of a difficult personal experience by linking my experiences to organizational culture and the broader political and social culture.

Autoethnography, as a research method, does not rely on traditional criteria to evaluate the validity of its findings [Sparkes, 2000 cited in 19]. Instead, I have reflected on questions [Ellis, 2000 cited in 19] to evaluate the worth of the autoethnography: I have considered whether I, the author, can legitimately make these claims and whether this story will help others cope with or better understand their worlds. By sharing my lived experiences in a systematic and analytical manner, and relating them to extant literature and theory, my study's findings are legitimate. I suspect that my story will help mothers who internalize the pressure to breastfeed. My story has the potential to challenge ideologies, impact the way mothers are supported in their

infant feeding decisions, influence the manner in which breastfeeding is promoted, and challenge organizations' and HCPs' worldviews. My research will ideally challenge others to "think differently about what constitutes knowing" [19, p. 147], as it has done for me. Health care professionals are socialized to a worldview that values a quantitative methodology. Education and training that incorporates the social sciences would expand this worldview. A curriculum that includes professional ethics and critical theories would enable HCPs to understand the social constructions and dominant discourses that impact their practice.

A third question, to evaluate an autoethnography's worth, is to consider whether the author learned anything new about themselves [Ellis, 2000 cited in 19]. A critical and constructionist approach broadened my understanding of the ideological nature of breastfeeding promotion. I found it enlightening to learn of the impact hegemony has on the social context that results in giving others the right to question personal practices. A critical approach and use of the SEM as a sensitizing concept for analysis reinforced that my stigma was socially constructed, as was my reliance on expertise and science-based evidence.

The intent of my research was to contribute to professional knowledge development and ultimately influence person-centred care. I propose recommendations to influence change; however, given the complexity of the system in place to influence breastfeeding, I acknowledge that there is not a simple way to change the system of beliefs and practices associated with the "breast is best" imperative. To minimize the negative consequences associated with breastfeeding normalization strategies, I propose recommendations that can be carried out by HCPs, but also pose recommendations to influence systemic change.

I have described how interpersonal interactions between HCPs and mothers may influence stigma. Conversely, positive support, in the form of respectful and no-blame

relationships, contributes to supportive therapeutic relationships and nurturing a mothers' agency. Communication techniques conducive to therapeutic relationships include showing concern rather than professional detachment, demonstrating respect, and creating a supportive partnership early [78]. It is important for HCPs "to have a planned and coordinated care response" [69, p. 319], reflect on the ways they interact with mothers, and use communication strategies, such as active listening.

To provide positive support, it is advantageous for HCPs to explore and challenge their own beliefs and attitudes with respect to breastfeeding as a moral choice, and recognize that:

- A person-centred approach to practice involves incorporating feelings and support into practice and adopting a manner of communication that is respectful and supportive;
- Infant feeding is complex and that mothers' decisions and behaviours reflect their personal context;
- If mothers do not comply with expert-driven messages, it may not be because mothers are ignorant of their messages. Rephrasing or repeating the message may be perceived as pressure to adhere to expert advice [77];
- Mothers may be highly sensitive to the attitudes and language of HCPs and may perceive their messages as blaming [79];
- Mothers may be angry, defensive, or depressed in response to feeling stigmatized as a "bad mother" and resist care and set boundaries between themselves and others [23,79], leading to alienation [59] and avoidance of professional advice or care [59,79].

It is important to eradicate mother blame in professional relationships between HCPs and mothers, and for HCPs to facilitate supportive relationships within mothers' social networks.

When developing community programs, aware of the potential for stigmatization and alienation,

consider building a supportive environment for all individuals [4]. A supportive environment includes providing information about infant formula and acknowledging and supporting every mother's infant feeding decision.

Planning and implementing infant feeding education and support strategies that minimize stigma and enable a woman to make a *truly* informed choice, recognizing that there are legitimate reasons for choosing formula, and communicating that there are options and risks and benefits associated with all options, may minimize the negative outcomes associated with denormalizing formula. Public health interventions should be evaluated for their impact on stigma [Lang and Rayner, 2005; Lobstein & Baur, 2005 cited in 4].

An autoethnography's purpose may also be to critique extant literature on a topic of personal significance [Stahlke Wall, 2012a, 2012b cited in 13,25]. Instead, I have critiqued professional practice resources, including breastfeeding promotion materials (Figures 7-10, 13), infant feeding guidelines [6] and PEN [7]. I recommend developing infant feeding resources that are unbiased and present information in language to support and respect a mother's choice. I recommend incorporating qualitative research findings into practice guidelines, statements, and practice resources (e.g. PEN) to enable HCPs to understand their client/communities' lived experiences and support evidence-based practice. My research has linked the "breast is best" imperative to the political impetus for the imperative. Recognizing the state's interest in the breastfeeding imperative and their use of knowledge to create power relations, I now recognize that there is a need to critique the literature that supports the breastfeeding imperative.

I propose further research to identify whether the "breast is best" imperative is warranted. Evaluate the quality and strength of the evidence and determine whether there is bias in the selection of evidence that informs infant feeding statements and messages. Interrogate research

findings that cast doubt on commonly accepted claims that breastfeeding is more beneficial than formula [71]. Explore whether the benefits of exclusive breastfeeding outweigh the risks of formula feeding and the moral risks associated with the “breast is best” imperative.

I have experienced the outcome of these moral risks. I now understand that my feelings of “failure” were socially constructed to persuade me to persevere and breastfeed. I suspect that had I not experienced internalized pressure and stigma, I would have better coped with the challenges associated with early motherhood. It is, therefore, somehow ironic that the “breast is best” imperative and societal mechanisms of control in place to persuade me to breastfeed contributed to my “failure.”

References

1. Holstein JA, Gubrium JF. Handbook of constructionist research. New York, NY: The Guilford Press; 2008.
2. Brookfield S. The power of critical theory: liberating adult learning and teaching. San Francisco: Jossey-Bass; 2005.
3. Corrigan PW, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. *Can J Psychiatry*. 2012 Aug [cited 2018 Feb 13];57(8):464-69. Available from: <https://doi.org/10.1177/070674371205700804>
4. MacLean L, Edwards N, Garrard M, Sims-Jones N, Clinton K, Ashley L. Obesity, stigma and public health planning. *Health Promot Int*. 2009 Jan [cited 2018 Feb 13];24(1):88-93. Available from: <https://doi.org/10.1093/heapro/dan041>
5. Morgaine CA. Alternative paradigms for helping families change themselves. *Fam Relat*. 1992 [cited 2018 Feb 13];41:12-17. Available from: <https://doi.org/10.2307/585386>
6. Health Canada [Internet]. Ottawa: Health Canada; 2015 [cited 2018 Feb 13]. Nutrition for healthy term infants: recommendations from birth to six months. Available from: <http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php>
7. Pennutrition.com [Internet]. Dietitians of Canada; c2005-2018 [cited 2018 Feb 1]. Available from: <https://www.pennutrition.com/aboutpen.aspx>
8. Shakespeare J, Blake F, Garcia J. Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression. *Midwifery*. 2004 [cited 2018 Feb 13];20:251-60. Available from: <https://doi.org/10.1016/j.midw.2003.12.011>
9. Lee E. Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. *Sociol Health Illn*. 2007 [cited 2018 Feb 13];29(7):1075-90. Available from: <https://doi.org/10.1111/j.1467-9566.2007.01020.x>
10. Sheehan A, Schmied V, Barclay L. Women's experiences of infant feeding support in the first 6 weeks post-birth. *Matern Child Nutr*. 2009 [cited 2018 Feb 13];5:138-150. Available from: <https://doi.org/10.1111/j.1740-8709.2008.00163.x>
11. Berg BL. Qualitative research methods for the social sciences, 5th ed. California State University, Long Beach: Pearson Education, Inc; 2004.
12. Peterson AL. A case for the use of autoethnography in nursing research. *J Adv Nurs*. 2014 [cited 2018 Feb 13];226-33. Available from: <https://doi.org/10.1111/jan.12501>

13. Stahlke Wall S. Toward a moderate autoethnography. *Int J Qual Methods*. 2016 Jan-Dec [cited 2018 Feb 13];1-9. Available from: <http://doi.org/10.1177/1609406916674966>
14. Hamilton ML, Smith L, Worthington K. Fitting the methodology with the research: an exploration of narrative, self-study and auto-ethnography. *Studying Teacher Education*. 2008 [cited 2018 Feb 13];4(1):17-28. Available from: <https://doi.org/10.1080/17425960801976321>
15. Holt NL. Representation, legitimation, and autoethnography: an autoethnographic writing story. *Int J Qual Methods*. 2003 [cited 2018 Feb 13];2(1):18-27. Available from: <http://doi.org/10.1177/160940690300200102>
16. Boyle M, Parry K. Telling the whole story: the case for organizational autoethnography. *Culture and Organization*. 2007 [cited 2018 Feb 13];13(3):185-90. Available from: <https://doi.org/10.1080/14759550701486480>
17. McIlveen P. Autoethnography as a method for reflexive research and practice in vocational psychology. *Australian Journal of Career Development*. 2008 [cited 2018 Feb 13];17(2):13-18. Available from: <http://doi.org/10.1177/103841620801700204>
18. Ellis C. Sociological introspection and emotional experience. *Symb Interact*. 1991 [cited 2018 Feb 13];14(1):23-50. Available from: <https://doi.org/10.1525/si.1991.14.1.23>
19. Stahlke Wall S. An autoethnography on learning about autoethnography. *Int J Qual Methods*. 2006 [cited 2018 Feb 13];5(2):146-58. Available from: <http://doi.org/10.1177/160940690600500205>
20. Stahlke Wall S. Easier said than done: writing an autoethnography. *Int J Qual Methods*. 2008 [cited 2018 Feb 13];7(1):38-53. Available from: <http://doi.org/10.1177/160940690800700103>
21. Liggins J, Kearns RA, Adams PJ. Using autoethnography to reclaim the ‘place of healing’ in mental health care. *Soc Sci Med*. 2013 [cited 2018 Feb 13];91:105-9. Available from: <https://doi.org/10.1016/j.socscimed.2012.06.013>
22. Vryan K. Expanding analytic autoethnography and enhancing its potential. *J Contemp Ethnogr*. 2006 [cited 2018 Feb 13];35:405-9. Available from: <http://doi.org/10.1177/0891241606286977>
23. Murphy E. Expertise and forms of knowledge in the government of families. *Sociol Rev*. 2003 [cited 2018 Feb 13];51(4):433-462. Available from: <http://doi.org/10.1111/j.1467-954X.2003.00430.x?journalCode=sora>
24. Lordly D. Once upon a time...storytelling to enhance teaching and learning. *Can J Diet Prac Res*. 2007;68:30-5. Available from: <https://doi.org/10.3148/68.1.2007.30>

25. Muncey T. Doing ethnography. *Int J Qual Methods*. 2005 [cited 2018 Feb 13];4(3):Article 5. Available from: https://sites.ualberta.ca/~iiqm/backissues/4_1/html/muncey.htm
26. Chang H. *Autoethnography as method*. Walnut Creek, CA: Left Coast Press; 2008.
27. Taber N. Institutional ethnography, autoethnography, and narrative: an argument for incorporating multiple methodologies. *Qual Res*. 2010;10(5):5-24. Available from: <http://doi.org/10.1177/1468794109348680>
28. Mykhalovskiy E, McCoy L. Troubling ruling discourses of health: using institutional ethnography in community-based research. *Crit Public Health*. 2002;12(1):17-37. Available from: <https://doi.org/10.1080/09581590110113286>
29. Jabareen Y. Building a conceptual framework: philosophy, definitions, and procedure. *Int J Qual Methods*. 2009 [cited 2018 Feb 13];8(4):49-62. Available from: <http://doi.org/10.1177/160940690900800406>
30. Bowen GA. Grounded theory and sensitizing concepts. *Int J Qual Methods*. 2006 [cited 2018 Feb 13] Sept;5(3):1-9. Available from: <http://doi.org/10.1177/160940690600500304>
31. Newes-Adeyi G, Helitzer DL, Caulfield LE, Bronner Y. Theory and practice: applying the ecological model to formative research for a WIC training program in New York state. *Health Educ Res*. 2000 [cited 2018 Feb 13];15(3):283-291. Available from: <https://doi.org/10.1093/her/15.3.283>
32. Golden SD, Earp JL. Social ecological approaches to individuals and their contexts: twenty years of health education & behaviour health promotion interventions. *Health Educ Behav*. 2012 [cited 2018 Feb 13];39(3):364-372. Available from: <http://doi.org/10.1177/1090198111418634>
33. Gregson J, Foerster SB, Orr R, Jones L, Benedict J, Clarke B, et al. System, environmental, and policy changes: using the social-ecological model as a framework for evaluating nutrition education and social marketing programs with low-income audiences. *J Nutr Educ*. 2001 [cited 2018 Feb 13];33(1):S4-S14. Available from: [https://doi.org/10.1016/S1499-4046\(06\)60065-1](https://doi.org/10.1016/S1499-4046(06)60065-1)
34. Rodgers BE. *An ecological approach to understanding stigma associated with receiving mental health services: the role of social proximity* [dissertation]. Virginia: Faculty of Virginia State Polytechnic Institute and State University; 2009 [cited 2018 Feb 13]. Available from: <http://hdl.handle.net/10919/29982>
35. Sparkes AC. The fatal flaw: a narrative of the fragile body-self. *Qual Inq*. 1996 [cited 2018 Feb 13];2(4):463-94. Available from: <https://doi.org/10.1177/107780049600200405>

36. Bochner AP. Narrative's virtues. *Qual Inq.* 2000 [cited 2018 Feb 13];7:131-57. Available from: <http://doi.org/10.1177/107780040100700201>
37. Spry T. Performing autoethnography: an embodied methodological praxis. *Qual Inq.* 2001 [cited 2018 Feb 13];7:706-32. Available from: <http://doi.org/10.1177/107780040100700605>
38. Richardson L. Evaluating ethnography. *Qual Inq.* 2000 [cited 2018 Feb 13];6:253-55. Available from: <http://doi.org/10.1177/107780040000600207>
39. Ellis C, Bochner AP. Autoethnography, personal narrative, reflexivity: researcher as subject. In: Denzin NK, Lincoln YS, editors. *The handbook of qualitative research*. 2nd ed. Newbury Park, CA: Sage; 2000; 733-68.
40. Creswell JW. *Narrative research designs*. Educational research: Planning, conducting and evaluating quantitative and qualitative research, 3rd ed. Upper Saddle River, NJ: Pearson Education, Inc.; 2008; 511-50.
41. Denshire S. On auto-ethnography. *Curr Sociol.* 2014 [cited 2018 Feb 13];1-20. Available from: <https://doi.org/10.1177/0011392114533339>
42. Ferguson LM, Yonge O, Myrick F. Students' involvement in faculty research: ethical and methodological issues. *Int J Qual Methods.* 2014 [cited 2018 Feb 13];3(4):2-14. Available from: https://sites.ualberta.ca/~iiqm/backissues/3_4/html/ferguson.html
43. Murray L, Pushor D, Renihan P. Reflections on the ethics-approval process. *Qual Inq.* 2012 [cited 2018 Feb 13];18(1):43-54. Available from: <http://doi.org/10.1177/1077800411427845?journalCode=qixa>
44. Tolich M. A critique of current practice: ten foundational guidelines for autoethnographers. *Qual Health Res.* 2010 [cited 2018 Feb 13];20(12):1599-1610. Available from: <http://doi.org/10.1177/1049732310376076>
45. World Health Organization [Internet]. Geneva:The Organization; c2018 [cited 2017 Apr 2]. Exclusive breastfeeding. Available from: http://www.who.int/nutrition/topics/exclusive_breastfeeding/en
46. Health Canada [Internet]. Ottawa:Health Canada; 2015 [cited 2017 Apr 2]. Infant feeding. Available from: <http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/index-eng.php>
47. Dietitians of Canada [Internet]. Dietitians of Canada; 2013 [cited 2017 Apr 2]. Breastfeeding. Available from: <https://www.dietitians.ca/Your-Health/Nutrition-A-Z/Breastfeeding.aspx>

48. Health Canada. [Internet]. Ottawa:Health Canada; 2015 [cited 2017 Apr 2]. Nutrition for healthy term infants: recommendations from birth to six months. Available from: <http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php>
49. Nova Scotia Health Promotion. Nova Scotia health promotion and protection policy statement [Internet]. Nova Scotia: Nova Scotia Health Promotion and Protection; 2010 [cited 2017 Apr 12]. Available from: <https://novascotia.ca/dhw/healthy-communities/documents/Provincial-Breastfeeding-Policy.pdf>
50. Thinkwell Research. Breastfeeding campaign: focus group research. 2007, Jul.
51. Dennis C. Mothering Transitions Research [Internet]. Ontario:Cindy-Lee Dennis. c2010 [cited 2017 Apr 2]. Available from: <http://www.cindyleedennis.ca/research/1-breastfeeding/breastfeeding-self-efficacy/>
52. Marshall JL, Godfrey M, Renfrew MJ. Being a good mother: managing breastfeeding and merging identities. *Soc Sci Med.* 2007 [cited 2018 Feb 13];65:2147-59. Available from: <https://doi.org/10.1016/j.socscimed.2007.06.015>
53. Ladores S, Aroian K. First-time mothers with a history of infertility: their internalized pressure to breastfeed. *J Hum Lact.* 2015 [cited 2018 Feb 13];1-7. Available from: <http://doi.org/10.1177/0890334415585511?journalCode=jhla>
54. Braimoh J, Davies L. When ‘breast’ is no longer ‘best’: post-partum constructions of infant-feeding in the hospital. *Soc Sci Med.* 2014 [cited 2018 Feb 13];123:82-89. Available from: <https://doi.org/10.1016/j.socscimed.2014.10.052>
55. Larsen JS, Kronborg H. When breastfeeding is unsuccessful – mothers’ experiences after giving up breastfeeding. *Scand J Caring Sci.* 2012 [cited 2018 Feb 13];848-56. Available from: <https://doi.org/10.1111/j.1471-6712.2012.01091.x>
56. Murphy E. Quiet coercions: medicine, morality and motherhood [inaugural lecture]; 2010 October; University of Leicester.
57. Public Health Agency of Canada [Internet]. Ottawa;Public Health Agency of Canada; 2015 [cited 2018 Feb 2]. Canada prenatal nutrition program (CPNP). Available from: <https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/programs-initiatives/canada-prenatal-nutrition-program-cpnp.html>
58. Newhook JT, Ludlow V, Newhook, LA, Bonia K, Goodridge JM, Twells L. Infant-feeding among low-income women: the social context that shapes their perspectives and experiences. *Can J Nurs Res.* 2013 [cited 2018 Feb 13];45(3):28-49. Available from: <http://www.ingentaconnect.com/contentone/mcgill/cjnr/2013/00000045/00000003/art00003#expand/collapse>

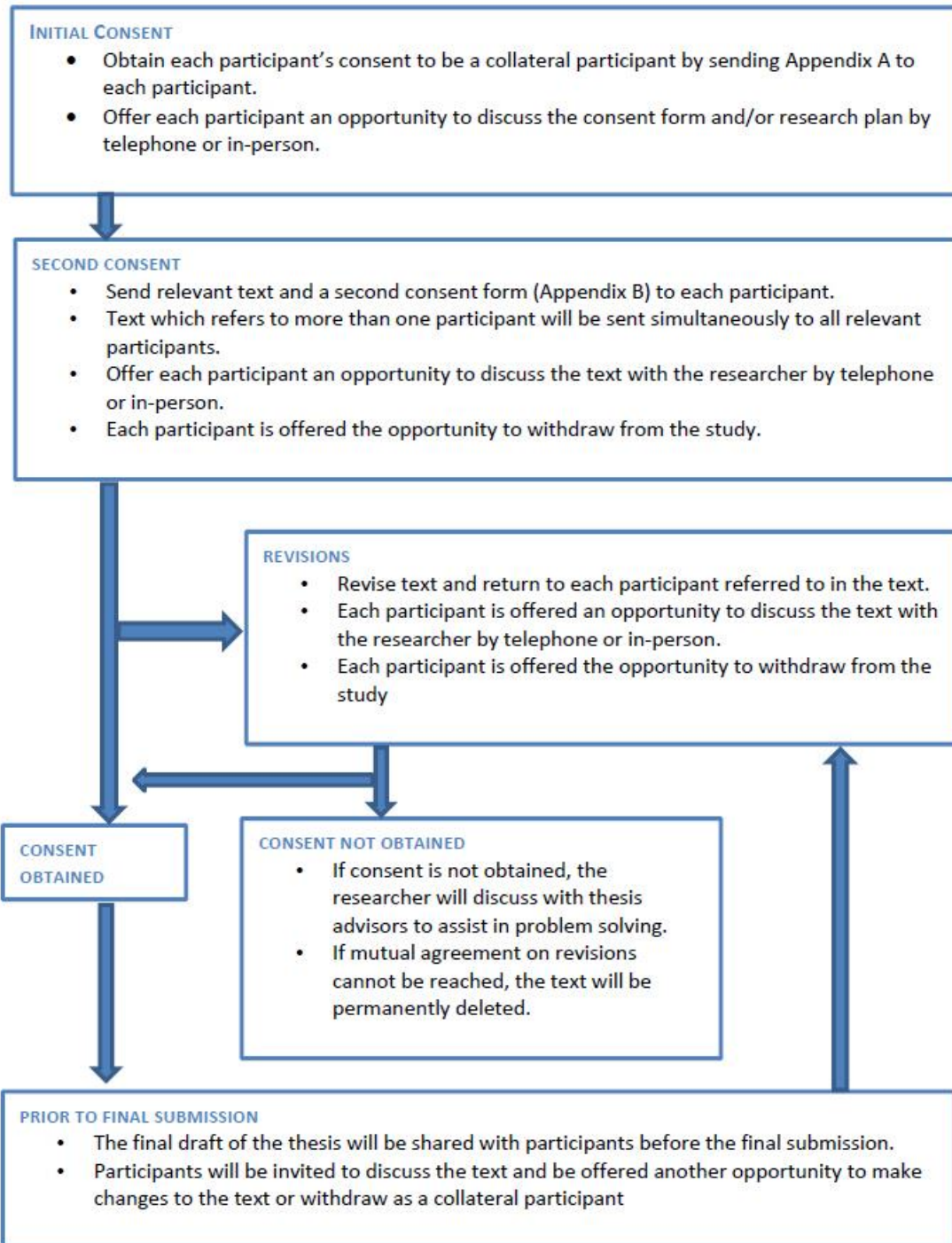
59. Murphy E. 'Breast is best': infant feeding decisions and maternal deviance. *Sociol Health Illn.* 1999 [cited 2018 Feb 13];21:187-208. Available from: <https://doi.org/10.1111/1467-9566.00149>
60. Rolfes SR, DeBruyne LK. *Life span nutrition: conception through life.* St. Paul, MN: West Publishing Company; 1990.
61. Stevens EE, Patrick TE, Pickler R. A history of infant feeding. *J Perinat Educ.* 2009 Spring [cited 2018 Feb 13];18(2):32-9. Available from: <https://doi.org/10.1624/105812409X426314>
62. Hall W, Hauck Y. Getting it right: Australian primiparas' views about breastfeeding: a quasi-experimental study. *Int J Nurs Stud.* 2007 [cited 2018 Feb 13];44:786-95. Available from: <https://doi.org/10.1016/j.ijnurstu.2006.02.006>
63. Murphy E. Risk, responsibility, and rhetoric in infant feeding. *J Contemp Ethnogr.* 2000 [cited 2018 Feb 13];29(3):291-325. Available from: <http://doi.org/10.1177/089124100129023927>
64. Knaak S. Contextualising risk, constructing choice: breastfeeding and good mothering in risk society. *Health Risk Soc.* 2010 [cited 2018 Feb 13];12(4):345-55. Available from: <https://doi.org/10.1080/13698571003789666?journalCode=chrs20>
65. Crossley ML. Breastfeeding as a moral imperative: an autoethnographic study. *Fem Psychol.* 2009 [cited 2018 Feb 13];19(1):71-87. Available from: <http://doi.org/10.1177/0959353508098620>
66. Striley KM, Field-Springer K. The bad mother police: theorizing risk orders in the discourses of infant feeding practices. *Health Commun.* 2014 [cited 2018 Feb 13];29:552-62. Available from: <https://doi.org/10.1080/10410236.2013.782225>
67. Hays S. *The cultural contradictions of motherhood.* New Haven and London: Yale University Press; 1996.
68. Ludlow V, Newhook LA, Newhook JL, Bonia K, Goodridge JM, Twells L. How formula feeding mothers balance risks and define themselves as 'good mothers'. *Health Risk Soc.* 2012 [cited 2018 Feb 13];14(3):291-306. Available from: <https://doi.org/10.1080/13698575.2012.662635>
69. Jackson D, Mannix J. Giving voice to the burden of blame: a feminist study of mothers' experiences of mother blaming. *Int J Nurs Pract.* 2004 [cited 2018 Feb 13];10:150-58. Available from: <https://doi.org/10.1111/j.1440-172X.2004.00474.x>

70. Singh I. Doing their jobs: mothering with ritalin in a culture of mother-blame. *Soc Sci Med.* 2004 [cited 2018 Feb 13];59:1193-1205. Available from: <https://doi.org/10.1016/j.socscimed.2004.01.011>
71. Fahlquist JN. Ethical problems with information on infant feeding in developed countries. *Public Health Ethics.* 2011 [cited 2018 Feb 13];4(2):192-202. Available from: <https://doi.org/10.1093/phe/phr019>
72. Williams K, Kurz T, Summers M, Crabb S. Discursive constructions of infant feeding: The dilemma of mothers' 'guilt.' *Fem Psychol.* 2012 [cited 2018 Feb 13];23(3):339-58. Available from: <http://doi.org/10.1177/0959353512444426?journalCode=fapa>
73. English Oxford Living Dictionaries [Internet]. Oxford:Oxford University Press; c2018 [cited 2018 Feb 20]. Available from: <https://en.oxforddictionaries.com/definition/wisely>
74. International Confederation of Dietetic Association [Internet]. c2010 [cited 2018 Feb 20]. Available from: <http://www.internationaldietetics.org/Downloads/ICDA-Definition-of-Evidence-Based-Practice.aspx>
75. Sackett DL, Straus SE, Richardson WC, Rosenberg W, Haynes RM. Evidence-based medicine: how to practice and teach EBM. New York: Churchill Livingstone; 2000.
76. Maclellan D, Berenbaum S. Dietitians' opinions and experiences of client-centred nutrition counselling. *Can J Diet Prac Res.* 2006 [cited 2018 Feb 13];67(3):119-24. Available from: <https://doi.org/10.3148/67.3.2006.119>
77. Kukla R. Ethics and ideology in breastfeeding advocacy campaigns. *Hypatia.* 2006 [cited 2018 Feb 13];21(1): 157-80. Available from: <https://doi.org/10.1111/j.1527-2001.2006.tb00970.x>
78. Mikhailovich K, Morrison P. Discussing childhood overweight and obesity with parents: A health communication dilemma. *J Child Health Care.* 2007 [cited 2018 Feb 13];11(4):311-22. Available from: <https://doi.org/10.1177/1367493507082757>
79. Jackson D, Wilkes L, McDonald G. 'If I was in my daughter's body I'd be feeling devastated': women's experiences of mothering an overweight or obese child. *J Child Health Care.* 2007 [cited 2018 Feb 13];11(1):29-39. Available from: <http://doi.org/10.1177/1367493507073059>
80. Sheehan A, Schmied V, Barclay L. Complex decisions: theorizing women's infant feeding decisions in the first 6 weeks after birth. *J Adv Nurs.* 2009 [cited 2018 Feb 13];66(2):371-80. Available from: <https://doi.org/10.1111/j.1365-2648.2009.05194.x>
81. University of Edinburgh Scottish Sensory Centre [Internet]: Edinburgh: The Centre. 2010 [cited 2017 Apr 2]. Informed choice from theory into practice. Available from: <http://www.ssc.education.ed.ac.uk/courses/deaf/dmar10.html>

82. Health Canada [Internet]. Ottawa:Health Canada; 2015 [cited 2018 Feb 18]. In practice: talking to families about infant nutrition. Available from: <https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months.html#a12>
83. Health Canada [Internet]. Ottawa:Health Canada; 2015 [cited 2017 Apr 18]. Breastfeeding initiation and duration rates increase with active protection, support, and promotion. Available from: <https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months.html#a5>

Appendix A

Consent and Debriefing Process



Appendix B

Collateral Participant Consent Form

MSVU Letterhead

My name is (insert name). I am a Master of Science in Applied Human Nutrition (MScAHN) candidate at Mount Saint Vincent University (MSVU) in Halifax. As part of my degree, I will be completing a thesis entitled, *The Social Construction of Stigma Associated with the Normalization of Breastfeeding. An Autoethnography*.

An autoethnography describes an author's personal experience in a scholarly manner to support her thesis statement. I am a dietitian and I will be describing my professional experience related to breastfeeding promotion strategies and my personal experience related to my choice to feed my babies formula. I am a mother of two children. I am particularly interested in this topic because of my past work experience as a public health dietitian in pre and postnatal education environments.

You have received this invitation as a potential 'collateral participant'. A collateral participant is an individual who will be referred to in my autoethnography. I am obtaining written consent from individuals who are referred to in my research. This consent form should be completed if you agree to allow me to include a description of an experience that refers to you. I am taking special care to avoid identifying the name of the workplaces where I worked, the province where I worked, or of any of my colleagues' personal information (e.g. name).

I will describe how my family and friends supported me during my breastfeeding experiences. I will describe how my former colleagues, as a team norm, addressed the questions and comments our clients had about infant feeding. I plan to describe team practices rather than to display anyone (or the team) in a negative manner; however, it is good ethical practice to obtain consent from all individuals referred to in formal research. The ethical components of this research study have been reviewed by the University Research Ethics Board and found to be in compliance with Mount Saint Vincent University's Research Ethics Policy.

Purpose of the research study

The purpose of the study is to explore the researcher's experience practicing as a dietitian within the 'breast is best' culture, and her experience as a mother who chose not to breastfeed. The study will contribute to a body of knowledge that health professionals can use to inform and support their practice in the development and delivery of programs to support and promote health.

Description of involvement

As a collateral participant, I will not be collecting data from you, however as I recall and reflect on my experiences as a healthcare professional and mother who chose not to breast feed, I may write about an experience that involved you in some capacity. If you choose to participate in the research study as a collateral participant, I will share the text that refers to you during the writing process and before the final paper is submitted. If you are not satisfied with the text, a revision to the text will be made to our mutual satisfaction or the text will be permanently and securely deleted.

Summary of the consent process:

Before thesis is written	Obtain each participant's consent to be a collateral participant
During the drafting of the thesis	Send participants the relevant text, a second consent form, an invitation to discuss the text, and offer the option to withdraw as a collateral participant.
When revisions are made to the relevant text	Whenever a revision is made, participants will be asked to review and approve the relevant content by signing the consent form. Participants will be invited to discuss the text with the researcher.
Prior to submission of the final thesis	The final draft of the thesis will be shared with participants before the final submission. Participants will be invited to discuss the text and be offered another opportunity to make changes to the text or withdraw as a collateral participant.

It is important that you understand that I will make every effort to protect your identity by:

- not referring to the specific names of the workplaces where I worked or the province where I worked to prevent identifying colleagues or workplace practices that may be construed negatively.
- not using any identifying information (e.g. name) to identify a particular individual.
- not including experiences that would enable someone to be identified or to self-identify within the autoethnography, unless I have received their written consent to do so.
- using a writing style that minimizes making references to individuals. Instead, practices will be described broadly.

I will send you text to review by email. The section of text will be in a password protected Word document. Alternatively, you may request that I send you the text by mail or fax.

Sometimes, reading a research account may result in some type of reaction. If after you read the research text that refers to you in some way, or in the future should you read a related text like a published article, and have some type of reaction to it, you may contact my supervisor or me (the contact information appears below). Alternatively, you may feel more comfortable making an appointment with your family doctor for a referral to a mental health professional.

If you have any concerns about my research or how I conduct my research, you may confidentially contact my research advisor or the chair of the Research Ethics Board. Contact information is below.

Risks and Benefits of Participation

As a collateral participant, you may feel misrepresented, embarrassed or regret. You may feel upset that previous actions contributed to mothers feeling badly about their feeding decision. You will have an opportunity to review the sections of the thesis pertinent to you and you will be asked to approve the content. If you do not approve the content or agree to revisions that I propose, the text will be permanently deleted.

Confidentiality & Privacy

The autoethnography will be written in an electronic format. It will be stored on a laptop computer that is password protected. Data will be backed up on a memory stick that will be stored in a locked cabinet in the author's home office for five years. Thereafter, data will be confidentially destroyed. Hard copies of the research will be stored securely.

Dissemination of my work

My thesis will be publicly available for review. I also plan to share my results in oral and written formats in relevant professional and academic venues and journals.

Changing your mind

If you change your mind about being involved in the research, you may change your mind at any time. If you have any questions or concerns about the research, you can contact any of the following individuals.

Researcher: (insert name) / (insert email address)

Research Advisor: (insert name, email address and phone)

You may also contact the Chair of the Research Ethics Board at MSVU, (insert name, email address) or (insert phone).

To indicate your support to be included in my work as a collateral participant please sign, date and return this form either by mail or via email to me. If you have any questions about this letter, or my research plan, I would be happy to arrange a telephone conversation with you. Please be advised that the Internet is a non-secure communication source so any materials communicated via email cannot be guaranteed as confidential. If you would like to mail me your letter, please advise me and I will send you a stamped envelope addressed to MSVU c/o (insert name).

I look forward to receiving your support.

Sincerely,

(insert name)

I agree to be a collateral research participant in this study:

Name

Date

Appendix C

Collateral Participant Approval of Content Form

MSVU Letterhead

My name is (insert name). I am a Master of Science in Applied Human Nutrition (MScAHN) candidate at Mount Saint Vincent University (MSVU) in Halifax. As part of my degree, I will be completing a thesis entitled, *The Social Construction of Stigma Associated with the Normalization of Breastfeeding. An Autoethnography*. I previously contacted you for your consent to be a collateral participant, and you agreed. Attached is a copy of the initial consent form.

I have attached a draft of the sections of my thesis that refer to you. Please read and contact me if you do not agree with the content and wish for me to revise. I will arrange a telephone conversation with you or you may wish to communicate your concerns by email. The Internet is a non-secure communication source so any materials communicated via email cannot be guaranteed as confidential. If you would like to mail me your feedback, I will send you a stamped envelope addressed to MSVU c/o (insert name).

If the section involves multiple people (e.g. my colleagues, family members), the section is also simultaneously being sent to all relevant others. Please treat the section of the thesis as confidential and permanently delete the password protected Word document from your computer after your review.

You may change your mind at any time about being involved in the research. If you have any questions or concerns about the research, you can contact any of the following individuals.

Researcher: (insert name and email address)

Research Advisor: (insert name, email address and phone).

You may also contact the Chair of the Research Ethics Board at MSVU, (insert name, email address and phone).

To indicate your approval of the sections of my thesis that I have shared with you please sign, date and return this form either by mail or via email to me. Please be advised that the Internet is a non-secure communication source so any materials communicated via email cannot be guaranteed as confidential. If you would like to mail me your letter, please advise me and I will send you a stamped envelope addressed to MSVU c/o (insert name).

I look forward to receiving your support.

Sincerely,

(insert name)

I approve of the content within the sections of the thesis attached.

Name

Date