A Critical Examination of Breastfeeding Education: A Qualitative Analysis of How First Time Mothers Learn About Breastfeeding

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Abstract

While breastfeeding initiation rates in the United States have risen to 79%, reaching long-term breastfeeding goals are still problematic for many women with the financial and educational resources to nurse their infants (CDC 2014). With the majority of research linking low breastfeeding rates to individual mothers, we took a novel approach that focused on breastfeeding education and tracked how this sample of women learned to breastfeed before their infant was born until the late postpartum period. We followed 120 first time mothers from online parenting groups from late pregnancy to the early and late postpartum periods, and analyzed their qualitative data from 4 open-ended questions that focused on learning across time. Our results revealed gaps in current breastfeeding education where factors vital to breastfeeding success were often ignored. Such factors included nipple pain, the active role of the infant, and maternal experiential knowledge. Additional findings showed that breastfeeding knowledge changed across time whereby pregnant women were more focused on factual information and technical aspects while mothers relied more on their own judgments and infant cues during the early and late postpartum periods. This change in learning increased maternal confidence in breastfeeding and decreased reliance on medical professionals for breastfeeding expertise. This research offers an alternative way to view breastfeeding education through the lens of first time mothers as the identification of previously unexamined variables can help create more effective educational campaigns while fostering maternal empowerment.

Keywords: breastfeeding, first time mothers, online, experiential learning, qualitative
Although the literature on the benefits of breastfeeding is growing exponentially, researchers are still concerned with low long-term breastfeeding rates in the United States. With numerous health organizations (e.g., American Academy of Pediatrics (AAP), World Health Organization, Centers for Disease Control (CDC)) and initiatives such as the Healthy People 2020 creating breastfeeding recommendations, we explore how women learn to breastfeed. With a greater understanding of common breastfeeding barriers that include lack of support, working outside of the home, socio-cultural apprehensions, nipple pain, and self-efficacy issues, we noticed the commonality of these barriers to occur after the birth of the infant (Kukla 173; USDHHS 2; Acker 477; Kent et al. 12248; Stanton 131-132; Blyth et al. 279). This observation led us to take a unique approach by focusing on how first time mothers (FTM) learn about breastfeeding before and shortly after their infant is born. We argue that current breastfeeding education is antiquated and reinforces a biomedical discourse that encourages mothers to rely solely on medical professionals for breastfeeding expertise. Under this discourse, medical experts play a dominant role in shaping how women are taught to breastfeed that often neglects the voices of the very women who perform this important work. This research seeks to balance this disparity by focusing on the lived experiences of FTM to better understand the effectiveness of our current breastfeeding education. We begin by tracking the historical influence of the biomedical model on breastfeeding practices.

**Biomedical Influence**

Before medical professionals began to influence breastfeeding, women and infants shared a symbiotic relationship whereby skin-to-skin contact right after birth encouraged mother and newborn to establish breastfeeding on their own. It was not unusual for healthy newborns to make their way up to their mother’s breast on their own volition and suckle but 18th century
obstetrics with its focus on fixed feeding schedules, patriarchal views, and scientific mothering began to reinforce ideologies that became detrimental to breastfeeding (Palmer, 24). We still find the effects of those past influences to shape our current breastfeeding education. Van Esterik believes that the adoption of a biomedical model encourages a commoditization of breastfeeding that fosters a disembodied view of the breast while reinforcing the dominant view of science as objective (14). This model highlights the nutritive benefits of breastfeeding while disregarding breastfeeding as a process that often involves negotiating between social and biological factors (Scavenius et al. 678-679). Ensuing effects of this biomedical influence are health care initiatives that focus on educating mothers to make the “right” choice as defined by policy makers to breastfeed their infant. With many pregnant women learning about breastfeeding from published literature, Seigel’s examination of pregnancy manuals found these guides to not only inform women about pregnancy but also indoctrinate them into believing that maternity and breastfeeding entail numerous risks that can only be assuaged by the expertise of medical professionals (79). Wolf defined this as the ultimate in maternal responsibility where medical and scientific mothering became regarded as the only legitimate way for mothers to care for their children (“Is Breast Best?” 72-73). As a result, increasing numbers of pregnant middle-class women comply with this indoctrination without ever questioning the agenda of these experts for fear that their objections may result in a child who is less healthy, less intelligent or damaged. This follows a disturbing trend where breastfeeding campaigns include fear-based tactics to scare new mothers into breastfeeding their newborns (Kukla 177; Wolf “Is Breast Really Best?” 600). Unfortunately, this pattern is not new as Kukla noted that women who fail to nurse are often portrayed as unfit and ignorant mothers unwilling to do what is best for their infants (163). These views are deeply embedded in our current breastfeeding culture where women are often blamed
CURRENT BREASTFEEDING EDUCATION

The biomedical model attempts to convince women of the nutritional aspects of breastfeeding through a scientific and evidence-based discourse with the goal of maternal bodies and breasts performing as taught and according to the breastfeeding recommendations set by policy makers. The use of these discourses to convince women to breastfeed is similar to Freire’s concept of “banking” where educators fill their students with subjective narration that is portrayed as objective (76). The problem lies where the focus on objectivity may not portray breastfeeding in the most complete manner and the emphasis on reaching arbitrary recommendations can result in feelings of failure when women are unable to reach these goals. In addition, this model of teaching encourages a passive learning style that promotes reliance on outside authorities to define the best way to breastfeed that often disregards the value of experiential knowledge. Seigel’s work analyzing the rhetoric of pregnancy manuals finds this method of teaching still prevalent in current breastfeeding literature (2-3). Teaching women how to breastfeed in this manner discounts the role of experiential knowledge because the pursuit of objectivity is at odds with the personal and embodied elements of breastfeeding. Brillinger supports the notion that effective learning should take into account each person’s uniqueness and be open to the myriad of ways of learning to incorporate new behaviors into lasting ones (174-175).

Based on a structuralist view of knowledge, meaning and understanding lies in scientific theory, clinical trials, and objectivity as opposed to personal experiences (Lyotard 7). Viewing breastfeeding primarily through this lens while disregarding the emotions involved in nursing one’s infant may be one reason why long-term breastfeeding goals set by the AAP have been
difficult to reach. If current breastfeeding pedagogy is based on this hegemonic mode of thinking, there is little incentive to change, which may be why few educators have questioned how current breastfeeding education affects breastfeeding outcome. Although there is a place for scientific research in measuring the tangible aspects of breastfeeding, objectivity cannot capture the dynamic and changing nature of breastfeeding. As the biomedical model encourages a dichotomous view of infant feeding as all or none, breast or formula, good or bad, there is a pressing need to move past this simplistic view of breastfeeding and expand our language to better capture the complexity of breastfeeding for each mother-infant dyad.

**Methodology**

**Participants.** One hundred and twenty pregnant women were recruited from pregnancy websites (babycenter.com, pregnancy.com, parenting.ivillage.com/messageboards, cafemom.com, forums.about.com) that hosted birth clubs, which are online support groups for women who are due the same month. Criteria for participation included being a first time mother, carrying a single child, experiencing no complications, 18 years or older, and expressing a desire to breastfeed. Participants were followed for three data waves consisting of prenatal (28 to 42 weeks of pregnancy), early postpartum (birth to 3 weeks) and late postpartum (4 to 12 weeks). During each data wave, the women were asked to complete a series of quantitative measures and open-ended questions for a larger project examining breastfeeding beliefs. Although all race/ethnicities were represented, the participants were primarily Caucasian (M_{age} = 28, age range: 22-34 years), college educated with a median income of over $100,000, and worked outside of the home. Complete demographic characteristics are shown in table 1.

Table 1

Demographic characteristics of sample (N = 120)
Demographic Characteristics | n  | (%)  
--- | --- | ---  
Age (mean + SD) | 27.8 | (± 6.02)  
Ethnicity |  |  
Caucasian | 101 | (84.2)  
Hispanic | 4 | (3.3)  
Asian | 2 | (1.7)  
African American | 4 | (3.3)  
Other | 7 | (5.8)  
Prefer not to say | 2 | (1.7)  
Education |  |  
High school/GED | 5 | (4.2)  
Some college | 30 | (25)  
Associate’s degree | 6 | (5)  
Bachelor’s degree | 49 | (40.8)  
Master’s degree | 27 | (22.5)  
Doctorate degree | 3 | (2.5)  
Relationship Status |  |  
Single/dating | 9 | (7.5)  
Cohabitating/engaged | 19 | (15.9)  
Married | 90 | (75)  
Separated | 1 | (.8)  
Prefer not to say | 1 | (.8)  
Income Level |  |  
< 200 K | 11 | (9.2)  
21 – 40 K | 21 | (17.5)  
41 – 60 K | 19 | (15.8)  
61 – 80 K | 16 | (13.3)  
81 – 100 K | 12 | (10)  
> 100 K | 31 | (25.8)  
Prefer not to say | 10 | (8.4)  
Work Outside of the Home? |  |  
No | 38 | (31.7)  
Yes | 82 | (68.3)  

Although the study began with 120 mothers, there was 8% attrition during the early postpartum (n = 110) and 35% for the late postpartum periods (n = 78). Data collection began in
March 2009 and continued until March 2010 to recruit a full 12 months for each of the three data waves. This study was approved by The Graduate Center of the City University of New York’s Institutional Review Board and participants’ names were changed to their corresponding data identification number in the final reporting.

**Qualitative strategy.** Responses to four open-ended questions related to learning were examined separately by two researchers using content analysis to categorize how women learned about breastfeeding during each data wave. During the prenatal data wave, women were asked to describe what they already knew about breastfeeding. After giving birth, mothers were asked to identify what they learned from a breastfeeding situation where they weren’t sure what to do. Lastly, women were asked to share which aspects of breastfeeding would they would concentrate on if they had to teach first-time mothers how to breastfeed and reflect on what they had learned about themselves during the late postpartum period.

Each response was read by two raters in an uncritical manner to generate the range of codes for recurrent themes and subsequent readings continued until saturation (Huckin 81-83). Each narrative could elicit up to 4 themes in the range of responses. As recurrent themes were identified and tallied, raters worked collaboratively to find patterns in the data with the goal of converging on overarching themes. As these themes emerged, we focused on changes between each data wave in how women learned about breastfeeding. Exemplars of overarching themes during each data wave were chosen based on the degree of detail in how the women described aspects of learning, how to breastfeed, and/or the application of their knowledge of breastfeeding.

**Data recording.** Online data collection was completed through SurveyMonkey (www.surveymonkey.com) and encrypted using Secure Sockets Layer encryption technology, which is a cryptographic system that secures the transmittance of private documents or
information via the Internet. At the time of the study, SurveyMonkey offered the VeriSign certificate Version 3, 128-bit encryption level.

**Breastfeeding themes across time**

The following section examines the overarching themes that emerged from the women’s responses to 4 open-ended questions that centered on learning. A comprehensive summary of all themes by data wave is presented in table 2.

Table 2

Overarching themes from open-ended responses related to learning by data wave

<table>
<thead>
<tr>
<th>Data Wave</th>
<th>Prenatal No. (%)</th>
<th>Early Postpartum No. (%)</th>
<th>Late Postpartum No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>N = 120</td>
<td>N=78</td>
<td>N=78</td>
</tr>
<tr>
<td><strong>What do you already know about breastfeeding?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy/best for baby</td>
<td>65 (54.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical aspects of breastfeeding</td>
<td>43 (35.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took class/read book</td>
<td>41 (34.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult</td>
<td>38 (31.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tough it out</td>
<td>23 (19.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What did you learn from that breastfeeding situation where you weren’t sure what to do?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant’s role in breastfeeding</td>
<td>34 (43.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differs from what they learned</td>
<td>21 (26.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust yourself</td>
<td>21 (26.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ok to ask for help</td>
<td>13 (16.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you had to teach first-time mothers how to breastfeed, what would you concentrate on?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latch</td>
<td>47 (60.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relax/Patience</td>
<td>23 (29.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned baby</td>
<td>20 (25.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistence/Can be difficult</td>
<td>14 (17.9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What have you learned about YOURSELF in these past few months?

- Determined/Persistent: 32 (41.0)
- Confident mother: 28 (35.9)
- Mentioned their baby: 21 (26.9)

a. The early postpartum data wave sample size dropped from 110 to 78 because only 78 (71%) participants responded to experiencing a breastfeeding situation where they weren't sure what to do.

Prenatal: What do you already know about breastfeeding? During the prenatal period, women understood breastfeeding as being the healthiest and best method of feeding and described breastfeeding in a technical sense where much of their knowledge was listed similar to a checklist providing little context beyond infant health benefits.

- I know that the areola should be entirely in the child's mouth so that the nipple is above the tongue and toward the back of the mouth. I know that you should always feed your baby on each breast at each feeding, or at least offer… I know that you will produce milk as long as your baby demands milk. I know that breastfeeding offers the most health benefits to baby - greater nutrition than formula and also the immunities that you just can't get out of formula. (004)

- Breastmilk is the healthiest choice for babies nutritionally; it can help mothers recover more quickly, lose weight faster, create a healthy attachment with baby; almost every woman is capable of breastfeeding and producing enough milk for her baby (053)

- 1) Good bonding experience 2) Best for baby, i.e. helps w/allergies, exactly what he needs, etc. 3) That it can be difficult and I need to not get discouraged 4) if the latch is correct it will not hurt! (040)

Not all mothers find it easy, some babies have issues latching. It has more
nutrients than formula, and studies prove that breastfed children have less
allergies and a better immune system later in life. (013)

These narratives may reflect the nature of how breastfeeding is taught to pregnant women in
breastfeeding classes and through published literature that focuses more on the logistics as
opposed to a process that is intimately tied to both mother and infant.

A third of the women in the prenatal data wave exhibited preconceived notions that
breastfeeding would be difficult with almost 20% expressing that they could tough it out. These
women noted, “That it could take a while to get used to the sensation/pain and that if you stick
with it, it will get better.” (087), “Keep trying even if it hurts, because it will get better.” (076),
and “That at first it can be hard, but you have to be willing to work at it because it is the best
thing for your baby.” (036). This theme of pain was quite robust with no suggestions on how to
alleviate it other than stating that mothers could or should overcome it. These responses place
enormous pressure on soon-to-be mothers who are basically facing an unforeseen and vague
obstacle. These feelings of uncertainty followed mothers into the early postpartum period.

Early postpartum: What did you learn from that breastfeeding situation where you
weren't sure what to do? Seventy-eight mothers shared a situation of uncertainty that primarily
consisted of fear that their infant was not eating enough, issues with latching or nipple/breast
pain. This period is considered a vulnerable time for many nursing mothers as difficulties
experienced during this time can increase the likelihood of weaning and supplementing with
formula (Stuebe et al. 408). During this time, over 40% of mothers referred to their infant’s
active role in breastfeeding and sometimes described their infant as being more knowledgeable
about breastfeeding than they were. Breastfeeding literature rarely mentions the active role of the
infant but these narratives show the contrary (Wayland 278). Mothers noted, “My baby is
different and his own person and isn't going to go by the textbook at all times.” (125), “to listen to her cries and figure out what exactly she needs instead of rushing to nurse her.” (111), “I learned that she is stubborn and wants milk instantly and if she doesn't get it, she gets mad.” (106), and “I believe that I need to learn how to listen to him better… I thought he was being fussy just because when he was truly hungry and not well.” (103a). As mothers listened more to their infant’s cues, they realized that the breastfeeding information they learned prior to giving birth didn’t always reflect their current needs once their infant was born. These revelations could be the catalyst for fostering a greater trust in their own nursing and mothering abilities.

As compared to the disembodied notions of breastfeeding during the prenatal period, mothers were more open to seeking assistance and using their experiential knowledge to problem solve. This theme seemed contrary to the narratives during the prenatal period where women felt they needed to “tough it out” as compared to the early postpartum period where it was acceptable to seek assistance. These women shared, “That when you need help, you should ask for it. Support is important.” (50), “Don't wait so long to ask for help!” (21), “that it's okay to ask for help.” (107), “That you have to be willing to seek help if it's available to you!” (14). This may be the crossroads where experiential knowledge leads women to trust their instincts and move away from generalized breastfeeding instruction as they negotiate ways to meet their own needs and accept that they need support from others to successfully breastfeed. Our next question asked mothers to reflect on their experiences and highlight what they deemed to be vital to new mothers.

**Late postpartum: If you had to teach first-time mothers how to breastfeed, what would you concentrate on?** Based on the narratives, achieving a good latch was the most common advice offered. This was not surprising as most mothers experienced this difficulty
during the early postpartum period but there was a change in how latching was viewed from the prenatal period. During this period, experiential learning helped mothers understand how a proper latch could affect long-term breastfeeding goals, milk supply, and maternal comfort.

Latching on. From the stories I hear of other mothers that is always the hardest thing. I was lucky and didn't have too much trouble. I also didn't have hardly any problems at all with sore nipples or anything like that. And I am sure that is because I was able to get my baby to latch on correctly right from the beginning. (108)

Making sure that the first latch happens within minutes of birth. Listening to what your baby is asking for, even if it's more than what the dr's say is required. My son's first 24 hours he was crying for the nipple sometimes every hour, but it made my milk come in by the 2nd day, bc [because] everytime he cried for it I gave it to him. (065)

Latching and positioning. I think for a first-time mom, feeling physically comfortable is a huge issue. For me, proper latching and positioning was so important for preventing and responding to problems. I imagine that if these are addressed and supported and reinforced for the mom, many other issues can be easier to deal with. (067)

These narratives continue the early postpartum theme of the active role of the infant which was tied to themes of being relaxed, patient, and persistent. These mothers noted the importance of “Perseverance. Even when it gets very difficult, take a break and try again later. Eventually you will learn and baby will learn, and it will be much easier.” (130), “Relaxing and enjoying the time with your baby” (103), “Being relaxed and confident in their own abilities.”
(69), and “Them being relaxed when they hold their child, and holding him/her in a way that they feel comfortable.” (31). We find an important connection that emphasizes a mother-infant-breastfeeding triad where experienced mothers develop their experiential knowledge through the realization that breastfeeding is more complex than simply following a set of rules. This process indicates a move away from the technical view of breastfeeding as these changes highlight the start of mothers reclaiming their power from breastfeeding experts. We continue to find a growing sense of maternal empowerment with our last question that asks mothers to engage in self-reflection.

Late postpartum: What have you learned about YOURSELF in these past few months? Asking this question during the late postpartum period allowed women to reflect on how their learning not only changed their views of breastfeeding but also their self-views. The following narratives provide evidence that although women subscribed to a martyr model of breastfeeding, they were able to take away positive aspects from enduring extreme pain. These women shared “That I am much stronger than I ever expected. I go without sleep, get my nipples destroyed by the baby feeding and it is okay and does get better.” (026), “that I can withstand bur[n]ing pain in my breasts and survive :/” (098), “I knew I had a strong will; my experience breastfeeding has borne this out. Even during clogged ducts, mastitis, traumatized nipples, and all the other difficulties that accompany a new mom learning to breastfeed, even when I wanted to throw in the towel so bad, I stuck with it because I believe it's the best thing for my baby and I want to give her every advantage.” (076), and “I am determined and will suffer and go the extra mile to do what I believe is right for my child.” (059). Based on these narratives, withstanding great pain was viewed as a badge of courage and triumph.

During the late postpartum period, we continued to find support for our previous theme
of infant agency as mothers became more in tuned to their infant’s reaction to their care and developed more confidence. These mothers shared, “That I am a confident mother. I know what is best for my baby and I am assured by her responding to my care.” (069), “When I put my mind to something I can succeed. At first breastfeeding wasn't working out but I kept trying for my son and it ended up working out - never let one fail determine your ability.” (010), and “Patience is very important, but most of all I learned to listen to my baby, and my instinct.” (079). As mentioned earlier, little research has examined the role of the infant in determining breastfeeding outcome whereby the majority of antenatal breastfeeding classes and published literature portray breastfeeding as a unilateral decision made solely by the mother (Wayland 278). Rarely is the impact of the infant in the breastfeeding relationship discussed other than to describe how to position their mouths to suckle correctly but our findings suggest that taking into account the role of the infant in breastfeeding can help foster maternal confidence in breastfeeding and mothering.

Increases in maternal confidence continued with responses such as, “I'm much more comfortable feeding on demand then on a schedule. I'm more laid back than I maybe thought I would be. (029), “I don't need people to agree with everything I do to parent my kids. I do what I think is right.” (003), and “I am one hell of a lot more determined than I thought. I thought with all the setbacks I would have just given in and given formula by now. I’m so proud of myself.” (104). As mothers gained confidence, some became more adept at criticizing the arbitrary nature of the rules related to breastfeeding and child care in general. Breastfeeding became less rule-driven and more infant-driven. This was a marked change from the prenatal period where breastfeeding centered more on following the rules as opposed to listening to one’s infant.

Breastfeeding at this stage also changed the way mothers felt about their bodies in a corporeal sense as they expressed amazement at how their bodies could nourish another human
being. They expressed this sentiment by writing, “I'm much more comfortable nursing in public without a cover than I thought I would be - I really stopped seeing my breasts as being sexual and have totally embraced their functionality.” (103), “I have felt my commitment to providing what's best for my child. I've also learned more about my body - how it works and what it's capable of.” (067), “It's better for my health and my babies' to do what my body tells me. Stress doesn't help milk production!” (042), and “I have limits. I will bend over backwards for my child, but have to draw the line when it impacts my own mental health.” (057). This corporeal awareness helped mothers become cognizant of their own needs and more confident in trusting their bodies.

**Gaps in Current Breastfeeding Education**

Following the lived experiences of this sample of mothers from their last trimester to the first few months of motherhood gave us a unique opportunity to critically examine how women learn to breastfeed. Our results suggest that current breastfeeding education may not adequately address maternal concerns supporting the notion that breastfeeding recommendations are often based on idealistic and unrealistic views that are very numbers-driven. The CDC Breastfeeding Report Cards have shown that no year from 2011 to 2014 has met the Healthy People 2020 breastfeeding objectives to increase the number of infants who are breastfed to 81.9% (any breastfeeding), 60.6% (at 6 months), 34.1% (at 1 year), 46.2% (exclusively breastfed through 3 months), and 25.5% (exclusively breastfed through 6 months) (CDC 2014). Hoddinott et al. stated that our overly technical and rule-driven breastfeeding education could diminish maternal confidence and negatively affect breastfeeding outcome (11). As women shared their prenatal knowledge of breastfeeding, their responses bordered on robotic and technical, often mirroring the teaching style of current breastfeeding classes and literature.
**Martyr complex.** The commonality of pain woven throughout the narratives during the early and late postpartum periods suggests a martyr complex where nipple pain was viewed as a normal part of breastfeeding with no mention of ways to alleviate pain suggesting that breastfeeding education neglects to properly manage one of the most common reasons why mothers wean (Kent et al.12256). Warm water compresses, pain relieving sprays consisting of 2% Chlorhexidine and alcohol, hydrogel dressings and glycerin gel therapy are effective at reducing nipple pain but none of the women referenced the use of these pain management therapies suggesting that antenatal and postpartum education needs to address ways to prevent and relieve pain (Joanna Briggs Institute 2-3). Adequate pain management can help mothers buffer feelings of uncertainty that can negatively affect their long-term breastfeeding outcomes.

**Uncertainty and disparity.** With 71 percent of our sample experiencing a breastfeeding problem where they were unsure of the solution, one theme was the disparity between what they learned and what they actually did to solve their dilemma. Negotiating this disparity resulted in more mothers trusting their ability to be good mothers and encouraged a shift in breastfeeding expertise from medical professionals to the mother-infant dyad. These women learned to read their infant’s cues and in some cases, follow their infant’s lead while working through their breastfeeding problems. Mothers often misconstrue their infant’s behaviors when normative developmental milestones such as waking up at night or crying are interpreted as not producing enough milk. When parents are taught to understand that these normative developmental milestones are not indicative of breastfeeding problems, they are more likely to continue nursing and feel confident in their mothering abilities (Tedder 244-245). For example, most nursing mothers introduce formula in response to increases of crying in their newborns during the first 2 to 6 weeks postpartum when in actuality, this is a common behavioral pattern that has nothing to
do with breastfeeding (Brazelton and Cramer 86; Kaley, Reid, and Flynn 597). When breastfeeding education does not address the normalcy of these behaviors, mothers will continue to erroneously believe that their milk is suspect and supplement with formula.

The themes of asking for help and trusting oneself suggests that women are actively negotiating between the mechanical and experiential aspects of breastfeeding to mitigate their feelings of vulnerability. Early postpartum was a critical juncture where women began to recognize that breastfeeding consisted of more than following a series of steps. Hoddinott et al. found a mismatch between the purist approach espousing breastfeeding guidelines and pragmatic breastfeeding when mothers criticized how antenatal programs frequently left them feeling unprepared for reality (4). This sentiment was found in our sample suggesting that women want to hear the pros and cons of breastfeeding so they can make an informed decision regarding infant feeding. In addition to being more active in their pursuit of breastfeeding knowledge, mothers also noted the active nature of their infants in breastfeeding outcome.

**Active role of infants.** The active nature of the neonate is often neglected as evidenced by the timing of antenatal classes being offered prior to birth. Pregnant women who believe that taking a prenatal breastfeeding class is adequate preparation to learn how to breastfeed, may not realize that what they learn from these classes is theoretical in nature because there is no infant to practice their techniques. This sends a strong message to women that infants play a secondary role, if any in the breastfeeding relationship, which is contrary as shown by our data. This view of breastfeeding as a unilateral decision made by the mother is a robust belief that has been resistant to change. Wayland discussed how the infant is repeatedly overlooked as an active agent and sought to dispel this view in breastfeeding promotion in Brazil (279). Similar views are found in the United States with breastfeeding education and instruction focused on the
mother with her infant viewed as a passive recipient in the breastfeeding dyad. Our sample suggests that infants do play an active role in breastfeeding and exhibit cues to express their needs. When mothers learn to read these subtle cues generated by their infants, they become more adept at doing what is best for both parties involved (DiCarlo, Onwujuba, and Baumgartner 205; Author, “Eat at Mom’s” 94; Author, “Booby Traps” 14). Learning to read their infant’s cues helped women develop their confidence which led to maternal transformations.

**Maternal transformation.** Maternal transformations between the prenatal to the late postpartum period were evident as passive recitations of health-related aspects of breastfeeding became action-oriented with mothers figuring out how to make breastfeeding successful based on their circumstances. The negotiations between what mothers “officially” learned and what “unofficially” worked while breastfeeding, gave rise to an appreciation of experiential learning and maternal instincts. Mezirow found that only through critical reflection and moving out of one’s comfort zone can true transformative change occur which described the path of many of these mothers during their breastfeeding journey (7). Nursing their child became more than a form of nutrition as mothers became increasingly aware of their inner strength, confidence, corporeality, and the value of listening to their instincts. In examining the embodiment of breastfeeding, Rudzik found similar differences between prenatal and postnatal experiences among mothers in Brazil (17). Such differences support the processual and embodied nature of breastfeeding which is in stark contrast to the current rhetoric that emphasizes following health recommendations or guidelines devised by policy makers. These intangible aspects of breastfeeding are regularly neglected in breastfeeding education but they play a critical role in helping women form a more complete picture of breastfeeding that extends beyond health benefits.
CONCLUSION

This research is among the first to examine the effectiveness of breastfeeding education and our findings suggest that there are numerous gaps that go unnoticed that include enduring nipple pain, seeking assistance when needed, incorporating the active role of infant, and listening to infant cues. Addressing these issues in breastfeeding education may increase breastfeeding success, make breastfeeding a more enjoyable process, and help educate policy makers who scapegoat individual women for low breastfeeding rates, that the problem is more complex. The decision to breastfeed is often portrayed as an individualized decision with failure to breastfeed equated with maternal shortcomings but our results indicate that belief is inaccurate as we have learned that breastfeeding is a dynamic process between mother and infant that can teach women to become more confident, critical of breastfeeding rules, and appreciative of their maternal bodies (Author, “If the Breast is Best” 91). At the 2016 Breastfeeding and Feminism conference, Christina Doonan stated, “If a woman does not breastfeed, maybe we shouldn’t ask how the woman failed, but how we as a community failed.” We hope this research extends the sentiments by Doonan and opens for discussion the importance of reexamining our fundamental beliefs in breastfeeding education so that every mother who wishes to nurse will be fully supported with the tools she needs to be successful.
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