BIO-BYWORD
SCIENTIFIC PUBLISHING PTY LTD

International Journal of General Practice Nursing, 2023, Volume 1, Issue 1
https://ojs.bbwpublisher.com/index.php/IJGPN

A Situational Analysis of the Discourse of Mothers Who Have Chosen an Alternative to Exclusive Breastfeeding: Challenges in Nursing Practice

Sandrine Vallée-Ouimet[1]*, Monique Benoit[2], Pierre Pariseau-Legault[2]

[1]Université du Québec en Outaouais, Saint-Jérôme, Québec J7Z 0B7, Canada

[2]Department of Nursing, Université du Québec en Outaouais, Saint-Jérôme, Québec J7Z 0B7, Canada

****Corresponding author:*** Sandrine Vallée-Ouimet, Sandrinv.ouimet@hotmail.com

Copyright: © 2023 Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution License (CC BY 4.0), permitting distribution and reproduction in any medium, provided the original work is cited.

Abstract: The health benefits of breastfeeding for infants have been established by numerous scientific studies. However, mothers who opt for alternatives to exclusive breastfeeding may feel guilty or that they have failed. This issue raises the importance of understanding the experiences of these mothers, who live on the fringes of public policies and healthcare practices that currently favor exclusive breastfeeding. This qualitative research presents a situational analysis of the experiences of nine mothers who chose alternatives to breastfeeding and interviewed in the form of semi-structured interviews. The results describe the decision-making processes involved in choosing an alternative to breastfeeding, situate this choice within a set of care measures that are culturally congruent with breastfeeding, and position this choice in relation to the social norm of breastfeeding. The discussion presents the processes of negotiation and resistance mobilized by the mothers concerning the different norms related to breastfeeding.

Keywords: Breastfeeding; Autonomy; Decision-making process; Situational analysis; Feminism

Online publication: June 26, 2023

1. Introduction

The benefits of breastfeeding for the health of infants and mothers have been well established in scientific literature [1,2], and many international organizations, including the World Health Organization (WHO) [3] and the United Nations International Children's Emergency Fund (UNICEF) [4], formally encourage exclusive breastfeeding for infants up to six months of age and strongly suggest that breastfeeding should continue for up to 2 years or more. With this in mind, various government recommendations such as those issued by the Ministère de la Santé et des Servicce sociaux (MSSS) [5] and professional groups such as the Ordre des infirmières et infirmiers du Québec (QIIQ) [6] and the Ordre des Sages-Femmes du Québec [7] support these guidelines in favor of exclusive breastfeeding. These international, provincial, and professional bodies produce standards that contribute to the development and maintenance of a culture favorable to exclusive breastfeeding.

In Quebec, the Baby-Friendly Initiative (BFI) is an example of a tool for making exclusive breastfeeding a norm in healthcare settings, as promoted by the WHO [3], UNICEF [4], MSSS [5], and OIIQ [6]. In order to achieve this objective of making breastfeeding the norm in healthcare settings, nurses are encouraged to promote, protect, and support exclusive breastfeeding [6]. As a result, nurses are at the center

of discourse and practice based on the promotion of infant health through standards relating to the benefits of exclusive breastfeeding [6].

Scientific literature suggests the presence of a tension between the discourse of exclusive breastfeeding and approaches that tolerate an alternative to this type of infant feeding, favoring other methods. This tension has raised several ethical issues within nursing practice itself. Firstly, the role of nurses [6] in promoting exclusive breastfeeding presents a risk of dissonance when it clashes with a care approach that is intended to be mother-centered if the mother encounters breastfeeding difficulties or does not choose exclusive breastfeeding for her infant [8]. Subsequently, nurses also run the risk of restricting the care relationship with patients [9], which lowers the quality of support offered to them [10-13].

Several recent qualitative studies have shown that mothers who do not opt for exclusive breastfeeding [14-20] tend to feel guilty or even a sense of failure [19,21]. The exploratory study by Hvatum and Glavin [12] suggests that these feelings of guilt, shame, and failure can be explained by the mother's desire to conform to the norms favoring exclusive breastfeeding. Furthermore, the transmission of informed information on the choice of infant feeding method is an ethical issue raised in literature [22]. In this sense, accessibility of information and modifying the availability of information are public health strategies used by the government to encourage the adoption of healthy behaviors [23]. These strategies generate a certain amount of control over the acquisition, use, retention, and transmission of information conveyed to the general public [23]. Consequently, the study by Fallon *et al.* [10] states that only 36% of mothers in their sample (601 mothers) who had chosen bottle-feeding felt supported by health professionals. In other words, this tension caused by the standards of practice favorable to breastfeeding raises ethical issues for nurses with regard to the transmission of enlightened information on infant feeding options [22], in addition to supporting women in making decisions about alternatives to exclusive breastfeeding [20].

The aim of this qualitative research was to understand the ethical and clinical tensions at work when care practices favoring exclusive breastfeeding clash with mothers' alternative choices in this respect. We based on Madeleine Leininger's theory of transcultural care [24] and was inspired by Adele Clarke's approach [25] in our methodological approach to analyze the discourse of mothers who choose alternatives to exclusive breastfeeding, Situational analysis is an iterative approach that takes into account the main perspective of the individual, the central social actor in the study, in order to observe the whole social universe in which the individual evolves [25]. This research aimed at answering the following question: how is the choice of an alternative to exclusive breastfeeding discursively constructed by mothers when confronted with institutional practices and social norms? The primary objective was to explore how the choice of infant feeding method is articulated by mothers who opt for alternatives to exclusive breastfeeding. The secondary objective was to describe the influence of norms associated with maternal and parental performance on mothers' decision-making regarding infant feeding method. The tertiary objective was to describe the effects of this choice on the general experience of motherhood, as expressed by the mothers.

2. Theoretical framework

The primary frame of reference used for this analysis was that of Leininger's transcultural care [24]. The main aim of using this frame of reference was to understand the sociocultural stakes of breastfeeding practices through the process of maintaining, negotiating, and restructuring care in a culture where breastfeeding is presented as a norm. Nurses, in their practice, can maintain culturally congruent care that is favorable to breastfeeding for mothers who wish to breastfeed, negotiate care for mothers who express a shared choice or constraints, or restructure care for mothers who choose not to breastfeed. With this in mind, the participants who chose alternatives to exclusive breastfeeding spoke of a subculture. The participants' discourse made it possible to observe the normative pluralism of the care culture favorable to breastfeeding, within which different norms converge or clash with varying degrees of force. Leininger's theory provides

a sociocultural understanding of mothers' breastfeeding practices when they deviate from the norms that characterize breastfeeding-friendly care practices. Through the many initiatives aimed at promoting breastfeeding, including the BFI, nurses must attend certain breastfeeding-related training courses, offer quality education about breastfeeding, adhere to the control of advertising for formula, encourage the implementation of the ten conditions for successful breastfeeding, *etc*. [5]. Consequently, these elements, coveted by Clarke [25], evoke non-material representations of the culture favorable to breastfeeding.

3. Qualitative methodological approach inspired by grounded theory

The qualitative approach chosen for this research was based on situational analysis of the discourse of mothers who have chosen an alternative to exclusive breastfeeding. This approach, developed by Adèle Clarke, emphasizes the perspective of the individual as the central element of the analysis in order to observe the whole social universe in which the individual evolves [25]. This analysis took account of discourses, silences, and the influence of the non-human, which includes cultural products, technology, animals, the media, and many other objects that have an influence on people's representations of the world they experience [25]. The data were analyzed using three main styles of mapping, which Clarke [25] described as situational, positional, and social/arena world maps. The aim of these maps is to describe all the elements inherent in the situation under study (*e.g.*, **Figure 1**), as well as the links between them, the social worlds and their overlaps, and the positions taken or not taken [25]. All these are based on an analysis of discourse inspired by Foucauldian theory, with a marked emphasis on the non-human and an important consideration of silence [25]. Situational analysis is inspired by feminist theories from which derive concepts that raise awareness of the object of study, such as intensive motherhood [17] or the sacrifice of motherhood [26].

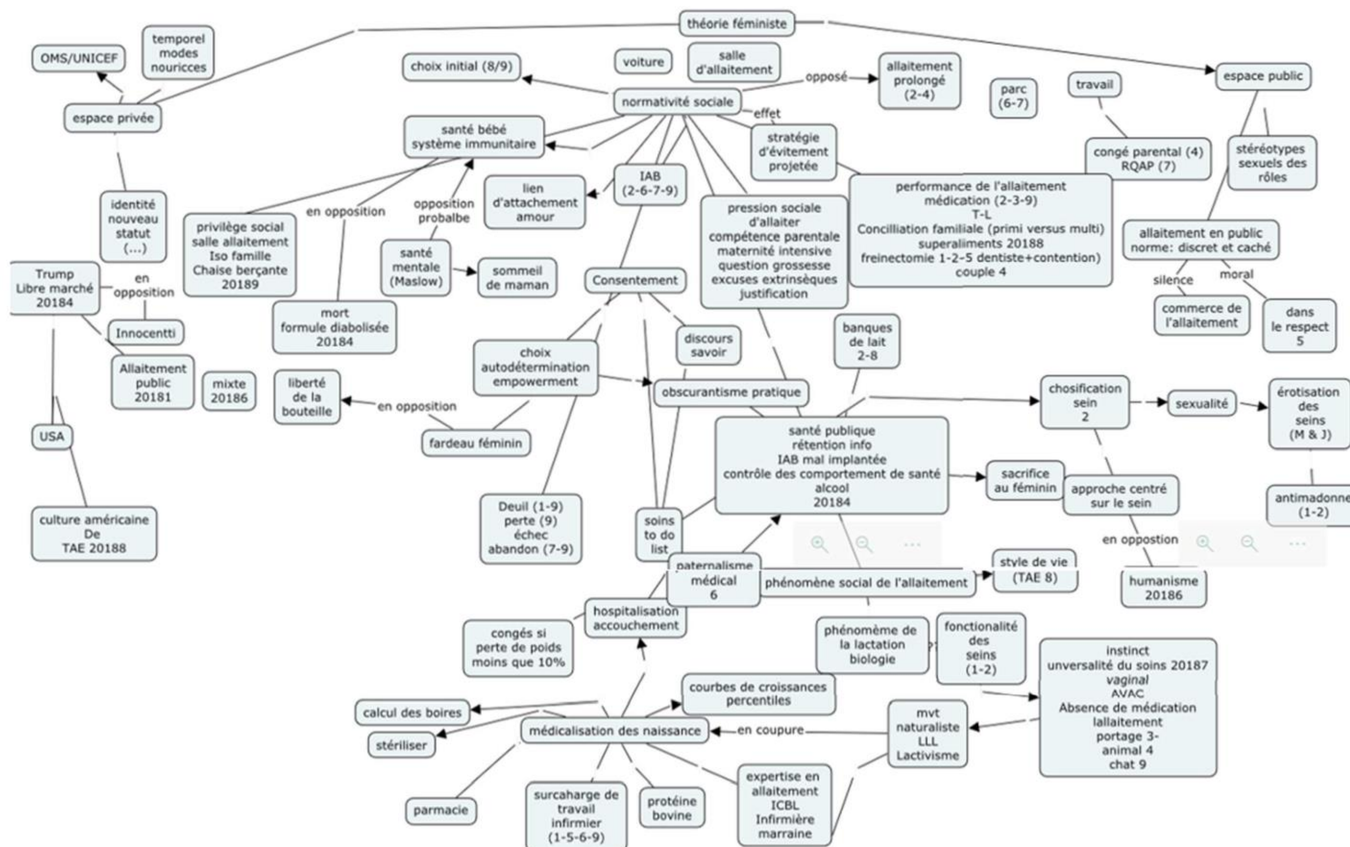

Figure 1. Mind map linking the all the elements in the study

4. Theoretical framework

In order to take part in this study, participants had to have chosen an alternative to exclusive breastfeeding and given birth in Quebec after 2008, the date on which the MSSS granted itself the mandate to certify the BFI establishments [5]. The year 2008 thus represents a symbolic date in terms of the culture of practice favorable to breastfeeding in Quebec, despite the fact that such practices existed well before then. Recruitment took place during the summer of 2018 with the help of a virtual poster presented on social networks. This type of passive recruitment was aimed at free and voluntary participation. A consent form was signed by each participant, and their anonymity was respected during this research, which was approved by the ethics committee of Université du Québec en Outaouais (UQO).

Sociodemographic questionnaires (**Table 1**) and semi-structured interviews lasting approximately one and a half hours were conducted with the participants in this study. The interviews were audio recorded, and the verbatim transcripts were then produced. Confidentiality was ensured by coding the first and last names of the participants. The results were analyzed simultaneously with the data collection in the form of mapping and mathematical analysis extracted from the verbatim transcripts of the interviews. In total, 14 childbirth experiences were shared by the nine participants aged between 26 and 40, including four primiparous women. Four participants described their alternative to exclusive breastfeeding as being exclusively formula milk, while for five participants, it consisted of a mixture of breast milk, obtained by breastfeeding or extraction, and formula milk.

Table 1. Sociodemographic characteristics of participants

Socio-demographic data	Number/%	
Age in 2018		
Between 26 and 30 years old	4	44.0%
Between 31 and 35 years old	1	11.0%
Between 36 and 40 years old	4	44.0%
Highest education level		
Secondary school	1	11.0%
College diploma	2	22.0%
Bachelor's degree	4	44.0%
Master's degree	2	22.0%
Marital status		
Common-law marriage	7	78.0%
Married	2	22.0%
Duration of parental leave		
Six months to a year	7	78.0%
More than a year	2	22.0%
Number of children		
One	4	44.0%
Two	5	56.0%

5. Results

Three main themes emerged from the results of this research: (i) maintaining the cultural norms of exclusive breastfeeding; (ii) adjusting and negotiating breastfeeding practices; and (iii) exclusive breastfeeding as a maternal performance issue. The aim of this article was to present the first two themes obtained with the help of verbatim and mapping analysis.

5.1. Maintaining the cultural norms of exclusive breastfeeding

This first theme primarily focuses on the development of an alternative choice to exclusive breastfeeding. This development evokes the initial choice, the decision-making constraints, and sometimes the complex and difficult process of clarifying the choice.

5.1.1. Initial choice

First of all, the choice of feeding for an infant in the preconception period was expressed, for the most part, by an initial desire to breastfeed: "I did a lot of reading on the subject, and I had always told myself that I was going to breastfeed my children" (P8). The two main reasons given were the benefits of breastfeeding for the infant's health and the attachment bond. For the next participant, infant health was presented in a dichotomous way to illness, and breastfeeding would, therefore, reduce the risk of the child being ill: "In terms of the child's health, it was that it (breastfeeding) promotes antibodies and children were less likely to be ill" (P7).

5.1.2. Decision-making constraints

In scientific literature, as in the public arena, it is possible to find an association between the image of a good mother and breastfeeding [9,14,15,17,27,28]. In this respect, mothers who wish to respond to the favorable injunctions of motherhood would, at first sight, have less decision-making space [29]. In this respect, the participants in this study questioned the free nature of the choice made with regard to the infant's mode of feeding. While retaining their freedom of choice, they had to negotiate the symbolic constraints associated with the social injunctions of good motherhood. The disappointment over the choice of bottle-feeding was described by a participant, who pointed to a very real constraint that qualifies the decision she made: "It seems that if you keep the door open for breastfeeding, bottle-feeding seems like a bad idea; but how far do you really go?" (P9). This perception of an imposed choice is explained by the posited superiority of breast milk found in the discourse of several participants: "Iron in breast milk is better" (P7). With this in mind, Thomson *et al.* [30] stated that bottle-feeding leads to a feeling in which one is not acting in the best interests of one's newborn child in order to ensure a good start. This notion of a good start is also found within the BFI, which portrays breastfeeding as a practice that ensures "every child the best possible start in life" [5]. This presentation is reminiscent of the concept of intensive motherhood, which reflects the mother's role as one of complete devotion to the child's full potential [17]. This presentation of motherhood leads to a form of performance that is not always compatible with other spheres of life, including family life [28].

The social representation of breast milk as superior to other forms of nutrition was illustrated in words by this participant: "We talked a lot about breast milk; it's the best option" (P4).

5.1.3. Clarifying the choice

All the participants talked about the benefits of breastfeeding. On this subject, several elements were mentioned, including the simplicity and practical aspects of breastfeeding: "I found it (breastfeeding) simple and effective" (P6) and "It's practical, you always have milk at hand, at the right temperature" (P5). On the other hand, the disadvantages of breastfeeding were hardly found in the discourse of the participants. However, the participants mentioned the negative impact that breastfeeding could have on the mental health of mothers. For this participant, the impacts were both physical and mental: "I would have liked it (breastfeeding) to work, but I made the choice between being exhausted while giving (breast) milk and choosing to be a fitter and a more patient mum" (P8). However, fatigue and the time it takes to breastfeed were not directly mentioned as disadvantages of breastfeeding. Certain advantages of bottle-feeding were highlighted, including a quicker return to work, sharing feeds with other parents, and greater freedom of

action. Moreover, Fahlquist [19] included statements by participants who associated breastfeeding with a lack of freedom of action. According to Badinter, breastfeeding at the baby's request undermines the woman's right to have time for herself, whereas bottle-feeding offers a compromise that frees the woman from her role as mother in order to reconcile her individual needs with those of the baby [26]. This participant's comments also evoked this association between freedom of action and bottle-feeding:

> "If I wanted to go out, I still have the freedom to leave (the baby) with dad, or my parents, or whatever, without feeling bad or telling myself that I'd have to be back in an hour because he is hungry" (P2).

Finally, the disadvantages of bottle-feeding reported by several participants included the logistics of preparation, cost, and general lack of information. Several studies have highlighted the lack of general information on the use of formula [10,12,18,31,32]. Some mothers even expressed their dissatisfaction when they sought information on formula from medical staff [13]. The following extract illustrates this dissatisfaction:

> "You don't have any support either. I have a friend for whom breastfeeding didn't work. I consulted her a lot, as the nurse at the local community service center (CLSC) didn't advise me on how to increase the amount of milk in the bottle (...), even the pediatrician didn't really know what to say. You're a bit lacking in resources" (P9).

According to Gostin [23], public health has a certain amount of control over the information transmitted and the behavior to adopt (or avoid) in order to optimize health. Breastfeeding is culturally seen as a choice that entails an uncertain level of risk for the health of babies [17,29]. The symbolic association of breastfeeding with health risks can be explained by the absence of any presentation of the disadvantages of breastfeeding, or even the advantages of bottle-feeding, in the participants' discourse. From this point of view, the presentation of the benefits of breastfeeding and the risks of formula feeding would evoke the rationality of public health in the retention and distribution of information about favorable (breastfeeding) or risky (formula feeding) health behaviors [30,33].

5.2. Adjusting and negotiating breastfeeding practices

The second theme emerging from the results was the tension between two current paradigms that coexist in the care offered to parturients in hospitals. This coexistence of paradigms – the medicalization of childbirth and the culture of care favorable to breastfeeding – creates confrontations of varying forces, the effects of which on mothers' experiences are tangible when their discourse is studied. The first paradigm of the medicalization of childbirth offers, by way of example, a control of parameters, including the baby's ingestions, which historically would have been facilitated by the introduction of formula milk [34]. However, the eighth of the ten conditions for successful breastfeeding, which is also a criterion for the accreditation of BFI-certified establishments, provides for the encouragement of breastfeeding on demand [5]. Breastfeeding on demand would thus break with the measurement of the amount of milk ingested by the baby and would be based on a timetable. As Rivard [35] suggested, the following extract illustrates the coexistence of these two paradigms in the information guides given to parents: "My breastfeeding friends were asked how much milk their baby drinks (...) It's written in Mieux-Vivre, a baby of this age is (supposed to) drink so much. My breastfeeding friends tell me that, but I don't know how much (he drinks)" (P2). This contradictory discourse creates uncertainty for some mothers, which was expressed in the following way by one participant: "The discourse isn't always uniform. For some parents, it's difficult to get their

bearings, and it can even create stress because you don't know who to trust" (P5).

5.2.1. Influence of medicalized care practices on mothers' experiences

Most of the participants referred to the existence of specialized breastfeeding practices, which testifies to the development of professional expertise in this field. Moreover, the development of expertise in breastfeeding was one of the aims of the medicalization of infant nutrition [4]. The term "specialist" was mentioned several times: "We saw a breastfeeding specialist (...) the breastfeeding specialist" (P1); [and] "A lactation nurse, she specialized in that" (P8). This expertise could give rise to a discourse of professional authority whose injunctions centered on maternal responsibility engender a feeling of guilt in this participant:

> "He (the pediatrician) looked at the (growth) curve and then started nagging: Yes, well, your child isn't putting on enough weight. You're not breastfeeding enough. What do you mean I'm not breastfeeding enough? At the same time, I thought to myself: How can we breastfeed more?" (P4)

For another participant, the expert discourse on breastfeeding espoused by health professionals was a power issue that placed mothers in a position of submission to authority. The words "influenceable", "don't know," and "taken in" praise the lack of control she perceived:

> "Because if you're even the slightest bit influenceable, and you don't know anything about it, and you're, let's say, either someone who's not educated or who doesn't know anything about the medical world, then you're easily taken in by it" (P6).

Various power issues between medical expertise and mothers' autonomy surfaced from the participants' discourse. For example, the lack of control over the situation and the hold of the medical framework were well presented by this participant, who attributed the end of the hospitalization to the criteria unilaterally defined by the medical authority. Breastfeeding was an issue in obtaining hospital discharge for the following participant, since the baby's weight gain was unsatisfactory according to the medical parameters established: "He (baby) has to eat. He's lost almost two pounds. You won't let me leave the hospital if he doesn't gain weight, but you refuse to let him take anything other than from the breast" (P6). This extract shows the cohabitation between medical approaches to care and those more favorable to exclusive breastfeeding, from which also stems a process of systematically blaming the mothers who are at the center of these tensions.

One participant used a symbolic form to represent these power issues: "She (the nurse) came with her big clogs into our room to explain (breastfeeding) to us" (P1). This excerpt depicts the nurse as rude, while positioning her as an authoritarian figure who explains breastfeeding to women who have become mothers. However, a rude and directive approach by health professionals would be associated with negative support and unfavorable to the development of self-confidence in mothers [36].

The non-verbal language of nurses responsible for the care of mothers was also raised by this participant: "I see the nurse at the doorway of the room, with hands on her hips, saying, 'You have chosen to feed by bottle,' I replied, 'Yes.' 'Well,' she says, 'We don't have any here.'" (P9). In this extract, the choice of words makes explicit the lack of availability for an alternative choice to breastfeeding, along with power issues expressed by different informal and persuasive strategies, such as attitude and exploitation of authority. The transgression of certain personal limits by the nurses toward the participants was also raised. Some of the interventions to which the participants were subjected were perceived as intrusive and

disrespectful of their private space. One participant described this intrusion in terms of her sense of self, as her consent was not sought before care was given to her and her child: “Then a nurse, who touches your breast, takes your baby like that. It’s mine. It’s my child. Don’t take my things” (P7). For this participant, it was the feeling of dispossession of her body that expressed this intrusion, thereby raising a form of objectification of the breast, here constructed as an object detached from the female body whose sole function would be to feed the baby:

> “At one point, in the hospital, I said to myself, ‘Okay, my body did not belong to me anymore.’ The first time, the nurse slid off my jacket, took my breast, and picked up the breast pump (...) I was in pain, and I just wanted to go home, so take them, my breasts, and just feed” (P9).

The permeability of the boundaries between private and public spaces in a breastfeeding context was also presented by this feeling of intrusion into the participants’ family life. The participant’s breast, generally considered to be part of a private sphere, is thus politicized and invested with the social injunctions associated with motherhood and breastfeeding. This deconstruction of the body is reminiscent of the paradigm of the medicalization of childbirth, which aims to control specific parameters, such as lactation, dissociated from breastfeeding as a bodily, cultural, and social practice, and as a family ritual [34]. The power, knowledge, and authority of medical staff here represent not only the public sphere, but also the professional authority invested in public health discourse on breastfeeding.

5.2.2. Effect of a breastfeeding-friendly healthcare culture on mothers’ experiences

Different representations of the culture of care favorable to breastfeeding were found in the discourse. Some cited, for example, the perceived authority of government bodies: “Health Canada advocates breastfeeding in relation to formula [milk]” (P1). For others, the pro-breastfeeding ideology that exists in the cultural environment was raised. This participant referred directly to the BFI:

> “I also thought it was a pity that hospitals have the baby-friendly banner. It’s baby-friendly, but in keeping with breastfeeding. It’s baby-friendly for breastfeeding, but for me, baby-friendly means adapting to the needs of the baby and the mother (...) I don’t think it reflects reality. Well, it reflects the reality of an environment where exclusive breastfeeding is advocated. But it doesn’t reflect the reality of a mother who isn’t able to breastfeed, or that it doesn’t work with her baby, or who just wants something else. It doesn’t reflect that reality, but it does reflect the reality of hospitals that advocate exclusive breastfeeding” (P2).

One of the criteria for BFI accreditation in hospitals is a breastfeeding rate set at 75% [5], with one of the participants questioning the existence of this target rate: “At one point, I wondered what would happen if there wasn’t a rating for the number of mothers who breastfeed” (P9). The results of a study by Hunt and Thomson [11] suggested that mothers sometimes have the impression that medical staff uses a functional and theoretical approach to breastfeeding in order to meet certain guidelines. For this participant, the breastfeeding-friendly culture of care had the effect of controlling information and a consequent lack of support for her decision:

> “She (the nurse) came to see us and told us, ‘We knew you couldn’t breastfeed, but we couldn’t tell you. We knew it wouldn’t work. But we’re so pro-breastfeeding.’” (P7)

Lakshman *et al.* [21] claimed that some health professionals offer no support for bottle-feeding in the postnatal period, which echoes the words of this participant: "As soon as that person makes her decision (referring to mothers), whether she (the nurse) agrees with you or not, you have to respect her. It comes down to the respect for human beings" (P6). On another note, several instruments designed to maintain exclusive breastfeeding were found in the culture of care that favored breastfeeding. The use of a spoon, a medication container, a syringe, and a teat would facilitate this culture. However, these tools were laborious and unsatisfactory for many of the participants (**Table 2**).

Table 2. Breastfeeding support tools

Tools	Examples
Spoon	"An hour after breastfeeding, you have to express your milk. Then, you have to spoon out what you've collected (...) A plastic spoon, from the cafeteria, a bit sharp on the edge. (...) Let's see. It's a baby. I wasn't ready for that (...) Seeing that I'm going to give him the little (milk collected), he (the baby) was struggling (...) Anyway, I had so little, that's what's ridiculous" (P9).
Medication container	"They tried that, the cup, the little medicine case. That's what worked best. Then it was really by chance, it was the nurse who said that was enough. But she didn't want to try the bottle" (P6).
Syringe	"I collected the colostrum, in fact I expressed the colostrum by massaging, in a small cup (container) which then, after that, he (the hospital staff) put it in a syringe, and then we gave it to her using our finger" (P2).
Breast shield	"They (the hospital staff) told me to get a breast shield, but a breast shield is like a silicone piece that you put on, with one end sticking. It didn't work; the little one (baby) would get agitated because it would slip off. It wouldn't hold. We said, okay, pumping the milk didn't work either, and then we both (couple) started crying" (P7).

As an instrument incorporated into care practices favorable to breastfeeding, the breast pump was the focus of several participants' discourse. In this case, with the medicalization of childbirth, the breast pump has made it possible to dissociate lactation from breastfeeding [37], to make breastfeeding optional in the desire to give mother's milk to her baby, and to quantify the number of breastfeeding [38]. One of the participants in this study disagreed with the way breast pumps were used in hospitals:

> "I have never, ever, ever, ever pumped my milk for him (baby) to drink. It's as if they (the hospital staff) made me sick of it by taking me away at night and forcing me. It's like they've taken away my desire" (P6).

Inevitably, the bottle is either disregarded, put aside, or presented from a position of fear. This fear refers to the risk of the infant subsequently refusing to breastfeed. In this sense, the ninth condition for successful breastfeeding, a BFI's certification criterion, proposes banning teats from breastfed babies [5]. With this in mind, offering a bottle or pacifier to their baby could arouse guilt in some mothers:

> "It's like if I give a pacifier, he (the baby) would get used to it, and he wouldn't want to make the effort to breastfeed anymore. So, if he stops suckling as soon as I give him a pacifier or a bottle, it's my fault" (P3).

According to another participant, this silence about bottle-feeding makes it impossible for exclusive breastfeeding to fail: "She (the nurse) never said to me: Listen, if you really see that it's not working, you can go for bottle-feeding. Never! That was never an option. Never, never. Never" (P9). However, Jones

and Stoppard [40] presented the transfer of information as an alternative to breastfeeding, including the use of a bottle, as a practice conducive to an informed decision-making process. This informed decision-making process requires the difficulty of exclusive breastfeeding to be foreseen and fully considered, rather than representing this (im)possibility as a personal failure.

Various studies have criticized the biomedical approach to breastfeeding and suggested that the needs of mothers should be more central to care [10, 40-43]. The person-centered approach was very significant in the journey of one participant. Her comments set out the relational dimensions, thereby providing individualized support:

> "Do you understand that in the health sector, you do business in two hours? Then she (the nurse) sat down and listened to me, gave me advice, and really did a great job" (P6).

The analysis of the results in this section reveals a significant tension in the participants' discourse, which can be explained by the coexistence of two paradigms: the medicalization of childbirth and the culture of care favorable to exclusive breastfeeding [35] (**Table 3**). The effect of this coexistence was the feeling of guilt or uncertainty in several participants. The boundaries between the dominant discourses are fluid and conversable [25], resulting in an encounter that is sometimes harmonious, sometimes discordant.

Table 3. Coexistence of the paradigms of a culture of care favorable to breastfeeding and the medicalization of childbirth

	Culture of care favorable to breastfeeding	Medicalization of childbirth	Tensions arising from the coexistence of the two paradigms
Focus	Women	Breast	Child
Process	Breastfeeding (social)	Lactation (biological)	Nutrition
Approach	Holistic	Technical	Child-centered
Guiding principle	Empowerment	Subjecting to experts	Subjecting to norms

6. Discussion

Within the discourses derived from the experiences of the mothers in this study, the choice of an alternative to exclusive breastfeeding is confronted with a heterogeneous set of social norms and institutional practices, which clash, or come together, in varying degrees of force. According to a cultural understanding of care, these discourses can be grouped under confusion, accommodation, apprehension, and justification.

6.1. Confusion

The results suggest a confrontation between two influential movements in health institutions offering perinatal care (the medicalization of childbirth and the culture of care favorable to breastfeeding). The coexistence of these two movements could cause confusion among the participants. The results revealed a dissonance in nurses' anamnesis, where their practice is to encourage breastfeeding in order to be culturally congruent with the culture of care, while seeking to control certain medical parameters, including the baby's ingestions. Mothers who had breastfed during hospitalization were perplexed and confused when the nurses asked them how much milk the baby had ingested. One study has suggested that mothers can become confused, even angry, when faced with contradictory advice from health professionals [20]. Consequently, it might be appropriate for nurses to monitor the various signs proposed by Ross [44] (number of voids, baby's behavior after feeding, quantity and color of stools, state of breast, baby's weight gain, *etc.*), rather than questioning mothers about the quantity of milk given to breastfeeding mothers.

6.2. Accommodation

The discourse of breastfeeding expertise, which stemmed from dominant knowledge, had placed some mothers in this study as learners. Various informational and persuasive strategies, including attitudes, the use of a position of authority, and the choice of words, had made it possible to present the power issues between nurses and the patients.

Striking silences had emerged from this linguistic selection, including the absence of presentation of the disadvantages of breastfeeding. This silence reflects an assumed rationality on the part of the actors invested with a public-health role, aimed at emphasizing the information favorable to exclusive breastfeeding and minimizing the importance of the information that could hinder the achievement of this objective. Informing mothers of the advantages of breastfeeding, while disregarding the disadvantages of breastfeeding, is a form of information control by public health in order to minimize behavior that is considered risky to health [17]. In this context, breastfeeding is presented as a safe choice and socially presented as a behavior that is risky to health or not in the best interests of the infant [15,17,29]. However, some authors have suggested that public health should focus more on education in order to provide the necessary tools to promote informed decision-making [33]. In addition, public health should also differentiate between the objectives of informing and persuading the population, since persuasion evokes a paternalism that is unfavorable to mothers' autonomy, the harmful effect of which, on their experiences of breastfeeding and non-breastfeeding, has been demonstrated by this study [45]. In short, a person-centered approach and greater presentation of alternatives to breastfeeding and their advantages could promote mothers' autonomy.

6.3. Apprehension

The experience of breastfeeding can be characterized by various fears among mothers, which can be explained by the authoritarian attitude of nursing staff and can also lead mothers to censor themselves or even lie to nurses about their chosen feeding method. Firstly, this apprehension in a care context runs counter to the expected properties of consent to care, which must be given freely and in full understanding of the facts [46]. Secondly, knowledge of information about breastfeeding must enable the patient to exercise her decision-making power, and the relational environment in which she lives must facilitate this decision-making. Mothers can only weigh up the factors they consider important if they possess general knowledge of all the issues involved in a situation, given a context free of fears related to the choice that will be made. In a care context that is culturally congruent with breastfeeding, Leininger's approach [24] presents an openness to mothers' decision-making process. This openness allows nurses to negotiate and even restructure culturally congruent care in order to take into account the shared or dissonant perspectives of the cared-for person [24]. From this perspective, it is possible for nurses who fully adhere to the culture of care that is favorable to breastfeeding to offer individualized care that meets the needs of the parturient. Negotiating or structuring the care offered to women who choose an alternative method to exclusive breastfeeding makes it possible to move toward cultural congruence. On the other hand, maintaining care favorable to exclusive breastfeeding for mothers who choose an alternative to breastfeeding creates a dissonance of care and may contribute to inequitable power relations between nurses and parturients. As a result, this inequity is expressed in certain respects by a discourse of apprehension. The challenge, therefore, is not to question the value of exclusive breastfeeding, but rather to ensure the implementation of practices that are flexible and respectful of mothers' experiences.

6.4. Justification

In scientific literature and among the participants in this study, the benefits of breastfeeding have been widely emphasized. At present, few mothers believe that breastfeeding is the optimal choice for the health

of their infant [47]. Consequently, all the participants in this study initially chose to breastfeed. This initial choice exposes the influence of the current norm, which favors breastfeeding, in their decision-making process. Bayard [47] questioned the morality of this norm, which would draw a line dividing “good” and “bad” mothers. Furthermore, Knaak [15] suggested that an alternative choice to exclusive breastfeeding is currently perceived as morally deviant in contemporary societies. The social pressure to breastfeed was emphasized by several mothers in this study, which illustrates this dividing line that is both symbolic and subjective. In such circumstances, the moral injunctions associated with motherhood appear to have a marked effect on the choices mothers make to feed their child. The repression of official authorities and expert discourse also has the effect of positioning breastfeeding as more than just an individual decision, since it directly involves the infant’s well-being [15]. In today’s society, the valorization of breast milk and the devaluation of milk-based formulas play a part in conditioning beliefs and decisions concerning the chosen method of infant feeding [15].

7. Advantages and limitations of the research

This research was mainly based on the contribution of Leininger’s initial conceptual framework [24] and presented from the angle of the social normativity of breastfeeding for a situational analysis [25]. This theoretical approach enabled us to observe the cultural issues involved in breastfeeding in order to better understand the particularities of the process of negotiation or restructuring of care when mothers choose alternatives. To this end, this study reports on the experiences of mothers who live in industrialized countries where breastfeeding issues are very different from those in developing countries. Although Leininger’s theoretical model [24] has made it possible to observe the cultural stakes of breastfeeding, it has certain limitations, the most obvious being the consideration of the sociology of genders involved in this phenomenon. Nevertheless, the contribution of situational analysis, as a research method, has made it possible to highlight the diversity and complexity of the construction of identity relations on the threshold of a representation of motherhood conveyed as natural and instinctive. With this in mind, Leininger’s theoretical model [24] alone was not sufficient to take account of the identity tensions found in the sensitizing concepts of intensive motherhood [17] or the sacrifice of motherhood [26], since it did not offer a direct analysis of the discourses on breastfeeding, one of the main vectors of this so-called biological norm of motherhood that feminist theories, especially those by Badinter [24], repeatedly deconstructed.

The results of this research were intended to advance knowledge of a little-studied phenomenon in the natural sciences and to position breastfeeding as an issue that is part of a global and cultural context, so that the phenomenon can be understood in an open-minded way. However, the state of knowledge on the subject is poorly developed, which limits the number of relevant and recent scientific articles. The results of this qualitative study were based on a small sample and did not aim to generalize the phenomenon to the entire population of mothers who choose alternatives to exclusive breastfeeding. These results made it possible to appreciate the discourses that refer to normative and ethical limits relating to the social injunctions targeting breastfeeding. The documentation of the views of the participants in this study offers the advantage of providing various avenues for reflection in order to contribute to the emergence of practices that are more sensitive, adapted, and respectful of the experiences of mothers who choose an alternative method to exclusive breastfeeding. Despite its considerable effectiveness, online recruitment was limited to people who were present on social networks and found it easy to read and express themselves on this platform. In addition, for some mothers, the birth experiences were some years ago, which can potentially alter their memory of certain events. All the research reviewed and the sample used in this study involved only heterosexual couples, although Lee [48] stressed the importance of being sensitive to LGBTQ+ communities in studies of breastfeeding.

Disclosure statement

The authors declare no conflict of interest.

References

[1] Binns C, Lee M, Low WY, 2016, The Long-Term Public Health Benefits of Breastfeeding. Asia-Pacific Journal of Public Health, 28(1): 7–14.

[2] Colen CG, Ramey DM, 2014, Is Best Truly Best? Estimating the Effects of Breastfeeding on Long-Term Child Health and Wellbeing in the United States Using Sibling Comparisons. Social, Science and Medicine, 109: 55–65.

[3] World Health Organization, 2021, Exclusive Breastfeeding, viewed on April 23, 2021. http://www.who.int/elena/titles/exclusive_breastfeeding/fr/

[4] UNICEF, 2021, Allaitement [Breastfeeding], viewed on April 23, 2021. http://www.unicef.org/french/nutrition/index_24824.html

[5] Ministry of Health and Social Services of Quebec, 2021, Initiative des Amis des Bébés [Baby-Friendly Initiative], viewed on April 23, 2021. http://www.msss.gouv.qc.ca/professionnels/amis-des-bebes/

[6] Ordre des infirmières et infirmiers du Québec, 2015, Standards de Pratique de l'Infirmière: Soins de Proximité en Périnatalité [Standards of Nursing Practice: Perinatal Care], viewed on November 2, 2020. http://www.oiiq.org/sites/default/files/4443-perinatalite-web.pdf

[7] Ordre des Sages-Femmes du Québec, 2020, Philosophie et Normes de Pratique [Philosophy and Standards of Practice], viewed November 2, 2020. https://www.osfq.org/quest-ce-quune-sage-femme/philosophie-et-normes-depratiques/

[8] Goberna-Tricas J, Banus-Gimenez R, Palacio-Tauste A, et al., 2011, Satisfaction with Pregnancy and Birth Services: The Quality of Maternity Care Service as Experienced by Women. Midwifery, 27(6): 231–237.

[9] Murphy E, 1999, "Breast is Best": Infant Feeding Decisions and Maternal Deviance. Sociology of Health and Illness, 21(2): 187–208.

[10] Fallon V, Komninou S, Bennett KM, et al., 2017, The Emotional and Practical Experiences of Formula-Feeding Mothers. Maternal and Child Nutrition, 13(4): 1–14.

[11] Hunt L, Thomson G, 2017, Pressure and Judgement Within a Dichotomous Landscape on Infant Feeding: A Grounded Theory Study to Explore Why Breastfeeding Women Do Not Access Peer Support Provision. Maternal and Child Nutrition, 13(2): 1–13.

[12] Hvatum I, Glavin K, 2016, Mothers' Experience of Not Breastfeeding in a Breastfeeding Culture. Journal of Clinical Nursing, 26(19–20): 3144–3155.

[13] Wirihana LA, Barnard A, 2011, Women's Perceptions of Their Healthcare Experience When They Choose Not to Breastfeed. Women and Birth, 25(3): 135–141.

[14] Chabrol H, Walburg V, Teisssedre F, et al., 2004, Influence of Mother's Perceptions on the Choice to Breastfeed or Bottle-Feed: Perceptions and Feeding Choice. Journal of Reproductive and Infant, 22(3): 189–198.

[15] Knaak SJ, 2010, Contextualising Risk, Constructing Choice: Breastfeeding and Good Mothering in Risk Society. Health, Risk & Society, 12(4): 345–355.

[16] Labbok M, 2008, Exploration of Guilt Among Mothers Who Do Not Breastfeed: The Physician's Role. Journal of Human Lactation, 24(1): 80–84.

[17] Lee E, 2008, Living with Risk in the Era of 'Intensive Motherhood': Maternal Identity and Infant Feeding. Health, Risk and Society, 10(5): 467–477.

[18] Mander R, 2008, Baby Friendly-Mother Friendly? Policy Issues in Breastfeeding Promotion. MIDIRS Midwifery Digest, 18(1): 104–108.

[19] Nihlén Fahlquist J, 2016, Experience of Non-Breastfeeding Mothers. Norms and Ethically Responsible Risk Communication. Nursing Ethics, 23(2): 231–241.

[20] Redshaw M, Henderson J, 2012, Learning the Hard Way: Expectations and Experiences of Infant Feeding Support. Birth Issues in Perinatal Care, 39(1): 21–29.

[21] Lakshman R, Ogilvie D, Ong KK, 2009, Mothers' Experiences of Bottle-Feeding: A Systematic Review of Qualitative and Quantitative Studies. Arch Dis Child, 94(8): 596–601.

[22] Chumova M, 2014, Le Guide Pratique Mieux Vivre Avec Notreenfant: Témoin des Discours et Représentations Autour del'allaitement [The Practical Guide to Living Better with Our Child: Witness to the Discourse and Representations Around Breastfeeding], in La Promotion de l'Allaitement au Québec [Promoting Breastfeeding in Quebec], Les Éditions du Remue-Ménage, Montreal, 45–65.

[23] Gostin LO, 2008, Public Health Law: Power, Duty, Restraint (2nd Ed.), University of California Press, Los Angeles.

[24] Leininger M, 2002, Culture Care Theory: A Major Contributionto Advance Transcultural Nursing Knowledge and Practice. Journal of Transcultural Nursing, 13(3): 189–192.

[25] Clarke A, Friese C, Washburn R, 2018, Situational Analysis: Grounded Theory After the Interpretative Turn, Sage Publications, California.

[26] Badinter E, 2010, Le Conflit, La Femme et La Mère [The Conflict, The Woman and The Mother], Flammarion, Paris.

[27] McBride-Henry K, 2010, The Influence of the "They": An Interpretation of Breastfeeding Culture in New Zealand. Qualitative Health Research, 20(6): 768–777.

[28] Spencer RL, Greatrex-White S, Fraser DM, 2015, 'I Thought It Would Keep Them All Quiet'. Women's Experiences of Breastfeeding as Illusions of Compliance: An Interpretive Phenomenological Study. Journal of Advanced Nursing, 71(5): 1076–1086.

[29] Striley KM, Field-Springer K, 2014, The Bad Mother Police: Theorizing Risk Orders in the Discourses of Infant Feeding Practices. Health Communication, 29(6): 552–562.

[30] Thomson G, Ebisch-Burton K, Flacking R, 2015, Shame If You Do–Shame If You Don't: Women's Experiences of Infant Feeding. Maternal and Child Nutrition, 11(1): 33–46.

[31] Lee E, 2007, Health, Morality, and Infant Feeding: British Mothers' Experiences of Formula Milk Use in the Early Weeks. Sociology of Health and Illness, 29(7): 1075–1090.

[32] Thomson G, Dykes F, 2011, Women's Sense of Coherence Related to Their Infant Feeding Experiences. Maternal and Child Nutrition, 7(2): 160–174.

[33] Wolf J, 2007, Is Breast Really Best? Risk and Total Motherhood in the National Breastfeeding. Awareness Campaign. Journal of Health Politics, Policy and Law, 32(4): 59.

[34] Eden AR, 2012, New Professions and Old Practices. Lactation Consulting and the Medicalization of Breastfeeding, in Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities, Rutgers University Press, New Jersey, 98–109.

[35] Rivard A, 2014, Histoire de l'Accouchement dans un Québec Moderne [History of Childbirth in Modern Quebec], Les Éditions du Remue-Ménage, Montreal.

[36] Sheehan A, Schmied V, Barclay l, 2009, Women's Experiences of Infant Feeding Support in the First 6 Weeks Post-Birth. Maternal and Child Nutrition, 5(2): 138–150.

[37] McCarter-Spaulding D, 2008, Is Breastfeeding Fair? Tensions in feminist Perspectives on Breastfeeding and the Family. Journal of Human Lactation, 24(2): 206–212.

[38] Johns HM, Amir LH, McLachlan HL, et al., 2016, Breast Pump Use Amongst Mothers of Healthy Term Infants in Melbourne Australia: A Prospective Cohort Study. Midwifery, 33: 82–89.

[39] Lowdermilk LD, Perry ES, Cashion K, 2018, Périnatalité [Perinatal], Chenelière Education, Montreal.

[40] Jones SR, Stoppard M, 2011, Baby Friendly Hospital: Are We Failing Mother Who Formula Feed Their Babies? Journal of Family Health Care, 21(1): 12–14.

[41] Battersby S, 2014, The Role of the Midwife in Breastfeeding: Dichotomies and Dissonance. British Journal of Midwifery, 22(8): 551–556.

[42] Benoit B, Goldberg L, Campbell-Yeo M, 2016, Infant Feeding and Maternal Guilt: The Application of a Feminist Phenomenological Framework to Guide Clinician Practices in Breast Feeding Promotion. Midwifery, 34: 58–65.

[43] Carroll M, Gallagher L, Clarke M, et al., 2015, Artificial Milk-Feeding Women's Views of Their Feeding Choice in Ireland. Midwifery, 31(6): 640–646.

[44] Ross L, 2003, Guide de Santé Postnatale 9 Mois Plus Tard [Postnatal Health Guide 9 Months Later], viewed on November 2, 2020. http://collections.banq.qc.ca/ark:/52327/bs57392

[45] Massé R, 2014, Éthique et Santé Publique. Enjeux, Valeurs et Normativité (6e Ed.) [Ethics and Public Health. Issues, Values and Normativity (6th Ed.)], Presses de l'Université Laval, Quebec.

[46] Government of Quebec, 1991, CCQ-1991: Code civil du Québec [Civil Code of Quebec], viewed on November 2, 2020. http://legisquebec.gouv.qc.ca/fr/ShowDoc/cs/CCQ-1991

[47] Bayard C, 2014, Introduction, in La Promotion de l'Allaitement au Québec [Breastfeeding Promotion in Quebec], Les Éditions du Remue-Ménage, Montreal, 17–22.

[48] Lee R, 2019, Queering Lactation: Contributions of Queer Theory to Lactation Support for LGBTQIA2S+ Individuals and Families. Journal of Human Lactation, 35(2): 233–238.

[49] Pepin J, Ducharme F, Kérouac S, 2017, La Pensée Infirmière (4e Ed.) [Nursing Thought (4th Ed.)], Chenelière Éducation, Montreal.

Publisher's note

Bio-Byword Scientific Publishing remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.