

## INCOMPATIBLE EXPECTATIONS: THE DILEMMA OF BREASTFEEDING MOTHERS

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**Yvonne L. Hauck, RN, RM, BScN, MN, PhD**

School of Nursing and Public Health, Edith Cowan University, Churchlands,  
 Western Australia, Australia

**Vera F. Irurita, RN, RM, DipNEd, BappScN, MN, PhD**

School of Nursing and Midwifery, Curtin University of Technology,  
 Bentley, Western Australia, Australia

The maternal process of managing established breastfeeding and, ultimately, weaning the child from the breast was explored using the grounded theory method. Data were analyzed from interview transcripts from mothers, field notes, postal questionnaires from fathers, and individual and discussion group interviews with child health nurses within a Western Australian context. A common social problem emerged for women in the management of their breastfeeding when personal expectations were found to oppose the expectations of others. Being confronted with these incompatible expectations resulted in confusion, self-doubt, and guilt for mothers. These findings are discussed to assist health professionals support breastfeeding mothers.

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### BACKGROUND

The role of women's attitudes toward decisions about infant feeding has become increasingly recognized (Losch, Dugny, Russell, & Dusdieker, 1995). In the past, health professionals consistently used the criteria of breastfeeding duration and infant growth to define success with breastfeeding, whereas the social sciences and lay literature considered maternal subjective experiences as an important criterion (Harrison, Morse, & Prowse, 1985).

Acknowledgment of mothers' perceptions of their breastfeeding and weaning experiences has received recent attention in the research literature. The maternal

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**Address correspondence to Yvonne Hauck, School of Nursing and Public Health, Edith Cowan University, Churchlands, Western Australia, 6018, Australia. E-mail: y.hauck@ecu.edu.au**

subjective experience of continuing to breastfeed (Bottorff, 1990; Locklin, 1995), its relationship to employment (Hills-Bonczyk et al., 1994), long-term breastfeeding beyond 12 months (Kendall-Tackett & Sugarman, 1995; Wrigley & Hutchinson, 1990), and the emotional experience of breast milk expression (Morse & Bottorff, 1992) have been examined within the North American context. British researchers recently investigated maternal perceptions on sensations associated with the letdown reflex during breastfeeding (Britton, 1998). Australian researchers exploring mothers' views on breastfeeding have focused upon the criteria used to determine success (Hauck & Reinbold, 1996) and, most recently, upon the ongoing experience of breastfeeding (Schmied & Barclay, 1999).

Support networks, both formal and informal, have been recognised as influencing maternal decisions and subjective experiences in relation to breastfeeding. For example, approval for breastfeeding decisions from the father of the child has been found to affect women's breastfeeding practices (Freed, Fraley, & Schanler, 1993; Littman, Medendorp, & Goldfarb, 1994; Raj & Plichta, 1998; Sharma & Petosa, 1997; Wylie & Verber, 1994), as has the social support from family members, such as the woman's mother and friends (Isabella & Isabella, 1994; Lipsky et al., 1994; Losch et al., 1995).

The importance of breastfeeding has been supported not only nationally within Australia but globally by the World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF; Lund-Adams & Heywood, 1995; WHO, 1989). To truly support breastfeeding mothers, greater understanding of the management of later phases of breastfeeding and subsequent weaning, from the perspective of women living the experience, can offer insight to those people attempting to offer effective support.

Studies in the literature that examined weaning predominantly originated from developing countries where the impact of traditional infant feeding patterns and weaning practices has a significant impact on infant growth and child health. Such investigations have been undertaken in Northern Thailand (Jackson et al., 1992), Saudi Arabia (Al-Mazrou, Aziz, & Khalil, 1990), Mexico (Lipsky et al., 1994), Mali in West Africa (Dettwyler, 1987), Nicaragua (Lindenberg, Artola, & Estrada, 1990), Nigeria (Uwaegbute, 1991), and most frequently in India (Chandrasekhar, Vasanthavani, & Thomas, 1990; Khan, 1990; Rao & Rajpathak, 1992; Singh, Kumar, & Rana, 1992; Vijayasree & Vani, 1992). Information regarding infant feeding practices from different countries must be recognised as being relevant to their specific context and therefore cannot be transferred readily or accurately beyond cultural or social boundaries.

Consequently, the focus of this research is to explore the experience and process of decision making with established breastfeeding and weaning within the social and cultural context of Western Australia. To further delineate the historical context of this research, the study period commenced in 1996 and data collection continued until the end of 1999 as the literature continued to be examined and analysed in relation to emerging findings.

## **BREASTFEEDING IN THE AUSTRALIAN CONTEXT**

Breastfeeding trends in Australia, and particularly in Western Australia, are important to demarcate the social context of this research. Breastfeeding has been promoted zealously in Australia, resulting in the expectation that new mothers will

breastfeed (Lund-Adams & Haywood, 1995). The introduction of breastfeeding immediately after birth, demand feeding, rooming-in, and the decrease in complementary and supplementary formula feeding have become widespread practices in many Australian hospitals. Australia has made determined efforts to support the WHO's statements to protect breastfeeding (WHO, 1981) by encouraging health professionals to follow their 10 recognised guidelines when promoting breastfeeding (WHO, 1989). The Australian Breastfeeding Association, formerly the Nursing Mothers' Association of Australia (NMAA), has been a significant support for Australian women since 1964 and is dedicated to the promotion and protection of breastfeeding (Paton, 1997). The Australian Breastfeeding Association is one of the largest nonprofit self-help groups in Australia and its main purpose is to provide mother-to-mother support to breastfeeding women (Gigacz, 1999).

Breastfeeding initiation rates in Western Australia have been higher than the national average, and although breastfeeding rates have been declining in other states, 83.8% of Perth mothers still initiate breastfeeding during hospitalization (Scott, Binns, & Aroni, 1996). However, the Western Australian Child Health survey found that 26% of women reported ceasing their breastfeeding at 3 months (Australian Bureau of Statistics Institute, 1995). These findings are supported by Scott and colleagues' (1999) recent Western Australian study revealing that although 61.8% of women were breastfeeding at 3 months, this figure decreased to 49.9% at 6 months. Bailey and Sherriff (1992) found that Perth women cited not enough milk and sore nipples as the most common reasons for ceasing breastfeeding prior to 3 months.

## METHOD

The management of breastfeeding is a significant task for many women as it symbolises womanliness and motherhood (Bottorff, 1990). Perceived success with this experience can contribute to maternal self-esteem and confidence (Rubin, 1984). The meaning assigned to specific events such as breastfeeding and weaning by mothers can influence their perceptions and subsequent actions. This assumption supports the premise of symbolic interactionism, the theoretical framework for the grounded theory method that suggests that human behaviour toward items or persons is influenced by the meanings attributed to them (Blumer, 1969).

Glaser (1978) stressed the importance of the grounded theory method for generating explanations to account for patterns of behaviour. The process of managing the later stages of breastfeeding, and, ultimately, weaning was regarded as being influenced by social and psychological factors. The identification of potential basic social processes such as incompatible expectations, in this study, is central to the grounded theory method. The constant comparative method of analysis proposed by Glaser and Strauss (1967) was used and supplied the grounded theory method with its precision and specificity in systematically generating theory grounded in context-based data (Chenitz & Swanson, 1986).

The purpose of this study is to analyse the maternal process of managing the later stages of established breastfeeding and, ultimately, weaning the child from the breast. We considered a minimum time of 6 weeks postpartum to be established breastfeeding, as discontinuing breastfeeding prior to this time was not regarded as the weaning process but more an interruption in the establishment of breastfeeding. The definition of weaning was restricted to the process that begins when the mother

and/or the child decide to stop breastfeeding and the child receives fewer breastfeeds until he or she is completely nourished by other foods and drinks (NMAA, 1985).

Using the grounded theory method meant that we used the processes of data collection, coding, memo writing, and analysis concurrently (Glaser & Strauss, 1967). Data were collected from interviews, questionnaires, field notes, books, parent magazines, local newspapers, and web sites. Our ongoing data analysis and discovery of categories was guided by theoretical sampling. Initially, substantive codes were revealed through open coding (Strauss & Corbin, 1990). Data were broken down, compared, and conceptualised into categories using a line-by-line and then sentence-by-sentence analysis. Constant comparison assisted us in noting potential categories, properties, and dimensions within the data. We made comparisons throughout data analysis that progressed in coding levels from the line-by-line detail in participants' stories to putting data back together to reveal connections between categories and the core categories to conceptualise the story of mothers' management of breastfeeding and weaning. Conceptualisation of the story line was developed through data analysis and advanced through diagramming visual representations of categories and their relationships.

Twenty-nine participants were recruited from a larger study being conducted, 3 women responded to an advertisement in the local community newspaper, and 1 woman was recruited in person from the local community. Information obtained from the larger study was used to select women with a wide range of breastfeeding and weaning experiences, incorporating aspects such as breastfeeding duration, pace of weaning, and weaning strategies. As categories began to emerge, we became more selective in focusing upon specific issues. To illustrate, the emerging issue of guilt guided the choice of participants who felt dissatisfied with their experience and were able to elaborate on those feelings. During ongoing sampling, potential negative cases were also sought in an attempt to test or challenge the categories.

Prospective participants were contacted by telephone, and the principal researcher explained the purpose and involvement required for the study. All but 2 women contacted via telephone agreed to participate in the study. Once we obtained verbal consent, an interview time and date convenient for the participant was arranged. As most participants had one or several small children, it was more convenient to conduct the interviews at the participant's home. At the interview, we again clarified the study's purpose, and the participant and principal researcher signed a consent form. A copy of the consent form with contact telephone numbers was left with each participant.

Data from partners and child health nurses provided a form of triangulation whereby data from these significant people were utilised to corroborate categories revealed by the participants' data (Creswell, 1998). Nine partners responded to a postal questionnaire and provided data regarding their spouse's weaning experience. The nature of this data as feedback was generally brief aside from two partners who highlighted the difficulties their wives encountered during breastfeeding and weaning. The principal researcher interviewed 5 child health nurses and conducted a discussion group with 7 child health nurses.

The participant profile of the 33 mothers who were interviewed and had weaned a child within 6 months of participating is presented as follows. Mother's ages ranged from 20 to 47 years, with a mean of 33 years. Seventeen of the women were first-time mothers and the remaining 16 had two or more children. These recent weaning experiences focused upon the weaning of 33 children—17 males and 16 females.

The age of weaning for the children ranged from 6 weeks to 6 years. The breastfeeding duration ranged as follows: 7 mothers weaned between 1½ and 3 months, 7 weaned between 3 and 6 months, 3 weaned between 6 and 9 months, 6 weaned between 9 and 12 months, 4 weaned between 12 and 18 months, and 6 weaned after 18 months. Experienced mothers were also invited to discuss their previous weaning experiences with other children, resulting in a total of 53 weaning experiences being reviewed during the 33 interviews. All participants were Caucasian and living with a partner at the time of weaning.

Although many participants were not currently employed or were on maternity leave at the time of the study, 25 identified their occupations, which were diverse and ranged from waitress to secretary, receptionist, teacher, botanist, and engineer to highlight a few examples. Eight women indicated home duties for their occupation. Twenty participants had completed an achievement certificate or year 12 in secondary school; 5 had obtained a trade, apprentice, certificate or diploma from a postsecondary institution; and 8 had one or more university degrees. In relation to family income in Australian dollars, 3 participants had an income of \$20,000 or less per year, 11 had an income of \$20,000 to \$40,000, and 19 came from families where the annual income was greater than \$40,000.

Two major categories, a basic social problem and basic social process, emerged in relation to the management of breastfeeding and weaning. The process of constructing compatibility has been outlined elsewhere (Hauck & Irurita, 2002), whereas the focus of this article is the problem of incompatible expectations. Pseudonyms have been assigned to participants when presenting supporting quotes in the findings.

## FINDINGS

Participants approached their breastfeeding and weaning experiences with specific expectations and goals. Mothers' beliefs and knowledge about these mothering tasks influenced their expectations. Beliefs and knowledge were dynamic in that they changed or were further developed with each breastfeeding and weaning experience. Several factors influenced mothers' beliefs and knowledge such as exposure to expert sources, including health professionals, media, and written publications, for example; past experiences with previous children; current experiences of breastfeeding and weaning; the experience of significant others such as friends and family members; and, finally, input from their partners. Resulting expectations were often derived from a complex personal negotiation and compromise between all of these influencing factors.

Expectations in specific areas such as breastfeeding or weaning could not be separated easily from expectations of mothering. Participants viewed their performance with breastfeeding and weaning as a component of their whole mothering experience. Achievements or disappointments in one area overflowed to other areas. As one mother expressed, "Breastfeeding gave me one little link to a positive mothering side. . . . I felt that I was being a good mother in breastfeeding. It was rewarding, feeling satisfied within, being happy with your nurturing abilities at that stage" (Ann).

Participants were vulnerable and sensitive to the comments and opinions of others regarding their breastfeeding and weaning performance. The degree of sensitivity to comments did vary, but all comments, supportive or critical, were perceived by participants as a reflection on their mothering abilities, for example, "Other mothers

or older people would comment on, 'Are you feeding him right or are you sure he's getting enough?' . . . It didn't help, other people's comments, as if I was doing something wrong" (Julie).

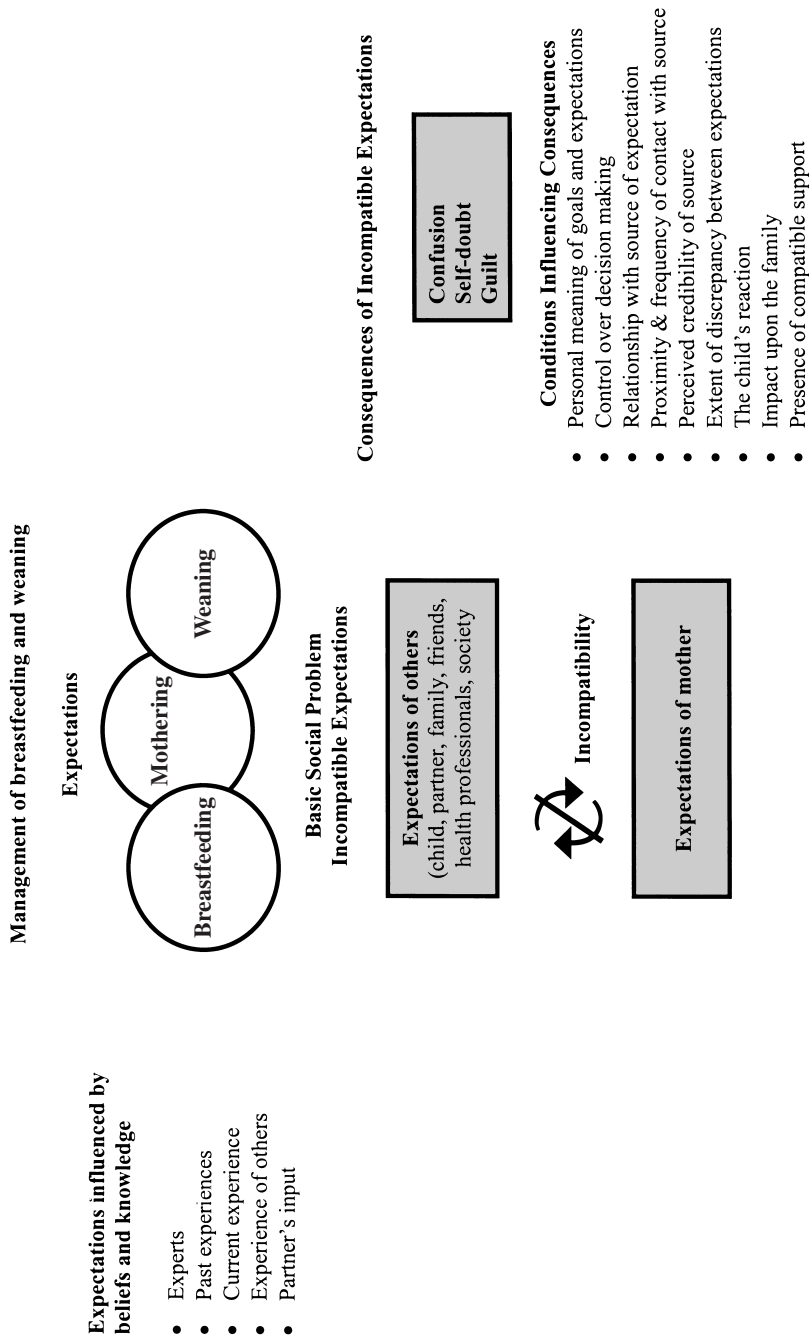
Advice on the management of breastfeeding and weaning was very forthcoming from family and friends, but acknowledgment and recognition for the effort displayed by mothers was not as prevalent as some participants would have liked. "[Family members said] 'You should stop feeding him by now.' Not one of them was interested in saying, 'You are doing a good job'" (Sue). Partners and child health professionals also commented that mothers did not receive the acknowledgment from others that they deserved for their efforts. One child health nurse stated, "I think that we don't give enough credit to mothers for mothering, really, as a society, this western society. We don't say, . . . 'You're doing really beautifully with your baby.' I try and do it. The people find it unusual to be getting praise for *something that is expected of you*. It's a hard job being a mum."

In order to feel that they were successful in their mothering role, participants used their expectations and the expectations of significant others as a benchmark to evaluate their efforts. Sometimes people openly expressed their expectations, whereas other expectations from family and friends were expressed as advice or implied from comments such as, "Why are you *still* doing this? You're sick . . . you're losing weight. Why are you trying to feed the child as well?" (Carol). The family members did not specifically tell the participant to stop breastfeeding, but this interpretation was clear to the mother. Another participant could not mistake her mother's intended message to stop breastfeeding, although she chose to ignore it: "Mum is of the opinion that they should be off the breast by 4 months anyway and when we went to [another Australian state to visit] that's what she said, 'Are you *still* breastfeeding her?' and it's like, 'thanks Mum'" (Mary).

The basic social problem of incompatible expectations is illustrated in Figure 1. All participants faced a common dilemma of how to manage their breastfeeding and weaning when exposed to conflicting expectations. Both experienced and first-time mothers acknowledged the presence of expectations although the specifics of the expectations differed considerably between individuals. Expectations were both self-imposed by the mothers and imposed by others. For example, mothers perceived the presence of expectations from the child being breastfed, other children, partners, family, friends, health professionals, and society.

Participants trying to manage their breastfeeding experiences were caught in the middle of the contradictory and confusing debate about the best or ideal way to manage breastfeeding and weaning: "[There are a] whole lot of set ideas out there about the right and the wrong way and you can really . . . get bogged down" (Carol). The answers to what was right and wrong were not always clear. There were no definite answers as new information continued to emerge, which challenged existing practices: "You tend to listen to what other people say and think, 'Oh am I doing the right thing'" (Nicole). Consequently, participants were left to sift through all of these differing opinions and suggestions, compare them with their personal goals and the reality of their experience, and discover a balance that was attainable and acceptable: "But you do feel a bit like a failure, you think, 'God, you know, all these people keep telling me this should happen and I should keep breastfeeding, but it wasn't happening'" (Beth).

All participants in this study noted areas of incompatible expectations in relation to their breastfeeding, mothering, and weaning. Figure 2 highlights the specific



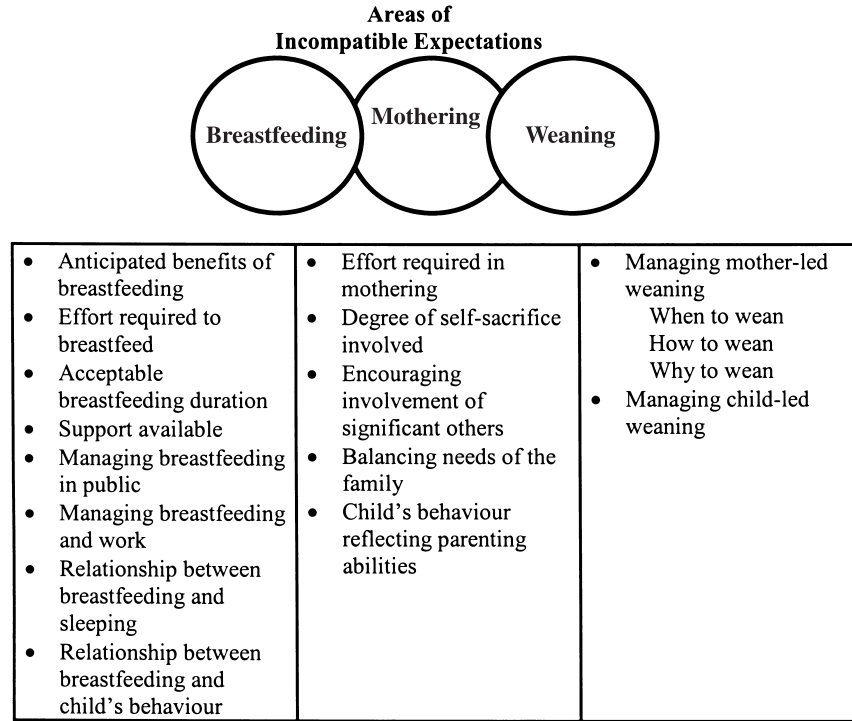
**Consequences of Incompatible Expectations**

**Confusion  
Self-doubt  
Guilt**

**Conditions Influencing Consequences**

- Personal meaning of goals and expectations
- Control over decision making
- Relationship with source of expectation
- Proximity & frequency of contact with source
- Perceived credibility of source
- Extent of discrepancy between expectations
- The child's reaction
- Impact upon the family
- Presence of compatible support

**Figure 1. Basic Social Problem: Incompatible Expectations.**



**Figure 2. Areas of Incompatible Expectations.**

areas where such incompatibilities were described. A select number of incompatibilities will be discussed to further illustrate this problem. All participants agreed that breastfeeding was best for an infant, but there was little conformity between expectations concerning the appropriate duration for breastfeeding. Some participants did not have a specific expectation for weaning but felt that any breast milk was valuable regardless of breastfeeding duration: "He had my nutrients so he had a good start" [weaned at 10 weeks] (Diane). This expectation was reinforced by some health professionals who acknowledged women for any efforts with breastfeeding, regardless of the duration.

The assumption that only babies are breastfed influenced people's perception of appropriate limits for breastfeeding: "I felt like he wasn't a baby anymore, he had grown up" (Pam). Weaning a child from the breast symbolised the transition from babyhood to toddlerhood: "My baby wasn't my baby anymore. You know that he was growing up" (Tracy). Weaning acknowledged this loss of babyhood: "I was letting go my baby" (Paula). When assessing readiness to wean, participants had to resolve this issue of timing according to their child's developmental age. Did they want to continue breastfeeding a baby, toddler, or preschool child? "Fourteen months just seemed kind of nice because he was still sort of babyish, he wasn't really a little boy yet. . . . He was getting on the solids really, but I just felt for me really it

was, I felt comfortable at 14 months” (Gwen). If the child initiated weaning prior to the mother’s desired boundaries for breastfeeding, the mother often expressed disappointment in not meeting needs perceived by her as being important for that stage of development: “She was only 10 months [child-initiated weaning], and I felt she was still a little baby and she still needed me [needed breast milk]” (Tracy).

Perceptions of the appropriate duration to breastfeed a child were revealed to participants by others’ subtle and not so subtle comments: “Isn’t that baby old enough to, isn’t that toddler old enough to be off the breast now” (Paula). Once participants approached or even exceeded the period of 12 months, the frequency of these comments increased: “And then towards the end [toward the end of the second year] he’d [partner] say, . . . ‘We’ve got to stop this. . . This has got to stop. When are you going to stop? She’s still going to do it when she’s five years old’ ” (Helen).

The reality of having to deal with sources whose expectations were incompatible with their own resulted in specific consequences for these women. Participants expressed feelings of confusion, questioned and doubted their own abilities, and shared the guilt they felt when confronted with this dilemma: “There was so much going [on] around me. Mother saying this and Auntie saying that and somebody else, a friend, saying this and it’s just so confusing” (Gwen). Confusion was often the first emotion expressed by participants when they became aware of conflicting expectations. First-time mothers with no previous parenting experience were especially vulnerable because, as awareness of this conflict became a reality, they were often unsure of how to respond: “Being a first mum like . . . you want to go ahead and do the breastfeeding and you’re not sure what to do because there’s no manual. . . She didn’t come with instructions or neither did my body at the time” (Beth).

In addition to feelings of confusion, participants also revealed how being forced to deal with differing expectations resulted in them questioning and doubting their own competence in choosing options and making decisions. The resulting dissonance between expectations impacted upon participants’ self-concept and self-esteem: “I remember crying, thinking it was just not fair, you know, you set yourself up to be so perfect” (Ann). Perceptions of achievements in their mothering role were important to participants, but this feedback was also provisional upon input from others: “Sometimes you tend to listen like when your friends make comments and you think well maybe I’m a bad mother” (Nicole). This perceived threat to their mothering self-concept resulted in women questioning their abilities to make decisions regarding breastfeeding and weaning. All participants had expectations regarding their breastfeeding and weaning experiences. When anticipated breastfeeding and weaning goals contradicted others’ expectations, participants wanted to know why?: “But why should I need this help? Why shouldn’t I be able to feed all day and get two minutes sleep, cook the dinner and be all pleasant and lovely and be able to go out and things like that” (Helen).

The final emotional consequence of incompatible expectations for these Western Australian women was guilt: “I think I felt guilty and depressed about, ‘Have I done the right thing’ ” (Pam). The issue of guilt was a recurring feature in most interviews. Participants continually assessed their mothering abilities based upon their expectations and the expectations of others. When an unforeseen incompatibility between expectations arose, participants could not ignore this fact. Because breastfeeding was perceived to be their sole responsibility, the confusion, self-doubt, and questioning were directed inward resulting in feelings of guilt: “I was feeling very guilty [for stopping breastfeeding] and I didn’t know what to do” (Sally). One partner of a

participant wrote, "Women when at their most vulnerable are made to breastfeed by the 'establishment.' If they can't, they are made to feel like second class citizens (failures)."

The degree of confusion, self-doubt, and guilt were influenced by the presence of specific conditions. Two of the conditions were related to mothers' individual expectations such as the personal meaning they attached to their goals and expectations and the importance of their perceived control in regard to decision-making. Additional conditions were related to other sources of expectations such as the breastfeeding child, partners, family members, friends, health professionals, and society. The relationship of the source to the mother, the proximity and frequency of contact with the source, the extent of discrepancy between the expectations, and, finally, the perceived credibility of the source all impacted upon participants' feelings when dealing with incompatible expectations. The remaining conditions involved the breastfeeding child's reaction, the impact upon the family, and the presence of some degree of compatible support.

The meaning or significance of participants' goals and expectations was a major influence on how they dealt with the problem of incompatibility. The meaning participants attached to their expectations influenced the level of commitment they invested in accomplishing their goals: "There's a sort of a fairy tale and then there's a reality, a harsh reality, and it also comes back to, . . . 'What are you actually prepared to do'" (Linda). The level of determination that participants felt toward honouring their goals of continuing or discontinuing breastfeeding, in the face of opposing expectations, affected how they responded to conflicting expectations: "I was still determined that I wanted to breastfeed to at least 12 months. So I stuck to it" (Tracy). Participants with very specific expectations and goals would put in added effort to meet their intentions.

Participants expected to have some degree of control over their breastfeeding and weaning. When they felt that the timing of the weaning was right, it often reflected recognition of readiness in both the mother and child. If mutual readiness was achieved, weaning progressed relatively easily. Some participants expressed satisfaction when they were able to assess this readiness and respond accordingly: "And I gave up because I wanted to and I did it over about a month. . . . I always enjoyed the second one because of that, because I was able to decide when I wanted to" (Gwen). Participants discussed particular unanticipated instances where they felt their control of decision-making was at risk: "You don't picture all those sorts of things you've been out of touch or control with, epidurals and Caesareans" (Ann). Participants pushed to make decisions before they were ready found this difficult to accept. There were several situations when participants felt forced to wean before they were ready. Examples of life events that necessitated prompt or undesired weaning were work commitments, another pregnancy, irreconcilable physical problems, maternal illness, medications that were contraindicated for breastfeeding, or unanticipated travel requirements.

The relationship between the source of expectations and the participant influenced the degree of confusion, questioning, and guilt that eventuated. The importance of this relationship to the participant influenced the impact of these consequences. A long-term close relationship with a partner or family member, such as the grandmother or mother-in-law, often was more meaningful to participants than a temporary relationship with a health professional or a brief encounter with a stranger at a supermarket or restaurant. Although participants noted conflicting expectations from

many people, the proximity of these persons and the frequency of contact influenced their impact upon the participants. Close, constant interaction with someone whose expectations contradicted their own caused some participants particular distress, for example, "She [mother] came over [from another state] for the birth, but that's another story. That was a nightmare, but I found that her help [with breastfeeding] was more a hindrance than help" (Mary). Close, frequent interaction with someone whose expectations coincided with theirs supported and reassured participants, whereas constant exposure to people whose expectations were contradictory accentuated the confusion, self-doubt, and guilt experienced.

Certain people exerted greater influence over participants than others, in relation to breastfeeding and weaning decisions. The perceived credibility of the dissenting person influenced how the participant dealt with their advice and expectations. Participants assessed the person's credibility based upon their knowledge of breastfeeding and practical experience. Many participants anticipated that health professionals would have the greatest knowledge on breastfeeding and weaning: "I looked to the clinic nurse to see what I was doing right. They stipulate everything and once hearing from them that I had done the right thing, 'Don't feel guilty, you've given him the best'" (Pam). Health professionals were generally regarded as having the most up-to-date information, but their credibility was lost if participants felt that they were giving inaccurate or outdated advice: "I can't be specific [concerns with outdated advice], I just wouldn't go to her [child health nurse] for advice. I'd join the Nursing Mothers' Association" (Lisa). Because participants were exposed to many sources of information, both personal and in written form, often they were able to determine when advice was outdated. To demonstrate, when one grandmother offered her advice the breastfeeding mother responded, "I'll just actually run that by the clinic sister which I know that book discusses too.' . . . It was like things have changed, babies still come out the same way, . . . but ideology has changed hasn't it" (Linda). If advice from one source conflicted with other sources, mothers became confused but then verified the suitability of that advice with perceived credible sources. Some participants lost confidence with certain health professionals, questioned their information, and became discriminating in accepting any advice.

A further condition that influenced the amount of confusion, self-doubt, and guilt experienced was the degree of discrepancy between differing expectations. A smaller degree of discrepancy did not cause the same amount of distress to participants as a larger degree. All partners of the participants were initially supportive of breastfeeding, so no one experienced a wide discrepancy between their partners' wishes and their own regarding breastfeeding. As time progressed, however, incompatible expectations did become apparent for some couples. The following example illustrated different expectations between parents in relation to the initiation of weaning: "I was also getting heaps of pressure from my husband by that stage to stop [pressure intensified at 18 months]. He, I think, had a bit of a hang-up basically with her breastfeeding when she was an older child [20 months], which I didn't really have" (Helen).

Participants faced with incompatible expectations monitored their child's reaction to breastfeeding and weaning decisions. Children who were happy, thriving, and contented were interpreted as having their needs met. These criteria reassured participants that their judgement in making specific decisions was appropriate for their child and reflected good mothering skills. Participants who felt that their child's needs and expectations were not being met faced the dilemma of deciding what

changes to make to reach this goal. Unfortunately, the amount of incompatible expectations placed upon the mother during this time often increased. Family, friends, and health professionals who were aware that the child was not contented or thriving as anticipated offered more advice, information, and opinions, such as, “Your milk’s getting too thin, obviously your milk’s drying out or you’re not eating well enough” (Gwen). The underlying message interpreted by participants was that they were doing something wrong, “Maybe it was the fear of feeling that you’re useless. . . . You can’t do anything right” (Gwen), which contributed to their self-doubts and guilt.

The impact of the consequences of incompatible expectations upon participants was influenced by how these expectations were affecting their immediate family. The reaction of the child to decisions on breastfeeding and weaning were identified as a major category and discussed previously. However, the impact upon the immediate family related directly to the recognised outcomes of breastfeeding and weaning decisions upon other family members, such as the partner and siblings of the breastfed child. If mothers perceived their partner or other children were being harmed or disadvantaged in any way due to their decisions, it put them in a dilemma. Participants then had to weigh the advantages or disadvantages of their breastfeeding and weaning decisions upon the family as a whole: “I felt very guilty [stopping breastfeeding], but it was just the point that I couldn’t, I was physically drained. It was affecting the relationship with my husband because I was always cranky” (Pam). Participants shared stories of how they were concerned with the impact of their breastfeeding or weaning goals upon their other children: “As she got older, it [breastfeeding] was more, putting him [older sibling] out more” (Emily).

Participants who had a supportive network of people with congruent expectations were better able to deal with comments from persons with conflicting views. Some people were especially understanding to participants because they felt their expressed expectations were acknowledged and respected. Participants stated how they benefited from this compatible support: “I was quite happy that no one else sort of said, . . . ‘At least you could’ve tried a bit more or whatever.’ So I was happy that everyone was supportive of what I’d done” (Beth). Compatibility meant there was no conflict present in the relationship and the mother and other source were working toward similar expectations and goals. Participants experienced less confusion, self-doubt, and guilt in the face of incompatible expectations if they had a supportive network of people around them whose expectations were in agreement with their own beliefs. Greater support was not guaranteed with more people being available to the mother. In fact, support referred to the comfort and reassurance offered by a single person or small group of people who agreed with the participant’s expectations or who were at least willing to acknowledge and respect the mother’s wishes should they differ from their own.

## DISCUSSION

The findings of this study have particular significance for health professionals in promoting awareness of women’s breastfeeding expectations and their associated meaning with mothering, acknowledging efforts in breastfeeding, reinforcing the issue of informed choice, and using anticipatory guidance.

Although participants expressed a wide range of expectations regarding their breastfeeding and weaning, they revealed that these expectations could not be considered separate from expectations regarding mothering. Interpretations by self and

others of their performance were seen to be a reflection of mothering competency. Based upon these findings, health professionals need to be aware of the significance of the tasks of breastfeeding and weaning to individual mothers. Women could be encouraged to explore the meaning these tasks hold for them and to share this information with health professionals, thus enabling care to be tailored to their individual needs. In his scholarly discussion of the social construction of self, Russell (1999) offered a framework whereby people identified what was important to them and how they defined themselves. This reflexive practice is compatible with the role of health professionals who could encourage mothers to clarify and articulate their expectations and goals regarding their own breastfeeding, weaning, and mothering experiences. Finally, if health professionals are aware of individual mother's expectations, they will be better able to support these goals and acknowledge the efforts undertaken to reach the goals.

Health professionals had a significant impact upon participants in this study who expected unconditional support for their decisions. However, often they received information and support that was conditional upon meeting the expectations of the health professional. The issue of whether mothers are truly informed of all relevant aspects of infant feeding when making decisions must be questioned in view of the findings of this study that suggested participants received conflicting and at times outdated and biased information from some health professionals. The provision of evidence-based breastfeeding information without bias or prejudice is an important obligation of all health professionals (Harding, 2000; Jamieson, 1995; Newman, 1997). As Dykes (1995) claimed, "Women are entitled to research-based, up-to-date information about breastfeeding . . . only then can they be said to have real choice" (p. 545). Walker (1993) argued that the paternalistic attitude of protecting parents from "knowing the possible consequences of making poor choices . . . robs them of their right to informed decision-making" (p. 103).

In order to make an informed decision women should have access to infant feeding information relevant to both infant and maternal health that includes physiologic, psychosocial, and environmental factors. Breastfeeding often is promoted as an infant health issue with minimal emphasis given to maternal health issues (Dermer, 1998). After all, maternal decisions are influenced by physical, social, ideological, and political factors defined by the culture in which they live (McDade & Worthman, 1998). Women have the right to be informed of the realities of breastfeeding as revealed in recent qualitative studies that have explored the subjective experience of breastfeeding and motherhood (Barlow & Cairns, 1997; Hartrick, 1997; McVeigh, 1997; Rogan, Schmied, Barclay, Everitt, & Wyllie, 1997; Stearns, 1999; Weaver & Ussher, 1997). These studies provide an understanding of collective experiences and variations within individual breastfeeding experiences. Personal realities endured by many breastfeeding women are rarely presented in the literature as findings and may reflect some "resistance to the demands of the pro-breastfeeding rhetoric and child centred discourses of mothering" (Schmied & Barclay, 1999, p. 332). The provision of this subjective information on breastfeeding and mothering could assist women to develop realistic expectations and reduce the possibility of perceiving their experience as a failure due to unrealistic expectations. Promoting informal women-to-women support could also enable new mothers to feel comfortable sharing their feelings and not be embarrassed to seek the support needed for breastfeeding and weaning. Continuing myths associated with mothering and breastfeeding must not be perpetuated. Sharing the realities of these experiences provides women with an

understanding of the realistic variations within breastfeeding and weaning experiences.

Expectations regarding breastfeeding and weaning directly influenced participants' plans and goals during their experience. Therefore, once health professionals have a clear picture of women's expectations they could utilise anticipatory guidance to assist mothers in assessing the realistic nature of these goals. According to Pridham (1993) the purpose of anticipatory guidance is to prevent undesired consequences or conditions based upon expert knowledge. Participants based their expectations upon their beliefs and knowledge regarding breastfeeding and weaning. Although experts were cited as one source of knowledge, these women also utilised their past and current experience, the experience of others, and their partners' input to influence their expectations and subsequent goals. Additionally, being aware of areas where incompatible expectations were noted by mothers could assist health professionals to target those areas when offering support (Figure 2). For example, examples of incompatible expectations emerged in this study due to unrealistic expectations in relation to the effort required for breastfeeding or the relationship between sleeping and breastfeeding. Health professionals perceived as credible sources of information could use anticipatory guidance to correct and dispel myths and incorrect advice offered from sources such as the media, family members, friends, and acquaintances. Finally, if women could anticipate the reality of incompatible expectations they may not feel the degree of confusion, self-doubt, and guilt that participants in this study experienced.

## CONCLUSION

In closing, these women from Western Australia have provided insight into the realities of managing their breastfeeding and weaning decisions. Although the dilemma of incompatible expectations was noted in a society that firmly advocated breastfeeding, the concept of incompatible expectations could be further explored within different contexts, such as a predominantly formula-feeding society. As stated by Strauss (1987) this process of exploration can provide an "eye-opener" to the reader who is given "a new way of seeing what we all know that's very useful" (p. 20). As revealed in this study, the experiences of breastfeeding and weaning and their impact upon mothering perceptions cannot be ignored. It is only fitting to reinforce these final statements with a quote from Swigart's (1998) discussion of the myth of the perfect mother:

It is not surprising that many women remain shy and mute when asked to speak honestly and openly about the experience of mothering. . . . To be found wanting as a mother is the worst crime most women feel they can commit. . . . The underlying meaning of this competitive spirit seemed to be the need to reassure themselves and others that they were not bad mothers; that they had done a good job raising their children. (p. 103)

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