Exploration of Guilt Among Mothers Who Do Not Breastfeed: The Physician's Role

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Abstract

Physicians commonly state the concern that, if they promote breastfeeding, they may "impose guilt upon those who do not breastfeed." This article explores the genesis of this fear, who may benefit from this construct, and the terminology of guilt, shame, and loss. The article also explores the responsibility for both lactation failure and associated shame, considering the roles and responsibilities of physicians, the media, and society as a whole. An alternative construct for the guilt is offered, based on the consideration that the woman experiences lack of breastfeeding as a loss at some level, conscious or subconscious, and whether the choice to not breastfeed is her decision or imposed. Proposed approaches for acting to prevent and to treat shame and guilt are presented. *J Hum Lact*. 24(1):80-84.

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Exploring "Guilt"

This transdisciplinary exploration of guilt and physician's roles necessitated repeated review of many documents,[1-13] identifying subtleties and commonalities throughout. The following is an amalgamation, expansion, and an occasional "next generation" of the ideas, concepts, and consensus drawn from these many documents, including those referenced later in the text, stemming from the author's conclusion that the "guilt" of not breastfeeding stems from loss of expectation, whether conscious or unconscious, and the associated essential physician's role in prevention, diagnosis, and treatment.

> When we feel guilty we need to learn that it is okay to have erred or failed. If we do not learn this, we will hold onto our guilt, and to our irritation with those who succeeded.[14]

What Is Guilt? What Is Shame?

Cultural anthropologists define shame as failure to realize one's own or society's expectations. Guilt is defined as the set of feelings experienced when one has done wrong, or has violated internal values. In the psychological literature, shame is a condition stemming from religious, political, judicial, and social control consisting of ideas, emotional states, physiological states, and a set of behaviors, induced by the consciousness or awareness of dishonor, disgrace, or condemnation. The difference

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between guilt and shame may be summarized as follows: You feel guilty for what you did not do, but are ashamed of having "failed."[1] If not addressed and expunged, shame may "mature" into guilt.

Who Should Be Bearing the Guilt for Breastfeeding Failure?

From the Rights Perspective

The Convention on the Rights of the Child[15] notes that it is every child's right to a healthy start in life and, therefore, among other dictates, is the consideration that all parents should be informed about the importance of breastfeeding. Given that being breastfed is a child's right, the mother is placed in the position of duty-bearer to the child; no one else is able to take on this particular duty, save the mother. However, in the rights construct, the mother can only be expected to accept this duty if responsibility is also accepted by those around her to fully enable her in this role.

It is therefore the responsibility of the family, the workplace, the health care provider, the third-party payer, and society as a whole to ensure that she has all necessary information and support that she may need to choose and succeed in breastfeeding. If this support is not provided, these others are the ones to bear the guilt of not fulfilling their responsibilities. No mother can or should be expected to fulfill this duty unless all fulfill their responsibilities to the mother. The guilty parties in this construct are policy makers, health care providers, and society in general.[16]

From the Physician's Perspective

The ability to choose what is best for the health of children is considered a universal parental right. It is the physician's responsibility both to communicate accurate information about healthy behaviors and to support the parents' efforts to achieve them. Physicians often use parental guilt to reinforce adherence to use of car safety seats, seat belts, bike helmets, and immunizations. However, such strategies are inappropriate if the parent is unable to comply. Shaming a mother, or inducing guilt, when action is not possible may justifiably lead to anger.

The physician's own past experiences, choices, and behaviors affect their communication with patients. For instance, subconscious justification, "I will not make women feel guilty for not breastfeeding/not exclusively breastfeeding, because I don't want to feel guilty for my child not having been breastfed/exclusively breastfed." This may give patients the message that not breastfeeding is good health behavior.

If a physician does not have sufficient knowledge or skills with respect to breastfeeding, it may be difficult for him or her to admit this to a patient. The patient may perceive the physician's attitude and commentary as an indication that she, the mother, has a problem or has done something wrong. This would be much more likely to lead to maternal guilt than if she were to "fail" to breastfeed under the care of a physician who admits a deficit and provides referral. In addition, if a physician does not possess these skills, he or she may respond with subtle frustration, or even anger, toward the mother/baby. This may lead to rapid or random referral to other health care providers, sending the message that a mother's breastfeeding is an irritant, a problem issue. The physician, frustrated by his or her inability to "fix it," may then construct an excuse for himself or herself for his or her lack of knowledge and skills: "Encouragement to breastfeed would make the patient feel guilty if she does not succeed."

Taken a step further, these responses and rationales may also allow physicians to justify and seek acceptance of incentives and gifts from the commercial sector, including formula companies. This rewards provision of partial, possibly misleading, information and lends "social/societal" support to their lack of encouragement of breastfeeding.

Therefore, if a physician wishes to avoid stimulating guilt feelings in the patient, the proper response is to work on increasing his or her own skills and knowledge, to support a personal, rapid, and appropriate referral for the patient with ongoing follow-up, and to avoid commercial alliances. The most inappropriate response is to "fall back on" the commercial alternative. This latter response also leaves the patient feeling like a failure, with self-recrimination and concomitant guilt. To quote Dr Nancy Wight, "As ethical, caring professionals we owe our patients accurate information, appropriate guidance and long-term support. Let us continue to promote what is *best* for infants."[17]

Maternal Guilt as a Marketing Ploy

Women who receive antenatal counseling on breastfeeding are more likely to initiate breastfeeding as well as to breastfeed longer.[18] There are reports that women who choose to formula-feed could have been persuaded to breastfeed if a health care provider had counseled them about the importance of breastfeeding.

To experience guilt, one must first perceive that there was something important that one did not do. Dr Jack Newman notes that the women who make an informed choice to bottle-feed do not feel guilty.[19] Rather, it is women who want to breastfeed, or attempt to breastfeed, but who were unable to breastfeed who feel guilt. Dr Newman suggests that to prevent women from feeling guilty about not breastfeeding, promotion of breastfeeding coupled with good, knowledgeable, and skillful support is required, not the avoidance of promotion of breastfeeding.

It is important to recognize that guilt can be good, when it serves as a motivator to "do the right thing." Guilt can serve as a tool, if properly channeled, to encourage "good" activity. But guilt also can be a burden and can be used to manipulate and exploit. Jean Kilbourne, in *Deadly Persuasion*, proposes that guilt-based advertising is a powerful tool in manipulation, particularly of young women.[20] She proposes that such advertising has led to many unhealthy behaviors, such as smoking and anorexia, seen in this demographic group. If guilt can be manipulated to provoke self-destructive behaviors, it can and will be used to support purchase and use of commercial products.

Objectification of the breast in advertising and marketing is not only a men's magazine approach. The recent *BabyTalk*[21] cover, which included a photograph showing only a large breast and a happy baby face, could also be seen as an objectification of the breast, perhaps in this case as a substitute for a bottle. There is no mother in the picture and certainly no image suggestive of interactive mothering. The offense taken at this objectification was interpreted by the media as anti-breastfeeding, when, in fact, the negative feelings may stem from the perception that all that is needed in breastfeeding is a disembodied mammary gland. This image is not one that "advertises" breastfeeding, but rather seems to be more similar to media that exploit the breast. Such an image does not serve to support breastfeeding as the important mother-baby relationship that it is.

Guilt Is Perhaps the Most Painful Companion of Loss

Feelings of loss and of anger can occur when expectations are not met or when one does not get what one wants. When a mother cannot or chooses not to breastfeed, she experiences a loss, consciously or subconsciously. This may augment feelings of loss associated with missed expectations in the birth experience or birth outcomes, such as the loss of "the perfect baby."[22] When a person experiences loss and grief, experiencing and accepting these feelings is an important part of the healing process. These 5 stages of grieving when a loss occurs, originally developed by Kubler-Ross for dealing with death and dying,[23,24] require support and care to support healthy healing.

The 5 sequential stages are:

Denial, numbness, and shock. This stage may serve to protect the individual from experiencing the intensity of the loss, and may be perceived by the casual observer as lack of caring about the loss. The feeling of numbness can last from hours to weeks. These feelings of denial diminish as the individual is able to acknowledge the experience and the associated feelings.

Searching, yearning, disorganization, and anger. Feelings commonly experienced are intense sadness, fear, relief, irritability, and guilt. Anger may result from feelings of resentment due to the perceived injustice of the loss. Sometimes anger is not directed at the loss, but instead toward another individual or group of individuals. Shame may prevent this anger from being targeted at the baby, so other targets are sought. During this phase, the mother is beginning to deal with the loss of the expected breastfeeding experience, and may feel disorganized, as well as needing to learn, and evaluate, the unexpected new experience. Inasmuch as bottle- and formula-feeding are normative in many settings, she may also be unable to discuss these feelings, as others may not perceive that there is any reason that she should be feeling any loss.

It is at this point that the mother who may have failed at breastfeeding, or has chosen not to breastfeed, may recognize and acknowledge that she is angry and will seek an explanation and/or focus for the anger. As the mother recognizes and acknowledges that she is angry, she may experience guilt for feeling that anger, since she is unable to find an external focus for that anger. Is it her child? Her physician? Other women, who may by their very success in obtaining what she has lost may seem to taunt her. The easiest target is often herself, and guilt will emerge as a result of "what she did not do." Although these feelings are natural and should be respected and addressed to resolve the grief of the loss, this is also a time when the feeling of guilt is open to manipulation or to resolution, depending on the support and care experienced.

Bargaining. Some individuals become preoccupied with the notion that they may have been able to prevent

the loss, and can get caught up in a cycle of self-recrimination when considering and reconsidering the way in which things could have been better, imagining all the things that will never be. Although this stage can provide insight, if not properly resolved, intense feelings of remorse or guilt may hinder the continuation of the healing process.

Depression. After recognizing the extent of the loss, some individuals may experience depressive symptoms, including sleeplessness, feelings of loneliness, emptiness, and isolation. Self-pity can also surface during this phase, contributing to this reactive depression.

Acceptance and reorganization. Over time, if the mother is given the opportunity to resolve the range of feelings that surface, healing can occur, and guilt and anger may decrease or resolve. However, for this to occur, she must fully integrate the "new" state as her own set of life experiences.

Helping the Mother Through the Stages of Grief and Loss

There are many approaches to the understanding and support for those experiencing grief, loss, and guilt. We in modern technological society prefer quick and easy remedies. For physicians, "pharmakos," Greek for "the rite of healing," may be the best approach in addressing the processes that lead to guilt and for supporting acceptance of the choices made.

There are at least 4 approaches to working through the stages of guilt resolution:

Self healing. Some women will come to terms with the choices and nonchoices that have occurred, and will not harbor guilt, shame, or anger. Some will recognize the feelings while being unable to resolve them, but they are still able to channel them in a constructive manner, such as providing additional care to themselves or other family members ("constructive affliction"). Other women have attentive supportive networks, whether family, friends, or others. This can allow healthy resolution of the internal conflicts that could lead to guilt and anger.

Religion. In many religions, there is support to help individuals address guilt or shame. Generally this support occurs through 5 stages: (a) Remorse (experiencing the necessary negative feelings related to loss or failure); (b) recanting the behavior or lack of behavior; (c) responding through rectifying the negative experience, where possible, or through other productive activity; (d) resolution of the internal conflict, or conflict with a higher power; and (e) reconciliation with oneself and the universal/eternal.

Psychology. The psychological reactions to loss or unmet expectations include fear, anxiety, anger, or depression. Each of these should be recognized and appreciated. They are reactive disorders and may be addressed with short-term therapy. Inadequately addressing these feelings can lead to guilt.

Pharmakos—"the rite of healing." Failure to progress through the previously mentioned stages of grief can result in delay of healing. The physician should recognize that there are factors that may hinder the healing process, including avoidance or minimization of the mother's positive and negative feelings and emotions, maternal use of alcohol or drugs, and maternal "overfunctioning" at mothering or at the workplace to avoid feelings. The physician can make the following suggestions to the mother to support the healing process:

- Allow time to experience thoughts and feelings openly.
- Acknowledge and accept all feelings, both positive and negative.
- Use a journal to document the healing process.
- Confide in a trusted individual; tell the story of the loss and/or trauma.
- Express feelings openly. Crying offers a release.
- Seek to identify if there are any related issues, try to address them and come to a resolution that relieves you of any untoward feelings.
- If the mother is open to it, suggest that religious and social groups may provide an opportunity to share experiences with others who have experienced similar losses.
- Ongoing follow-up with the physician and/or referral for professional help.

In summary, physicians must provide evidence-based health care advice and counseling with respect to breastfeeding promotion and support. If the patient cannot or chooses to not follow this advice, and consequently experiences guilt, the physician could not have prevented this outcome. However, the physician can facilitate healing by recognizing the significance of this experience to patients, encouraging communication about feelings and concerns, and supporting mothers to achieve closure. Table 1 summarizes some of the considerations for physicians to consider in helping women to resolve anger and avoid the feelings of guilt, derived from many of the references cited. In conclusion, the essential role of the physician is to ensure that

Table 1. Counseling and Supporting Mothers Through the 5 Stages of Grief,[23, 24] With Respect to Loss of Breastfeeding

1. Denial
   This may be a stage when communication with the patient is limited. The best response may be, "I am available to talk to you about your birthing or feeding experience, whenever you are ready." Ongoing supportive contact is vital.
2. Anger
   The physician should (a) understand that the mother is not necessarily angry at the physician. It may be difficult to support a hostile patient. To take the mother's anger personally does not help resolve negative feelings. The physician should (b) know that anger when things do not proceed according to expectations or desires is natural. Talking about feelings of anger can help ensure that there is productive focus for this energy. The tendency to turn the anger inward, creating guilt, or outward against those who succeed in breastfeeding where they "failed" can thus be avoided. The physician should (c) communicate reflectively and nonjudgmentally.
3. Bargaining
   Bargaining is a normal defense mechanism. Patients may have unrealistic expectations from physicians ("fix my child's congenital problem," "make my missing glandular tissue produce milk," etc). Accept the mother's behavior, even though her requests and wishes may seem unrealistic, and discuss realities. Additional counseling services may play a constructive role in helping the mother deal with unmet expectations that may be associated with guilt.
4. Depression
   This is a reactive depression; for some mothers, short-term therapy may be indicated. For all mothers, support by the physician and the family should be encouraged, and referral to support groups might be considered. The words you use to express your advice and support are extremely important, especially when addressing what form of additional counseling the patient may find acceptable. For example, a patient who hears "I think you need a priest/rabbi/religious counselor/shrink" from a health professional may feel additionally guilty or ashamed. A more effective way to communicate the need for considering counseling intervention might be, "I have been giving thought to the (anger/guilt/sadness/confusion) you shared with me. I would like to suggest that, in addition to speaking with me about it anytime you wish, you may wish to discuss these concerns with your (pastor/priest/religious counselor/psychological counselor/etc)."
5. Acceptance
   At this stage, the patient may benefit from the physician's support and confirmation of appropriate adaptation. Reconfirm to the patient, with examples, that she is a good mother, and counsel her if she is seeking ways to further improve her mothering and health care skills.

his or her own knowledge and skills are sufficient to enable optimal breastfeeding, thereby reducing any possible maternal feelings of failure, and to assist in patient healing.

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