Maternal Guilt and Shame in the Postpartum Infant Feeding Context: A Concept Analysis

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Study highlights

Guilt and shame possessed unique attributes, antecedents, and consequences

Guilt and shame also shared overlapping attributes, antecedents, and consequences

Constructed definitions evidence overlapping and concept-exclusive characteristics

Definitions can be used to address risk factors, to prevent guilt and shame

Future research should aim to empirically support concept analysis relationships

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Abstract

Background

After birth, guilt and shame are differentially experienced by breastfeeding and formula feeding mothers. Despite this, currently utilised guilt and shame definitions lack context specificity, leaving concepts open to misinterpretation.

Objective

The current study aimed to develop infant feeding-specific definitions of postpartum guilt and shame.

Methods

Study selection involved a three-stage systematic screening process, outlined in Jackson et al (2021). Walker and Avant's (2005, 2019) concept analysis framework was then applied to included articles to identify guilt-specific, shame-specific, and overlapping attributes, antecedents, and consequences.

Results

A guilt-specific, shame-specific, and overlapping definition were generated based on exclusive and overlapping antecedents, attributes, and consequences. Guilt and shame belonged to the empirical referent *Moral Emotions*, which may explain some of the overlapping antecedents, attributes, and consequences identified during analysis.

Conclusions

The overlapping definition provides a broad scope for shared characteristics, while specific definitions allow for more in-depth and focused investigations of guilt and shame experiences within an infant feeding context. Utilising context-specific definitions may serve to improve research homogeneity. Shame was found to be uniquely associated with postnatal depression. As such, suggestions are made for future research to further investigate the relationship between shame, infant feeding, and maternal wellbeing outcomes.

Implications

Identified antecedents may be used by healthcare professionals to provide additional support to mothers at risk of experiencing guilt and shame, to prevent the occurrence and consequences of these emotions.

Keywords

Breastfeeding

Infant formula

Postpartum

Guilt

Shame

Morals

Introduction

Breastfeeding is associated with positive maternal and infant health outcomes (Horta et al, 2015a, 2015b; Victora et al, 2016). As such, the World Health Organisation (WHO) recommend exclusive breastfeeding for the first six months postpartum and continued breastfeeding up to two years postpartum (UNICEF, 2017a). The disparity between breastfeeding intention and initiation and breastfeeding duration to six months postpartum is present in many developed countries (Australian Government: Department of Health (AGDH), 2019; Chalmers et al, 2009; Centers for Disease Control and Prevention (CDCP), 2019; Theurich et al, 2019). For example, according to the last UK Infant Feeding Survey, 66% of pregnant women intended to exclusively breastfeed, and an additional 10% intended to breastfeed to some extent (McAndrew et al, 2012). Despite high rates of breastfeeding intention and a large proportion (81%) of UK women initiating exclusive breastfeeding, few (1%) exclusively breastfeed to six months postpartum (McAndrew et al, 2012). Given these trends, exploration of the barriers to successful breastfeeding should be of paramount importance for infant feeding research.

For many women, the inability to meet breastfeeding intentions is a perceived transgression of motherhood (Harrison et al, 2018). The widespread understanding that exclusive breastfeeding is optimal for maternal and infant health among mothers can consequently lead to feelings of guilt and shame for women who cannot or do not want to breastfeed (Lagan et al, 2014; Lee, 2007a; Thomson et al, 2015). Guilt and shame arise due to discrepancies between breastfeeding expectations in pregnancy and unanticipated postpartum challenges (Fahlquist, 2016; Hanell, 2017). Perceived lack of support from social networks and healthcare professionals (Fallon et al, 2019), and perceived pressure to breastfeed due to promotional strategies

(Leeming et al, 2016; Marshall et al, 2011) contribute towards unrealistic breastfeeding expectations and poor emotional wellbeing outcomes (Flaherman et al, 2012). The Baby Friendly Initiative (BFI) is an accreditation programme which aims to create an informative and supportive breastfeeding environment (UNICEF, 2017b). However, a systematic review of 11 studies examining the effectiveness of BFI compliant care in the UK found that current delivery of infant feeding support fails to sufficiently prepare mothers for the realities of breastfeeding challenges and may contribute towards feelings of guilt for those who struggle to overcome these difficulties (Fallon et al, 2019).

Guilt and shame have differential outcomes for maternal wellbeing (Hvatum & Glavin, 2017). Although guilt and shame can both originate from the same perceived or actual transgression, guilt is behaviour-directed, while shame is self-directed (Lazare, 1987; Tangney et al, 1996). In an infant feeding context, guilt has been associated with feeling defensive about one's infant feeding method (Fallon et al, 2016), whereas shame has been associated with dissociation from one's maternal identity (Asiodu et al, 2017). Despite differential outcomes for maternal wellbeing, a recent systematic review of 20 studies found that only 2 papers exploring maternal guilt and/or shame in relation to infant feeding outcomes sought to define these concepts (Jackson et al, 2021). Of studies which defined them, general definitions were utilised, which lacked context specificity.

Thomson et al (2015) use Niedenthal et al's (1994) general definition of guilt, "When guilty, people are consumed with the idea that they did a 'bad thing' (or failed to do a good thing)." (*pg.587, in text)* and shame, "Shame involves an evaluation of the self. Although a specific failure or transgression may trigger a shame reaction, the implications of the event are attributed to the self." (*pg.586, in text*). Although

general definitions provide some clarity concerning operationalisation of lived experiences, lack of context-specificity leaves constructs open to potential misinterpretation.

In Jackson et al's mixed-methods systematic review (2021), some included literature grouped guilt and shame in thematic analysis, which risked leading to concept misattribution (e.g., Asiodu et al, 2017). For example, dissociation from one's maternal identity in response to early breastfeeding cessation, and associated feelings of depression and anxiety which were reported under Fahlquist's (2016) theme '*feeling like a failed mother'* (*pg.234*), would seem to be in line with a definition of shame (Niedenthal et al, 1994). Similarly, in Lee (2007b), mothers spoke of feeling like a "bad mother" (*pg.303*), feeling "not good enough" (pg.304) and engaging in avoidance behaviour in the form of hiding formula feeding bottles from healthcare professionals (Lee, 2007a, 2007b, 2007c; Lee & Fuerdi, 2005). Despite such accounts being detailed under the theme, '*Worry, guilt, and failure'*, these accounts would seem to reflect the internalisation of perceived transgressions to the self, specific to shame (Niedenthal et al, 1994). Therefore, constructing academic definitions of concepts is necessary to improve construct validity.

Other infant feeding literature differentiated between shame and guilt accounts in thematic analysis, but without explicitly outlining how concepts were distinguished (Asiodu et al, 2017; Crossley, 2009; Hvatum & Glavin, 2017; Lagan et al, 2014). Additionally, examinations of guilt in quantitative infant feeding literature have involved binary response options, which risks offering a reductionist view of this complex psychosocial experience and limiting conceptual understanding (Chezem et al, 1997; Fallon et al, 2016; Komninou et al, 2016). Walker and Avant's (2005, 2019) systematic, analytical framework demonstrates utility in creating clearer boundaries

between what does, and does not constitute a concept occurring, and in clarifying distinctions between concepts. Applying this framework involves the identification of specific Attributes i.e., characteristics most commonly associated with the concept to help the reader distinguish the concept experience from similar, related, and dissimilar concepts; Antecedents i.e., events which must occur prior to the concept occurring, for the concept to be present; and Consequences i.e., events which occur as a result of the concept occurring (AACs; Walker & Avant, 2005, 2019) with the ultimate aim of generating workable, academic definitions for concepts whereby a phenomenon is otherwise ill defined.

Also integral to concept analyses is the consideration of context: AACs (Walker & Avant, 2005, 2019) may differ in an infant feeding context (e.g., Hvatum & Glavin, 2017) compared with other contexts evocative of guilt and shame e.g., being tested for Sexually Transmitted Infections (e.g., Balfe et al, 2010). Recently published perinatal literature has also utilised concept analyses to extend definitions of phenomena to an infant feeding context e.g., self-objectification (Toledo & Cianelli, 2018) and to the context of postpartum mental health e.g., pregnancy-related anxiety (Bayrampour et al, 2016). However, to the author's knowledge, there have been no previous attempts to create postpartum infant feeding-specific definitions of guilt and shame. Creating such definitions would allow precise measurement of constructs and potentially lead to better research homogeneity. The current study aims to: a) construct academic definitions of postpartum guilt and shame in the context of infant feeding, and b) understand the unique and overlapping AACs of postpartum guilt and shame.

Methods

Stage 1: Study selection

Studies were selected for inclusion following a three-stage systematic screening procedure (Jackson et al, 2021). A search strategy was developed in line with Population Exposure Outcomes criteria (PEO; University of London, 2020) and was applied to [University name]'s DISCOVER database, powered by EBSCO. Key terms utilised in the search strategy were determined using a scoping literature search. Boolean operators were used to blend keywords, and truncation was used to identify variations of keywords e.g., 'breastfeed*'. Identified articles were then screened using inclusion criteria at title, abstract, and full-text stages. See supplementary document 1 for the list of databases which the search strategy derived, and frequency counts for number of articles identified at the initial stage of study selection, split by database. See Jackson et al (2021) for full details of study selection, screening, and inclusion.

Stage 2: Framework application

Walker and Avant's (2005, 2019) theoretical framework was then applied to eligible papers (see Table 1 for details of analysis steps). This framework was chosen because it uniquely aims to create workable academic definitions of a concept within a specific context.

[Table 1]

Notably, the distinction between antecedents and attributes is nuanced. Walker and Avant (2005, 2019) define an antecedent as, "An event(s) which '*must*' occur prior to the concept occurring, for the concept to be present." i.e., if the phenomenon is experienced, the concept *will* be felt. Whereas an attribute is defined as, "characteristic(s) most commonly associated with the concept." Unlike an

antecedent, the concept can be experienced in the absence of a particular attribute being experienced (Walker & Avant, 2005, 2019). If the attribute is present, however, it is more likely that the concept is to also be present simultaneously with the attribute (Walker & Avant, 2005, 2019).

Results

Due to the shared rationale for concept inclusion, shared study aims, and purpose, guilt and shame were analysed together in step one and two (Walker & Avant, 2005, 2019). Then due to their different AACs, guilt-specific and shame-specific analyses were conducted for steps three to seven. In some instances, AACs were common to both guilt and shame in included literature. As such, in steps three to seven, a separate analysis of overlapping AAC's and academic definition generation was also conducted. Also included in this overlapping analysis were instances where concepts were grouped in thematic analysis, without it being explicitly specified whether guilt and/or shame were being referred to. This separate overlapping analysis was conducted to ensure exclusivity of constructed guilt-specific and shame-specific definitions.

Chronology of events presented in participant and author narratives determined AAC selection e.g., for the Thomson et al (2015) account,

"I ended up suffering from quite severe postnatal depression, I have always wondered whether that was something to do with it, if I could have breastfed would it have happened." (in text/Jill, pg.41)

Firstly, the paper in question explored shame only, so participant narrative was analysed in the concept analysis under the lens of shame (Thomson et al, 2015). In this participant's account, stopping breastfeeding earlier than one would have liked (i.e., early breastfeeding cessation) were seen as a potential cause for

one's negative emotional experience of postnatal depression, inferred by the connecting statement, '…if I could have breastfed would it have happened', allowing causality to be surmised (Thomson et al, 2015).

Step One: Identify concept(s)

Step one involved identification of concepts of interest to answer the research question(s). Guilt and shame were chosen due to their association with infant feeding outcomes (e.g., Fallon et al, 2016; Komninou et al, 2016; Thomson et al, 2015) and their frequent interchangeable use in existing infant feeding literature (e.g., Lee, 2007c).

Step Two: Aims and purpose

Step two involved outlining study aims and how concept analysis findings intended to bridge into future research. Despite guilt and shame both being elicited by the perception of having committed a moral transgression (English Oxford Living Dictionaries, 2018a; English Oxford Living Dictionaries, 2018b), there are guilt-specific and shame-specific characteristics which evidence concept exclusivity (Fallon et al, 2016; Hanell, 2017). The current study aimed to better understand the overlapping and unique AACs of guilt and shame through the construction of academic definitions.

Identifying relationships between characteristics of maternal guilt and shame would allow for the identification of specific factors (i.e., antecedents and attributes) which healthcare professionals could use as direct conversational prompts during infant feeding discussions with postpartum women. In turn, this may allow additional support to be put in place for women feeling guilty and/or shameful in relation to their infant feeding experiences, to prevent consequences from occurring. Clearly

identifying boundaries between concepts would serve to potentially improve research homogeneity by implementing generated definitions in future infant feeding literature.

Step Three: Identify all uses of the concept

Step three involved identifying as many uses of the concept as possible. General guilt has been defined as, “A feeling of having committed wrong or failed in an obligation.” (*pg.1, in text*, English Oxford Living Dictionaries, 2018a*).* In an infant feeding context, perceived moral failing and resultant guilt have been associated with early breastfeeding cessation and formula supplementation, especially for women with antenatal breastfeeding intentions (Crossley, 2009; Hvatum & Glavin, 2017; Lee, 2007b; Murphy, 2000). Thomson et al (2015) use Niedenthal et al’s (1994) general definition of guilt as a feeling of regret in response to a moral misconduct. This definition has been supported by academic literature linking breastfeeding cessation to feelings of guilt and subsequent feelings of failure for not ‘doing the right thing’ by one’s infant (Mozingo et al, 2000).

Previous research has also defined guilt in relation to behavioural failings which motivate reparative behaviour (Kemper, 1987; Lewis, 1995; Miceli & Castelfranchi, 2018; Rotkirch & Janhunen, 2009; Taylor & Wallace, 2012). In an infant feeding context, this reparative behaviour has taken the form of maternal defence of infant feeding method, in attempt to reframe one’s decision as one of a ‘good mother’ (e.g., Lee, 2007a). Guilt-induced reparative behaviour has also taken the form of externalised anger towards healthcare professionals, who were sometimes perceived to exacerbate postnatal guilt through contributions towards perceived pressure to breastfeed (e.g., Fahlquist, 2016).

General shame has been defined as, “A painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behaviour.” (*pg.1, in text,* English Oxford Living Dictionaries, 2018b). Academic literature has also defined shame in terms of internalised moral transgressions, especially when perceiving oneself as having failed in front of other people (Kemper, 1987; Lewis, 1995; Miceli & Castelfranchi, 2018; Taylor & Wallace, 2012). Breastfeeding challenges have been associated with shame (e.g., Hanell, 2017), supporting Tangney et al.’s (1996) definition, as utilised in Thomson et al (2015).

Hanell (2017) uses Ahmed’s (2014) general definition of shame as an intense and distressing internalisation of a failing to the self. This definition has been supported by infant feeding literature demonstrating that not exclusively breastfeeding was associated with dissociation from one’s own maternal identity (Thomson et al, 2015). Thomson and colleagues use Niedenthal et al’s (1994) definition of shame as an internalisation of a failing to the self, especially when the individual perceives themselves as failing in front of others. This general definition may account for feelings of inadequacy, self-blame, and fears of judgement experienced by women facing breastfeeding challenges (Asiodu et al, 2017; Hanell, 2017).

Step Four: Defining attributes

Step four involved identifying characteristics most associated with the concept (Walker & Avant, 2005; 2019). See Table 2 for guilt-specific, shame-specific, and overlapping AACs.

[Table 2]

Uncertainty about having made the right infant feeding decision was an identified attribute of guilt (Lee & Fuerdi, 2005; Lee, 2007c). Guilt was experienced by women who felt that formula feeding had to be kept secret, as it was perceived as less healthy than breastfeeding (Hvatum & Glavin, 2017). Lack of social support was another identified attribute of guilt. For exclusively breastfeeding mothers, guilt was associated most commonly with maternal support networks e.g., feeling guilty because family members were unable to share infant feeding responsibilities (Komninou et al, 2016).

Public breastfeeding fear was an identified attribute of shame (Dalzell, 2007; Thomson et al, 2015). Having unmet, unrealistically high breastfeeding expectations was also an identified attribute of shame which resulted in feelings of inadequacy and disappointment when antenatal intentions were unmet (Asiodu et al, 2017; Hvatum & Glavin, 2017; Mozingo et al, 2000). Such breastfeeding expectations originated from: understanding breastfeeding health and attachment benefits to infant (Asiodu et al, 2017; Hvatum & Glavin, 2017; Mozingo et al, 2000); personal goals (Asiodu et al, 2017; Mozingo et al, 2000); healthcare promotion manifesting pressure to breastfeed (Hvatum & Glavin, 2017; Mozingo et al, 2000) and previous familial exposure to breastfeeding (Asiodu et al, 2017). Perceived insufficient breastmilk production was an identified attribute of shame as it concerned feelings that one was failing a biological obligation (Asiodu et al, 2017; Hanell, 2017).

Overlapping attributes were identified in cases where characteristics were common to both guilt and to shame, and in cases where it could not be determined whether the characteristic in question was attributed to guilt or to shame i.e., if guilt and shame were grouped in thematic analysis.

Fears about the infant health consequences of formula feeding were identified attributes of guilt and shame (Fahlquist, 2016; Mozingo et al, 2000). This was supported by quantitative literature which found that 33% of mothers felt guilty for exclusively formula feeding their infant, and 20% of mothers felt concerned about the potential infant health consequences of exclusively formula feeding (Lee, 2007a, 2007b, 2007c; Lee & Fuerdi, 2005). Fear of judgement from others concerning infant feeding method was an identified attribute of postpartum guilt and shame. Women experiencing guilt who were transitioning from breastfeeding to formula feeding perceived that healthcare professionals viewed formula feeding as inadequate (Lagan et al, 2014) and perceived that friends and family were undermining of breastfeeding efforts (Komninou et al, 2016; Spencer et al, 2014).

Women experiencing shame concealed infant feeding challenges due to fears about being judged by healthcare professionals for experiencing difficulties with breastfeeding and for not breastfeeding exclusively (Spencer et al, 2014). In quantitative literature, 23% of women were concerned about how healthcare professionals would feel about transitioning to formula feeding from breastfeeding (Lee, 2007a, 2007b, 2007c; Lee & Fuerdi, 2005).

Step Five and Step Six: Identification of a model case and other generated cases

Step five and step six aimed to distinguish between the concept being present and the concept being absent, through generating a model case and other cases for guilt and shame (Walker & Avant, 2005; 2019). This step involved the generation of short vignettes: using generated attributes to create clearer distinctions between the concept being present and the concept being absent, through use of examples (Walker & Avant, 2005, 2019). Vignettes created include the following cases: model

(an example of the concept being used within the identified context, whereby all defining attributes are present); borderline (most, but not all, defining attributes are present); related (similar to the concept of interest but differs when examined more closely); contrary (a clear example of the concept not occurring); inverted (contains ideas outside of personal experience); and illegitimate (example of the case being used improperly or in a context separate from the context of interest). See Table 3 for generated cases for the current concept analysis findings.

[Table 3]

Step Seven: Identification of antecedents and consequences

Step seven involved the identification of antecedents i.e., identification of events which must occur prior to the concept occurring, for the concept to be present, and consequences i.e., identification of events which occur due to the concept occurring (Walker & Avant, 2005, 2019). Lack of and inconsistent infant feeding advice and guidance was an antecedent of guilt which concerned insufficient guidance regarding safe formula feeding practice (Hvatum & Glavin, 2017), and infant feeding guidance perceived to be biased towards breastfeeding (Fahlquist, 2016; Lee, 2007b, 2007c). This led women to feel undermined and disconnected from healthcare professionals (Fox et al, 2015).

Defence of infant feeding method was an identified consequence of guilt which occurred in response to feeling ill-supported with breastfeeding challenges, by healthcare professionals and social support networks, to maintain one's 'good mother' identity (Fox et al, 2015). Perceived selfishness was also an identified consequence of maternal guilt. Breastfeeding mothers felt selfish in response to fears regarding insufficient infant weight gain (Fox et al, 2015). Formula feeding

mothers also felt selfish in response to fears about not having done the right thing for their infant's wellbeing (Lee, 2007c; Mozingo et al, 2000; Murphy, 2000).

Censored formula feeding discussions was an identified antecedent of shame, as it served to increase perceived pressure to breastfeed and contributed towards feelings of dejection and perceived lack of infant feeding choice (Crossley, 2009; Thomson et al, 2015).

Dissociation from one's maternal identity was an identified consequence of shame. For breastfeeding mothers this manifested through lowered self-confidence in response to receiving negative comments about breastfeeding during pregnancy and having little or no prior breastfeeding exposure (Thomson et al, 2015). For formula feeding mothers dissociation was experienced in response to early breastfeeding cessation (Asiodu et al, 2017). Combination feeding mothers experienced dissociation in response to experiencing breastfeeding challenges which contradicted antenatal breastfeeding expectations (Hanell, 2017).

Experiencing depressive symptoms was an identified consequence of shame for formula feeding mothers, which occurred in response to having not done 'best' by one's infant by breastfeeding (Thomson et al, 2015). Extreme distress, which fell under the shame-specific consequence 'panic/fear', occurred in response to perceived objectification of the breasts and focus on biological milk transfer during breastfeeds by healthcare professionals, and in response to fears that one was being judged negatively for experiencing breastfeeding challenges (Hanell, 2017; Thomson et al, 2015). Avoidance behaviour was an identified consequence of shame which took the form of avoiding parenting classes, hiding formula bottles from healthcare professionals, and experiencing distress related to perceived

breastfeeding inability (Crossley, 2009; Lee, 2007a, 2007b, 2007c; Lee & Fuerdi, 2005; Thomson et al, 2015). Humiliation was an identified consequence of shame, which occurred in response to manipulation and objectification of breasts by healthcare professionals who were attempting to facilitate breastfeeding (Thomson et al, 2015).

Early breastfeeding cessation was an identified antecedent for women experiencing guilt and shame (Asiodu et al, 2017; Fahlquist, 2016; Hvatum & Glavin, 2017; Lamontagne, et al, 2008; Murphy, 2000; Spencer et al, 2014). Not achieving personal breastfeeding goals was associated with significantly higher guilt scores than women who met personal breastfeeding goals (Chezem et al, 1997). Perceiving that one had failed their personal breastfeeding expectations also preceded shame, which was exacerbated when mothers perceived that they were being judged by other mothers based on their infant feeding method (Hvatum & Glavin, 2017; Murphy, 2000).

Pressure to breastfeed was an identified antecedent of guilt and shame (Hvatum & Glavin, 2017; Spencer et al, 2015). Pressure to breastfeed was experienced in relation to healthcare professionals (Lamontagne et al, 2008; Crossley, 2009) and maternal support networks (Crossley, 2009; Lamontagne et al, 2008).

Healthcare professionals: giving unbalanced infant feeding advice in favour of breastfeeding (characterised by primary focus of infant feeding conversations being placed on the infant and maternal health benefits and perceived 'ease' of breastfeeding, while omitting information about common breastfeeding challenges, and excluding guidance about safe formula feeding practice); insufficiently preparing mothers for postnatal breastfeeding challenges; giving conflicting advice; making

discouraging statements; providing inadequate emotional support; and resisting maternal wishes to transition to formula feeding were elements of inadequate and inappropriate healthcare professional support which preceded guilt and shame for postpartum women (Cloherty et al, 2004; Fahlquist, 2016; Fallon et al, 2016; Fox et al, 2015; Spencer et al, 2014).

Feeling like a failure was a consequence of guilt and shame for women supplementing with formula (Mozingo et al, 2000; Murphy, 2000). Perceiving that healthcare professionals were undermining of maternal reasons for early breastfeeding cessation led to feelings of failure, which manifested as externalised anger being held towards healthcare professionals (Fox et al, 2015; Lee, 2007c).

Constructed definitions

The identification of guilt-specific, shame-specific, and overlapping AACs led to the construction of the following context-specific definitions:

"In the context of infant feeding, guilt is characterised by the following attributes: feelings of uncertainty about having made the right infant feeding decision, and perceived insufficient social support. Lack of and inconsistent infant feeding advice and guidance was an identified antecedent of guilt, which resulted in the following consequences: feeling the need to defend infant feeding method and experiencing feelings of selfishness."

"In the context of infant feeding, shame is characterised by the following attributes: objectification and manipulation of breasts by healthcare professionals; perceived lack of milk production; fears of public breastfeeding and unrealistic breastfeeding expectations; and antecedent: censored attempts to discuss breastmilk substitutes. Antecedents and attributes led to an array of aversive

emotional (postnatal depression; panic/fear; dissociation from one's maternal identity, humiliation) and behavioural (avoidance behaviour) consequences for the mother."

"In the context of infant feeding, women who experienced both guilt and shame shared the following attributes: fearing infant health consequences of formula supplementation and fearing judgement from others for infant feeding method. Antecedents of both guilt and shame included: perceived pressure to breastfeed, inadequate and inappropriate healthcare professional support, and having not breastfed for as long as intended during pregnancy. The shared consequence of both guilt and shame was feeling like a failure."

Step Eight: Definition of empirical referents

The aim of step eight was to identify wider concept(s) to which guilt and shame belong, linking to the theoretical underpinnings of the concepts. Both concepts belong to the empirical referent *Moral Emotions*. As supported by general definitions identified in step three (Walker & Avant, 2005, 2011), guilt and shame were elicited from some of the same perceived transgressions e.g., not breastfeeding for as long as initially intended during pregnancy. Women experiencing guilt and shame felt they were not good mothers if unable to breastfeed (Asiodu et al, 2017; Lamontagne et al, 2008). Experiencing "moral collapse" (*pg.472,* Lee, *in text,* 2007a) was an identified theme which captured the jeopardised maternal identity in response to breastfeeding inability (Lee, 2007b, 2007c; Lee & Fuerdi, 2005). Lack of practical support from healthcare professionals exacerbated these feelings, leaving women feeling the need to defend infant feeding method to reframe themselves as good mothers (Fox et al, 2015).

Focus on the maternal body as failing a biological obligation when experiencing breastfeeding difficulties also exacerbated feelings of self-blame and inadequacy for women experiencing shame (Dalzell, 2007; Hanell, 2017). Interestingly, non-altruistic motivations for breastfeeding were also linked with moral conflict i.e., experiencing guilt when breastfeeding for weight loss purposes (Crossley, 2009). Reframing formula supplementation as a moral sacrifice in the best interest of infant health alleviated moral conflict about having done the right thing (Lee, 2007c; Murphy, 2000). Given shared AACs, both overlapping and exclusive definitions should be utilised in the examination of guilt and shame in infant feeding literature.

Discussion

The current concept analysis generated infant feeding-specific definitions of postpartum guilt and shame. Guilt and shame both belong to the wider empirical referent, *Moral Emotions*, which may explain some of the overlapping characteristics identified. This is also supported by evidence from general definitions of guilt and shame, which concern differing internal responses to the same perceived moral transgression (Ahmed, 2014; English Oxford Living Dictionaries, 2018a, 2018b; Niedenthal et al, 1994; Tangney et al, 1996). Identified guilt-specific and shame-specific AACs also evidenced construct exclusivity. Consequently, both specific and overlapping definitions should be utilised in future infant feeding research. Overlapping definitions provide a broad definition of these moral emotions and detail shared characteristics of concepts, while specific definitions provide a greater scope for more in-depth and focused investigations of guilt and shame experiences within an infant feeding context.

The generated guilt definition was supported by general definitions (Niedenthal et al, 1994) and involved immediate emotional responses to the perceived moral transgression of formula feeding e.g., feeling selfish (Murphy, 2000). Conversely, shame involved more introspective and potentially prolonged effects e.g., dissociation from one's maternal identity (Fahlquist, 2016). Given these differential maternal wellbeing outcomes, it is important for healthcare professionals to ask mothers about potential experiences with antecedents and attributes unique to guilt and to shame. This would allow for earlier identification of mothers at risk of experiencing these emotions, which may in turn allow early intervention to prevent their consequences from emerging.

Shame that was elicited in response to early breastfeeding cessation concerned feelings that the self was failing a biological obligation, which was in turn associated with loss of self-confidence (Hanell, 2017; Thomson et al, 2015). Low breastfeeding confidence has been associated with lower frequencies of breastfeeding initiation and shorter breastfeeding duration (Mossman et al, 2008). Additionally, shame was uniquely associated with postnatal depression (Thomson et al, 2015), which has been linked with shorter breastfeeding duration and early exclusive breastfeeding cessation (Dias & Figueiredo, 2015). These findings warrant further exploration of shame in relation to infant feeding outcomes, to optimise maternal wellbeing and infant feeding outcomes.

Insufficient and inconsistent infant feeding guidance was a key attribute of maternal guilt. In previous literature, formula feeding women often spoke of having wanted to receive more information about safe formula feeding practice (Appleton et al, 2018; Tarrant et al, 2013). Breastfeeding mothers related the exacerbation of guilt to having received insufficient formula feeding advice, which manifested a perceived

pressure to breastfeed (Fahlquist, 2016). Current study findings were further supported by previous literature findings that perceived judgement from others regarding the experience of breastfeeding difficulties prevented help-seeking behaviour (Hunt & Thomson, 2017). Additionally, receiving unrealistic breastfeeding guidance which omitted postnatal breastfeeding challenges (e.g., pain) led to dissatisfaction with healthcare professional support when there was a disconnect between breastfeeding expectations and experiences (Fox et al, 2015). This is problematic as 19.6% of women reported that their breastfeeding difficulties were not solved by healthcare professionals (Gianni et al, 2019). In providing more balanced and realistic infant feeding guidance regarding safe formula feeding practice and management of breastfeeding difficulties, it may be possible to create a more inclusive infant feeding environment that promotes open communication to work through infant feeding challenges.

Also securing moral conflicts around infant feeding decision-making is the widespread promotion of formula milk, with financial investment steadily increasing since 2015 (Hastings et al, 2020). Promotion of breastmilk substitutes is problematic because advertisements are frequently interpreted as confusing for new parents (Barennes et al, 2015). Furthermore, aggressive marketing of formula milks have been shown to successfully increase prevalence of formula feeding (Piwoz & Huffman, 2015). Linking with the antecedent, '*Lack of and inconsistent infant feeding advice and guidance*', recommendations are made for healthcare professionals to provide accurate formula feeding guidance to those who choose to supplement with breastmilk alternatives, to falsify misleading marketing strategies. To address wider societal concerns about the impact of increased formula feeding prevalence on maternal emotional wellbeing, including guilt and shame experience, calls are also

made for tighter regulations on the marketing of infant formula milks (Harris & Pomeranz, 2020; Romo-Palafox, Pomeranz, & Harris, 2020).

Censored attempts to discuss formula supplementation was an identified attribute of shame. In previous literature, formula feeding mothers tended to use formula tin instructions to guide feeding practice and felt that formula was stigmatised by healthcare professionals (Appleton et al, 2018). This is problematic because many parents struggle to comprehend nutritional content on formula product labelling and find difficulties in choosing brands (Malek et al, 2019). Healthcare professionals have also raised issues regarding misleading formula product information, inconsistencies in infant feeding information, and time restrictions on delivery of care from other staff (Dykes et al, 2011). Providing more balanced guidance about safe formula preparation and appropriate interpretation of formula packaging may therefore improve perceived satisfaction with healthcare professional support by dissipating formula feeding stigma and by promoting informed infant feeding choice.

Concept analysis findings confirm that one's sociocultural context is an important determinant of infant feeding guilt and shame experience. Feeling that one is being pressurised to breastfeed is affirmed by polarised discourse that portrays breastfeeding as 'best', 'good', and, 'right' (Cummins, 2020). Current breastfeeding promotional efforts (UNICEF, 2013) construct a morally dichotomous environment that leads mothers to feelings of inadequacy and failure if breastfeeding challenges or transitions to formula feeding are experienced (Braimoh & Davies, 2014; Fallon et al, 2019). This may explain the guilt-specific consequence, *'Feeling the need to defend one's infant feeding method'* as a function of cognitive reframing theory (Robson & Troutman-Jordan, 2014). This involves the alteration of negative, self-

defeating beliefs into more positive beliefs, so to improve personal wellbeing (Robson & Troutman-Jordan, 2014).

In other domains of health research e.g., weight loss in those with overweight or obesity, setting manageable goals is essential in determining sustained and positive behavioural change (Bailey, 2017). As such, poor breastfeeding outcomes may be a function of an inefficient sociocultural context that urges a moral imperative to exclusively breastfeed to 6 months. Instead, adopting an incremental approach to setting breastfeeding goals may serve to improve longer term breastfeeding outcomes (Brown, 2016; Símonardóttir & Gíslason, 2018).

The following identified domains associated with infant feeding guilt and shame, '*Public breastfeeding fear*', '*Perceived insufficient social support*', and '*Uncertainty about having made the right infant feeding decision'* restate societal barriers to breastfeeding. Formula feeding has become a cultural norm in the UK (Thomson & Dykes, 2011). This has been shaped by a number of maladaptive factors: lack of vicarious exposure to breastfeeding in popular media (O'Brien, Myles, & Pritchard, 2017); other female family members having formula fed their infant(s), resulting in the loss of influential breastfeeding advocates for the new mother (Sriraman & Kellams, 2016); perceived or actual intolerance of the general public to non-discreet breastfeeding practice (Jamie, McGeagh, Bows & O'Niell, 2020); and insufficient support from one's employer in facilitating work and infant feeding goals (Snyder et al, 2018).

Concept analysis findings extend the above literature base by demonstrating that such an unconstructive social environment forms the basis of adverse maternal emotional e.g., fear, and behavioural e.g., avoidance behaviour, outcomes. Adopting

a multicomponent public health strategy that invests in health services, population-level breastfeeding promotion, supporting maternal legal rights, protecting maternal wellbeing, and more tightly regulating the marketing of formula milks may be viable intermediaries for improved breastfeeding and postpartum emotional wellbeing outcomes (Brown, 2017).

Implications for clinical practice

Given the different consequences that guilt (e.g., defence of infant feeding method, Fox et al, 2015) and shame (e.g., postnatal depression, Thomson et al, 2015) elicited, it is important for clinical practitioners to identify and discuss attributes and antecedents of guilt and shame during postpartum infant feeding discussions to prevent negative maternal wellbeing outcomes. Defence of infant feeding method occurs in response to receiving inadequate and inappropriate healthcare professional support, which can leave mothers feeling dissatisfied and disconnected (Barimani et al, 2017; Shmied et al, 2011). As such, by healthcare professionals directly encouraging open and honest communication regarding women's postnatal infant feeding concerns, it may also be possible to improve perceived quality of healthcare professional support. There are currently no psychometric measures which assess postpartum guilt and shame. Earlier identification of mothers at risk for and/or vulnerable to these emotions could result in the provision of additional support to work through perceived barriers, to promote positive breastfeeding and maternal wellbeing outcomes. Additionally, by understanding guilt and shame antecedents, it may be possible to predict and intervene early, so to prevent these emotions from occurring.

Limitations

Misattribution and interchangeability of concepts in existing literature (Jackson et al, 2021) limits ability to form firm conclusions. Establishing causality between AACs was problematic given the inclusion of mainly cross-sectional papers (Crossley, 2009; Dalzell, 2007; Fahlquist, 2016; Fallon et al, 2016; Fox et al, 2015; Hvatum & Glavin, 2017; Komninou et al, 2016; Lagan et al, 2014; Lamontagne et al, 2008; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005; Mozingo et al, 2000; Spencer et al, 2014; Thomson et al, 2015). Future research should therefore aim to use longitudinal methodologies to evidence directionality between guilt and shame AACs, and to quantitatively validate the proposed relationships identified in the current study.

Also, quality of included papers limited ability to form firm conclusions. Most quantitative literature included in the concept analysis did not report statistical analyses in full (Chezem, Montgomery, & Fortman, 1997; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005), and one study lacked scale validity testing (Fallon, Komninou, et al., 2016). Qualitative literature oft recruited unrepresentative samples of mainly White, highly educated, partnered, primiparous women of high socioeconomic status (Asiodu et al, 2017; Fox et al, 2015; Hvatum & Glavin, 2017; Lagan et al, 2014; Lamontagne et al, 2008; Mozingo et al, 2000; Murphy, 2000; Spencer et al, 2014; Thomson et al, 2015), and some included papers omitted the routine collection of some demographic characteristics (Crossley, 2009; Fahlquist, 2016; Thomson et al, 2015), collectively limiting transferability and generalisability of findings.

Constructed definitions may only be applied to the context of postpartum infant feeding. However, antenatal breastfeeding intentions also influence postpartum breastfeeding duration, with intent to use formula being associated with significantly shorter breastfeeding duration (Kim et al, 2013). Future research should

therefore seek to create antenatal-specific definitions of maternal guilt and shame based on context-specific AACs e.g., inhibited attempts to openly discuss formula supplementation at antenatal parenting classes (Crossley, 2009), so that comparisons can be made with postpartum definitions.

To meet study aims, a homogenous sample of studies from developed countries was systematically selected for inclusion so that clear, context-specific definitions of guilt and shame could be generated. Given cultural variation in breastfeeding practices and maternal wellbeing between developed (Leahy-Warren et al, 2017) and developing (Wanjohi et al, 2017) countries, generated definitions may serve as a key comparator in the event that future research seeks to compare cross-cultural differences in guilt and shame experiences within an infant feeding context.

Conclusions

Constructed definitions provide an in-depth analysis of the key characteristics which distinguish infant feeding-specific guilt and shame. Using constructed definitions may allow future research to achieve greater research homogeneity due to improved construct validity. Future research should aim to construct definitions, specific to the antenatal infant feeding context, to allow earlier identification of guilt and shame. Given the identified link between shame and postnatal depression, future research should focus efforts on investigating the relationship between shame and infant feeding and maternal wellbeing outcomes. Finally, future research should aim to empirically support identified AACs for use in infant feeding literature.

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Table legends

Table 1: Description of Walker and Avant's (2005, 2019) concept analysis framework steps

Table 2: Overlapping and unique attributes, antecedents, and consequences of maternal guilt and shame, within the postpartum infant feeding context

Table 3: Generated cases for maternal guilt and shame, within the postpartum infant feeding context

Supplementary documentation

Supplementary document 1: List of databases which the initial search strategy derived, with frequency counts for number of articles identified per database in the initial phase of study selection

Table 1: Description of Walker and Avant's (2005, 2019) concept analysis framework steps

Step of Walker and Avant's (2005, 2011) concept analysis framework	Description
1. Select concept	Choose a concept of interest which is most suited to answering the research question(s). Choose a concept which is manageable and specific.
2. Determine analysis aims/purpose	Outline how the concept analysis findings intend on bridging into future research. The concept analysis is not the end point.
3. Identify all uses of the concept	Identify as many uses of the concept as possible. Consider all uses of the term to gain a contextual understanding of how concepts are utilised and understood.
4. Identify attributes	Identify the characteristics most commonly associated with the concept. They act as criteria which help the reader to distinguish the concept experience from similar, related, and dissimilar concepts.
5. Identify model case	An example of the concept being used within the identified context, whereby all defining attributes are present.
6. Identify borderline, related, contrary, inverted, and illegitimate cases	To more clearly distinguish between the concept being present and the concept being absent, additional cases are generated. Examining cases which are of interest and similar to the concept of interest, but not identical, will help to clarify boundaries for what constitutes a defining attribute and what does not: ***Borderline*** Most, but not all, defining attributes are present. The generated case is inconsistent with the concept in some way. ***Related*** Similar to the concept of interest but differs when examined more closely. ***Contrary*** A clear example of the concept not occurring.

	Inverted Contains ideas outside of personal experience. ***Illegitimate*** Example of the case being used improperly or in a context separate from the context of interest.
7. Identify antecedents and consequences	***Antecedents*** Identification of events which must occur prior to the concept occurring, for the concept to be present. ***Consequences*** Identification of events which occur as a result of the concept occurring.
8. Define empirical referents	Wider concept(s) to which the concept of interest belongs. Empirical referents are linked to the theoretical underpinnings of a concept.

Table 2: Overlapping and unique attributes, antecedents, and consequences of maternal guilt and shame, within a postpartum infant feeding context

	Guilt only	Shame only	Guilt and shame
Attributes	Perceived insufficient social support *(Fallon et al, 2016; komninou et al, 2016)* Uncertainty about having made the right infant feeding decision *(Lee, 2007c; Lee & Furedi, 2005)*	Objectification and manipulation of breasts *(Dalzell, 2007; Thomson et al, 2015)* Perceived lack of milk production *(Asiodu et al, 2017; Hanell, 2017)* Public breastfeeding fear *(Thomson et al, 2015)* Unrealistic breastfeeding expectations *(Asiodu et al, 2017; Hvatum & Glavin, 2017; Mozingo et al, 2000)*	Fear of infant health consequences due to formula supplementation *(Fahlquist, 2016; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005)* Fear of judgement from others for infant feeding method *(Lagan et al, 2014; Lee, 2007b; Lee & Furedi, 2005; Spencer et al, 2015)*
Antecedents	Lack of and inconsistent infant feeding advice and guidance *(Fahlquist, 2016; Fox et al, 2015; Hvatum & Glavin, 2017; Lee, 2007b, 2007c)*	Censored attempts to discuss breastmilk substitutes with healthcare professionals *(Crossley, 2009; Thomson et al, 2015)*	Perceived pressure to breastfeed *(Crossley, 2009; Fahlquist, 2016; Fox et al , 2015; Hvatum & Glavin, 2017; Lamontagne et al, 2008; Lee, 2007c; Murphy, 2000; Spencer et al, 2015)* Inadequate and inappropriate healthcare professional support *(Cloherty et al, 2004; Fahlquist, 2016; Fallon et al, 2016; Fox et al , 2015; Komninou et al, 2016; Lagan et al, 2014; Lamontagne et al, 2008; Lee & Furedi, 2005; Murphy, 2000; Spencer et al, 2015)* Not breastfeeding for as long as intended during pregnancy *(Asiodu et al, 2017; Chazem et al, 1997; Dalzell, 2007;*

			Fahlquist, 2016; Hvatum & Glavin, 2017; Lamontagne et al, 2008; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005; Mozingo et al, 2000; Murphy, 2000; Spencer et al, 2015)
Consequences	Feeling the need to defend infant feeding method *(Fallon et al, 2016; Fox, et al, 2015; Komninou et al, 2016; Lee, 2007c; Lee & Furedi, 2005)* Perceived selfishness *(Lee, 2007c; Murphy, 2000)*	Dissociation from one's maternal identity *(Asiodu et al, 2017; Fahlquist, 2016; Hanell, 2017; Thomson et al, 2015)* Postnatal depression *(Thomson et al, 2015)* Panic/fear *(Hanell, 2017; Thomson et al, 2015)* Humiliation *(Thomson et al, 2015)* Avoidance behaviour *(Crossley, 2009; Fahlquist, 2016; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005; Thomson et al, 2015)*	Feeling like a failure *(Fahlquist, 2016; Fox et al, 2015; Hvatum & Glavin, 2016; Lamontagne et al, 2008; Lee, 2007a, 2007b, 2007c; Lee & Furedi, 2005; Mozingo et al, 2000; Murphy, 2000)*

Table 3: Generated cases for maternal guilt and shame, within a postpartum infant feeding context

Case type	Guilt only	Shame only	Guilt and shame
Model	Magdalena is a primiparous mother to Jade. Whilst in hospital, Magdalena exclusively breastfed with the support of her midwife and physician. Upon discharge, Magdalena faced a number of breastfeeding difficulties. Jade was extremely hungry, and demand fed throughout the night, leaving Magdalena feeling sleep deprived and irritable. Magdalena believes that Jade's tongue tie may be causing latching difficulties, as breastfeeding became increasingly painful. Despite Magdalena's midwife reassuring her that Jade was feeding normally, Magdalena maintained that something was wrong. Magdalena lived alone and was not very close to her immediate family. Unable to settle these issues, Magdalena decided to formula feed. Lack of guidance on purchasing the correct formula left Magdalena feeling overwhelmed with choice. Magdalena often thought to herself that she must be a truly selfish	Isobel had a terrible experience at hospital. Her midwife would often grab and manipulate Isobel's breast in response to her asking for advice on positioning, rather than offering advice and guidance, which left Isobel feeling humiliated and disempowered. Her midwife, Anne, had only discussed breastfeeding with Isobel during the postpartum period and often refused to talk about the possibility of supplementing with formula when Isobel was out and about. All of Isobel's family and friends had exclusively breastfed their babies, and so Isobel set herself a target to exclusively breastfeed for 9 months, which she found a frightening prospect. Isobel also did not like breastfeeding in public – she felt as though everyone were judging her technique. As a result, Isobel very rarely left the house, and if she did, ensured that it was close enough to be able to return promptly to feed her child if needed. Isobel feels that the stress she is under is causing her to not produce enough milk because her infant is increasingly fussy at the breast and has begun to feed more frequently and for longer periods of time, especially during	Roisin is a 32-year-old, primiparous pregnant mother to baby Darren. Roisin likes to think herself well prepared for the realities of breastfeeding. She has read all the parenting books and attended many antenatal classes discussing the challenges of breastfeeding and what to expect. Roisin is planning to return to work at 4 months postpartum, so intends to exclusively breastfeed until then. Roisin feels that her partner, Warren, is particularly pushy for her to exclusively breastfeed. She also feels that there is a lot of pressure from her group of friends who are all either currently exclusively breastfeeding or intending to do so. They have been friends since they were in high school, so she does not want to be considered the 'odd one out' in the group. After giving birth, Roisin found breastfeeding more difficult to manage than expected. Due to Roisin's high responsibility career, her employer requested that she return to work earlier. Roisin struggled to maintain exclusive breastfeeding with heavy work commitments, and consequently decided to formula feed when at work (so that Warren could help) and breastfed in the evenings and in the morning

	person for not trying harder to breastfeed.	the night. As a result, Isobel isn't sleeping very well, and is at a loss as to what to do.	before work. Despite this, Roisin felt like a failure for having stopped exclusively breastfeeding at 2 months postpartum when she had hoped to exclusively breastfeed for 4 months postpartum.
Borderline	Rachael, aged 19, is a primiparous mother to 17-week-old Matthew. Rachael took six months away from college during her third trimester but has now returned for her final year. Upon returning to college Rachael struggled to maintain the exclusively breastfeeding which she maintained easily when not studying. Lack of sleep as a result of night feeds started to have an aversive effect on Rachael's academic performance. Rachael's mother, Sam, suggested that she take on some of Rachael's night feeds so that Rachael can rest and focus more on her studies. Sam formula fed all of her 5 children and shows Rachael how to properly clean bottles and purchases the appropriate formula for Matthew.	Denise is a new mother to a healthy 3-week-old boy, Kieran. During pregnancy Denise decided to exclusively breastfeed until Kieran was 4 months old, at which point Denise intended to return to work. All of Denise's friends had exclusively breastfed their children to 6 months postpartum and were very insistent that Denise continue exclusively breastfeeding when she returned to work. Denise felt that her midwifery team and physicians were especially 'pushy' of exclusively breastfeeding too and would often silence Denise's attempts to discuss safe formula feeding practice. Denise has recently stopped attending parenting classes after receiving derogatory comments from non-breastfeeding mothers the last time she attended. Denise also dreaded visits from her healthcare practitioner, as she would often 'ram' Kieran's head on Denise's boob to make him eat, without explaining what she was doing.	Nora is a mother to twins, Becky and Ben. During pregnancy Nora intended to exclusively breastfeed both of her babies. However, a few days after giving birth Nora found that Becky was very distracted at the breast and disinterested in feeding compared with Ben. As such, 10 days postpartum Nora decided to swap Becky to formula, whilst she continued to exclusively breastfeed Ben to 7 months postpartum.
Related	Luna has a 2-week-old infant named Delilah. Luna combination feeds her infant so that her partner, Bill, could	Kathrine is a 34-year-old stay-at-home mother to Ryan [9], Lewis [4], and Niamh [1 week]. During pregnancy, Kathrine was not sure how she	During pregnancy Sabina felt like she was under exceptional pressure to breastfeed from her GP and midwifery team. They would often

	share parenting duties. Luna and Bill decided to combination feed during pregnancy and are happy with their choice. Nevertheless, Luna is extremely concerned about the long-term consequences of formula supplementation on Delilah's health and feels like a bad mother for not exclusively breastfeeding.	wanted to feed Niamh. She had received contradictory advice from healthcare professionals and family. She knew that breastfeeding was the healthiest option, so decided to give it a go. Niamh took to breastfeeding well, and so Kathrine exclusively breastfed Niamh. Kathrine felt too ashamed to take Niamh to her local parenting group, as she feared that her technique would be judged by the other mothers. Since Niamh was feeding so well, Kathrine did not want to jeopardise this by risking doubts being introduced from other mothers.	question her if she asked questions about formula supplementation and would strongly promote the benefits of breastfeeding at her check-ups. Sabina experienced lots of pain whilst breastfeeding during the postpartum period and, despite intending to breastfeed with occasional formula feeds until 15 weeks postpartum, exclusively formula fed by 11 weeks postpartum. Given the difficulties and pressure she had experienced, Sabina was content with her feeding achievement.
Contrary	Patricia has an 8-month-old son named Cameron. Patricia is now engaging in infant-led weaning, after 7 months of exclusive breastfeeding. Patricia received exceptional support from her midwifery team and boyfriend which allowed her to meet her infant feeding goals. Without Patricia's "amazing" midwife, she does not feel that she would have been able to exclusively breastfeed for as long as she did.	Carine is a new mother to 5-week-old twins. Carine had decided during pregnancy that she was going to exclusively breastfeed her children. Carine's midwife, Florence, was a wonderful source of support. Whenever Carine needed guidance or reassurance, Florence was there to lend a helping hand and to be a shoulder to cry on.	Nadia is a very career-driven woman who intended to breastfeed exclusively until she returned to work at 20 weeks postpartum and then intended to pump whilst working for a further 4 weeks. Perceiving herself as a very determined and persevering person, Nadia achieved her infant feeding goals with little difficulty. She watched lots of YouTube tutorial and asked parenting forums to aid her in resolving any breastfeeding challenges she faced postpartum.
Illegitimate	Rob is a 29-year-old man, whose wife had passed away during childbirth.	Laira is a 38-year-old woman to identical twins, Nick and James. Nick and James are 4 years	Charlie when weaning her baby, did not necessarily expose her baby to as many

	Rob is the primary caregiver to his 3-week-old daughter, Madeleine. Although struggling to come to terms with the loss of his wife, Rob is enjoying his new role as a father and frequently takes Madeleine to postpartum parenting classes. Rob is exclusively formula feeding Madeleine, whom is a happy, healthy baby.	old. Laira decides one Saturday morning to take her infants to a soft play group. Nick and James started to play roughly with some of the other children at the playgroup, resulting in Nick taking a tumble and bumping his head. Laira ran over to check on Nick, feeling bad for not having intercepted the situation sooner.	different types of foods as she thinks that she should have, especially fruits and vegetables. Now her son is 2.5 years old and is an extremely picky eater. Concerned for her son's wellbeing, she takes Sean to the doctors for advice. Charlie feels regretful for not having given her son a better start to healthy eating.
Inverted	Jessica is a 42-year-old mother of 3 sons and 2 daughters. Her youngest child has recently started high school. Jessica had neglected her education to start a family, and now she has more free time has decided to go back to university to follow her passion for English Literature. Jessica has not engaged in any activities purely for herself since the birth of her second child, and consequently is experiencing much conflict as to whether she is doing the right thing. Jessica worries that her children will need her more than she anticipates and is concerned that she may be making a rushed or selfish decision.	Aria has gone on holiday with her 6-year-old daughter, Demi. One day Aria takes Demi to the beach but forgets to put sun cream on her. Demi becomes badly sunburnt and has to spend the rest of the holiday covered up with the shade. Aria feels like a bad mother for failing to protect Demi from the sun appropriately. Disapproving looks from other parents at the holiday park made Aria feel humiliated.	Nathan is a single dad to 18-month-old Jamie. Jamie is 6 years old and particularly difficult around bedtime, often having a tantrum at the prospect of getting ready for bed. Nathan was having a particularly difficult week at work and decided to allow Jamie to stay awake until Jamie felt tired, which was 10:45pm. The next day Jamie's teachers pulled Nathan aside to inform him that Jamie had been falling asleep at the desk and was struggling to concentrate during class discussions. Nathan felt angry at Jamie's teachers for, what he thought, as them thinking him an inadequate father. More truthfully, though, Nathan thought himself a failure for disrupting Jamie's routine.