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This paper presents the theme of objectification of breastmilk, which results from long-term breast expression by parents of hospitalised very low birth weight (VLBW) preterm infants. An interpretive phenomenological study, involving 17 Australian parents was undertaken to explore parents' experiences of breastfeeding very low birth weight preterm infants from birth to twelve months of age. The discussion presented here is elicited from 45 individual interviews held with both mothers and fathers, which were then transcribed verbatim and analysed using thematic analysis. Objectification of breastmilk was one of the prevalent themes throughout all of the interviews. The effects of this objectification on the parents and their lactational experience will be discussed. Objectification of the breastfeeding experience, it will be shown, is incongruent with the parents' expectations and has a negative impact on their breastfeeding experience.

Keywords: breastfeeding, breastmilk, breast expression, objectification, preterm
INTRODUCTION

Preterm birth continues to be a reality worldwide and is recognised as a major cause of family stress and disturbance (Miles 1989; Shields-Poe & Panelli 1997). Parents of hospitalised preterm infants are restricted in their ability to perform the normal tasks of parenting a newborn child because of the altered care needed, the physical barriers imposed through this care and the nurse–parent relationship. With the baby in NICU, parents are found asking permission to do simple tasks such as touching their own baby (Golombeski 2000; Fenwick, Barclay & Schmied 2001; Lupton & Fenwick 2001; Higgins & Dullow 2003).

Infant feeding is a primary task of new parenthood. For parents of hospitalised preterm infants, the act of feeding their infant is a significant symbol of parenthood (Martin & Pridham 1992; Thoyre 2001). If the new mother chooses to breastfeed she must commence lactation during a time of intense turmoil. Studies around the world have shown an inverse relationship between infant gestation at birth and duration of breastfeeding (Meier & Brown 1996; Yip, Lee & Sheehy 1996). Moreover, some results indicate that more than half of those women who initiate breastfeeding for a preterm infant abandon it prior to the infant’s discharge from hospital (Kaufman & Hall 1989; Hankeler et al. 1994; Ingram, Redshaw & Harris 1994; Hill, Ledbetter & Kavanaugh 1997; Jaeger, Lawson & Filteau 1997; Furman, Minich & Hack 1998).

Perceived milk insufficiency is the most commonly cited reason for all women (term and preterm births included) to cease breastfeeding (Hill 1991; Brown et al. 1994; Whelan & Lupton 1998). Whelan and Lupton found ‘insufficient milk’ to be ‘the acceptable “public face” of breastfeeding cessation and often concealed a whole range of private breast-feeding difficulties’ (1998, p.100). For mothers of preterm infants, mother–infant separation has been recognised as a barrier to successful breastfeeding since Budin (1907) first wrote of caring for the preterm infant. Admission of newborn infants to neonatal units, the nature of the NICU environment, the health status of the preterm infant as well as hospital feeding routines all continue to be obstacles to successful breastfeeding (Nyqvist, Sjoden & Ewald 1994). Other reasons recognised in the literature for ceasing breastfeeding for a preterm infant include prematurity, twins, medications, convenience, smoking and negative past experiences (Lefebvre & Ducharme 1989), detachment, difficulties with pumps and conflicting advice (Jaeger, Lawson & Filteau 1997), and weak suck, refusal and fussiness (Hill, Ledbetter & Kavanaugh 1997). It is known that mothers of preterm infants are commonly concerned about whether their baby consumes sufficient volume from breastfeeding once home (Hill, Hanson & Mefford 1994; Pinelli, Atkinson & Saigal 2001).

Infant feeding has been dominated by assessment of intake in one form or another. MacLean (1990) suggests that failure of breastfeeding for term infants is often the result of our being accustomed to numbers, of thinking in terms of volume consumed and from the difficulty in trusting what cannot be measured. Mothers of preterm infants have expressed similar concern at being unable to quantitatively breast milk intake during at-breast feeds (Kavanaugh et al 1995). When investigating mothers’ experiences of bottle-feeding their preterm infants, Thoyre (2001) found the hospital staff focused only on the objective measures of infant feeding. ‘Mothers reported having little feedback on their feeding technique other than the amount their infants ingested’ (Thoyre 2001, p.47). Whilst there is a range of reasons women give for ceasing breastfeeding for preterm infants, no prospective qualitative study has been undertaken that follows the trajectory of breastfeeding for VLBW preterm infants, still less within the Australian context. The purpose of this study was to increase knowledge and understanding of how parents experience breastfeeding for a preterm infant, to assist nurses and other health care professionals to improve the clinical care received by families and to improve their preterm breastfeeding experience.

METHOD

Interpretive phenomenology as described by Benner (1994) was chosen to guide the research process. Interpretive phenomenology is a science that is interested in the study of people, of what it is to be human, and offers an advance of our knowledge by increasing our understanding of lived experience (Benner 1994). Interpretive phenomenological research does not aim to explain, control or theorise; rather, it offers a plausible interpretation and description that is intended to reveal, enhance or extend our understandings of the human experience as lived (Diekelmann & Ironside 1998).

Setting of the study

This study was conducted in an Australian metropolitan hospital providing Level II and Level III neonatal services as well as domiciliary services following discharge. The hospital had a policy to promote breastfeeding for all newborn babies, including preterm infants, unless there is a medical contra-indication. The research was conducted by a registered nurse and midwife with neonatal postgraduate qualifications, employed solely for the purpose of the research. The researcher had not worked in the participating hospital prior to the study and was not providing any direct care to the parents or their neonates.

Participants

The primary temporal consideration was that participants could be recruited at the outset of the phenomena in question and followed through while living the phenomenon. Parents identified as intending to breastfeed their preterm VLBW infant(s) were approached within one week of the birth. Parents were excluded from selection if they did not speak English; if their infant had a congenital abnormality likely to affect feeding; or if their infant was considered gravely ill by the attending neonatologist. There were 10 mothers and 7 fathers who consented to participate in the study. Table 1 provides further information on the families involved in the research. In the following quoted passages a unique locating code is used to indicate family (1 to 10), gender
(A=mother, B=father), interview number (1 to 3) and paragraph number of original transcripts.

**Ethical considerations**
This study was conducted under strict ethical guidelines, including ethics approval from the University of South Australia Human Research Ethics Committee and the Women’s and Children’s Hospital Research Ethics Committee. Participants were provided informed consent, total confidentiality, and anonymity with the use of pseudonyms.

**The study data**
Data were collected through 45 semi-structured interviews. Sequential rather than single interviews with participants were used to track the experience over time. First interviews were held within 2 weeks of birth, the second at 8-10 weeks post birth and the third interviews were held at 12 months post birth. Some parents chose not to complete all three interviews and two families were not contactable for the final interview. Individual interviews were held to enable mothers and fathers to freely describe their own personal experiences. These interviews were akin to natural, informal, relaxed conversations, which allowed the participants to speak freely about their most salient experiences and perceptions of breastfeeding their preterm infant. In order to enable spontaneity of discussion, interviews were audio-tape recorded. These recordings were then transcribed verbatim and analysed using thematic analysis. Analysis commenced with note taking after each interview, then listening and re-listening to each individual interview while following the written transcript to get an overall sense of the participant's experience. Following this tape listening, a line-by-line reading and 'coding' of the transcripts was done. Following the coding of each interview, the data were then listened to again and questioned more rigorously in order to develop ideas, categories and concepts and to link and compare these across individual participants and participant groups. This analysis was a process of moving back and forth between the parts and the whole of the data, to reveal themes and issues and to generate new questions about their experiences. Data management was achieved with the use of NVivo—a computer program designed for qualitative data analysis.

**Limitations**
As with interpretive phenomenology, this research is my interpretation of the breastfeeding experience of 17 parents of preterm infant(s). It must also be recognised that the study includes a relatively small number of participants and cannot be generalised to the broader breastfeeding population. This study has been conducted with white, Anglo-Australian men and women. This represents a narrow demographic which may not be representative of all parents of preterm infants (although demographic data were not collected to analyse this statistically). Similarly, while uncovering the meanings and experiences of people in a given time and place, these will not remain fixed, for they are social beings in a dynamic and changing social and cultural world. What is considered culturally appropriate behaviour today may not be so tomorrow or in the next generation of parents.

**RESULTS**
The analysis of the parents’ experiences revealed numerous contradictions, tensions and disparities between what the participant parents expected their breastfeeding to be like and what became their reality. All participants considered breastfeeding to be integral to the performance of motherhood and good parenting. Mothers, in particular, tried hard to cope with these contradictions and their implications. Whilst the experience of breastfeeding was often considered positively, the negative aspects of their individual experiences are what parents spoke mostly about and therefore underpin the results presented here. Further discussion of other aspects of this study’s results will be published in the near future.

One major theme evident from the interpretive analysis is that of the objectification of breastmilk. Breastmilk, once expressed from the mother’s body becomes an object; it is detached from her and is a separate entity. The milk not only becomes a valued material object sought after by the parents performing the breast expressing, but also by the staff who desire it for feeding the preterm infant. This is fostered from birth and the onset of expressing. When a mother has a baby that can be put immediately to the breast, milk quantity is not known. With expression of the breastmilk, the milk becomes tangible and visible and can be scrutinised and examined by all people.

From the very outset of expressing, participants were acutely aware of their breastmilk volume. Julie spoke of the disheartenment she had when beginning her breast expression. She was able to see her milk—its colour, consistency and volume—and able to criticise it:

The first day we did it..., I was still getting nothing, well practically nothing, I may have got 30 ml the whole day. I

**TABLE 1: Participant details**

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<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Average age of mothers</strong></td>
<td>31.5 years (range 18–40)</td>
</tr>
<tr>
<td><strong>Type of birth</strong></td>
<td>Vaginal birth = 3</td>
</tr>
<tr>
<td></td>
<td>Caesarean section birth = 10</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<tr>
<td></td>
<td>De facto = 2</td>
</tr>
<tr>
<td></td>
<td>Single = 2</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td>Primipara = 6</td>
</tr>
<tr>
<td></td>
<td>Multipara = 3</td>
</tr>
<tr>
<td><strong>Number of infants</strong></td>
<td>Total = 14</td>
</tr>
<tr>
<td></td>
<td>6 singleton births</td>
</tr>
<tr>
<td></td>
<td>4 sets of twins</td>
</tr>
<tr>
<td><strong>Average birth weight of infant</strong></td>
<td>980 grams (range 620–1420 grams)</td>
</tr>
<tr>
<td><strong>Gestational age of infant</strong></td>
<td>24–27 weeks = 7</td>
</tr>
<tr>
<td></td>
<td>28–30 weeks = 7</td>
</tr>
<tr>
<td><strong>Assisted reproduction</strong></td>
<td>4 assisted pregnancies</td>
</tr>
</tbody>
</table>
mean, I just ditched that down the sink, because it wasn’t, well for me at the time, it wasn’t worth saving two drops and worrying about sterilising, or having a sterilised container in the freezer with this much, and then adding this much to it, so I just put it down the sink, and it looked like water anyway to me. (2A#2par48)

Similarly, Paul said:

You know 10 ml of that [colostrum] you couldn’t buy I don’t think. So, yeah. And then slowly, slowly the milk started to come and you know when, like you know 10 ml, 20 ml, 5 ml and then bang then it started to flow, and now it’s starting to flow, like in the mornings she’ll tell me like ‘I got 110 ml out’ you know. And I said ‘yeah, well you’ll be putting Dairyvale’ out of business soon’ you know, so she’s doing really good. (4B#1par68)

Paul aligns his wife’s breast expression with a cows milk production company. In essence, he praises his wife for being a good milk producer from the high quantities of output that she was able to produce. For this praise, the objectified milk was idealised.

The milk, as the object of their breast expressing efforts, very quickly became highly valued. Helen chose to hand express for fear of losing even one drop of her breastmilk:

I felt like I wasn’t getting anything through the pump and half of it was being wasted on the sides, and it was easier to hand express and save every drop. (9A#1par91)

The worry of losing milk was an experience common to many participants. John recalled his concern for saving every last drop of his wife’s breastmilk:

Chris does the first express (...) you know [you] don’t, don’t bump her, because you can’t spill it sort of thing. So, yeah, you know, like every drop you get, you don’t want to lose it. (5B#2par272)

The breastmilk as the valued object was treated as valuable and precious. Parents spoke of their breastmilk being like gold. As Julie poignantly remarked:

Because every little drop is gold, that’s what they teach, you know. (2A#2par76)

Gold was a powerful metaphor for breastmilk. Paul said:

We got a bit of colostrum I think it’s called, we got a reasonable amount of that out. I mean that’s like liquid gold I heard, so, you know. (4B#1par64)

Referring to expressed breastmilk as gold has an incredibly powerful connotation. Such a reference values the milk highly, which reinforces the importance of the object breastmilk and the imperative to succeed. Participants in this study are not the first people to make reference to expressed breastmilk being like gold (see for example Nursing Mothers’ Association of Australia 2000). And as Julie said, the term ‘liquid gold’ was everyday language in the NICU.

For the parents in this study, as time passed and mothers continued to express, parents’ knowledge and awareness of milk volumes increased further. They become very fixated and controlled by the volume of milk for each expression. Fiona spoke of how she persisted to express to achieve a specific volume each time even though it took a long time:

I’d have to work for every drop, you know, and I’d be lucky if I got 20 ml each go, and it would take me 40 or 50 minutes to get that. (8A#1par83)

The volumes of milk produced became paramount to the experience of all of the participant parents.

There was a strong tendency for parents to measure and compare their lactational performance. Measuring up performance went beyond the boundaries of self, and both mothers and fathers compared the volumes produced to those of other families. John spoke of seeing the milk from other mothers in the refrigerator, and he suggests it adds to the stress of the experience, particularly when your supply is less than that of other families:

I mean, some women you see, and you look in the fridge there and they’ve got jugs of milk running everywhere. (...) But when they’ve got, you know, a 250 ml jug full and you’ve got ½ inch in the bottom, that’s a little bit disappointing then. You know, you think, you sort of start to lose a bit of faith in it then. So that’s probably why I tend to put the jugs in the fridge so that if she, Chris doesn’t see it she doesn’t feel so bad then. (5B#1par232)

Such experiences suggest that the refrigerator is the centre point around competition as milk producers; it is responsible for a type of ‘performance anxiety’ whereby ones lactational performance can be viewed and scrutinised by all who access the refrigerator.

Many of the parents read literature relating to breastfeeding and breast expression; however, they found the recommended daily volumes of breastmilk collection unrealistic, when compared to their experience. Chris remembers her concerns at her milk supply in relation to the textbook recommendations:

I think they all expect you to get too much but, you know, like you read all the literature and it says you’ll get x amount, but you don’t. (5A#1par31)

Peter found that such literature, which is meant to be helpful, became very distressing:

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1 Dairyvale is a large (cows) milk producing company in Australia.
Well ... it’s hard enough expressing and then to have this doubt placed in their mind, the fact they’re only getting, in round figures, half of what the books say. (...) It puts the element of doubt in it, ‘shit, we’re not doing good enough’. (SB#2par24:32)

All parents made some reference of comparing their breast expression experience to other people or to breastfeeding literature. All of these references cited only milk volume or duration—objective measures—as a source of lactational comparison.

Most participant mothers were so focused on breastmilk volumes that they began to chart their milk production. This was not requested by the hospital or suggested in any of the pamphlets that were provided. It was just something that these mothers initiated themselves. Fiona said:

I’ve been keeping a little diary, I keep a list of how many times I express a day and how much I got through each expression, and, you know, [I] count up, you know, the sum total of what I got through the day. (8A#2par267)

Alison kept a record of her breastmilk volume for the hospital staff in case she needed to approach them for advice. She felt they would recognise, and act on, the written record of evidence of her milk supply, rather than rely on her verbal account and recall of volumes:

So what I’m doing now is I’m keeping a chart, you know, so that way they can have a look and say ‘no, you’re fine’, or ‘yeah, we have to do something’. Because me obviously just saying it, they just put it down to me being a prem mum, you know. So I just thought, oh I’d do it this way so. (7A#2par175)

For Alison, charting became a form of proof of being a good parent; it gave her tangible objective evidence. Recording her expressing became a way in which she could demonstrate her compliance and effort with the expression regime regardless of the outcome.

The preterm infant’s feeding schedules also foster the fixation on quantity and of the objectification of breastmilk. The preterm infant is started on feeds of only a few millilitres per hour; thus, parents get an awareness of the exactness of their feeding. Paul remembers clearly the early days of his baby receiving milk feeds:

... they gave her 1 ml, then 2 ml, 3 ml and then that and that increased, like it went for 4 hours, to 3 hours, to 2 hours to every hour, so the feeds got closer and closer and the dose, the amount got higher and higher. (4B#1par260)

Paul referred to his baby’s feeding as a prescribed ‘dose’ in a very precise way. This small variation, one millilitre at a time, was seen as so important to this infant’s feeding schedule that the parents too became concerned about their every millilitre. By using the metaphor ‘dose’ for his baby’s milk, Paul is suggesting that the infant feeding is a medical prescription; an exact science.

Bottle-feeding was actively practiced in the participating hospital’s newborn nurseries, and all of the babies in the study were fed by bottle (EBM if available, otherwise infant formula) during their hospitalisation. Bottle-feeds are an absolute: an objective assessment of infant intake. Bottle-feeding was not the feeding method of choice for these families, and some parents were apprehensive about their use at the outset. Parents recognised that it was important for the baby to learn to suck feed, and as the mothers could not be present all of the time, they came to consider bottles inevitable and unavoidable. Even when the breastfeeding mother was available, bottle-feeds were sometimes given. Lisa said:

I mean, you know the routine with them, they start them on, you know, one breastfeed and then they go to one bottle feed, and I mean, I was there giving her one bottle feed and initially she couldn’t have another breastfeed because it was just too tiring for her, because she was still so small, [sigh] so. (4A#3par100)

Because of the powerful discourse of bottle-feeding being easier for the baby and bottle-feeding associated with known quantities of intake, Lisa reluctantly participated in the routine. The active use of bottle-feeding caused much tension and conflict for Lisa. She had not chosen to bottle-feed her baby with breastmilk; she had chosen to at-breast feed.

Parents were accustomed to knowing their infant’s intake per feed in the nursery when fed via bottle or gavage, but found the unknown quantities of at-breast feeding very difficult to get used to post-discharge. Dennis spoke at depth about the inability to measure milk intake with at-breast feeding:

See, with breastfeeding there’s no, well, as you can imagine it’s not like giving him 150 ml amount of, or 150 ml of milk or 100 ml of milk, where if he drinks it or he doesn’t drink half, you know what he’s had. Where with the breastfeeding, you don’t know how much he’s had ... (7B#3par31)

... [with bottle-feeding] you’ve got the measurement and that was the integral part, again whatever you put in that bottle, whatever he drunk, it’s got markings for every, you know, down to every ml so you know what he’s having. (7B#3par75)

In a world where every millilitre of milk counted, breastfeeding was unpredictable and unmeasurable. The dependence on objective measurement was such a strong focus of the in-hospital management of their baby’s feeding that it remained after discharge and therefore undermined breastfeeding for these families.

Preterm infants are weighed at birth and at frequent regular intervals thereafter, for the duration of their hospital stay and into the post-discharge period. The regular weight monitoring caused
much conflict for the parents. The views of Chris and John were in contrast to those of all other participants. While most parents spoke with resentment of the staff’s dependency on monitoring the infants’ weight, Chris and John wanted the monitoring to continue to assure them that all was well.

... they weigh every day, so every day we got, like, a report card of how many grams he put on or whatever, so we had to mark that on the calendar every day what his weight was. (5A#3par184)

Chris likened the daily weight as a ‘report card’—an objective measure of performance and hopefully success. A report card is usually a way to evaluate and grade a person’s performances as passing or failing at the assessable undertaking. This is common in institutions of education, but it is not usually associated with health care provision or breastfeeding.

Six of the seven families that participated in the third interview gave complementary feeds (either EBM or infant formula) in addition to breastfeeding in the first weeks at home as a direct result of infant weight assessment. Lisa recalled:

Domiciliary nurses from the hospital were coming out every second day and weighing her ... And the reason for that was, she was not putting on enough weight ... which was unfortunate and I was having to supplement every feed whether it was initially I was expressing between feeds and topping up with the bottle, um or then in the end it was either that or formula, and her weight was just (...) it was really slow going on, so, in the end, I had to go over to formula completely. (4A#3par8)

When infant weight gain was not as quick as the health professionals wanted, breastmilk intake was assumed responsible and parents were requested to give the infants complementary feeds. This assumption sent mothers a powerful message that their breastfeeding was insufficient, and the need for infant formula signalled failure of their breastfeeding. Parents began to question the value of their breastfeeding when they followed up with a bottle of breastmilk substitute. Indeed, within a few weeks of complementary feeding 5 of 6 families chose to cease breastfeeding and continue with bottle-feeding using an infant formula. Dennis and Alison swapped to bottle-feeding with infant formula as a way to increase Joel’s weight rapidly:

I think it was about four weeks, if I hazard a guess, before we had to go bottle-feeding to try and get the weight on him in hurry, which seemed to be the important thing, according to the doctors. (7B#3par19)

Since the health professionals’ focus was on a quantifiable milk intake and substantial infant weight gain, it is no wonder that parents came to accept this same measure of infant progress and feeding success to the detriment of their at-breast feeding.

**DISCUSSION**

In the experience of breastfeeding a hospitalised preterm infant, it is the breastmilk that matters more than the maternal experience. The dominant ethos in the NICU is on the nutritional needs of the baby rather than at-breast experiences. The hospital staff—and subsequently the parents—concentrate on milk volume intake and the baby’s weight gain, and this focus persists throughout the entire infant period.

An object is a tangible and visible thing. As Young explains, ‘practically, the object is property’ (1990, p191). An object is measurable, precisely countable and comparable. Breastmilk, in normal at-breast feeding, is not measurable. However, in breast expression as it dominates the preterm breastfeeding experience, breastmilk is separated from the mother, measured and given to the hospital to assist caring for the preterm infant. The collection of this object breastmilk becomes the focus of the mothers’ behaviours, thoughts and feelings, while the measured milk becomes the focus of infant feeding. As has been shown from the participants’ experiences, there are many ways in which the breastmilk is objectified in the preterm breastfeeding experience. Objective measurement is seen as the gold standard for success in our society and any objective facts or figures are highly recognised and regarded (Enkin et al. 1995). Within the hierarchy of knowledge, scientific evidence claims superiority and neglects individual variability of experience. If you can measure it and compare it you can prove it as successful or not. This dependency on quantitative objective measurement is evident in all of the participant’s experiences of breastfeeding preterm infants.

As has been shown, some of the women went to excessive effort to document their milk production in minute detail to see daily variances and weekly changes. Meier (2001) argues that mothers should be encouraged to maintain written diary records of their breastmilk expression to provide objective information about their lactational performance. In the NICU environment there is an imperative to document and chart every detail pertaining to the infants’ wellbeing; every millilitre of milk is seen as important and worthy of noting. Parents may see charting their expressed breastmilk as an extension of this nursery culture and practice. Charting milk production gives the parents detailed knowledge of their own lactation and, in our society, knowledge is power. This represents a way in which they can regain some control over their breastfeeding experiences, but this practice is not always helpful.

Michel Foucault (1977) suggests self-surveillance is a form of self-discipline through which people strive to conform to the norm. Parents in this study described their record-keeping as a useful, and possibly even necessary, component of managing—particularly less than optimal—preterm lactation. Using the work of Foucault on surveillance, it is possible to see how the hospital environment’s concentration on infant nutrition through known milk quantities and fixed routines has, in itself, fostered similar behaviours within (in particular) the mothers in the study. However, the surveillance
and objectification of lactational performance, for example, can have unintended consequences. As Foucault (1977) has argued, such self-surveillance and self-discipline may not necessarily be a good or bad thing, but often has unintended consequences. For example, the self-regulation and self-discipline of women with their breast expression routine leads it to become, in a sense, an obsession or distraction to their everyday world. While this may be helpful to improve lactational performance, it may become harmful to their emotional state and psyche—particularly if the outcome does not meet the expected norm. The diarising of milk volumes—a vivid form of self-surveillance—was not asked for or encouraged by the health professionals, but the micro culture of the NICU and its focus on volumes and objective assessment influenced the participants to undertake it. This, it could be argued, was a way for them to avoid self-blame if the lactational outcome was less than that desired. An example was shown with Alison who expressed fear of being deemed a bad mother despite doing everything she felt humanly possible to produce sufficient breastmilk. Even though she was able to self-regulate her health state—in this instance related to lactation—Foucault’s work suggests that an unintended consequence of such self-control is blame when things do not have a positive outcome.

Throughout the experience of having a preterm infant in hospital the objectified feeding is of utmost importance. Because of the dominant discourse in the NICU of child welfare and optimal nutrition through breastmilk provision, it is of little surprise that the parents soon underwent an acculturation process and began to ascribe to the same notions of worth, being objective breastmilk feeding. Parents found it too difficult to trust what cannot be measured and therefore quantifiable bottle-feeding (with breastmilk substitute) prevailed for all but one family. This is not surprising, given that the medical model of infant breastfeeding, which focuses on the infant and breastmilk, has long been known to deny the maternal—infant interaction. Indeed, research priorities involving breastfeeding are testament to this (Ewing & Morse 1989). The maternal breastfeeding experience is of little significance in the nutritional care of the preterm infant. Reports such as that by Schmied (1998) highlight the disconnection and disembodiment and essentially objectification that the medical model imposes upon breastfeeding. Whilst Schmied’s (1998) study refers to term infant feeding this objectification is particularly profound in the preterm breastfeeding experience as shown by the participant parents in this study.

This change in focus for the parents—from natural connected breastfeeding, to objective measured infant feeding—caused immense conflict and confusion. On the one hand, the parents chose to breastfeed; to feed their baby ‘naturally’—directly from the breast—the way nature intended. On the other hand, the preterm birth and subsequent exposure to the NICU environment resulted in a dependence on numbers and quantifiable infant feeding, devoid of the natural connectedness they expected. The preterm breastfeeding reality was that this was not the breastfeeding they desired or wanted to do. The paradox was significant and the parents constantly struggled with the opposing viewpoints of their desires to their reality.

The objectification of breasts and breastmilk is perpetuated in the professional literature. Breastfeeding texts directed towards the education of health workers emphasise the physiology of breastmilk production, the ability of a woman’s breasts to function adequately, the quality of a woman’s breastmilk and infant nutrition (Schmied 1998). Rarely is breastfeeding presented as a significant relationship in a woman’s life, and more often than not the woman, her family, and their experiences are absent from such practical education guides (Schmied 1998). The experience of the participant families has added strength to this literature and shown how, in the preterm context, the objectification of breasts and breastmilk is profound.

CONCLUSION

The analysis reveals that there are many aspects of the preterm breastfeeding experience that result in objectification of breastmilk and the breastfeeding experience. Indeed, the objectification of the preterm breastfeeding experience has had a major influence on the practice of breastfeeding and also on attitudes about breastfeeding—what it is and what it should be. The exclusivity of breastfeeding as the mother’s domain is lost in the preterm breastfeeding experience. The focus is taken away from these women’s mothering/feeding practices and is placed on objective infant feeding. Past research would explain the breastfeeding outcomes with this group of parents as perceived milk insufficiency, as evidenced by the initiation of complementary feeds in addition to at-breast feeds. However, the reasons for the discontinuance of breastfeeding for these families are far more complex than ‘perceived milk insufficiency’ implies. What the analysis has shown is that the health professionals’ support both during and after hospitalisation was predominantly counterproductive to the parents’ exclusive at-breast feeding efforts. The findings suggest that nurses and other health professionals need to acknowledge the impact of their practices—both positive and negative—on parents’ experiences of breastfeeding a preterm infant. This is not to suggest that they need to change infant feeding to the detriment of the neonate, but rather be mindful of the unintended consequences of the care they provide and the practices they encourage.

Research into breastfeeding preterm infants is only just beginning to question the dependence on objective infant feeding. Pridham and colleagues (2001) have questioned the need for over-zealous complementary feeding for the majority of preterm infants and have found that if exclusive on-demand breastfeeding is allowed to continue without the interference of complementary and supplementary feeds then, in many cases, it may well be successful. Furthermore, experiential studies on (particularly) women’s experiences of breastfeeding at term are beginning to emerge. Further research applying a social model as opposed to a medical model of breastfeeding will continue to provide new knowledge of the preterm breastfeeding experience.
This study has shown that the objectivity of the preterm breastfeeding experience can lead to negative breastfeeding experiences for women and their families. Objective infant feeding, dependent on simply milk provision or food service, places no value on the subjective experience of breastfeeding women. Preterm infant feeding, dependent on known quantities of milk intake and surveillance, only serves to undermine the mothers’ breastfeeding desires, abilities and outcomes.

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