Mothers' Emotional Benefits of Breastfeeding

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Abstract

The purpose of this study is to discover if breastfeeding education and support affect the feeling of guilt mothers may experience who did not reach their breastfeeding goals. The participants are women that have previously breastfeed, who participate in the Women Infant Children (WIC) program. The participants completed a survey about the breastfeeding education and support that they received, their breastfeeding goals, and about any feeling of guilt they felt when they stopped.

Emotional Benefits of Breastfeeding

Choosing a feeding method for a baby is something many do not think about until they are pregnant and expecting a child. Many factors can weigh on these decisions, but the emotional breastfeeding benefits for the mother are often not considered, because there are no easily accessible sources to this information, and it is not common knowledge. The World Health Organization recommends breastfeeding for 2 years (WHO, n.d.). The current initiating breastfeeding rate in the United States is 83.2%. The continued breastfeeding rate is 35.9% at 6 months (CDC, 2018). When 83.2% of women choose to breastfeed on the first day of life, it shows intent to have breastfeeding goals (2018). The dramatic drop over the first 6 months suggests that there is a reason women are not continuing to breastfeed.

Social culture has a large impact on the rates of breastfeeding, as women support one another in the method of infant feeding that they have chosen. Their success or failure in reaching their breastfeeding goals has the potential to affect their breastfeeding philosophy, what they share with others, and their social influence on others regarding breastfeeding. This is not limited to friends advising one another, but also medical professionals, community leaders and those setting policies at a state and national level. More research is needed as to determine how breastfeeding support and education affect feelings of guilt in mothers who do not reach their breastfeeding goals. This paper explains many emotional benefits of breastfeeding, how guilt about not breastfeeding affects mothers, and how mothers cope with the guilt they feel when they stop breastfeeding.

Awaliyah, Rachmawati & Rahmah (2019) researched maternal breastfeeding satisfaction in a study with 204 breastfeeding participants in Indonesia. The cluster sample of participants were chosen based on the criteria of breastfeeding their infant for 4-8 months postpartum and

having no significant physical problems that negatively affected breastfeeding (p. 2). The participants were surveyed regarding maternal breastfeeding satisfaction, breastfeeding knowledge, attitude toward breastfeeding and breastfeeding self-efficacy on previously developed scales of measurement (p. 2).

Breastfeeding satisfaction is defined as, "the satisfying feeling obtained during breastfeeding resulting from cooperation between the mother and the infant to fulfill desires or needs" (Awaliyah et al., 2019, p. 6). It is contributed to by the hormones oxytocin and prolactin and promotes bonding and a feeling of happiness, benefiting the mother's emotional well-being (p. 6). Researchers concluded that breastfeeding satisfaction is correlated with breastfeeding self-efficacy, which was the most influential factor (p. 5). Higher income and vaginal birth were all associated with breastfeeding satisfaction. The last correlating factor was breastfeeding education. Researchers discovered that more breastfeeding education led to higher breastfeeding rates, as well as breastfeeding satisfaction.

Lawal & Idemudia (2017) examined whether maternal age, breastfeeding self-efficacy and health locus of control directly influence a mother's psychological well-being. Dimensions of psychological well-being included, "sense of autonomy, purpose in life, self-acceptance, positive relationships with others, environmental mastery and personal growth" (p. 1231). For this study, a convenience sample of 291 breastfeeding mothers in Nigeria provided demographic information. The effect of the variables on psychological well-being was measured through analysis of survey questions. The survey contained statements that began with "I can always" and answers were given in a 5-point Likert scale (p. 1232). A higher selection on the scale indicates a higher level of breastfeeding self-efficacy and belief in the mother's control of her state of health in regard to breastfeeding. Psychological well-being was measured in the same

way.

The researchers concluded that maternal age, breastfeeding self-efficacy and health locus of control all contribute to a mother's psychological well-being in its many facets. Specifically, maternal age had direct influence of environmental mastery; breastfeeding self-efficacy was positively correlated with a sense of autonomy; and health locus of control was positively associated with relations with others, as well as the mother's personal self-acceptance (Lawal & Idemudia, 2017, p. 1236). This indicates that when a mother is confident in breastfeeding, she is more content, feels pleased with herself and gains positive emotional benefits that affect her well-being. When a mother believes she can strengthen her and her baby's health through breastfeeding, she is able to take determined steps toward and therefore succeed with breastfeeding, which in turn gives her confidence in social situations, as she is self-assured (p. 1236). There are combined benefits of the variables that also reached the same results. The conclusion is that confidence while breastfeeding and control over decisions and aspects of breastfeeding, are essential for a mother have and enjoy the benefits of psychological well-being while breastfeeding (p. 1230).

Parkinson, Russell-Bennett & Previte (2018) analyzed the application of the theory of planned behavior on the complex social behavior of breastfeeding. Researchers wanted to discover the effect of emotions and previous experience on the behavior of breastfeeding (p. 839). The participants were 1,275 women from America (796) and Australia (479) with a child under 18-months-old who were currently or previously breastfeeding (Parkinson et al., 2018, p. 845). They completed an online survey using a Likert scale to answer questions regarding their attitude about breastfeeding, emotions regarding their breastfeeding experience, immediate social norm influences, perceived ability to breastfeed and overcome challenges, positive and negative

anticipated emotions, future breastfeeding intentions, and desires about breastfeeding (p. 846). Based on the data, mothers were categorized in one of two groups: novice or experienced in breastfeeding (p. 847).

The researchers concluded that breastfeeding self-efficacy was more significant in affect on experienced mothers than novice mothers, revealing that as breastfeeding experience is gained, self-efficacy increases. Negative anticipated emotions significantly affected desire to breastfeed in both groups (Parkinson et al., 2018, p. 852). Emotions of positive anticipation and subjective social norms affected desire to breastfeed and breastfeeding behavior of novice mothers more than experienced mothers was supported. The combined desires to breastfeed had a strong impact on breastfeeding behavior in both novice and experienced groups, but were significantly stronger in the novice group (p. 855). Conversely, researchers found that beliefs and attitudes regarding breastfeeding did not affect the desire to breastfeed in either novice or experienced participants (p. 851).

Little, Legare & Carver (2018) explored, "whether mother–infant physical contact predicted feeding in response to early hunger cues versus feeding on a schedule or after signs of distress among U.S. breastfeeding mothers" (p. 2). The participants in these studies were breastfeeding mothers in the US. Two different study methods were used to test the hypothesis based on self-reporting and actual behavior. Study 1 was an online survey regarding types and frequency of physical contact with their infant, as well as self-reported responses to hunger cues. In Study 2, the participants kept a three-day journal of detailed information from each feeding, including proximity to baby and reason for feeding.

In Study 1, data on physical contact during the day and night was gathered in order to determine if proximal care affected the mother's responsiveness and if responsiveness predicted

better breastfeeding outcomes (Little, Lagare & Carver, 2018, p. 3). There were 626 participants with infants between newborn and 24 months old (p. 3). The measurement of physical contact was taken by asking the mothers questions about the primary method they used to transport their baby and where the baby sleeps. The mothers' beliefs about their responsiveness to their infant's hunger cues were measured through a series of questions in which they rated their answer between one and five from disagree to agree (p. 4). They were also asked about their feeding philosophy, whether they feed on demand, on a schedule or a combination.

In Study 2, mother-infant contact was examined to discover if it was closely linked with mothers responding to early hunger cues, and increased the likelihood of feeding their baby for comfort (Little, et al, 2018, p. 8). There was a distinction made between mother-infant proximity and mother-infant contact, and it was predicted that contact would increase mother responsiveness (p. 8). For each feeding, information was asked for including proximity of baby when mother decided to feed and what signs baby gave that he/she was hungry (p. 9).

The results of the studies confirmed that mothers having more physical contact with their infants predicts that they are more likely to respond to early hunger cues, and specifically, mothers responded more frequently while having mother-infant contact during hunger cues (Little, et al, 2018, p. 11). Early signs of hunger are smacking sounds, hands to mouth and nuzzling, while the main late sign of hunger is crying. Babies who are fed on demand when showing first signs of hunger are not pushed to the point of distress before feedings, keeping a more positive connection between mother and baby (p. 9). Mothers who spend more time in close contact with their baby are more aware of the baby's emotional state, which allows the baby to communicate more clearly with the mother (p. 12). Researchers also concluded that visual contact was not enough for mothers to increase the non-hunger infant led breastfeeding

sessions, confirming that physical contact during breastfeeding initiation lead to more comfort feedings. Little et al, also concluded that mothers who practice babywearing and co-sleeping are intentional to maintain contact with their infants in order to comfort and feed them, meeting emotional and physical needs on demand at the same time (p. 12).

Weaver, Schofield, & Papp (2018) hypothesized that observable maternal sensitivity over time is increased by the length of breastfeeding. This is based on the desire to understand if emotional bonding between a mother and her baby during breastfeeding creates a long-term bond that helps mothers to feel more connected to and better care for their babies. Maternal sensitivity is defined in the study as the mother's quickness of response to her baby as well as her ability to read her baby's cues, her emotional response to cues and ability to meet needs. If a mother continues to remain sensitive, then she is more intentional to guide the emotional development of the child and control her own emotions as she does so. Previous studies have found correlations between breastfeeding and maternal sensitivity, but this study aimed to eliminate possible variables that would negate control, including ethnicity, education level, presence of romantic partner and parental attitudes (p. 220).

The participants in this study were 1,272 mothers from all over the United States, who brought their children in 8 times between birth and 11 years old to participate. To measure breastfeeding duration, parents were interviewed at 1 month and then several intervals up to 3 years (Weaver, et al., 2018, p. 223). Measuring maternal sensitivity was accomplished by recording parent and child interactions of completing an assigned task together (p. 222). Attachment security was measured during a 2-hour observation in the participants home when the child was 2-years-old. Maternal breastfeeding, attachment and sensitivity, were all measured, and measurements were intentionally done at different times.

The researchers found that breastfeeding did increase maternal sensitivity and could be used to accurately predict maternal sensitivity up until age eleven (Weaver, et al., 2018, p. 224). Breastfeeding duration was a predictive factor in maternal sensitivity, and this was not dependent on the mother's background. Though attachment was a correlated factor in maternal sensitivity, it could not be determined as the mediator in this study meaning that there are likely multiple factors that influence the mother and child bond past the age of two (p. 225).

An exploratory study by Sim, Hattingh, Sharriff & Tee (2014) analyzed the attitudes and perspectives of breastfeeding mothers while using herbal galactagogues to improve milk supply (2014). Researchers wanted to know why the participants chose the path of herbal supplementation to improve breastfeeding effectiveness; specifically, what factors motivated the decision (p. 2). A convenience sample of 20 breastfeeding women currently using galactagogues in the Perth Metropolitan area were used (p. 3). Data was collected in one-on-one interviews, using an interview guide, with questions collecting documentation of galactagogue use, participant's perceived efficacy, and the perspectives and attitudes of participants toward herbal supplementation (p. 2)

Analysis of the qualitative data revealed the motivations for using galactagogues included confidence in desire and will to continue breastfeeding, determination to persevere in breastfeeding and parental and peer influences (Sim et al., 2014, p. 4). Other themes included the need for more support and resources for galactagogues including safety and efficacy studies, and increased natural breastfeeding support from health professionals. Participants had an overall positive attitude toward the use of galactagogues and all supported the philosophy that 'breast is best', as well as had a positive attitude toward natural feeding and natural methods of increasing breastfeeding success (p. 9). Researchers found that the majority of participants had verbal

support and had received recommendations that supported their strong desire to continue to breastfeed, as well as improve milk supply and effectiveness. There are psychological and emotional benefits are potential for mothers who use galactagogues, including empowerment, self-efficacy and autonomy (p. 9).

Dietrich & Misskey (2015) investigated the infant feeding experiences of mothers during the first six months postpartum in order to discover why early breastfeeding cessation remains common. The participants were 191 mothers from Western Canada, who completed a survey regarding how they felt about the experience of breastfeeding. Researchers hypothesized that analysis of the mothers' responses would confirm the need for individualized personal and emotional support for women who are breastfeeding (p. 2). The survey was designed to gather personal reflections, experiences, opinions and justifications for feeding decisions through open-ended questions. Qualitative content analysis was used to separate the participant's statements about breastfeeding into positive experiences, mixed emotions and negative experience (p. 3).

Researchers found that the majority of the participants had positive experience reflections and expressed pride, pleasure, strength, and delight in their breastfeeding experience (Dietrich & Misskey, 2015, pp. 3-4). Participants with mixed emotions liked or disliked certain aspects of breastfeeding, including frustration, pain and stress, and those who reflected on their experience with negative statements commonly used the words 'frustrating' and 'difficult' to describe the physical and emotional challenges they experienced; the most common being latching and milk supply issues (p. 4).

Dietrich & Misskey concluded that the findings supported incorporating psychosocial and emotional breastfeeding support due to breastfeeding experiences being diverse and not simply based on biological factors. Providing encouragement, reassurance and breastfeeding knowledge

are all-important in overcoming the conflict of breastfeeding difficulties and personal and social expectations. Supporting duration rates for breastfeeding includes the need for individualized support for mothers who feel guilt or sadness because of their breastfeeding experience (p. 7).

Radzyminski & Callister (2016) performed a descriptive, qualitative study of the beliefs, attitudes and decisions of breastfeeding and formula feeding mothers. The goal of the study was to analyze the personal perception of mothers on the process of choosing her infant feeding method. Researchers interviewed a convenience sample of 152 mothers within 72 hours following the birth of their child at the same hospital in the District of Columbia (p. 21). The interviews were completed and audio recorded in a private room at the hospital, where participants were asked open-ended questions about why they chose the infant feeding method they were currently using, and whether they had considered other feeding methods and why. The interviews were analyzed and Radzyminski categorized the considerations of mothers' infant feeding method into infant nutritional benefits, maternal benefits, knowledge about breastfeeding and personal and professional support (p. 18).

The feeding method results were 38% exclusively breastfeeding, 16% exclusively formula feeding and the 46% feeding by combining both methods (Radzyminski & Callister, 2016, p. 21). Researchers concluded that exclusively breastfeeding mothers had significantly more infant-minded responses, cited feeding method knowledge as a motivator, and were confident with their decision, while exclusively formula feeding mothers gave more self-minded responses, were more likely to be defensive, and stated a lack of information or desire to know more about feeding methods (p. 25). The majority of breastfeeding mothers is both the exclusive and combination groups identified their motivation for breastfeeding as benefiting the health of the baby, and none of the exclusively formula feeding mothers cited infant nutritional benefits as

a motivator for their feeding method (p. 24). The benefit that exclusively formula feeding mothers referred to for their feeding method was for maternal benefits including avoiding physical pain, independence and convenience (p. 25). A recurring theme in responses from exclusively formula feeding mothers about whether they had considered breastfeeding, was that it was socially uncomfortable or unacceptable in the presence of others; a sentiment not mentioned by any exclusively breastfeeding mothers. Overall there was very severe contrasts between the exclusively breastfeeding and formula feeding beliefs and attitudes about their chosen feeding method, while those who were combination feeding revealed a combination of the beliefs and attitudes of both of the other groups.

Ayton, Tesch & Hasen (2019) studied the cessation of exclusive breastfeeding. Researchers desired to understand how women experience breastfeeding cessation. A convenience sample of 127 mothers in Tasmania self-reported their breastfeeding and cessation experiences in interviews with researchers (p. 2). Researchers used the term 'breastfeeding grief' to define the negative emotional response of participants to breastfeeding cessation when the mother had a deep desire to breastfeed, but used formula to feed their baby (p. 7). In this study, breastfeeding cessation is defined as any cessation from baby receiving only breast milk (p. 1).

Researchers observed common language pertaining to the normal and natural act of breastfeeding, while formula was considered unnatural and wrong (Ayton et al, 2019, p. 3). They also discovered a theme of self-reported personal endurance to overcome struggles that were physical, personal and/or social including having low milk supply, feelings of loneliness and being socially shamed (p. 5). The mothers express the benefit of social and physical capital including having resources available to them, family and partner support, consulting with health professionals, as well as breast pumps, bottles and pacifiers (pp. 5-6). These factors positively

contributed to their ability to overcome challenges, while the mothers who were not successful in overcoming challenges to reach their goal of exclusive breastfeeding face breastfeeding grief. Researchers concluded that, "The cessation of exclusive breastfeeding through formula use often results in feelings of prolonged grief and failure, making it potentially harmful to women's emotional well-being" (p. 7).

Holcomb (2017) sought to discover what women who want to breastfeed do when they use formula instead of breastfeeding (p. 364). The participants in this study were 22 first-time mothers, with a total of 96 interviews completed at intervals beginning prenatally (p. 364). The in-depth, semi-structured interviews were conducted for 12 months, or until the woman stopped breastfeeding, which was defined as feeding baby human milk from the breast or bottle (p. 365).

Six mothers breastfed exclusively the entire 12 months, 5 mothers used formula for only a short time and then breastfed exclusively, and the other 11 transitioned to fully formula feeding (Holcomb, 2017, p. 365). Only 2 out of the 16 who used formula verbalized expressions of guilt for stopping breastfeeding (p. 365). The other 14 mothers were observed as having used 3 coping strategies to deal with the guilt of using formula. First, some of the mothers stated that using formula was not her choice and could not be avoided because it was either done without their consent or was recommended by a doctor (p. 366). These mothers did not express guilt, as they were not the ones who made the decisions, though it is possible that medical professionals, "could undermine their desire to breastfeed" (p. 367). The second coping strategy was recognizing effort, when mothers justified formula feeding by seeing their breastfeeding accomplishments as satisfactory (p. 368). The third coping strategy was mothers focusing on their overall well-being where she stopped breastfeeding in favor of personal, psychological or practical preference of using formula (p. 369). Holcomb concluded that these coping strategies

were a method of mothers maintaining their personal identity as a good mother, when they experience, "dissonance between their breastfeeding expectations and experiences" (p. 370).

Research regarding the maternal emotional benefits of breastfeeding provides valuable information regarding the positive emotional response to mothers reaching their breastfeeding goals, and also the emotional repercussions of not reaching these goals. There is an abundance of evidence suggesting the need for social, educational, emotional and physical support from many sources. Women stop breastfeeding for many reasons, including lack of ability or choosing to stop, but research shows a common theme of mothers claiming feelings of guilt when this change occurs. Based on the lack of data in previous research regarding guilt associated with unmet breastfeeding goals, this study will help discover if receiving breastfeeding education and support before and during breastfeeding reduces their feeling of guilt. The hypothesis for this research is mothers who receive both prenatal breastfeeding education and post-partum breastfeeding support have less feelings of guilt about unmet breastfeeding goals.

Methods

Purpose

This research studies mothers who have previously breastfed in order to discover if both prenatal breastfeeding education and postpartum breastfeeding support reduce feelings of guilt when a mother stops breastfeeding.

Participants & Sampling Procedures

Mothers that breastfed and who are clients in the state WIC program.

Research Design

This study is exploratory and descriptive and aims to determine whether mothers who receive both prenatal breastfeeding education and post-partum breastfeeding support have less feelings of guilt when they stop breastfeeding. Both quantitative and qualitative data were

collected in order to accomplish the research.

Instrumentation

The instrumentation used to extrapolate data was a survey designed specifically for this study. Most of the variables are ordinal as response options were ranked on a Likert scale in order to promote unbiased self-perception responses.

Data Collection

Participants were given a verbal invitation either in person or on the phone, followed by offering a paper version of the survey or emailing an online version of the survey via surveymonkey.com.

Ethical Consideration

See attached IRB application.

Bias

The bias in this research is against those mothers who have limited transportation, internet or phone access.

Assumptions

Research is done based on the assumption that participants will answer the questions honestly.

Limitations

Issues with memory may interfere with survey results.

Results

Sample

The sample is 21 mothers who breastfed from Kootenai County. All clients are WIC participants, and therefore meet the WIC eligibility guidelines of a yearly income that falls under

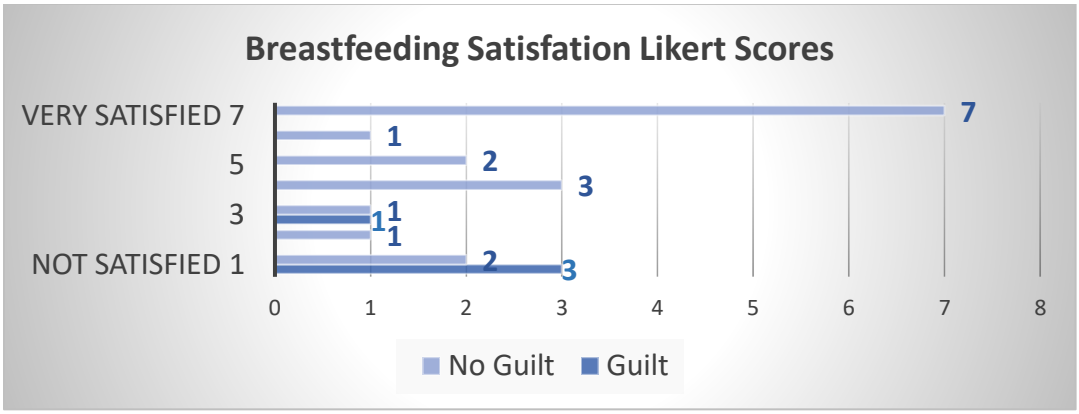
the national poverty level. Women's breastfeeding experiences ranged from 3 days to 2 years, and all received some form of prenatal breastfeeding education and breastfeeding support.

Survey Findings and Observation

Of the 21 participants, 17 answered that they do not feel guilt about stopping breastfeeding, while 4 answered that yes they do have feelings of guilt. The research findings are based on a comparison of these two groups.

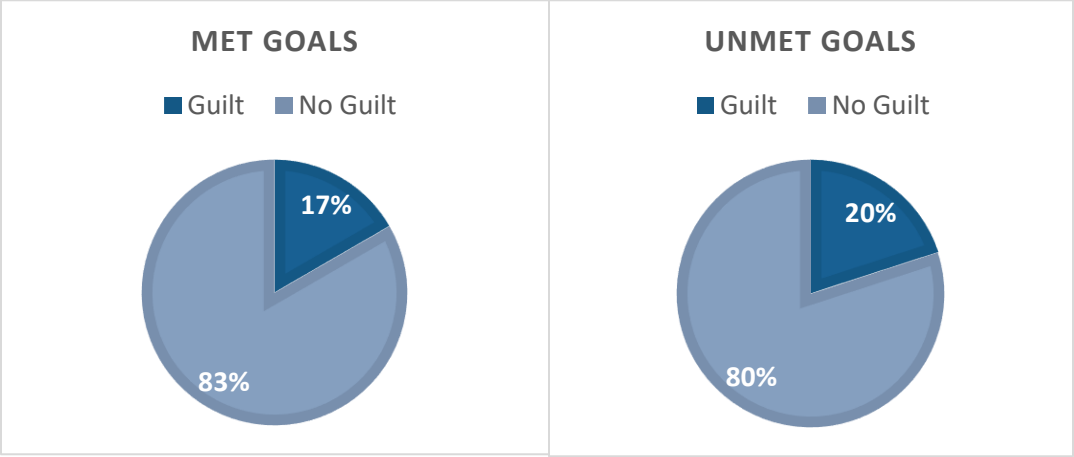
Breastfeeding Satisfaction

Based on a Likert scale of 1-7, participants rated how satisfied they were with their breastfeeding experience. You can see on the chart below that all participants in the top range (4 - 7) of feeling satisfied with their breastfeeding experience did not have feelings of guilt when they stopped breastfeeding**,** while mothers who expressed feelings of guilt, all rated their breastfeeding satisfaction in the lower range (1 – 3). There were 4 additional mothers who scored in the low range of satisfaction, but who did not have feelings of guilt about stopping breastfeeding. The lower satisfaction scores are the result of the mothers' breastfeeding experience not meeting their expectations. However, they did not feel guilty because they believed the decision to stop was out of their control, such as the inability to produce enough milk.



Breastfeeding Goals

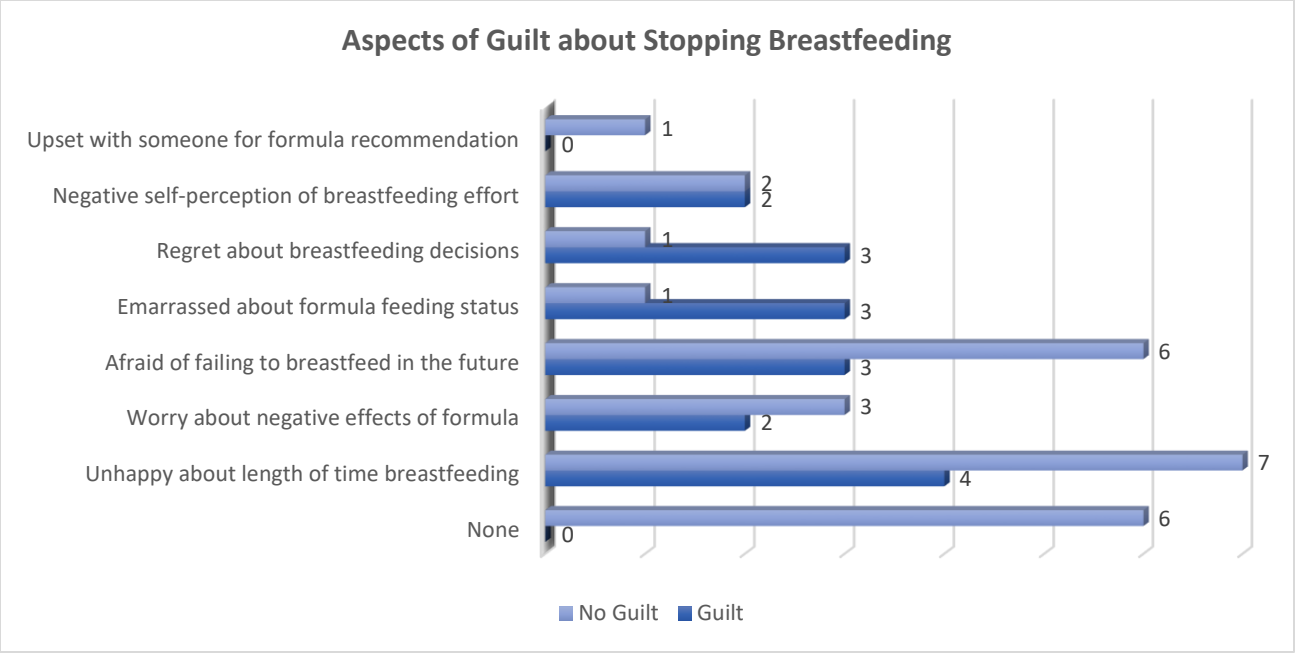
It was expected that mothers who met their breastfeeding goals would not feel guilty about stopping. As shown in the first pie chart below, 83% of mothers who met their breastfeeding goals did not feel guilt. However, an interesting finding from this research is that nearly the same percent of mothers who did not reach their breastfeeding goals, also did not feel guilty about it. As hypothesized, this could be a result of the positive effect of breastfeeding education and support providing confidence and satisfaction whether or not breastfeeding goals are met.



Aspects of Guilt

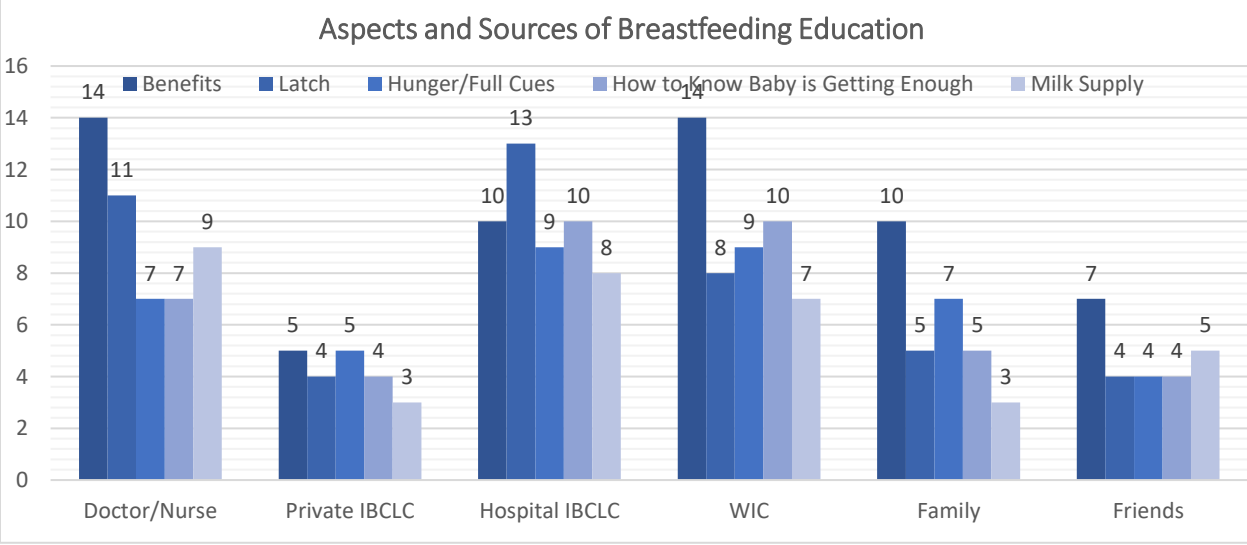
Participants were asked to review a list of possible reasons for feeling guilty after they stopped breastfeeding. Mothers who did not feel guilty about stopping breastfeeding checked an average of 1.2 items. This group indicated their two greatest concerns were being unhappy about the length of time they breastfed and fear of failing to breastfeed in the future.

Mothers who felt guilty about when they stopped breastfeeding checked an average of 4.5 items. Their greatest concern was also being unhappy about the length of time they breastfed, but as indicated in the chart below, mothers with feelings of guilt cited multiple reasons for their guilt.

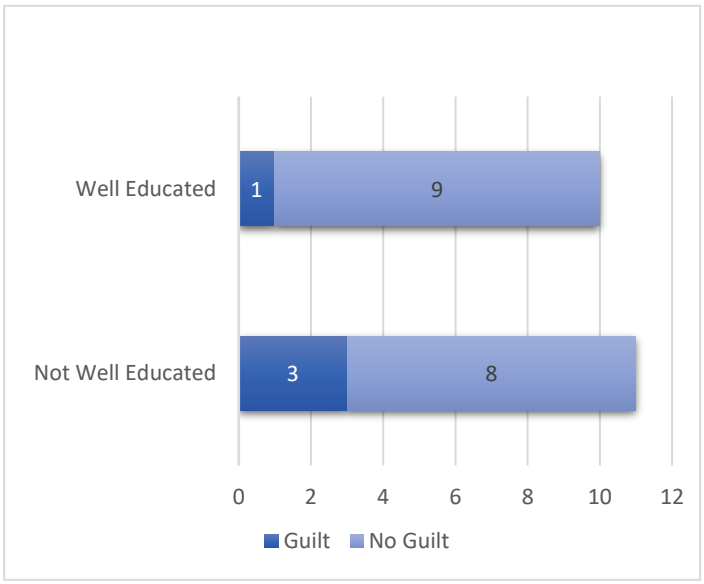


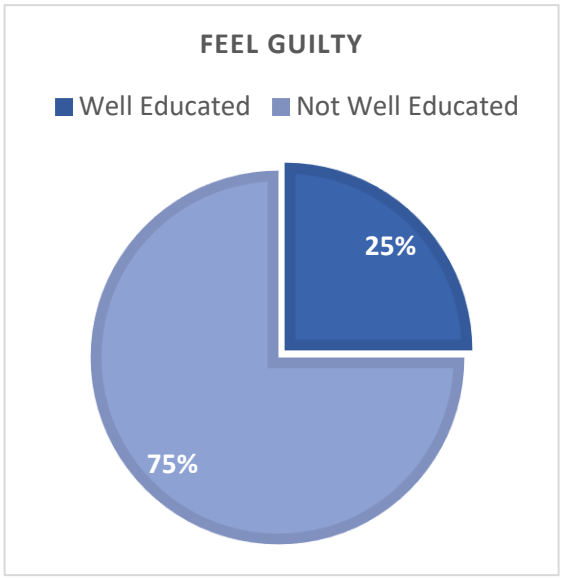
Prenatal Breastfeeding Education

As shown in the chart below, the prenatal aspect of breastfeeding most covered by nearly every educational source was information about the benefits of breastfeeding, such as reducing risk of illness and increasing bonding. Participants received the most breastfeeding education from medical professionals including Doctor/nurses, Hospital IBCLCs and WIC.



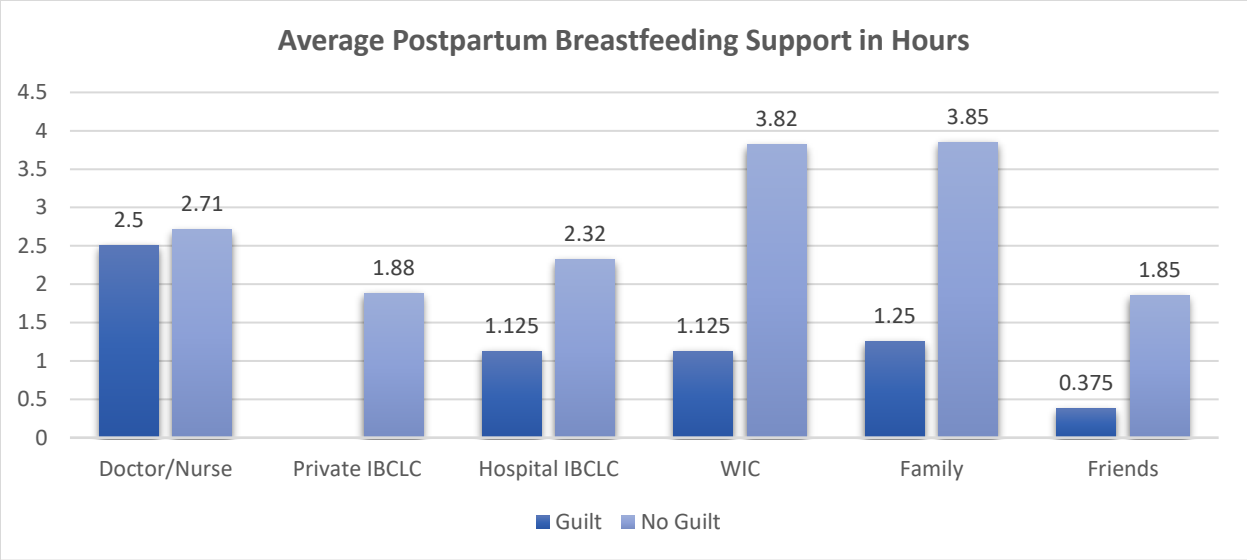
Mothers who received breastfeeding education from at least two sources in all five aspects were considered well-educated for the purposes of this study. Ten participants, (nearly half) met the criteria for well-educated in breastfeeding aspects. Regarding breastfeeding education and feelings of guilt, the data revealed that 75% of mothers who feel guilty about stopping breastfeeding were not well educated. This confirms the hypothesis that participants who were well educated about breastfeeding were less likely to feel guilty after they stopped breastfeeding.





Postpartum Breastfeeding Support

Participants were asked to estimate the number of postpartum breastfeeding support hours they received from various sources. The group of mothers who did not feel guilty about stopping breastfeeding had an average of 10 more hours of postpartum support than the group of mothers who felt guilty about stopping breastfeeding. This data supports the hypothesis that postpartum breastfeeding support is correlated with a lower likelihood of mothers having feelings of guilt when they stop breastfeeding.



Discussion and Implications

The purpose of this research was to discover factors that contribute to feelings of guilt when a mother stops breastfeeding, because this guilt has a significant negative effect on mothers' lives. It became clear through this research that unmet breastfeeding goals was one of the contributing factors to mothers' guilt, however, much of that guilt was placated by a mother becoming well-educated in all of the aspects of breastfeeding. In this study, over 70% of mothers who set breastfeeding goals did not reach them, but still did not feel guilty when they stopped breastfeeding. Participants who did not have feelings of guilt stated they believed they did everything they could, which indicates self-efficacy which correlates with breastfeeding satisfaction.

WIC teaches about breastfeeding benefits and baby behavior, especially hunger and full cues, to all of their clients. Latching, milk supply and how to know baby is getting enough are more specialized topics that are available through the Breastfeeding Peer Counselor program at WIC. Dietrich & Misskey (2015) concluded that latch and milk supply issues were the most common factors that lead to negative emotions regarding their breastfeeding experience (p. 4). If

these negative emotions contribute to feelings of guilt for a breastfeeding mother, then these aspects of breastfeeding need to be more universally available to mothers.

Currently, breastfeeding education is not included in the standard of care in OB or pediatric offices. Because the findings of this research conclude that breastfeeding education reduces feelings of guilt, mothers need to be made aware of current education programs through OB offices that can recommend breastfeeding education prenatally, and pediatric offices that can make recommendations for breastfeeding support after baby has arrived.

Once a baby is born, the hospital breastfeeding standard of care is 1 hour of latching support. After mothers leave the hospital, they are responsible for locating continued support on their own. Consistent hospital referrals to postpartum breastfeeding resources will help mothers connect with support programs, making them less likely to feel guilty when they stop breastfeeding.

What was learned from this study is that providing more breastfeeding education and support can not only reduce feelings of guilt, but also effect a woman's confidence, satisfaction and emotional well-being. WIC provides breastfeeding education to all mothers planning to or currently breastfeeding, followed by referral to the Peer Counselor program for further prenatal education and postpartum support. In this study, 35% of participants, all of which are WIC clients, answered that they did not receive any breastfeeding services from WIC. In order to assure mothers receive the breastfeeding services they are entitled to as WIC clients, clinical assistants need to more consistently refer mothers to the Peer Counselor program. One way to ensure this happens is by auditing WIC referral practices for breastfeeding education and support. Abiding by these recommendations will reduce mothers' feelings of guilt that are associated with her breastfeeding decisions and increase maternal emotional well-being, which

effects all areas of her life including the ability to have positive relationships with others, mastery of her personal environment, and feelings of empowerment.

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