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Breastfeeding with primary low milk supply: a phenomenological exploration of mothers' lived experiences of postnatal breastfeeding support

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Abstract

Background Most women can produce enough milk to exclusively breastfeed. However, a small cohort are prevented from doing so due to a condition known as *primary low milk supply*. The aim of the study was to provide new insights into how mothers with this condition experience help and support from professionals, volunteer support groups, and partners.

Methods Interpretative phenomenological analysis was used to explore the lived experiences of nine first-time breastfeeding mothers in Ireland who had primary low milk supply. One-hour interviews were conducted over Zoom between April and October 2021.

Results *Being with Others*, one of four superordinate themes identified in this study, concerns the participants' experiences of receiving professional, voluntary, and partner breastfeeding support. Four sub-themes were identified: *Disconnected Encounters*, *Perceiving Judgement from Others*, *Being in a Safe Space* and *Having a Saviour*. The encounters of participants with healthcare professionals revealed a lack of rapport, intrusive hands-on support, poor perceived quality of breastfeeding support and a heightened sensitivity to language and tone. Participants expressed that they valued empathy and emotional support from lactation professionals as much as they valued skilled lactation support. Furthermore, participants appeared to experience an enhanced motherhood self-identity and self-acceptance through seeing their experiences mirrored in the experiences of other mothers with primary low milk supply in specialist low milk supply-specific support groups.

Conclusion The interactions that mothers with primary low milk supply have with various *others* in their world (healthcare professionals, lactation consultants, volunteer breastfeeding supporters, and partners) can shape how they view themselves and can have a profound impact on their breastfeeding journey. There is a need for greater knowledge and understanding among healthcare professionals of the phenomenon of primary low milk supply so that women suspected of having the condition may receive appropriate support. Where possible, mothers with primary low milk supply should be directed to specialist breastfeeding support groups.

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Background

Most mothers produce enough milk to breastfeed exclusively in line with the World Health Organization (WHO) recommendations [1]. However, a small cohort of women are prevented from doing so due to a phenomenon known as *primary low milk supply* [2, 3]. This is an intrinsic condition which may be caused by insufficient glandular tissue (IGT) [4–6], metabolic disease or hormonal factors such as Polycystic Ovarian Syndrome (PCOS) and insulin resistance [2, 7, 8]. Primary low milk supply is distinct from *perceived low milk supply* where by a mother has an unfounded belief that she is not producing enough milk [9] and *secondary low milk supply*, arising from poor breastfeeding management [10].

There is very little research on the incidence of primary low milk supply. One large epidemiological study conducted in New Zealand in 1958 found that at least 6% of participants did not breastfeed due to primary low milk supply caused by IGT or other medical issues [11]. A more recent study of 319 breastfeeding mothers in the U.S. conducted in 1990 found that 15% of participants had *persistent lactation insufficiency* [12]. However, the principal author subsequently stated that she believed the true rate of primary low milk supply for western women to be 4% [13]. There have been no further large-scale studies in recent decades to investigate the incidence of primary low milk supply. The condition is not listed among conditions that are deemed by the WHO and UNICEF as acceptable medical reasons for the use of breastmilk substitutes [14].

There has been a growing awareness of the importance of understanding the emotional impact of difficult breastfeeding experiences [15, 16] and how psychological well-being is linked to breastfeeding 'success' or 'failure' [17, 18]. Recent studies have highlighted the practical challenges and emotional impact of having primary low milk supply among breastfeeding mothers [19–21].

Regardless of the reasons why breastfeeding may be challenging, evidence indicates that when women receive appropriate breastfeeding support, the duration and exclusivity of breastfeeding is increased [22–24]. The manner in which Healthcare Professionals (HCPs) provide breastfeeding support and engage with mothers also matters [24]. Negative breastfeeding experiences in the first week increase the incidence of low breastfeeding self-efficacy [25] and receiving conflicting information can have a negative impact on mothers [26]. Recent studies have called for individualised and evidence-based breastfeeding support for specific issues including low milk supply and consistency in the advice given by HCPs [19, 27]. Furthermore, efforts to help mothers overcome breastfeeding challenges and to understand lactation failure have been listed among the priorities for breastfeeding research [28]. In Ireland specifically, many mothers are dissatisfied with the quality of breastfeeding support that they receive, pointing to a lack of individualised support, difficulties in accessing help and support that is inadequate for specific challenges [29, 30]. Furthermore, significant gaps have been identified in the provision of breastfeeding education for HCPs in Ireland [31–33].

Voluntary breastfeeding support is widely regarded as playing an important role in helping mothers reach their breastfeeding goals and having their social needs met [33, 34]. However, a potential weakness of these studies is that they are based on the experiences of women who choose to engage with voluntary support services. It is possible that the needs of women who choose not to engage with these supports are missed.

The present study of women's experiences of breastfeeding with primary low milk supply is an attempt to engage with women's lived experiences of accessing breastfeeding support with the goal of adding to the existing body of work on breastfeeding difficulties. Four superordinate themes were identified in the broader study that was undertaken by the primary researcher (CW) with the support of her supervisors at University College Dublin. One of the superordinate themes, which explores the participants' emotional experiences of having primary low milk supply has been published elsewhere [20]. The superordinate theme, *Being with Others*, is addressed in this article. *Being with Others* is an analysis of the participants' experiences of interactions with HCPs, IBCLCs (International Board Certified Lactation Consultants), support groups, and partners as they endeavoured to breastfeed.

Methods

Interpretative Phenomenological Analysis (IPA) [36] was used to explore the lived experiences of women in Ireland who are breastfeeding with primary low milk supply. IPA is a seven-step qualitative research methodology concerned with revealing new insights about how individuals experience and make sense of phenomena (Fig. 1: Interpretative Phenomenological Analysis Seven-Step Process) [37]. Three key areas of philosophical knowledge namely, phenomenology, hermeneutics and idiography inform the epistemological foundation of IPA [36]. Phenomenology is concerned with revealing the meaning that participants derived from their lived experiences, hermeneutics guides researcher interpretation of the data, and idiography relates to the detail and uniqueness of each participant's experience [36]. IPA is considered useful for exploring topics that have emotional dimensions [37] and for under-researched phenomena or perspectives [38].

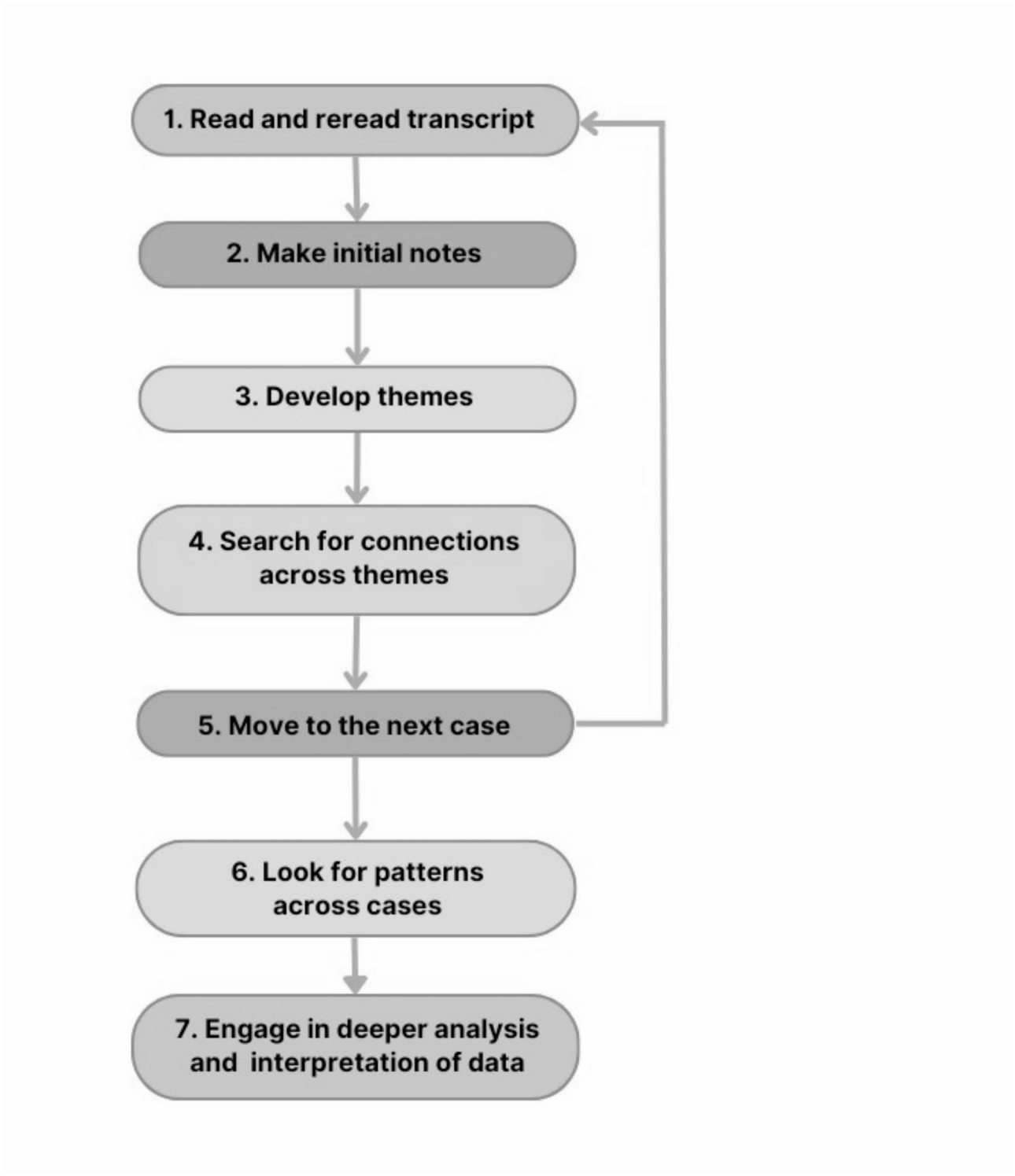

Fig. 1 Interpretative phenomenological analysis seven-step process

Setting

This study took place in Ireland, where there are only 58 dedicated infant feeding positions in the public health maternity services, serving a population where 58,443 babies were born in 2021 [39]. Eight of the nine participants in this study accessed the services of private IBCLCs, while just one was referred to an Health Service Executive (HSE) community IBCLC. It is common for women in Ireland experiencing breastfeeding difficulties to pay privately to see an IBCLC, as midwives, Public

Health Nurses (PHNs) and IBCLCs working withing the HSE often lack the time and/or skills required to provide optimal breastfeeding support for specific problems such as primary low milk supply [29].

Participants and recruitment

Purposive sampling was used to recruit nine participants. The sample size in IPA studies of this type tends to be small to allow for a detailed and in-depth exploration of participants' lived experiences of the phenomenon being studied, rather than data that aims to be statistically significant [38]. What matters is the richness of data, the depth of analysis, and the homogeneity of the sample [40].

Recruitment was via social media. Mothers who met the inclusion criteria were invited to contact the main researcher (CW) by email. These criteria were as follows: (i) being over 18 years of age, (ii) having breastfed their baby for at least four months, (iii) having primary low milk supply identified by an IBCLC or HCP, and (iv) having a baby of less than two years of age. The criterion of having breastfed for a minimum of four months was determined by the need to allow a reasonable timeframe to establish breastfeeding, and for primary low milk supply to be identified. Within two weeks of initiating recruitment, 32 women made contact with the researcher (CW) and the first nine who met the inclusion criteria were selected. Initial telephone contact was made to initiate rapport and to schedule an interview. Prior to giving birth all participants had intended to breastfeed exclusively. The characteristics of the participants are presented in Table 1.

Data collection

Interviews were conducted between April and October 2021 via Zoom and lasted between 55 and 75 min.

Table 1 Participant profile

	Pseudonym	Age	Baby's age at time of interview	Breast-feeding duration	Reported cause of PLMS
1	Caroline	33	11 mo	5 mo	PPH, PCOS
2	Fiona	37	11 mo	9 mo	IGT
3	Megan	40	16 mo	11 mo	IGT, PCOS
4	Amy	31	13 mo	5 mo	IGT, FA
5	Sinead	32	11 mo	10 mo	IGT
6	Kate	34	14 mo	14 mo +	IGT
7	Orla	32	10 mo	10 mo +	Hypothyroidism, possible IGT, FA
8	Ruth	36	9 mo	9 mo +	IGT, FA
9	Donna	38	2 years	18 mo	IGT

FA, Familial Alactogenesis. IGT, Insufficient Glandular Tissue. PCOS, Polycystic Ovarian Syndrome. PLMS, Primary Low Milk Supply. PPH, Postpartum Haemorrhage

The interviews were loosely structured around an interview guide that covered topics such as the motivation to breastfeed, experiences with breastfeeding, the practical and emotional impacts of having primary low milk supply, and supports accessed. Participants were eager to share their experiences and were very engaged in the topic. Interviews were audio recorded and stored in compliance with General Data Protection Regulation. Written informed consent was provided by participants prior to interview. Participants were assigned pseudonyms. It was anticipated that talking about their challenges with breastfeeding might trigger difficult emotions for participants. Ahead of the interviews, participants were advised that if they felt emotionally overwhelmed, the interview could be paused or terminated. While all participants became upset during interviews, they were happy to continue and complete the interview.

Reflexivity

Reflexivity is a process used in qualitative research to increase the credibility of findings [41]. It enables researchers to become self-aware and understand their influence on the research, and to consider how these might be minimised [42]. The first author (CW) was cognisant of her dual role both as a researcher and an IBCLC. She was aware of how being perceived by participants as an insider could influence the data, and was conscious that as a mother who breastfed her three children, she would bring a certain nuanced understanding of participants' experience to the process. Specific techniques that the first author employed to bring reflexivity to the research were (i) keeping a journal to allow for meaningful reflection, (ii) seeing a psychotherapist every six weeks to debrief, (iii) engaging with the principles of hermeneutic phenomenology prescribed by IPA. This involved interpreting how participants made sense of their experiences while also being attuned to researcher interpretations and sense-making (iv) engaging regularly with supervisors to limit the subjectivity of interpretations and (v) writing interpretative summaries after each interview. Writing interpretative summaries provided awareness of subjective responses to the data and potential to influence the research.

Data analysis

Data analysis was performed by following the steps prescribed by IPA [36]: (1) Becoming deeply engaged in the world of the participant by careful reading and re-reading of the transcripts. Transcribing the audio recordings also gave the main researcher (C.W.) an opportunity to become fully immersed in the participants' accounts of their experiences, and to pay close attention to the nuances of tone of voice and syntax. Participant pseudonyms were used in transcriptions and any identifying

information (such as the names of the participants' babies) in the audio recordings was omitted. (2) Making initial observations, facilitated by a table with transcribed text copied to a column in the table, and then unpacking the text to expose its language, semantics and content in a second column. (3) Identifying themes from the initial observations and actively connecting the data to the researcher's ideas, interpretations and reflections. (4) Searching for links across emerging themes. (5) Progressing to the next transcript and repeating steps 1–4. Each time the researcher moved to the next interview, it was important to be mindful of a tendency to want to find themes that had already been identified in previous interviews. (6) Scrutinising and documenting trends, themes and sub-ordinate themes across all nine cases. (7) Advancing to a more refined and in-depth level of interpretation of the data. Writing interpretative summaries after each interview provided a means of getting closer to the data and engaging in a phenomenological way with the identification of themes and interpretations. The main researcher (CW) also created mind maps for each participant (Fig. 2: Participant Mind Map) and for themes (Fig. 3: Theme Mind Map) as they were developed and found this visual way of engaging with the data a useful means of gaining insights that might not otherwise have been revealed.

This combination of different ways of analysing the data - IPA, creating mind maps and writing interpretative summaries - or *triangulation*, not only provided deeper insights but enhanced the credibility of the results (Fig. 4: Triangulation in Data Analysis). Oversight of this process by the main researcher's (CW) supervisors also helped to ensure the credibility of the results.

Results

Four superordinate themes were identified in this study namely: *Being in the Whirlwind*, *Being with Others*, *Reimagining Motherhood* and *Embodiment*. This article focuses on *Being with Others*. The title of this superordinate theme comes from Heidegger's concept that individuals experience themselves in a world with and through other people, and that their self-understanding is interwoven with the self-understandings of others [43]. As participants experienced the phenomenon of primary

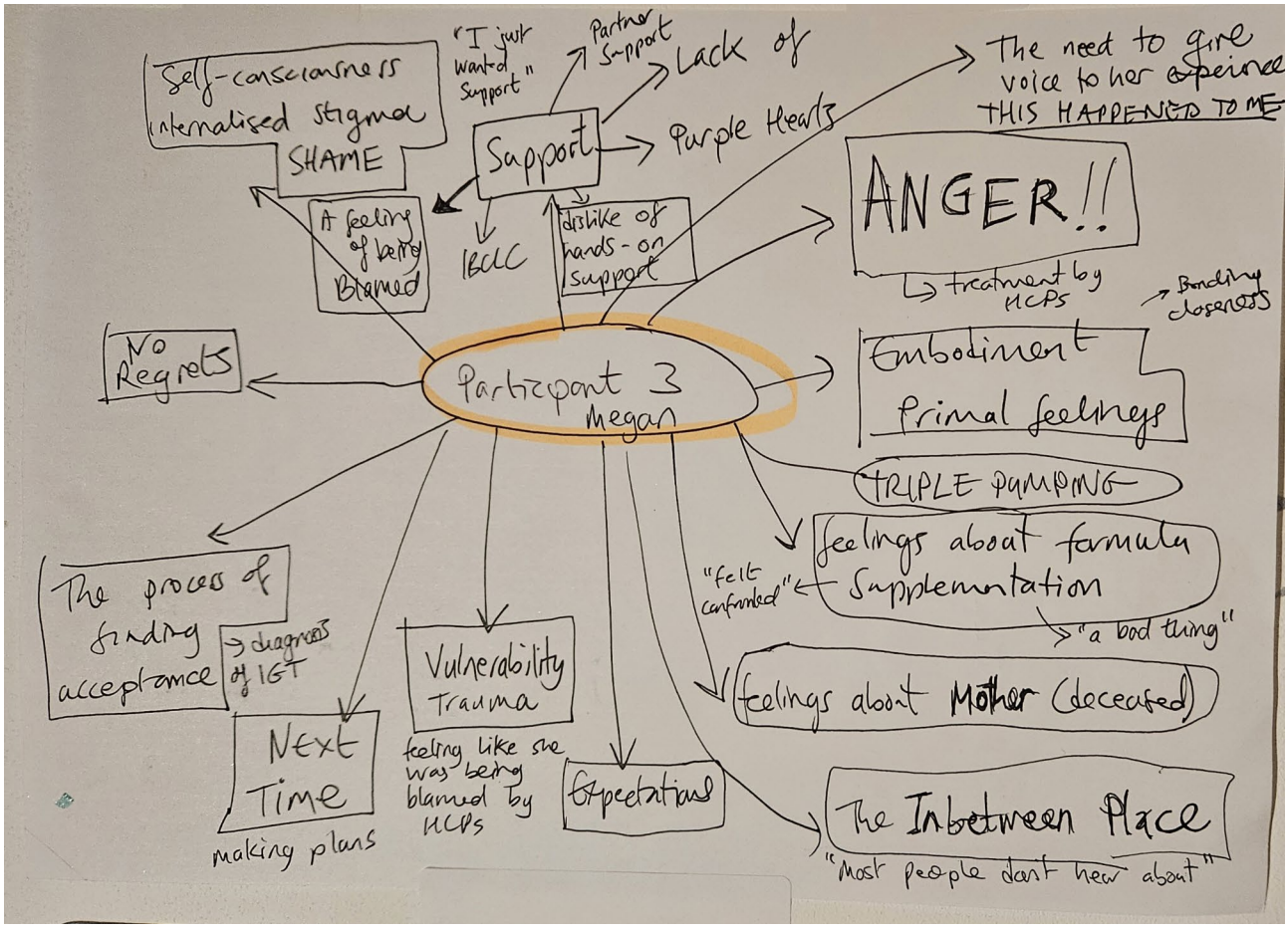

Fig. 2 Participant mind map

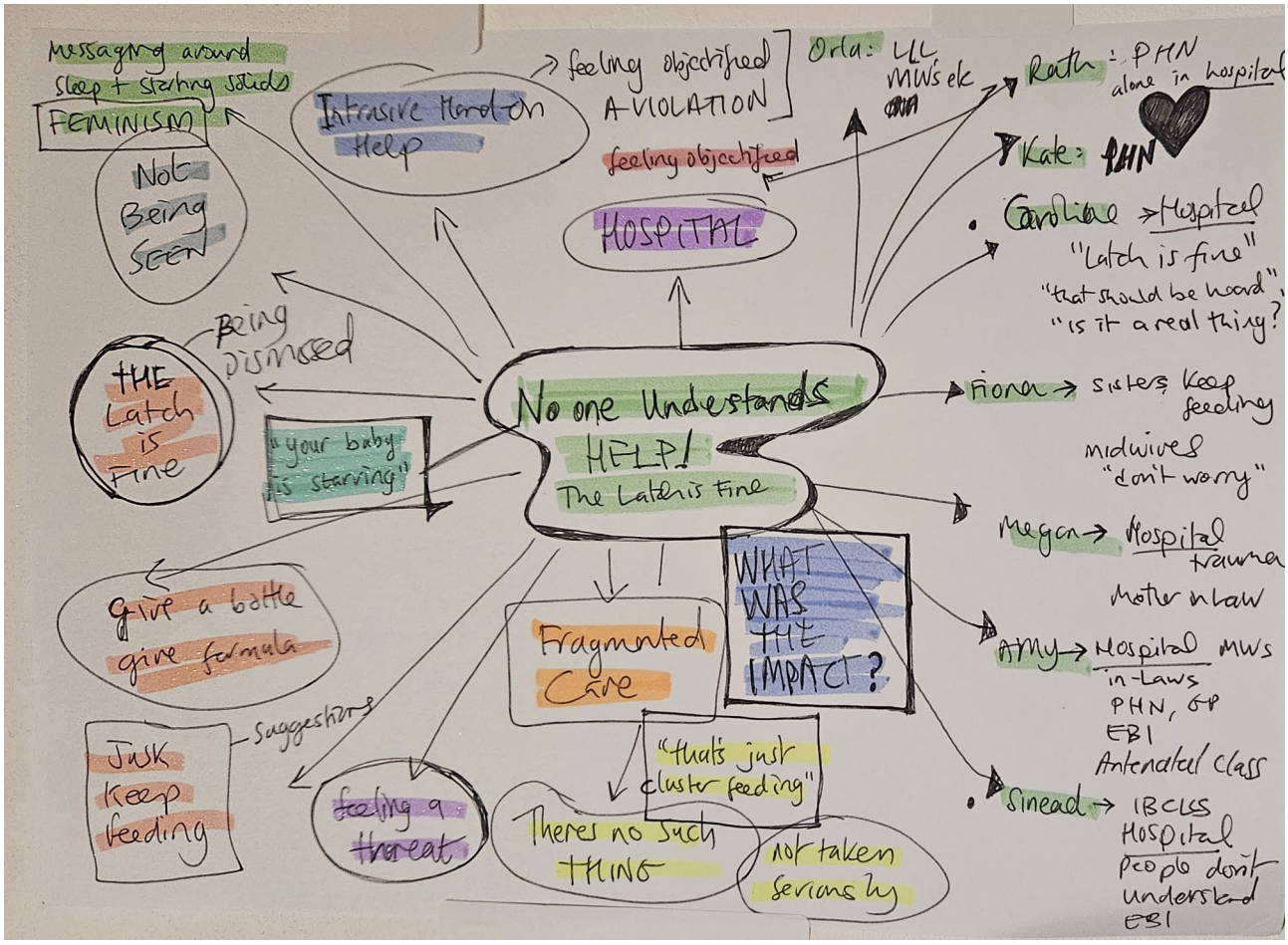

Fig. 3 Theme mind map

low milk supply, they had to engage with HCPs, IBCLCs, voluntary supporters and partners. The interactions that participants had with these various *others* shaped how they viewed and experienced themselves, and how they derived meaning from being a mother with primary low milk supply. There were four subthemes of *Being with Others* and these were *Disconnected Encounters*, *Perceiving Judgement from Others*, *Being in a Safe Space* and *Having a Savior*.

Disconnected encounters

This subtheme considers how participants experienced a lack of meaningful connection in encounters with people providing professional and voluntary breastfeeding support, and how these encounters resulted in them feeling that they were not being heard.

While in hospital, most participants felt that the focus of midwives was their baby's latch and that concerns they expressed about milk supply were dismissed. As a result, participants felt vulnerable and unseen, and had the impression that staff were not attuned to how important breastfeeding was to them:

> *I didn't really have any support in the hospital…the midwives would just take a quick glance and say "the latch is fine"…[Caroline].*
> *I tried to express colostrum….I didn't know what I was doing, the midwife tried to show me but she was really busy….I brought what I had to the nurses, they were just…"that's nothing, that's no good to him"… [Sinead].*

Recalling these encounters evoked sadness and anger for participants. Megan became quite distressed when she recalled an interaction she had with a paediatrician after it was discovered that her baby was not gaining weight:

> *…he said, I'll never forget it "oh she must have been starving" and that just [voice breaks, crying], that hurt me so much…I interpreted that as him saying I was trying to starve my baby [sobbing, deeply upset].*

Some participants were also unhappy about *how* Healthcare Professionals (HCPs) and International Board Certified Lactation Consultants (IBCLCs) communicated information about primary low milk supply and IGT to

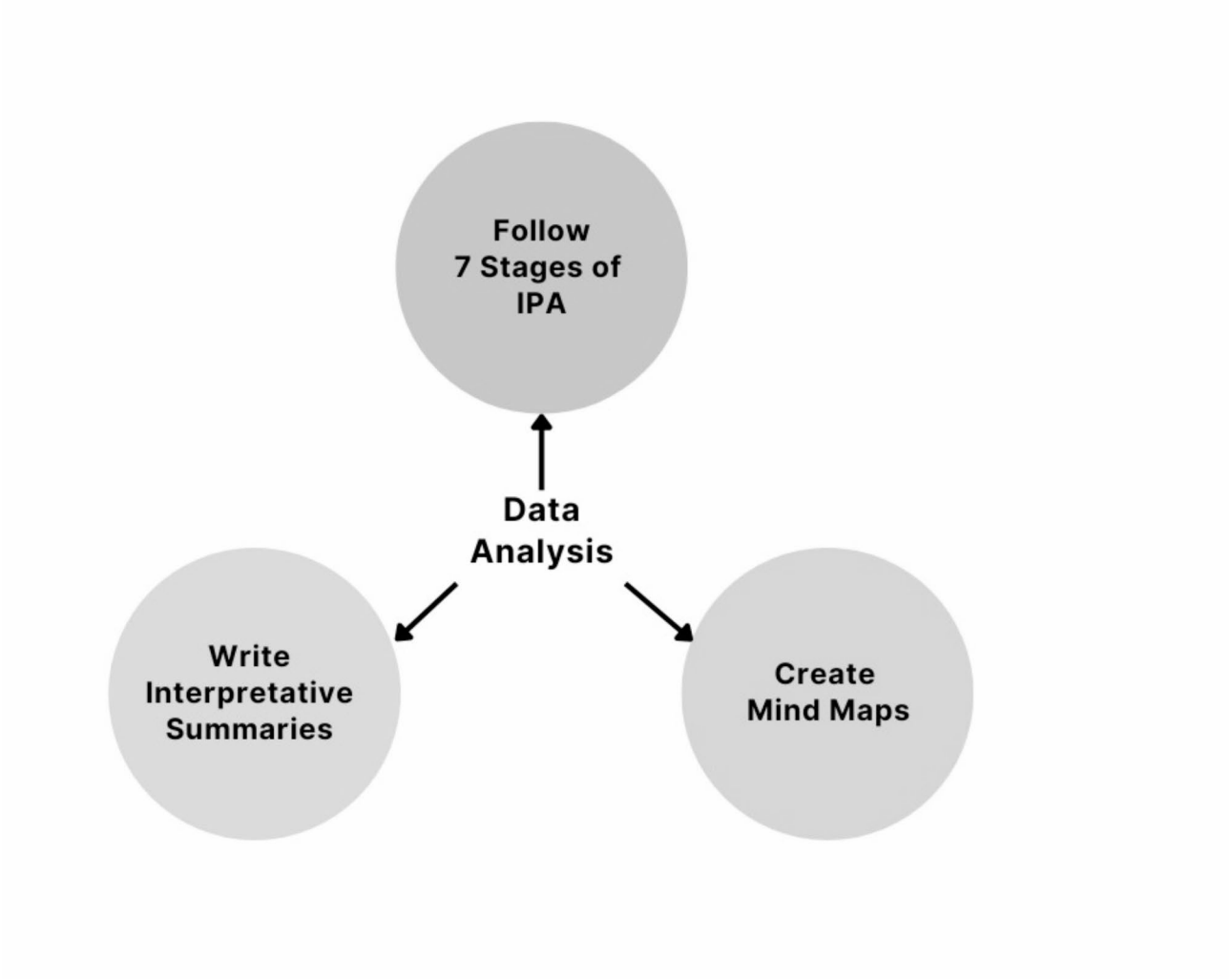

Fig. 4 Triangulation in data analysis

them. Being told these conditions are rare or uncommon made them feel alone and marginalised:

> *I asked her if it was common and she said "maybe I have one every couple of years"…It just made me feel more alone…it would be helpful if they had more compassion and knew a bit more about it. [Sinead]*

Another aspect of breastfeeding support in hospital that some participants mentioned was unwelcome hands-on support from midwives. At a time when participants were vulnerable and anxious, this insensitive care increased their anxiety:

> *…she is one of those people who tries to get her hands in, it was such an invasion of my personal space, I felt violated by her, she was so uncaring. [angry tone of voice]. [Megan]*

Participants described very unsatisfactory interactions with PHNs. Kate regarded her PHN's attitude as not only unreasonable and unhelpful, but a threat to her sense of agency:

> *The PHN got so annoyed with me for going to an IBCLC…she was being a huge pain, and I was like… "look I am just doing what I can to get the support I need"…it's my choice who I go to… [annoyed and exasperated]. I was so frustrated, it was such a head-wreck…all added stress. [Kate]*

Ruth also had a deeply upsetting experience with her PHN which left her feeling objectified and humiliated. She described a meeting with the PHN her in her local health centre and became very upset as she recounted what was said to her:

I was just a new mom…not used to feeding in front of strangers… she looked at me and said "you have a very large gap between your breasts", direct like that and kind of cold which automatically just made me feel like a freak….I said I was feeding her all the time,…and she said "well that is because she is starving"… [Ruth].

There was clearly a lack of empathetic connection between Ruth and the PHN, and an apparent lack of awareness on the part of the PHN of Ruth's vulnerability. Furthermore, Ruth interpreted the comment that her baby was "starving" as an implication she was negligent as a mother.

One of the difficulties participants perceived in breastfeeding support groups was the attitude that there is no such thing as low milk supply. Amy describes her reaction to comments in a Facebook group and Orla recounts her experience of attending a La Leche League group:

…someone commented about low supply and most of the comments were "there's no such thing, you just latch your baby and your supply will build up and don't believe anyone saying you have low supply." It made me angry. [Amy]

I was talking to La Leche League and the ladies were just telling me "just put him on the boob, don't worry, the milk will come in, don't give him formula at all…" [Orla].

Like other participants, Amy and Orla appeared to be very attuned to others' opinions about low milk supply and angry that their concerns were dismissed. They internalised the message to keep breastfeeding as dismissive and undermining.

Perceiving judgement from others

In social settings, many participants feared judgement from others. They felt different, they were embarrassed about giving infant formula and they felt a need to explain to people why they were not exclusively breastfeeding. This could be interpreted as *internalised stigma* - an awareness of others' perception of an 'undesirable difference' in them that makes them feel that they are falling short of what they ought to be. Many participants described feeling self-conscious and even ashamed about giving their babies infant formula in social settings and expressed that they felt a need to explain to people why they were not exclusively breastfeeding. They gave the impression that formula-feeding in public undermined their sense of who they were as a mother:

I feel a little bit ashamed with people seeing me formula feed her…And sometimes I over-share, I might say "oh she is combination fed", I feel like have to say it…. [Ruth]

I always want to tell people about the IGT…then it's "that's why I'm not breastfeeding"…it's just, I'm still a breastfeeding mum even though I'm not breastfeeding, or whatever that is. [Caroline]

Caroline strongly identifies breastfeeding as inseparable from her identity as a mother and craves acknowledgement that she had a difficult time breastfeeding:

I need the opportunity to talk about it or you kind of want it acknowledged… [Caroline is crying].

Megan used an at-breast supplementer and explained how she felt using this in front of other mothers. She portrays herself as vulnerable and self-conscious, unable to understand why her body cannot make enough milk for her baby yet feeling obliged to explain to others why she was feeding this way:

…they weren't rude about it but they were like "what is that?" [tone and facial expression of disgust]… "and you're breastfeeding her, and there's formula and a tube?", they were trying to be nice about it but it wasn't something they had ever been exposed to. Having to explain it when I didn't even know why I had to do it….

Rather than give their babies infant formula in front of other people, some participants chose not to as they did not want people to know they had low milk supply. Donna described attending a breastfeeding support group and leaving when she knew her baby needed extra milk, rather than giving him formula in front of the other mothers:

I couldn't fully participate in some of the things because I was supplementing…it was totally my perception. It was shame…this is the dirty laundry piece…not wanting people to know or to see that I couldn't fully feed him. There was always a coffee after the breastfeeding group, and I remember looking at my baby thinking he's hungry and…I just wasn't willing to feed him the bottle in front of other people, having emptied both breasts. It sounds totally idiotic…all I should have said was "I have low supply" but in a group of people who had all successfully achieved supply for their children I couldn't do that.

Donna felt that she was falling short of a level of achievement which she believed all the other mothers at the group had attained. She feared judgement for not

exclusively breastfeeding and compared having primary low milk supply to having 'dirty laundry' – something to be hidden or ashamed of. The consequence of this internalised feeling of stigma for Donna was isolation from the other mothers.

Some participants recalled experiences of being in a large breastfeeding support group on Facebook. The perceived negative attitudes towards the use of infant formula and scepticism about low milk supply made them feel stigmatised and angry. Both Amy and Sinead subsequently left this group:

> *I think there's a lot of hatred for combination feeding in that group because it is seen like "oh you just want a break from breastfeeding" or "you just don't want to do night feeds" or "you're just not committed to it."…it made me angry…. [Amy]*
> *…I feel that there is a sense of being really sceptical of people who say they have low supply and they don't know what it is to triple feed…and always be obsessing about your supply. [Sinead]*

Kate described not being able to breastfeed exclusively as being like denied admission to an 'exclusive' club. This analogy is representative of how participants experienced having primary low milk supply. Kate highlighted a common perception that mothers either breastfeed or formula feed, and asserts that she did not fall into either of these categories, rather, she was 'in-between:'

> *I hate the word 'exclusive' it's like it's this exclusive club that I'm not in…it makes it seem like it is all or nothing…but there is lots in-between.*

Being in a safe space

This section discusses experiences of peer-support from other mothers with primary low milk supply. Four of the participants were members of a WhatsApp support group for mothers experiencing breastfeeding difficulties called *The Purple Hearts* group. Most of the women in this group had primary low milk supply. Two of the participants joined a low milk supply support group on Facebook. They reported similar experiences of being in these groups. The one benefit they stressed above all others was that of being understood, and therefore validated:

> *….they accepted me into the Low Milk Supply group, and…I was so overwhelmed because I was like "this is actually a thing!" [excited tone]…other people have this…I started reading other people's posts… that was a real changing point for me in my journey. Just like life-changing…. My journey would have been much worse if it hadn't been for that Facebook group. [Sinead]*
> *…it felt really good to be connected with other women who know this is important to me as a mum. [Fiona]*

Being in these groups helped the participants come to terms with having primary low milk supply. The understanding and empathy they described contrasts with the lack of understanding they reported in their interactions with HCPs. Megan became emotional as she elaborated about what it was like to feel that she was in a 'safe space' among people who had had similar experiences:

> *…people who get that grief, who understand the challenges and practicalities of that…there are people who have been through similar things, who'll say "I've tried this", or people who…can say "yeah I went through that it was so hard". For new mums to the group everyone really rallies round and says "you're doing so well keep going"…it's just really compassionate people…[starts crying]…it's just a really safe space. [Megan]*

Another aspect of being supported by other women with primary low milk supply was reassurance that they were not on their own:

> *…hearing different women's problems and hearing the hardship that they had to go through…gave me a sense of belonging and then knowing that you're not the only one…you feel listened to. [Orla]*

Hearing other women's stories appeared to give participants greater insight into their own experience of having primary low milk supply and a realisation of how much effort they had invested in breastfeeding. Being in the groups served to hold up a mirror to them and helped them develop a greater sense of self and a stronger motherhood self-identity – an identity which had previously been shattered by having primary low milk supply:

> *…when you talk to all of those women…you realise we do 500 percent more than the women whose baby latches ok. [Orla]*
> *…being able to give advice to other mums kind of made me realise how far we have come. I remember one of the women…her baby was maybe five weeks and she just looked so sad, it was like looking in a mirror… and I could just relate so much, she looked exhausted and so sad and frustrated and…it made me realise we have come a long way.. [Fiona]*

Kate and Donna spoke about being supported by other mothers with primary low milk supply. Their reflections echoed the comments of the participants who were in

online groups, in that they gained insight and self-acceptance through seeing their experiences mirrored in the experiences of others. These encounters seemed to represent a significant shift in how they understood and perceived themselves:

> *…she was kind of like me, she really wanted to make breastfeeding work and she did the best she could…she was like "look, you have to know that just because you have low supply it doesn't make you any less of a mom". She was really supportive. She had gone through something similar. [Kate]*
> *I kind of feel an affiliation with her because she had the low supply as well. [Donna]*

Having a saviour

Participants identified two main sources of invaluable help and support as they struggled with the challenges of breastfeeding with primary low milk supply, their IBCLCs and their partners. They credited IBCLCs with providing skilled and empathetic support that helped them continue breastfeeding and come to terms with having primary low milk supply. Participants also described how their partners gave them practical help and emotional support.

Caroline described her HSE community IBCLC as an 'absolute lifesaver', and Kate credited her private practice IBCLC with being the 'saviour' of her breastfeeding relationship:

> *….she was fantastic and was my main support for the remainder of my breastfeeding journey…she an absolute lifesaver, I wouldn't have breastfed for as long without her… [Caroline].*
> *My lactation consultant was the savior of our breastfeeding relationship. [Kate]*

Participants stressed the importance of the empathy and emotional support that they received from their IBCLCs, giving the impression that it was as important as the practical support to continue breastfeeding:

> *It would have been a very different journey if I hadn't had someone who understood completely and was empathetic. She didn't just support me with breastfeeding, she supported me emotionally at times as well. And that was so important. No one else had any knowledge about it, apart from my lactation consultant. [Amy]*

Another aspect of the support IBCLCs provided to participants was helping them to understand the embodied nature of breastfeeding, that it is more than a means of providing milk, and that having primary low milk supply can be experienced as a loss:

> *She put into words, what I didn't realise I felt, you know like not being able to breastfeed fully…can be viewed as a loss. And that breastfeeding is about so much more than feeding your baby, and that it's a connection, it's bonding. But I didn't know that. [Ruth]*

The participants stressed how much they valued being listened to by their IBCLCs. This and being emotionally supported are in stark contrast to participants' earlier experiences in maternity settings of feeling unseen and unsupported:

> *….that felt like the first time someone was really listening to what we were saying… I felt supported. [Megan]*

The participants' partners also played an important role in providing support. At a practical level, they helped with preparing bottles and minding the baby while participants rested or pumped:

> *I have the most supportive husband on the planet. He was flat out running and getting me bottles and like sterilizing things, and washing bottles… [Kate].*
> *….he would put her in the sling and work away in his office and she'd be asleep on him, and that was my chance to have a rest or whatever. That was absolutely fundamental, it is not possible to do this without somebody. [Caroline]*

The participants credited their partners with giving them encouragement when they were finding breastfeeding difficult and with being a source of ongoing emotional support. When Ruth spoke about her partner, she described him as a steadying and calm presence, who encouraged her to just do what she could without pressuring or discouraging her. She said he helped her to rationalise things and to see her situation more objectively, while also understanding that breastfeeding mattered to her:

> *….he admired the effort that went into it and never pushed me to keep going,…he would say "just give her what you can" and would help me to rationalise things and just to realise that he was there for me. [Ruth]*

The participants also reflected on the role their partners played in helping them to appreciate how much effort they had put into breastfeeding, giving them a clearer

perspective on their experience of having primary low milk supply:

> *He knew how much it meant to me, and he tried to reassure me that I was doing a good job no matter how much I got or if I took a break, but like, "look at everything you are giving to him, look at how well he's doing." [Amy]*

Kate became emotional when she talked about how her partner supported her and how he had so much faith in her. She gave the impression that he was a calm and wise presence throughout her breastfeeding journey, who had an unconditional belief in Kate's ability to care for her baby, despite Kate's own misgivings:

> *I'm going to cry now thinking about how well my husband supported me, not that I could ever love him more. It has made us so much stronger. He was never like "oh maybe you should switch to formula", he was always supportive of what I wanted to do and…he knew that somewhere deep inside I knew what she needed. [Kate]*

Discussion

This study provides valuable insights into how mothers with primary low milk supply experienced breastfeeding support from HCPs, IBCLCs, partners and voluntary supports. It also reveals how crucial that practical and emotional support from partners was to participants. Four subordinate themes were developed: *Disconnected Encounters*, *Perceiving Judgement from Others*, *Being in a Safe Space* and *Having a Saviour*.

The encounters of participants with HCPs in the early postpartum period were largely unhelpful. These negative encounters were rooted in a perceived lack of rapport or connection between the HCP and the breastfeeding mother, unwanted and intrusive physical support, an apparent insensitivity to how important breastfeeding was to the mothers and that HCPs lacked knowledge about primary low milk supply. These findings corroborate previous studies that explored experiences of breastfeeding support [30, 43–45] and echo a recent study which found that women with primary low milk supply were dissatisfied with support received from HCPs [19]. An impediment to rapport evident in the participants' accounts of their interactions with HCPs was their heightened sensitivity to language and the way in which information was conveyed. Participants internalised remarks from HCPs as dehumanising, as a threat to their sense of agency and as calling into question their ability to care for their babies. These findings align with those of Spannhake et al. [46] who called for sensitivity and understanding on the part of HCPs when interacting with mothers with breastfeeding problems and are consistent with research that mothers experience hands-on breastfeeding support as intrusive [47–49]. Our study also echoes evidence that greater consideration should be given to the relationship between breastfeeding experiences and maternal identity [50–52]. In terms of voluntary or peer breastfeeding support, the women in this study were dissatisfied with their experiences of generic face-to-face and online groups. They perceived a scepticism around the existence of primary low milk supply and felt that their concerns were dismissed. They also perceived that they were being judged for using infant formula and that this led to an internalised feeling of stigma. While many studies support the importance of voluntary and peer support for breastfeeding mothers [22, 23, 35, 53], there has been very little exploration of the notion that they might not necessarily be a *one-size-fits-all* solution for mothers with specific breastfeeding difficulties such as primary low milk supply.

In contrast to the participants' encounters with HCPs, their experiences with IBCLCs were mostly positive. They valued the knowledge of IBCLCs and credited them with enabling them to continue breastfeeding, with some referring to their IBCLCs as "the saviour of our breastfeeding relationship" and "an absolute lifesaver". Participants valued the sensitive and empathetic manner with which IBCLCs delivered support, and the way they helped them appreciate the more nuanced aspects of being a breastfeeding mother. Many participants expressed how their IBCLCs facilitated acceptance of primary low milk supply. These results are consistent with studies that identified the importance of individualised support, sensitivity from HCPs and respectful, mutual dialogue [54, 55] and evidence that IBCLC support in the postpartum period has the potential to improve breastfeeding outcomes [56, 57]. Our findings reflect the need to move away from viewing breastfeeding support through a purely biomedical lens and to place greater emphasis on person-centered emotional and psychological support for breastfeeding mothers [45, 58]. Little has been reported about the role of IBCLCs in providing this kind of emotional and psychological support. Indeed, in a position paper on the role and impact of IBCLCs [59], neither emotional nor psychological support were included among the nine roles that were suggested for IBCLCs. A more recent paper has highlighted the need for more research on the impact of the IBCLC in outpatient and hospital settings [57]. It should be noted that participants in this study had several consultations with their private IBCLCs, each lasting at least one hour. Both the duration and frequency of consultations facilitated rapport between participant and IBCLC and greater continuity of care.

The participants valued and were grateful for the encouragement and support that they received from their partners. They experienced this support as non-judgemental, unconditional, and fundamental to being able to continue breastfeeding with primary low milk supply. Despite the challenges that primary low milk supply presented for the participants and their partners, there was no evidence of tension or discord. Rather, they gave the impression that they adapted well as a couple to the challenges of breastfeeding with primary low milk supply and one participant even expressed that the experience made their relationship stronger. Our finding that women credited the support of their partners with them being able to continue breastfeeding is consistent with previous studies which have identified the importance of partner support to feelings of breastfeeding self-efficacy and duration of breastfeeding [60].

One finding of the current study was the degree of internalised stigma that resulted from the participants' encounters at peer and voluntary support groups. Internalised stigma is an "undesirable difference" in the eyes of others that undermines a person's identity, or the feeling of falling short of what one ought to be [61]. The phenomenon represents what many of the participants experienced in the company of other breastfeeding mothers. They described how they did not want other breastfeeding mothers to see them give formula to their babies, feeling shame when they did so, and not understanding why they felt this way. A probable explanation for this is that formula-feeding did not align with participants' internalised self-identity as a breastfeeding mother. This hypothesis is supported by feminist literature which contends that breastfeeding can be conceived of as a public display of one's chosen way to mother, of showing the world who you are [62]. Not being able to conform and breastfeed exclusively in front of other mothers resulted in some participants leaving social gatherings early to avoid being seen bottle-feeding, being embarrassed using a supplemental nursing system, and feeling a need to explain to people why they were giving formula. These encounters made mothers feel ashamed and isolated and echo previous research which used the term "failing before the other" to describe womens' experiences of unsuccessful attempts to breastfeed in the presence of other people [63].

Another finding of the current research was the way in which the participants valued and benefitted from the support of others with primary low milk supply. Seven of the nine participants received help and/or support from others with primary low milk supply via social media groups or their own social contacts. They variously described this support as like "being in a safe space" and "feeling less alone". The women valued the sense they had of feeling understood and of being among others who "get what it's like". Being among other women with primary low milk supply appeared to give the participants a greater degree of self-understanding. One participant described hearing other women talk about their experiences as like "looking in a mirror" and another described how seeing newer members join the group helped her realise how far she had come. Another participant even described her first contact with a low milk supply support group as a "turning point" in her journey. Peer and voluntary breastfeeding supports are widely accepted as being important for most mothers [35, 53]. However, these studies tend to consider peer and voluntary support as generic and do not consider the possible value of problem-specific breastfeeding support. One study which explored women's embodied experiences during breastfeeding, reported that mothers experienced profound relief when they came across other mothers who had had similar experiences to them [53]. The mothers in the study said that being with other mothers who had had similar experiences alleviated their sense of defectiveness and gave them a sense of having a "safe space" in which they were able to talk about their experiences. Similarly, Spannhake et al. [46]. found that some of the emotional burden of breastfeeding difficulties was relieved by having contact with and sharing experiences with other women having similar problems. Our finding that participants benefitted from the support of others with primary low milk supply is consistent with these studies. It also supports the theory that when people are faced with challenging life events, they seek belonging with "like-minded allies" and that doing so enables them to create meaning and a capacity for transcendence [64].

We conclude that there is a need for greater knowledge among midwives and other HCPs of primary low milk supply as a condition and the importance of referring these mothers to an IBCLC. Our findings also highlight the importance of supporting breastfeeding women in a sensitive and empathic manner. HCPs would benefit from further education on the more nuanced aspects of breastfeeding, such as how it can impact on motherhood self-identity and emotional well-being. Regarding voluntary and peer support for mothers with primary low milk supply, we suggest that where possible, they be directed to groups for women experiencing breastfeeding difficulties and/or primary low milk supply.

Conclusion

Our findings reveal a need for a greater emphasis on sensitive, individualised, person-centred care that is cognisant of the deeply personal way in which some women perceive breastfeeding, and their heightened sensitivity in relation to HCPs' actions and words. There is a need for greater knowledge and understanding among HCPs of the phenomenon of primary low milk supply so that

women suspected of having the condition may be offered a referral to a lactation specialist. Furthermore, greater consideration should be given by HCPs providing breastfeeding support to women with primary low milk supply to the important role of their partners in continued breastfeeding and in providing emotional support.

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Author contributions
C.W. conducted the research and wrote the main manuscript. D.O.B and A.H. provided supervision and reviewed the main manuscript.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Ethics
The Human Research and Ethics Committee at the university at which the researchers are based granted ethical approval for the study (Ref. LS-21-25-Whelan-OBrien). All participants were given written information about the study and the opportunity to ask questions before consenting to participate.

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