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**The Experience of Being the First to Breastfeed in a  
Family: An Interpretative Phenomenological Analysis**

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## **Abstract**

The benefits of breastfeeding for mother and baby are well established; however, only 37.5% of Scottish women are currently breastfeeding at six to eight weeks with less than 1% breastfeeding exclusively for six months, as recommended by UK and international health policy. Family influence is amongst the socio-demographic factors which affect breastfeeding initiation and duration and women who were not breastfed themselves are 25% less likely to initiate breastfeeding.

While there is a growing body of literature which seeks to understand breastfeeding by exploring the perspectives of breastfeeding mothers, no studies can be found describing the experience of making a different feeding choice from that of one's family-of-origin, nor of the potential impact of this decision on relationships with them. As such, this study exploring the experience of being the first in your family to breastfeed is novel.

The aim of the study was to investigate the experience and meaning of being the first person to breastfeed in a family. Consequently, areas explored included women's experience of initiating and sustaining breastfeeding when they have no immediate family history of breastfeeding, how women make sense of their decision to breastfeed and their understanding of how their decision has affected their relationships.

A methodological development in the form of an Infant Feeding Genogram was used to record relevant demographic and family information and semi-structured interviews with fourteen women obtained in-depth narratives. Interpretative phenomenological analysis (IPA) was used as an approach and to analyse the data. Following the completion of idiographic analysis, cross participant analysis was undertaken and four superordinate themes emerged: Breaching Family and Social Norms; Volitions and

Imperatives; Unprepared for the Challenge; and A Sacrifice but Worth It. Within these superordinate themes, 13 themes were identified and articulated.

Findings from this research were synthesised to provide an account of how women experience being the first to breastfeeding in a family, make sense of their decisions and the impact this has on their relationships with their family. This provides an understanding of women's experience in an original context, and the contextualising within the existing literature generates commonalities and highlights differences between the experience of this group of breastfeeding women and the wider cohort.

The findings of this research inform recommendations for practice at both an individual and public health levels, and have implications for policy makers, health professionals and breastfeeding support organisations. It is asserted that policy makers and the health service need to acknowledge the unanticipated consequences of some current breastfeeding discourses associated with health promotion practices, and take a mother and family focussed approach to breastfeeding that acknowledges women's embodied experience, which often includes breastfeeding difficulties. A mother and family centred approach can identify and adapt to women's support needs in their own particular context, which may include very limited community and family support for their decision.

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## **Preface**

I breastfed my children and always knew I would. I was breastfed and I grew up with stories and experience of breastfeeding by female relatives. My own breastfeeding experience was not easy, but I received support and encouragement from my family, particularly my own mother, and I was sure I would manage despite the challenges. Through a breastfeeding support group, I quickly found a network of friends and I breastfed each of my children for as long as I wanted to.

Several years later, I became aware of a statistic from the Infant Feeding Survey, that fewer mums who were not breastfed themselves went on to breastfeed their own babies. As a family psychotherapist I was well aware of family influence on parenting decisions; and as a breastfeeding peer supporter, I had heard anecdotes from women about their families' feelings about their decision to breastfeed. Suddenly, my two areas of work, which had previously seemed separate, became entangled, and I became fascinated to know what it might be like for women to breastfeed without having this in their family culture and how this might impact on their relationships. This is where my journey to this PhD started.

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# Chapter 1 - **Introduction**

## **1.1 Rationale**

The benefits of breastfeeding for mother and baby are well established (Renfrew *et al*, 2012a) with health advantages for both baby (Quigley *et al*, 2012; Fisk *et al*, 2011; Quigley *et al*, 2007) and mother (Yang and Jacobson 2008; Ip *et al*, 2007). Given the impact of breastfeeding on health status, exclusive breastfeeding (breastmilk only with no other food, milk or drinks) is recommended for the first 6 months of life (WHO, 2001).

While these benefits are well recognised and understood by women (McAndrew *et al*, 2012), routine data collected in 2013 indicated that only 35.2% of women in Scotland were exclusively breastfeeding at the health visitors first postnatal visit around day 10 (ISD 2013). Breastfeeding rates drop further in the early postnatal weeks and at the 6-8 week review and the exclusive breastfeeding rate was 26.2%, a figure which has varied little over the last decade (ISD, 2013). This is despite the passing of legislation which legally protects women's right to breastfeed in public (Breastfeeding etc (Scotland) Act 2005) and substantive investment to develop a national Maternal and Infant Nutrition Strategy (Scottish Government, 2011) and improve National Health Service (NHS) breastfeeding support services.

Breastfeeding is influenced by a range of socio-demographic factors including maternal age and education with marital and socio-economic status highly influential (Bradshaw *et al*, 2013; Bolling *et al*, 2007; Beale *et al*, 2006). Differences in breastfeeding rates are not however fully accounted for by these variables and, a range of social and cultural factors are also known to influence infant feeding choices (Forster *et al*, 2006; Kong

and Lee, 2004; Scott *et al*, 2001). Therefore, a wider consideration of women's personal perceptions and their family and societal context needs to be understood.

Most mothers consider social and family support for breastfeeding to be important (Barona-Vilar *et al*, 2009; Swanson *et al*, 2006), often more so than health service support (McInnes and Chambers, 2008). Having a social and family network which is congruent with the mother's breastfeeding intentions appears to be significant, with support from their female relatives and particularly the mothers' own mother, being identified as most important (McInnes and Chambers, 2008). Women who have family support for breastfeeding report more breastfeeding confidence (Dykes *et al*, 2003; Scott and Mostyn, 2003; Hoddinott and Pill, 1999). Mothers spoke of how useful it was when their own mother shared their own breastfeeding experiences (Grassley and Eschiti, 2008) and offered practical suggestions (Hoddinott *et al*, 2010). Conversely, there is evidence to support the idea that mothers can be undermined by their social network's lack of knowledge or by negative attitudes and beliefs and that this can have a direct result on feeding method (Suisin *et al*, 2005). Some researchers argue that women's reliance on family members' views and support was so influential that the authors proposed interventions with family members to help them better support a woman to breastfeed (Grassley and Eschiti, 2008; Lavender *et al*, 2006).

Family experience is reflected in women's infant feeding decision making and women who were not breastfed themselves are less likely to intend to, or actually initiate, breastfeeding (Andrew and Harvey, 2011; Forster *et al*, 2006; Ekstrom *et al*, 2003; Scott *et al*, 2001; Meyerink and Marquis, 2002; Dykes and Griffiths, 1998; Sullivan and Jones, 1986) with some mother's stating that how their mother fed them had a direct

influence on their infant feeding decision (Andrew and Harvey, 2011). The significance of family experience is reflected in UK breastfeeding survey data which reported that 89% of women who were breastfed intended to breastfeed compared to 60% who were formula fed, more than a 20% difference in breastfeeding rates at four weeks after birth (McAndrew *et al*, 2012). This means that in a Scottish context where few women breastfeed, fewer still will breastfeed when they have no breastfeeding family history.

There is a growing body of literature which seeks to understand breastfeeding by exploring the perspectives of breastfeeding mothers (Afoakwah *et al*, 2013; Larson *et al*, 2008; Nelson 2006). Despite this existing literature, a number of researchers have argued that insufficient attention has been paid to the experience of breastfeeding (McBride-Henry, 2010; Schmied and Lupton, 2001; Spencer, 2008; Mozingo *et al*, 2000), particularly in a social context (Leeming *et al*, 2013). Additionally, they argue that research has often failed to explore the lived experience of breastfeeding from women's perspectives (Palmer *et al*, 2010). They argue that professional caregivers therefore do not have access to adequate understanding and knowledge to be able to give woman centred, individual care to breastfeeding mothers.

While research about the importance of breastfeeding history and family influence suggests that family support is important and plays a role in breastfeeding experience, no studies have been identified which considered the experience of women who have decided to breastfeed when they have no immediate family experience of breastfeeding.

Hence, the aim of the study is to explore the experience and meaning of being the first person to breastfeed in a family. It will explore women's experience of feeding when they have no immediate family history of breastfeeding, how women make sense of

their decision to breastfeed and their understanding of how their decision has affected their relationships.

## **1.2 Research Question**

This study will investigate the experience and meaning of being the first person to breastfeed in a family. The research questions this study addresses are:

- What is the experience of women who are the first to breastfeed in their family?
- How do women make sense of their decision to breastfeed?
- What impact, if any, does this have on their relationships with their family?

## **1.3 Research Contribution**

This research firstly offers insights into breastfeeding experience in an original context; that of being the first to breastfeed in a families recent history. By using an interpretative phenomenological perspective, it allows for both socially constructed and embodied aspects of the experience to be explored.

The main methodological contribution of this research is the development of the Infant Feeding Genogram, an adaptation of an existing tool, the genogram, which is widely used in a therapeutic context, to be used in a research context to supplement the collection and interpretation of participant generated data. This is supplemented by the proposed use of the Infant Feeding Genogram in a practice context.

As a result of this study, new understandings of women's experience of breastfeeding emerge. These have public health and practice implications both for women who are the

first to breastfeed in their family, but also potentially for other women, irrespective of their infant feeding intentions.

Finally, the findings of this research contribute to the development of policies and practices to support pregnant and breastfeeding women, with implications for the training of healthcare and voluntary sector workers.

## **1.4 Organisation of Thesis**

This thesis commences with two chapters offering a review of the literature. Chapter 2 provides the background to the research, establishing the health advantages of breastfeeding and its recognition as a public health issue. An account of the evolution of infant feeding over time is offered, including the medicalisation and commercialisation of infant feeding, and detail of the efforts on an international and national basis to return breastfeeding to the norm. The complexity of breastfeeding within women's lives is reflected on, reviewing contemporary infant feeding rates and trends, and introducing some of the influences on women's infant feeding experience and decision making, using the ecological model as an organising framework.

Chapter 3 discusses the role of the family in influencing infant feeding experience. In considering the importance of family history and culture on infant feeding, intergenerational transmission of parenting and the role of family support will be discussed with consideration of the implications for breastfeeding decisions, experience and family relationships.

Chapter 4 then provides an overview of potential research approaches methods which could answer the research questions posed in this thesis. Given the interest in individual

experience, a number of qualitative methods are considered and critiqued. Interpretative phenomenological analysis (IPA), the chosen methodology, is situated within the field and the rationale for its use is provided.

Chapter 5 describes the research setting and methods used in the design of the research including the recruitment of the participants, the collection of data using semi-structured interviews and how the data was analysed.

Chapter 6 introduces The Infant Feeding Genogram. This is a methodological development of an existing clinical tool, the genogram, for use in this research context. A genogram from this study is presented and this is contrasted with my own genogram.

Chapter 7 outlines the research findings, with an outline of the superordinate themes and themes found by the analysis of the research data provided by participants.

The next four chapters: 8, 9, 10 and 11, present the study findings, describing the four superordinate themes identified in the study and the themes which support them: Breaching Societal and Family Norms, Volition and Imperatives, Unprepared for the Challenge and Worth the Sacrifice.

Chapter 12 concludes the thesis with an exploration of the superordinate themes which arose from the data and considers these in relation to the research questions and the wider literature and existing research. The original contribution of the research is identified and implications for practice and future research are made.

## **Chapter 2 - An Introduction to Breastfeeding**

### **2.1 Introduction**

This chapter provides a background to the research and discusses the health implications of, and critical influences on, infant feeding. This includes the evolution of infant feeding over time and the complex interaction between commercial forces, dominant ideologies and family life. There will be a focus on: the medicalisation of infant feeding and the marketing of breastmilk substitutes, and their impact on breastfeeding; the subsequent recognition of breastfeeding as a public health issue and the efforts on an international and national basis to return breastfeeding to the norm. Finally, the complexity of influences on infant feeding is illustrated through the use of the ecological model.

### **2.2 The Evolution of Infant Feeding**

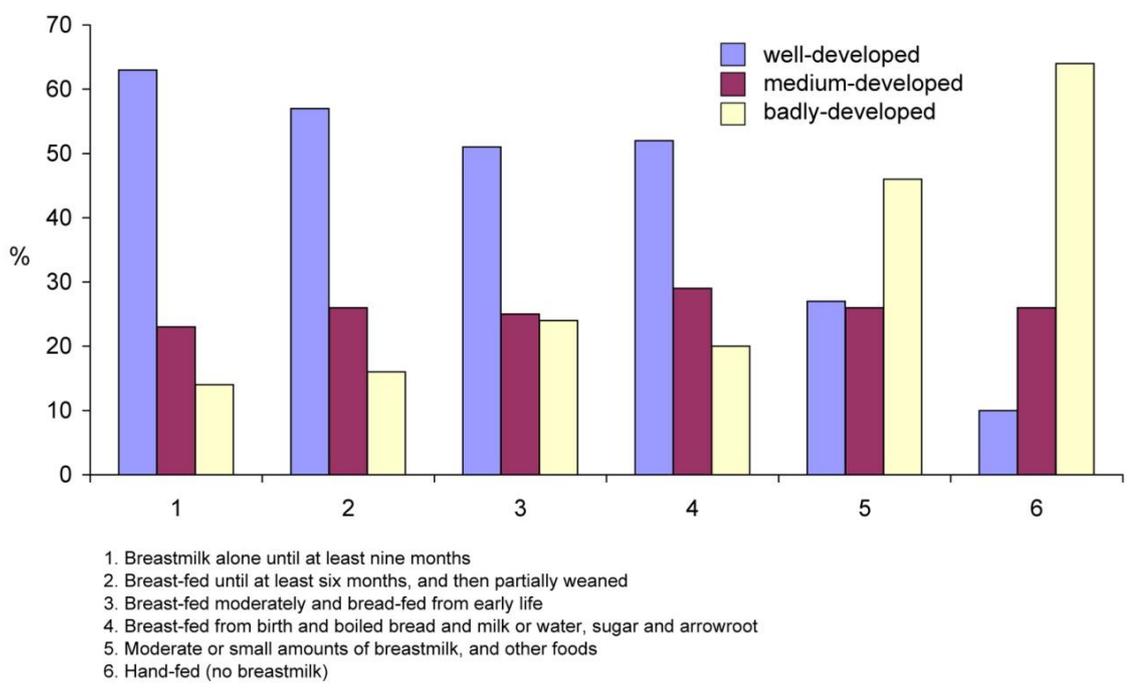
Anthropological (Baumslag and Michels, 1995) and historical (Apple, 1987; Fildes, 1986; Radbill, 1981) research demonstrates infant feeding has always encompassed diversity, with variations in local and global practices. The recent history of infant feeding has included dramatic changes due to the industrial revolution, scientific and medical developments in the 20<sup>th</sup> Century with women being active in changing infant feeding practices through changing expectations for themselves and their families (Apple, 1987). This is embedded in the wider socio-cultural context, including the feminist movement. While a detailed exploration of the history of infant feeding across different cultures is beyond the scope of this study, an outline of the development of infant feeding over time and across cultures, sets this research in its wider context.

Feeding babies products other than breastmilk has been recorded since earliest times. (Stevens *et al*, 2009). Societies supplemented with herbs, foods and fluids, which often had a symbolic meaning within the culture and often designed to protect the baby or to purge it from the perceived dangers of unpassed faeces. For example, local valued foods such as butter and honey were given in India while rice and banana predominated in Bali (Radbill, 1981) and oatmeal and whisky in Scotland (Hardyment, 2007). It is argued that the dominant practices in any culture reflect current societal values with science, nature, culture and religion shaping these practices. Our current feeding trends are therefore built on both our current understandings but also many millennia of historic discourses (Carter, 1995).

Until the Modern historic period, babies were predominantly breastfed, but not necessarily by their own mothers (Minchin, 1998). Wet nursing is an ancient tradition thought to have begun as early as 2000BC and was one of women's first paid occupations (Stevens *et al*, 2009). It is referenced in the bible in the stories of Moses and of Deborah and Rebecca (Baumslag and Michels, 1995) and slaves were often used as surrogate mothers in ancient times (Fildes, 1986). Even before the Middle Ages, wet nursing had become an organised profession with writings outlining the duties and qualities of a wet nurse and laws to regulate its practice (Stevens *et al* 2009). In more recent European history, wet nursing has existed in many different contexts; from foundlings abandoned by their impoverished parents, to the children of the aristocracy and royalty (Baumslag and Michels, 1995). Despite the apparent commonality of wet nursing, and the fact that it was the best alternative for babies who were not being breastfed by their own mothers, written records indicate disapproval of wet nursing with it being associated with women of 'poor character' (Stevens *et al*, 2009). As the

19<sup>th</sup> Century proceeded, wet-nursing was increasingly discredited by the medical profession for its nutritional, health and moral failings (Dykes, 2006a)

The other variation in infant feeding from breastmilk, whether the mothers own or from a wet nurse, is artificial feeding using substitutes for breastmilk, known as ‘hand-feeding’. The lack of clean water, difficult to clean vessels, poor milk storage facilities, lack of pasteurisation and absence of protection from infectious disease that breastfeeding confers, lead to catastrophic survival rates (Acton, 1859). Therefore, during the first years of the twentieth century infant feeding became a public health and political issue due to the perceived threat to the national health. There was good reason for concern, as can be seen in Figure 1, where breastfeeding status had a dramatic effect on children’s nourishment as determined by their weight (Weaver, 2009).



Source: Weaver, 2009.

Figure 1 Infant Feeding Method and Infant Development in 1860

Consequently, doctors began to focus on the development of infant nutrition (Apple, 1987). The medical profession had long had an interest in how women fed their babies. Many were supportive of maternal breastfeeding, as exemplified by Dr Bull in 1837 (Hardyment, 2007) who built on the earlier advice from Dr William Cadogan (Palmer, 2009) in trying to inform and educate mothers, through the production of childcare manuals, on what was best for their babies. Unfortunately their advice had unintended consequences, as many of their methods were counter-productive to breastfeeding success. For example, the introduction of routine feeding (4 hourly) had a negative impact on women's milk supply and their confidence in their bodies' ability to produce enough milk thus increasing the use of wet nurses or breastfeeding supplements (Hardyment, 2007). While Dr Cadogan was one of the first medical doctors to advise women on how to raise and feed their babies, others have followed (Dykes, 2007).

It is argued that some of the dominant ideas within the medical profession were influenced by wider scientific discourses associated with the industrial revolution and a desire to regulate and supervise women's bodies and infant feeding more generally (Dykes, 2006a). Due to concerns about the inadequacy of many of the commercial products, and the associated financial benefits for a profession which relied on private practice, physicians began to argue that the medical supervision of infant feeding was required. This was initially through the production of 'custom made' products for babies, but with mothers continuing to buy over the counter products (Palmer, 2009; Minchin, 1998). Companies and doctors began to collaborate with the milk substitutes being supplied through doctors under medical supervision and instruction (although companies continued to sell their products directly to mothers). Mothers themselves

began to embrace ‘scientific motherhood’, believing that science and technology could improve child care and feeding practices (Apple, 1987).

From the 1850’s milk technology developed to manage the surplus milk production from better dairy management (Palmer, 2009) and a number of methods of preserving milk, such as condensing, became available. It is argued that infant feeding uses were developed as a means of finding a market for this potential surplus product, not because of suitability but in the interests of commercial gain (Palmer, 2009). Despite the idealised advertising of these products as being suitable for infants (Baumslag and Michels, 1995), this unsuitable use of condensed and evaporated milks as a breastmilk substitute lead to reports of malnutrition, scurvy and rickets due to its nutritional inadequacy (Minchin, 1998). In the 1860s a series of developments in the artificial feeding industry occurred and the first commercial artificial breastmilk substitutes were produced, first in a liquid and then in a powdered form. This consisted of cow's milk, wheat and malt flour, and potassium bicarbonate (Palmer, 2009) and was called the ‘perfect infant food’ (Minchin, 1998). Although this product was reported to not be a commercial success, other products followed and by 1873 Nestle baby milk was selling 500,000 boxes a year (Palmer 2009) and by 1883, there were 27 patented brands of infant food on the market (Stevens *et al*, 2009) alongside the numerous brands of evaporated and condensed milk, which were also marketed as baby foods (Palmer, 2009). Many of the manufacturers began to use the term ‘formula’ to describe their products, capitalising on its modern and scientific associations, and this term remains in modern parlance. Most of these had very negative health consequences as they paid scant regard to the nutritional needs of babies despite their nutritional claims (Minchin, 1998).

Collaboration between the medical profession and the baby milk industry continued into the 20<sup>th</sup> Century with each appreciating the mutual benefits of their association. By marketing their products through healthcare providers, restricting instructions on formula packets and making some products prescription only, companies gain approval from professional associations and doctors benefit from repeat visits. Consequently formula companies courted healthcare professionals with gifts and financial incentives to favour their products (Dykes, 2006a) a practice which continues to the current day. It is argued that by the 1940s and 1950s, doctors and the wider community regarded the use of formula as a safe substitute for breastmilk (Stevens *et al*, 2009).

Throughout this period, socio-economic, cultural, intergenerational and commercial influencers were impacting on women's lives and infant feeding. Carter's (1995) study of women who raised babies from 1920 to 1980 in a Northern town in England, details many of these issues. She confirms that there were clear barriers for the women participating in her study who were in poorly paid occupations. Compounding this was poor quality, often over-crowded housing, shared by several generations and with little privacy. Carter argues that these stresses on women, combined with a dominant narrative that breastfeeding was for women who could not afford to buy formula, and the feeling that bottle feeding could offer some feelings of control over her body and life circumstances, meant that breastfeeding became less favoured.

Concurrently, women from higher socio-economic groups were engaging in action to demand their rights (Carter, 2005) and the feminist movement argued to free women from their biological ties (Bartlett, 2002). The additional focus on freedom from domestic tasks through technology meant that the bottle and infant formula became a

modern symbol of women having control and influence over their own lives (Dykes 2006a).

A highly significant factor which emerged over the 20<sup>th</sup> Century was the portrayal of women's breasts as exclusively sexual while their primary function appears to have been marginalised (Palmer, 2009). The contrasting representations of the breast as a sexual object while simultaneously being a maternal object created dissonance for women (Dykes, 2007; Stearns, 1999; Carter, 1995) leading breastfeeding to be seen as an activity which transgresses social rules and therefore produces discomfort (Stearns, 1999) The decline in breastfeeding, combined with society's and women's ambivalence about it as an embodied activity, means it is not commonly practised in public and bottle feeding has become the visual norm (Dykes, 2007) thus further marginalising it.

Consequently, breastfeeding rates in the UK fell throughout the 20th Century, from having been the norm (Fildes, 1986) to very low levels in the 1960s and 70s. Concerns began to be raised about the decline in breastfeeding giving rise to the first Infant Feeding Survey, conducted in England and Wales, in 1975. This found that only 51% of women initiated breastfeeding with 24% of babies still being breastfed at 6 weeks, and 13% at 4 months (Martin, 1978).

During this period of very low breastfeeding, concerns about the inadequacy of formula were raised and the risks of 'commerciogenic malnutrition' (Jelliffe, 1972). Fears were further raised by manufacturing errors, such as the bacterial contamination of one formula milk in 1978 and homogenisation problems with another in 1979 (Minchin, 1998). Alongside this, since the 70's, research has continued to uncover previously

unknown health and developmental benefits associated with breastfeeding leading to breastfeeding being recognised as a public health issue.

## **2.3 Breastfeeding as a Health Issue**

### **2.3.1 The Nature of Human Milk**

The investigation of breastmilk has shown that it is a complex, live substance containing large numbers of previously unknown compounds that have both nutritive and non-nutritive qualities, with others whose purpose is yet to be identified. While all animal milks contain carbohydrate, protein, fats, vitamins and minerals they are species specific, and therefore vary significantly as milks evolved for different nutritional and growth needs and parenting strategies (Wiley, 2010). Variation also occurs within species; varying between mothers, depending on their physiology and diet, and within the same individual over time as milk adapts in response to the needs and demands of the baby (Lawrence, 2010).

While a comprehensive review of the composition and function of milk is beyond the scope of this review, it is important to note that human milk serves both nutrient and biochemically active functions. The nutrients include fats, vitamins and minerals which are used in cells, tissues and organs to support the baby's development. Among the biochemically active ingredients are: immunoglobulins and oligosaccharides, which have anti-infective properties protecting mucosa from bacteria and viruses; nucleotides which act as metabolic regulators and alter enzyme activity within the cell; enzymes which serve the infant's digestive and developmental functions; hormones which retain physiological activity after ingestion; prostaglandins which are thought to have a role in gastrointestinal motility and maintenance of mucosal integrity; and epidermal growth

factor which is involved in a variety of protective functions including maturing mucosal cells in the pulmonary and gastrointestinal systems (Lawrence, 2010).

Babies who are not breastfed are fed on a breastmilk substitute. This is commonly known as infant formula and is usually cow's milk that has been modified to comply with government regulations making it more suitable for human babies. Some infant formulas are designed for babies who are unable to tolerate cow's milk formula and are based on soy protein, as required by the Infant Formula and Follow-on Formula (Scotland) Amendment Regulations 2014. In either case, infant formula, despite its modification is dissimilar to human milk in many ways, including the omission of many important factors which are only manufactured in the human body, the 'live' components of breastmilk. As such, it is considered to contain adequate, as opposed to optimal nutrition for babies (Minchin, 1998).

### **2.3.2 The Health Benefits of Breastfeeding**

Breastfeeding can bring health benefits both due to the composition of human milk and because it reduces the risks associated with inappropriate or unsafe alternative feeding methods. These risks are particularly high in developing countries where access to appropriate breastmilk substitutes, clean water and suitable sterilising facilities for feeding equipment can result in catastrophic outcomes for babies (Maternal and Child Nutrition Group, 2013). Because this research is set in a developed world context, only studies which are applicable to the UK context will be included in the overview of health benefits.

The nutritional, immunological, psychosocial and developmental benefits of breastfeeding for babies, in a first world context, have been well established (Horta

*et al*, 2007) and have been widely published (Renfrew *et al*, 2012b). A recent economic analysis established the cost effectiveness of breastfeeding as a public health intervention and considered the robustness of the available health evidence (Renfrew *et al*, 2012a).

While there are a significant number of health advantages for infants who are breastfed, from systematic reviews and meta-analysis, only those with the most robust evidence, as identified by Renfrew *et al* (2012a) will be considered here. The first group are the infective conditions and this includes: reduction in ear (Fisk *et al*, 2011; Ip *et al*, 2007), respiratory and gastro-intestinal infections (Fisk *et al* 2011; Quigley *et al*, 2007). In practice, exclusive breastfeeding for six months resulted in a 53% decrease in the rate of hospital admissions for diarrhoea and 27% for respiratory tract infections compared to non-breastfed infants (Quigley *et al*, 2007). The protective effects appear to be ‘dose related’ with the longer an infant is breastfed the greater the protection gained or the more positive the impact on long-term health (Kramer *et al*, 2003).

Other conditions where breastfeeding is protective are: lower levels of necrotising enterocolitis (estimated to be 6 – 10 times lower risk) in premature babies (Ip *et al*, 2007); reduced incidence of Sudden Infant Death Syndrome (Hauck *et al* 2011); improved cognitive outcomes (Iacovou and Sevilla-Sanz, 2010), particularly in premature babies (Quigley *et al*, 2012) and there is also evidence that breastfed babies gain weight more slowly and are less likely to be obese as adults (Horta *et al*, 2007).

A number of health benefits have been established for women who have breastfed with evidence that they are at lower risk of breast cancer (Yang and Jacobson, 2008, Ip *et al*, 2007) and plausible evidence for a lower risk of ovarian cancer (Ip *et al*, 2007).

The evidence that breastfeeding confers health advantages, which justifies its inclusion as an area of public health intervention has been challenged (Wolf, 2007). Amongst the criticisms are that due to ethical and pragmatic considerations, randomised controlled trials are very rare among health related infant feeding studies, although some trials of relevant interventions exist (Quigley *et al*, 2007; Kramer *et al*, 2001). The evidence base for breastfeeding as a health issue therefore relies mainly on observational data, which might not account for confounding factors such as socio-economic status, maternal age and education. Wolf (2007) argues that the concept of ‘total motherhood’ where women are expected to protect babies from the risk of harm, however small, is influencing the reporting of research, exploiting the public’s difficulties in understanding research data. The ‘total motherhood’ discourse is then used to justify the State’s intrusion into private family decisions.

The criticism of the robustness of the evidence has been strongly contested with arguments to suggest that the evaluation of the evidence of breastfeeding benefits is conservative (Renfrew *et al*, 2012a). There is, for example, evidence for differential outcomes for exclusive (only offering breastmilk) and non-exclusive breastfeeding (partial breastfeeding which is supplemented by infant formula), and as this is often not controlled in research studies, the health benefits of exclusive breastfeeding may be underrepresented in research findings (Kramer *et al*, 2003).

### **2.3.3 Disadvantages and Risks of Breastfeeding**

There are some circumstances when the disadvantages and risks of breastfeeding may make it not in the mother’s or baby’s interests to initiate or continue breastfeeding. For the baby, risks exist through the possibility of harm from drugs (Hale, 2010), chemicals

(Koppe, 1995) or infective conditions (Riordan, 2005) through the mother's milk. From a mother's perspective there are few health disadvantages although it could be argued that breastfeeding difficulties, such as mastitis and thrush, can be associated with some maternal ill health (Kvist, 2013; Evans and Heads, 1995). The larger group of disadvantages are those associated with maternal psychosocial wellbeing, as opposed to their physical health (Clemons and Amir, 2010). Barriers such as the recommended requirement for lifestyle adaptations such as diet (NHS Choices, 2013) the need to balance work (McCarter-Spaulding, 2008; Dykes, 2005) can make it difficult for women to feel positive about breastfeeding, which impacts on their wellbeing and mental health.

## **2.4 Attempts to Restore, Protect and Promote Breastfeeding as the Norm**

Having recognised the importance of infant feeding for mothers and babies, attempts have been made to challenge the decline in breastfeeding. While much of the focus of the discussion of infant feeding in this thesis has been in a UK context, it is important to locate Scotland's attempts to protect, promote and restore breastfeeding in an international context.

### **2.4.1 International Context**

Concerns raised in the 1970's by doctors and aid agencies in the developing world (Muller, 1974; Jelliffe, 1972), about the impact of aggressive and unethical marketing of infant formula, lead to international action to protect and promote breastfeeding. As a result, in 1979, the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) convened a meeting on infant and young child feeding. This resulted

in the World Health Assembly (WHA) developing an International Code of Marketing of Breast-milk Substitutes, known as the WHO Code (WHO, 1981). This intends to promote breastfeeding and control the inappropriate marketing of fluids and foods which might be used to replace breastmilk, and the bottles and teats used to administer them. The implementation of the WHO Code required governments to implement it in their own legal system, but this has been substantially influenced by the vested interests and power of multi-national companies, with a number of aspects of The Code not being implemented in law.

With the continuing decline in breastfeeding (Palmer, 2009), a further effort was made to challenge the increased use of infant formulas. The WHO and UNICEF published *Protecting, Promoting and Supporting Breastfeeding* (WHO/UNICEF, 1989) a joint statement summarising core evidence based principles, which included the ‘Ten Steps to Successful Breastfeeding’ (Ten Steps) and which was later ratified and recommitted to, to include the banning of subsidised or free breast-milk substitutes in hospitals. This was followed by The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO, 1990) which gave a set of recommendations to try to restore breastfeeding as the cultural norm through increased breastfeeding initiation and duration rates.

In UK the ‘Baby Friendly Hospital Initiative’ was launched to improve health services and ensure they provide a minimum standard in their support of breastfeeding. It instructs hospitals in how to implement the ‘Ten Steps to Successful Breastfeeding’ (The Ten Steps), and contains an accreditation process for hospitals meeting its standards. This was followed by the launch of the ‘Seven Point Plan for Sustaining

Breastfeeding in the Community’ (The Seven Point Plan). These policies require health services to restrict advertising, as per the WHO code, provide standards and programmes for staff training, prevent unnecessary use of breastmilk substitutes and dummies and identify sources of support for breastfeeding women (UNICEF, 2014).

The most recent global initiative to be launched is the *Global Strategy for Infant and Young Child Feeding* (WHO, 2003) whose aim is to ‘improve - through optimal feeding - the nutritional status, growth and development, health, and thus the survival of infants and young children’. It calls for a renewed commitment to earlier strategies and includes the recommendation that infants are exclusively breastfed for the first six months of their lives, with breastfeeding continuing for up to two years and beyond alongside appropriate complementary foods. The strategy places an emphasis on the need for both healthcare and community support for breastfeeding women including mother to mother support and calls upon governments to initiate the development, implementation and evaluation of a national policy on infant and young child feeding.

#### **2.4.2 Implementation of International Policies in a UK and Scottish Context**

Despite the UK government speaking strongly in support for the WHO Code and its subsequent resolution, and committing to the Code being applied “as a minimum requirement” to be “implemented in its entirety”, it has only been partially brought into UK law. This means that although there are restrictions on the marketing of breastmilk substitutes, the law does not cover bottles, teats or follow-on milks (infant formula marketed as being suitable for older babies). This allows companies to advertise their infant feeding brand ranges as long as they do not include products specifically intended for babies under six months, which is much weaker than in the WHO Code.

It is clear however, that the protection and promotion of breastfeeding requires more than a control on marketing. It has been argued that the complex cultural, socio-economic and health service barriers to supporting breastfeeding requires a strategic, coordinated, multifaceted approach if rates of breastfeeding duration, especially of exclusive breastfeeding, are to increase (Renfrew *et al*, 2012a, 2012b; Dyson *et al*, 2006). A range of strategy and policy documents have been developed, a number of which are informed by the UNICEF Ten Steps and Seven Point Plan, which are intended to enable and support women to breastfeed (for example, Renfrew *et al*, 2012b; Dyson *et al*, 2006). However, implementation of this best practice has been inconsistent, possibly due to a lack of prioritisation of resources for the multi-faceted approach needed to address the issues (Hoddinott *et al*, 2009a). A challenge to this lack of resource has been made through a recently undertaken economic analysis which has demonstrated the cost effectiveness of promoting and supporting breastfeeding in later savings for the public sector (Renfrew *et al*, 2012a).

Additionally, legislation has been passed to assist with cultural barriers to breastfeeding in public. This has been implemented separately in Scotland and in the rest of the UK due to the different legal systems and Scotland led the way with the Breastfeeding etc (Scotland) Act (2005) which makes it an offence to ‘prevent or stop a person in charge of a child who is otherwise permitted to be in a public place or licensed premises from feeding milk to that child in that place or on those premises’. The Equality Act (2010) was later passed in England and Wales and is legislation with the wider remit of protecting people from discrimination, but which included protection for breastfeeding in public. While there is no evidence that either law has been used in an infant feeding context, it sets an expectation in society that breastfeeding is permissible, but whether it

is effective in promoting a society where breastfeeding is seen as acceptable, even to be encouraged, as was the intention in the Scottish legislation, is yet to be established.

Since devolution in Scotland in 1999 (The Scotland Act 1998), Scotland and the rest of the UK have had separate and divergent healthcare policy and systems. To develop the Scottish Government Maternal and Infant Nutrition strategy (Scottish Government, 2011), a range of national and international policies and research evidence was reviewed, with the aim of producing a comprehensive action plan to improve the nutrition of women and babies. This aimed to enable parents to make an informed choice about infant feeding, to support women to initiate and continue breastfeeding for as long as they wish and to ensure that infants are given timely and appropriate complementary foods. This strategy included recommendations for UNICEF BFI accreditation for hospitals, university based midwifery, public health nursing and other healthcare profession programs. It also aimed to influence childcare providers and to encourage breastfeeding support from the health and third/voluntary sector, including peer support; information and support on formula feeding, and practical information or support for weaning/healthy eating.

Significant financial investment has accompanied attempts to promote and support breastfeeding in recent years. In 2008 the Scottish Government prioritised £19 million of funding to the National Health Service (NHS) Boards to invest in maternal and child nutrition, including breastfeeding. The investment was intended to increase breastfeeding rates, as measured by a Scottish Government national Health Improvement, Efficiency, Access and Treatment (HEAT) target at 6 – 8 weeks postnatal. The HEAT target was to increase the proportion of infants exclusively

breastfed at 6–8 weeks from 26.6% in 2006/7 to 33.3% in 2010/11 nationally.

Recognising the variation in breastfeeding rates across Scotland, local targets were set with an expected increase of 2% a year in each area, which would combine to deliver the national target. Unfortunately no NHS Board area was able to produce this rise either in the expected time frame or since, and breastfeeding rates in Scotland have remained static over the last decade (Scottish Government, 2011).

## **2.5 Contemporary Infant Feeding Trends**

### **2.5.1 Breastfeeding Rates in the UK and Scotland**

A range of data sources are used to determine breastfeeding rates and trend but comparing data from different sources needs to be done with some caution. The main sources of information used in this section are the Infant Feeding Survey (McAndrew *et al*, 2012), a UK wide quinquennial survey; the Information Service Division (ISD), part of NHS National Services Scotland, who produce statistics for the Scottish Government from routine health service collected data and The Scottish Public Health Observatory (ScotPHO) a collaboration which is co-led by ISD Scotland and NHS Health Scotland. The main differences between these data sets are the different data collection times and methods. The Infant Survey (IFS) uses survey methods recruiting a sample which is influenced by selective participation by families, while the ISD source rely on whole population figures as supplied by health professionals through the Scottish Maternity Record and Child Health Surveillance Programme (CHSP). The Infant Feeding Survey figures follow the same trends as the ISD but are slightly higher, which is thought to be because of the more socio-economically advantaged participants. Given the difference, in this section I will only compare data within each data set rather than across them.

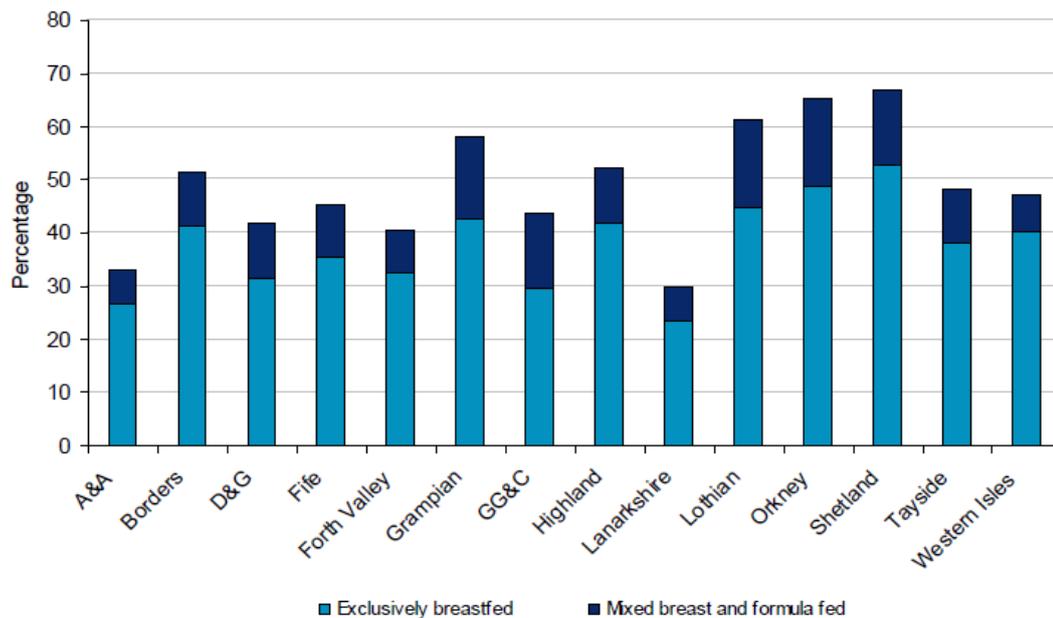
Breastfeeding rates are low in Scotland compared to the UK with breastfeeding initiation in Scotland currently on average 74%, considerably lower than the United Kingdom (UK) average of 81% (McAndrew *et al*, 2012). Breastfeeding rates drop rapidly in the early days and weeks after birth, despite significant international and national strategies, legal intervention to create a more accepting public feeding environment, a national target to steer NHS action and financial support to implement activities,.

In Scotland in 2012/13, 47.1% of babies were breastfed at the first post-natal visit by the health visitor (around 10 days after birth), comprising 35.2% of babies who were exclusively breastfed (which in this reporting framework means nothing other than breastmilk in the last 24 hours) and 11.9% who were mixed fed receiving both breast milk and formula milk in the last 24 hours. By the 6-8 week review breastfeeding had substantially reduced to 36.5% of babies being breastfed with 26.2% exclusively and 10.3% mixed. The overall breastfeeding figures at the first visit and at 6 – 8 week have remained largely unchanged over the last decade, with a slight increase in mixed breastfeeding a slight decrease in exclusive breastfeeding (ISD, 2013).

There is significant variation in the prevalence of breastfeeding by geographical area within Scotland, for example, in 2013 in NHS Ayrshire and Arran, at the first post-natal visit, 32.8% of babies were being breastfed (including mixed feeding) with an exclusive breastfeeding rate of 26.6%. Whereas in NHS Lothian, the total breastfeeding rate at the first visit was 61.3% and exclusive breastfeeding at 44.8% (ISD, 2013). A similar picture can be seen in the 6 – 8 week breastfeeding prevalence figures with 22.5% of babies in NHS Ayrshire and Arran being breastfed (including mixed feeding) with an

exclusive breastfeeding rate of 16.8%, whereas in NHS Lothian, the total breastfeeding rate at 6 – 8 week review was 48.7 % and exclusive breastfeeding at 34.6% (ISD, 2013).

The variation across health board areas can be seen in Figure 2.



Key  
A&A: Ayrshire & Arran  
D&G: Dumfries & Galloway  
GG&C: Greater Glasgow & Clyde

Source: ISD Scotland, CHSP Pre-School Aug 2013

**Source: ISD Scotland, CHSP Pre-School Aug 2013**

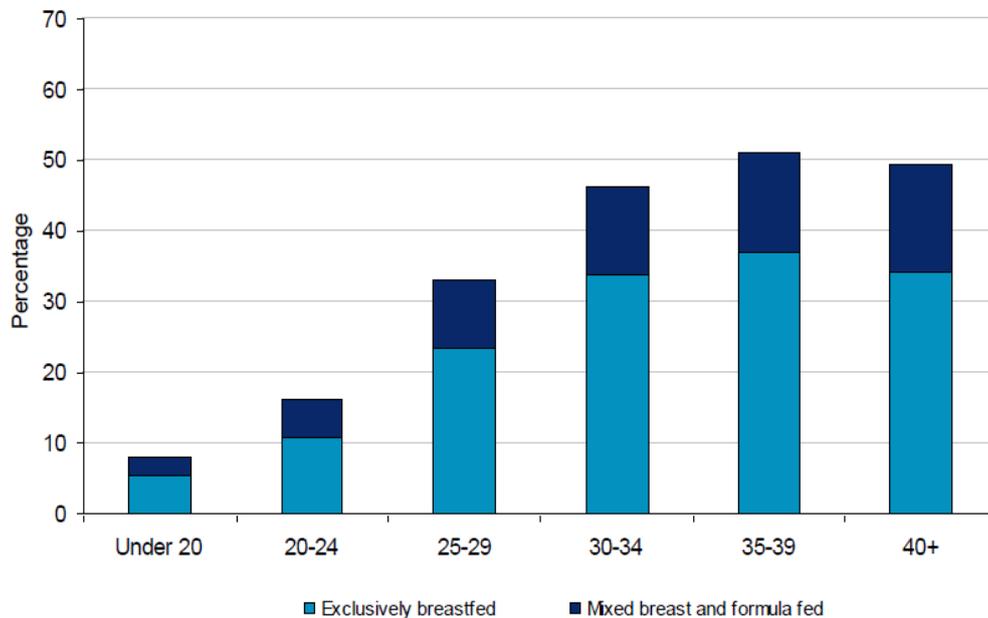
**Figure 2 Breastfeeding by Health Board Area**

Breastfeeding rates also vary within a health board area, for example, in 2010, the most recently analysed figures, breastfeeding rates at 6 -8 week visit in Ayrshire and Arran ranged from 49.5% in Alloway and Doonfoot to 6.4% in Stevenston Haydocks (ScotPHO, 2013). While the reasons for this variation are complex, a number of major influencers have been identified and will be further explored.

## 2.5.2 Demographic Factors Affecting Breastfeeding Outcome

There is evidence that a number of demographic (maternal age, marital status, education, socio-economic), familial, individual (knowledge and confidence) and support (health service and peer/community) factors influence breastfeeding outcome. With the exception of family influencers and support, which will be explored in depth in the following chapter, these factors will now be outlined.

Maternal age is one of the factors most strongly influencing the initiation and duration of breastfeeding, with the trend that breastfeeding increases with the age of the mother until their 40's when it decreases slightly, as can be seen in Figure 3, which shows breastfeeding at 6 – 8 weeks. This trend remains even when other factors such as socio-economic status are controlled.

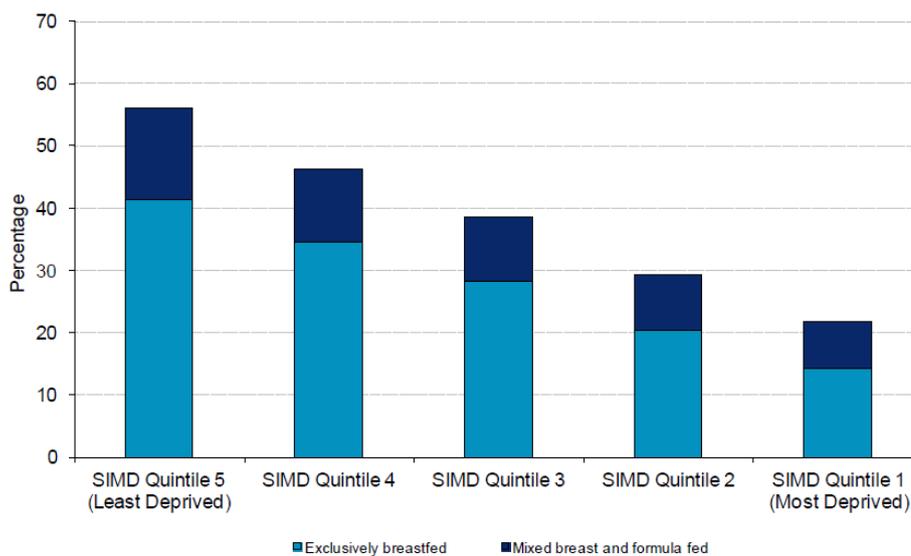


Source: ISD Scotland, CHSP Pre-School Aug 2013

Source: ISD Scotland, CHSP Pre-School August 2013

Figure 3 Breastfeeding by Maternal Age at 6 – 8 weeks

There is a clear association between socio-economic status/deprivation and breastfeeding, with far fewer women who are experiencing deprivation breastfeeding than those who are most affluent, as can be seen below in Figure 4. This is a well established (Beale *et al*, 2006) and complex trend. As this trend is clearly visible at 6 – 8 weeks, previously given explanations such as the demands of returning to low paid, long hours at work are an inadequate explanation, as women in this type of work take longer maternity leave than those in professional roles (McAndrew *et al*, 2012), thus other cultural factors are involved, with deprivation also associated with a range of less than optimal health behaviours such as smoking (Lakshman, 2011).



Source: ISD Scotland, CHSP Pre-School Aug 2013

**Source: ISD Scotland, CHSP Pre-School Aug 2013**

**Figure 4 Breastfeeding by Socioeconomic Quintile at 6 – 8 Weeks**

Maternal education and marital status are the final two demographic considerations associated with breastfeeding. Neither of these factors is evaluated in ISD figures, but in the IFS, the impact of maternal education is significant with 60% of degree-educated mothers exclusively breastfeeding for six weeks or more compared with 18% of those

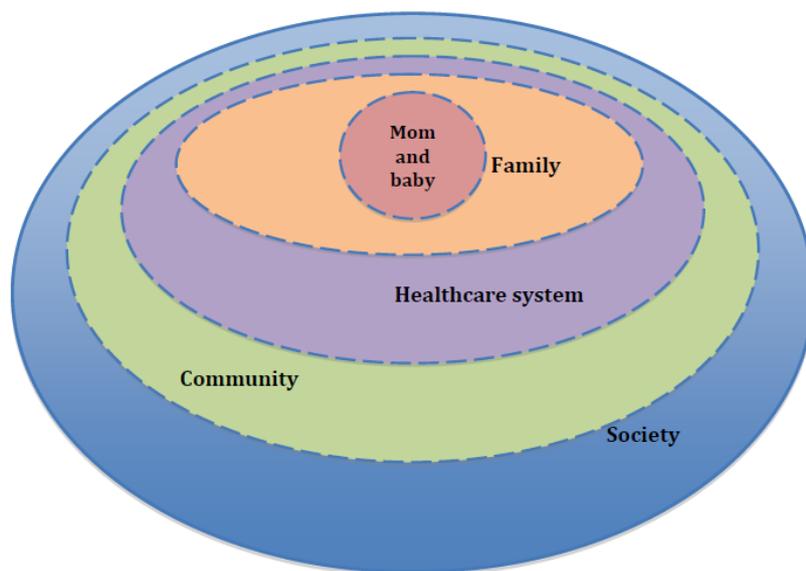
with only Standard Grades (McAndrew *et al*, 2012). It could be argued that maternal education is simply a proxy measure for socioeconomic status; however, compared to other measures, such as household income, education has the most significant impact on breastfeeding duration (van Rossem, 2009). Marital status is also influential with married women and women who lived with a partner more likely to breastfeed (McAndrew *et al*, 2012). This is thought to be related to the availability of partner support; however, given its association with other health behaviour and wellbeing indicators, this is likely to be more complex and may also encompass socio-economic confounders (Kiernan and Pickett, 2006).

## **2.6 Influences on Breastfeeding: The Ecological Model**

Despite it being evident that women's infant feeding decisions differ according to a number of demographic factors, this does not account for the issues that lie behind their infant feeding experience and choices. For this, a wider consideration of the person's perceptions and their family and societal context needs to be undertaken. A number of factors, individual to each mother in her own particular familial and societal context, influence breastfeeding experience including initiation and duration and it is known that a range of individual, cultural and social factors also influence infant feeding outcomes (Forster *et al*, 2006; Kong and Lee, 2004; Scott *et al*, 2001).

One conceptual framework which allows for consideration of the complexity of health behaviours and influences is the ecological model. The original ecological model (Bronfenbrenner, 1977) focussed on levels of environmental influences and this framework has been adapted to include intrapersonal or individual factors, such as the knowledge, attitudes, skills and developmental history of the individual (Belski, 1980).

Thus the ecological perspective includes: the individual, all the levels of context and influence and the relationships and interactions between each level. A simplified model has been adapted for breastfeeding MacKean and Spragins (2012), and is shown as Figure 5, which includes the mother and baby dyad, as opposed to the sole consideration of the individual, as in other models.



Source: MacKean and Spragins (2012)

Figure 5 The Ecological Model for Breastfeeding

### 2.6.1 Mother and Baby

There are a number of areas of influence within this sub-category including factors for the mother and baby individually and as a dyad in interaction with each other. There has been substantial research into the individual and dyadic factors which influence breastfeeding, and only a brief overview will be presented here. These include: maternal and baby health, including physical difficulties with feeding and individual maternal factors such as maternal knowledge, self-efficacy and confidence.

The physical challenges experienced by mothers and babies are widely reported and are cited by mothers as a reason to stop (McAndrew *et al*, 2012). There are a number of factors associated with the baby, which influence breastfeeding duration, including a number of health conditions and illnesses, such as jaundice, prematurity and the baby's readiness to breastfeed, which can be affected by a difficult birth (Riordan, 2005). Further difficulties included perceived low milk supply (Twamley *et al*, 2011), poor infant weight gain (Flower *et al*, 2008) and painful nipples (McClellan *et al* 2012). Mother's health is also important with a difficult birth having an impact on their ability to breastfeed, for example a delay in their milk supply due to caesarean section (Mannion *et al*, 2013) or blood loss, as well as having an impact on their physical comfort (Riordan, 2005).

Women have a high knowledge level about the benefits of breastfeeding with 86% of Scottish women knowing that breastfeeding brings health advantages and 79% of women able to name a specific benefit. This is higher than the UK average at 83% and 75% respectively (McAndrew *et al*, 2012). Information provided during pregnancy appears to influence feeding intentions and behaviour with mothers who remembered receiving health benefits information about breastfeeding being more likely to initiate breastfeeding (83%) compared to those who did not remember receiving information (73%) (McAndrew *et al*, 2012). Knowing about health advantages; however, does not directly translate into breastfeeding intention or duration, with the levels of knowledge of health advantages of breastfeeding being higher than the Scottish initiation rate and many times greater than the breastfeeding prevalence rate at 6 – 8 weeks (ISD, 2013).

Maternal confidence and self-efficacy have been found to be enablers of breastfeeding and can assist women to continue, even when they experience problems. Women who are more confident about their ability to breastfeed and have a high degree of self-efficacy are more likely to initiate breastfeeding and feed for longer (Burns *et al*, 2010; Blyth *et al*, 2002; Dennis, 1999). This appears to be particularly important in relation to breastfeeding duration. In a meta-synthesis to try to understand why, despite widespread breastfeeding knowledge and high initiation, many women stopped breastfeeding (Larsen *et al*, 2008), a major factor was found to be that women's expectations did not meeting the reality of their experience (Grassley and Nelms, 2008) and this leads to a loss of confidence and esteem in their perception of themselves as a mother. These negative stories are subsequently shared in the community. As a result women often approach breastfeeding with trepidation and say that they are going to 'try' breastfeeding (Hoddinott and Pill, 1999) and may quickly move to formula milk feeding if they encounter problems. In contrast, high confidence, self-efficacy and intention to succeed, appears to help women continue when they hit difficulties (Twamley *et al*, 2011; Entwistle, 2010; Manhire *et al*, 2007). Finally, infant feeding decisions are inextricably linked with women's identity and the concept of the 'good mother' (Marshall *et al*, 2007) which may act at an unconscious level and challenge models which presume rational decision-making.

### **2.6.2 Family**

It is known that the family's breastfeeding history, attitudes, beliefs and support of the family are contributing factor to women's infant feeding decisions and potentially their experience. Family is greater than the traditional nuclear family and includes the wider family of origin (the mother's and her husband/partner's parents and relations, as they

considered relevant). As this is the major area of exploration of this thesis, it will be considered in detail in the following chapter.

### **2.6.3 Healthcare System**

There is evidence that professional breastfeeding support is valued by women and can be effective in extending the breastfeeding period, but may not be effective in enhancing exclusivity of breastfeeding (Renfrew *et al*, 2012b). While many women look to the healthcare system and its professionals for support, the culture of our hospitals and community services and the attitudes, skills and knowledge of healthcare professionals can be barriers to breastfeeding and do not always meet the expectations of women.

Within a hospital context, it has been argued that the impersonal and medicalised surroundings of the hospital maternity ward in the UK are not conducive environments and that women are treated by overworked midwives as objects in a production line. It highlights that, in spite of the promotion of breastfeeding, there is often a lack of support for women, which is not satisfactory for the women or the midwives who are providing the service (Dykes, 2006b). Health service support was characterised as rushed, not always available, sometimes unhelpful and inaccurate and contained conflicting advice (McInnes and Chambers, 2008). Shortages of staff, both in hospital and in the community can result in a lack of postnatal support both in hospital and at home (Furber and Thompson, 2007).

It has been reported that there are major deficits in knowledge and skills across the professional healthcare workforce with poor levels of competence and confidence (Renfrew *et al*, 2006). This is confirmed in a training-needs survey of 750 health care

workers (Wallace and Kosmala-Anderson, 2007) which concluded that the workforce is ill prepared to offer the skilled support required by breastfeeding women. Additionally, it has been found that health professionals' attitudes to breastfeeding varied considerably and that some women reported negative attitudes of health professionals to breastfeeding (McInnes and Chambers, 2008).

Professional education and training has been found to impact on the self-reported breastfeeding attitudes, knowledge, skills, beliefs and confidence of health professionals (Khoury *et al*, 2002; Dinwoodie *et al*, 2000). However, it has been suggested that traditional educational intervention alone may not be enough (Dykes, 2006b) and that health professional training needs to address negative attitudes to breastfeeding possibly because they have had adverse breastfeeding experiences themselves or are from a community with low breastfeeding rates. It has been proposed that evidence based training which addresses these issues directly through debriefing and challenge to existing beliefs should be implemented to address this issue (Darwent and Kempenaar, 2014).

A number of changes to the support available and to the quality of support through appropriate training have been identified through the development of the Maternal and Infant Nutrition Framework (Scottish Government, 2011). However, while there has been some additional funding for health promotion and additional training for health professionals, many of the cultural and structural conditions such as time pressures and a lack of women centred care remain.

#### 2.6.4 Community

A major barrier to breastfeeding at the community level is the discomfort and embarrassment many women feel about breastfeeding in public (Bailey, 2007) and this might include feeding in front of anyone, including their partner (Scott *et al*, 2006). As a result women may perceive that breastfeeding will make it difficult for them to participate fully in daily life, and they may therefore be socially excluded and isolated (Stewart-Knox *et al*, 2003).

Embarrassment appears to be about the breach of community cultural norms, which are influenced by dominant ideas in society and it is argued that while these invisible rules remain unchallenged, the taboo remains, making the practice even more daunting because women feel very conspicuous. This has led to community activism, to breastfeed in an organised way, for example through breastfeeding picnics, to try to reduce its marginalisation as a practice and challenge or undermine social norms about the acceptability of breastfeeding (Boyer, 2010).

Low breastfeeding rates and the marginalisation of breastfeeding in public have combined to mean that many women have no prior experience of breastfeeding before making their own infant feeding choice (Scott and Mostyn, 2003). One factor which has been shown to be important in influencing breastfeeding intention and behaviour is vicarious experience, i.e. seeing other women breastfeed (Hoddinott *et al*, 2009b; Dewan *et al*, 2002; Hoddinott and Pill 1999). In a Scottish study, women who reported seeing breastfeeding within the preceding 12 months, and who described this positively, were significantly more likely to intend to breastfeed themselves than those who had no

contact. This factor was far more influential than all the others in the study, such as seeing breastfeeding in the media (Hoddinott *et al*, 2009b).

Breastfeeding peer supporters, women who have breastfed themselves and who assist other women with breastfeeding, have been identified as having an important role in supporting breastfeeding, being identified as a key part of the breastfeeding workforce (Scottish Government, 2011). There has been some evidence that providing peer support can increase the initiation and duration of breastfeeding (Renfrew *et al*, 2012b; Dyson *et al*, 2006) however this has been challenged with a recent systematic review suggesting that in wealthier countries where routine healthcare is provided, peer support interventions are ineffective (Jolly *et al*, 2012). However, given the importance of vicarious experience, peer support may have a wider role in making breastfeeding more visible in a community, by supporting women's breastfeeding confidence to feed in public and to share positive breastfeeding stories. In particular, it has been promoted as a way of increasing breastfeeding rates in communities with low breastfeeding prevalence where there is a predominant bottle feeding culture (Morrow *et al*, 1999; Alexander *et al*, 2003; Scott *et al*, 2003).

### **2.6.5 Society**

Breastfeeding is a culturally embedded activity and exists within and is shaped by societal expectations and views, including those about the breast and breastfeeding. Within society, an individual internalises its dominant ideas, learning the cultural norms and expectations and, affecting women's decision making and her experience of breastfeeding. As such, societal influences exist in their own right and affect all aspects of the ecological model. There are a number of conflicting dominant ideas about

women's lives, breasts and breastfeeding, and this makes it an increasingly complex moral field that women need to navigate through.

It is commonly reported that the 'bottle feeding culture' is an influence on women, where formula feeding rather than breastfeeding is seen as the norm. This culture is witnessed in interaction with communities and responses from family, but influencing all of this is the representation of feeding through the media. A content analysis of the representation of infant feeding in newspapers and on television in the UK, demonstrated the rarity of breastfeeding being shown on television with only one representation of breastfeeding being shown with 170 scenes showing the preparation of formula or bottle feeding (Henderson, 2000). While formula feeding was usually portrayed as a background non-problematic, everyday activity, breastfeeding, when mentioned, was part of the storyline and worthy of comment, with negative 'body out of control' or embarrassed features. There also appeared to be class associations in the portrayal of infant feeding, with bottle feeding being associated with "ordinary" families whereas breast feeding is associated with middle class or celebrity women.

Adding to the complexity of messages is the sexualisation of breasts and breastfeeding. As mentioned in the history of breastfeeding section, the idea of breasts as purely sexual objects has risen over the 20<sup>th</sup> Century in the UK and Americas. This increases the embarrassment women report when feeding and the need to be seen to be modest if feeding in front of anyone (Moran, 1999). Mixed images of the breast in modern Western society and, in particular, the emphasis perpetuated by the mass media of breasts as sexual objects can lead to breastfeeding being viewed as a sexual rather than a

feeding activity thus causing concern when breastfeeding occurs in public within the community (Harris *et al*, 2003; Mahon-Daly and Andrews, 2002).

An area of particular complexity is the medicalisation or scientific colonisation of infant feeding. This includes a number of tricky areas for women to negotiate as it contains some conflicting influences. It is argued that as scientists and doctors became 'the experts', various practices were introduced to control and regulate the amount and predictability infant feeding. This became so important that measurement was required to know if the baby is 'getting enough' and infant feeding was controlled by the clock, rather than the mother or baby (Dykes, 2006a). As women followed the scientific paradigm, they lost confidence in their bodies and their ability to know and nourish their babies, resulting in lack of confidence in breastfeeding (Scott and Mostyn, 2003; Dykes, 2006a).

A final societal influence is the changed expectations of women in their role as mothers and wage earners. In many household two incomes are required to pay the mortgage or rent and living expenses and many women have to return to work soon after their children are born; trying to manage these demands and breastfeeding can be hugely challenging (Rojjanasrirat and Sousa, 2010). Where society highly values paid work outside the home, and devalues work that is carried out predominantly by women (Grimshaw and Rubery, 2007) additional pressure is put on women and a complex juggling act can ensue. As such, society appears to demand that women have to juggle the requirement of breastfeeding in order to ensure the health of their babies, at whatever the personal cost, while facing the challenge of trying to integrate

breastfeeding into their lives (McBride and Henry, 2010; Marshall *et al*, 2007; Lavender *et al*, 2006; McFadden and Toole, 2006; Dykes, 2005; Stewart -Knox *et al*, 2003).

## **2.7 Conclusion**

Having recognised the health and public health implications of infant feeding, the international, UK and Scottish Governments have designed strategies to try to return breastfeeding to the norm. These strategies and interventions have largely been based on biomedical and population based approaches but, despite effort and investment, this has had relatively little success, at least in the last ten years. It is clear from the ecological model, that infant feeding experience and decisions are embedded in complex social structures with embedded norms and values, and have been so throughout history. Therefore, in the next chapter, breastfeeding within the family context is explored.

## Chapter 3 -Breastfeeding and the Family

### 3.1 Introduction

In this chapter, the influence of the family on infant feeding will be explored, with a particular focus on the significance of family infant feeding history. Families bring their own history and culture to parenting decisions, including breastfeeding, which influences the initial breastfeeding decision and the support families' can offer the mother with her breastfeeding experience. The impact of infant feeding history on breastfeeding rates will be considered and two related and interlinked aspects to the significance of family infant feeding history will be explored. The first is the intergenerational influences including the family culture and stories which influence parenting beliefs and behaviour and this is appears to be particularly important when considering embodied experiences such as birth and early parenting practices. Second is the significance of family support for breastfeeding and the impact of family history on family members' ability of the family to provide this support. Finally, the impact of infant feeding decisions on family relationships will be considered.

### 3.2 Defining the Family

While the family is traditionally defined as two parents, living with their children (Oxford Dictionary, 2013), this definition of family has been critiqued by Feminist (Satz, 2013) authors because of its failure to consider the wider cultural and normative assumptions that underpin it. Over time across and within cultures, families take different shapes and although the traditional definition of family as a nuclear family, which encompasses parents and children living in a household, has become the accepted social norm in the UK this is largely a constructed phenomenon with relatively

recent origins. Post World War II, Talcott Parsons played a central role in defining the perception and representation of the family, based on neo-liberal values (Thompson, 2012). He treated the family as a group that served functions for the larger society and argued that nuclear families which constituted of married parents, in which men's roles included goal-oriented, outward looking activities and women specialized in relationship, home focused roles were particularly well adapted to the demands of industrial society. This Parsonian structural-functionalism ignored historical and cultural variation and marginalised the variation in family forms, establishing the nuclear family as the norm.

Contemporary family structures are more complex than represented in the 'traditional' family model; thus, cohabitation, marriage and divorce patterns and ethnic variation in society, need to be considered. The interaction of these factors results in increasingly complex and varied family structures, for example, the Growing up in Scotland (GUS) survey of babies born in 2010/11 identified that 79% of babies live with 2 parents (50% were married and 29% cohabiting) and 21% live with a single parent (19% were single and 2% were either separated or divorced). The proportion of married parents has decreased from 54% while the proportion of parents cohabiting has increased from 26% over the six years since the previous survey (Bradshaw *et al*, 2013).

It can therefore be seen that the concept of the nuclear family is far from universal, even in Scotland where there is little ethnic diversity. Further, defining the family exclusively as a group who live within one household, as was done within the GUS survey, minimises the role of other extended family members: such as each parent's family of origin (the family that each parent grew up in and consists of their parents, siblings and grandparents) whom many consider to be important. For all types of family,

grandparents are a key source of support for parents in Scotland and were involved in many support and childcare roles, with almost all families receiving support from grandparents and the majority receiving both practical and financial support. This included regular childcare and babysitting where grandparents provided the most common form of childcare with nearly 70% of parents benefitting from this, often unpaid, support. Grandparents provided most support when living close by with the greatest number of hours provided by parents of those on low incomes or who were younger (Bradshaw *et al*, 2013).

Within this thesis the concept of family will encompass both the nuclear family and will consider the role of the extended family.

### **3.3 Impact of Family Infant Feeding History on Breastfeeding Rates**

Family experience is reflected in women's infant feeding decision making and women who were not breastfed themselves are less likely to intend to, or actually initiate, breastfeeding (Andrew and Harvey, 2011; Forster *et al*, 2006; Scott *et al*, 2004; Ekstrom *et al* 2003, Meyerink and Marquis, 2002; Dykes and Griffiths, 1998; Sullivan and Jones, 1986) with some mothers stating that how their mother fed had a direct influence on their decision to initiate breastfeeding (Andrew and Harvey, 2011).

The relationship between how mothers were fed themselves when they were babies and whether and how long they breastfed their own children is reflected in the UK breastfeeding rates with the Infant Feeding Survey reporting that 89% of women who were breastfed, intended to breastfeed compared to 60% who were formula fed. Of those who did not know how they were fed, 68% went on to breastfeed. Similarly, mothers who knew they were formula fed were much more likely to plan to use infant

formula, 30%, compared to only 6% of women who knew they were breastfed. With regard to continuation of breastfeeding, 27% of breastfeeding mothers who were themselves entirely formula fed stopped breastfeeding in the first two weeks, compared to 9% of mothers who were only breastfed themselves. These differences continued and at four weeks, 63% of mothers who were exclusively formula fed as babies were still breastfeeding, compared to 85% of those who were exclusively breastfed. The Infant Feeding Survey concludes that while being breastfed oneself 'is not an essential prerequisite for breastfeeding' the mother's own infant feeding status is an important factor (McAndrew *et al*, 2012).

The significance of women's own feeding history was confirmed in a recent Scottish study investigating breastfeeding women's decision making and continuation. Twenty six of the 36 women who participated in the study (72%) had themselves been breastfed and a pattern was observed for early cessation of breastfeeding if the woman herself had not been breastfed and did not have a significant other who had successfully breastfed. Of the nine women who stopped breastfeeding before six weeks, four had not been breastfed, and three had mothers who had not breastfed for more than six weeks, (Hoddinott *et al*, 2012).

To further consider the role of family in breastfeeding, two of the inter-connecting issues which may be implicated will now be explored, namely, the intergenerational transmission of parenting and infant feeding culture and the role of family support for breastfeeding.

### **3.4 Intergenerational Transmission on Parenting and Infant Feeding**

It has been suggested that family culture and beliefs are passed through the generations within families, and that grandparents are involved in influencing beliefs about what constitutes appropriate infant care and the rationale for parenting behaviours (Harkness and Super, 1994). While there is significant literature and research on the importance of family support for breastfeeding, there is less writing and research on the trans-generational transmission of infant feeding within families. Therefore, the wider writing on the transmission of parenting through generations more generally will be considered, with particular reference to breastfeeding where there is evidence.

Trans-generational transmission is the process by which one generation influences the parenting attitudes and behaviours of the next generation, whether intentionally or unintentionally (van Ijzendoorn, 1992). Mechanisms for this transmission have been proposed by several authors including: Bandura through social learning theory (Bandura, 1971 and 1997), Smart from anthropology (Smart, 2007), who argues for the role of memory as a mechanism, Byng-Hall from the psychotherapeutic tradition who talks of family scripts (Byng-Hall, 1998 and 2003) and Thomson (Thomson *et al*, 2011) from sociology, who has developed ideas about maternal identity work.

A dominant theory about how culture is transmitted through generations comes from social learning theory (Bandura, 1971 and 1997) which proposes that behaviour is learned from the environment through the process of observational learning and then reinforced by the environments i.e. the family and society's response to them. This theory is used to explain the development of gender roles and parenting behaviour. Several researchers suggest that the socialisation process described within it explains

breastfeeding behaviour arguing that the most likely explanation is that positive attitudes toward breastfeeding come about through socialization during childhood. This socialization that occurs in a breastfeeding household prompts women to select breastfeeding and helps them to be successful by perhaps increasing their expectations of success (Dykes and Williams, 1999).

It is argued that memory shapes family biographies, playing an important role in creating a sense of self, identity and social connectedness (Smart, 2007). This memory is said to be most important at major moments of life transitions such as birth. At the birth of a child, parents are thought to draw on memories of their own childhood and are likely to have a changed perspective on their own parents and parenting. This, in turn, can result in the influence of their parents by both explicit and implicit means, on their own parenting.

Socialisation and memory theories to explain infant feeding decisions are inadequate as children have limited exposure to breastfeeding. With smaller family sizes and with breastfeeding taking place for a limited period of time in most families, the amount of experience a child will have observing breastfeeding means they are very unlikely to recall events. It has been suggested that instead, a breastfeeding culture has been 'absorbed' from their families (Ekstrom *et al*, 2003). There is therefore a need to look further to try to make sense of the differing infant feeding trends.

The role of family history and its implications for parenting has been widely discussed within the writings of John Byng-Hall. While much of his work focuses on clinical populations who are experiencing distress, his work is applicable with all families, and he has developed the concept of family scripts. Scripts are patterns of behaviour which

are transmitted through generations and are considered to provide the family with guidance about how best to act (Byng-Hall, 2003). These scripts are underpinned by shared belief systems, not all of which are conscious and can take the form of ‘this is how we do things’ within a family. Scripts can take the form of both ‘replicative’ scripts which is doing the same way that your parents did things and ‘corrective’ scripts which is the decision to do things differently, often in opposition to the way that you were parented (Byng-Hall, 1995).

A number of longitudinal studies have studied what happens when couples become parents or women become mothers, and have found that parents believed that they had been ‘bequeathed legacies’ (Cowan and Cowan, 2000) or a ‘cultural inheritance’ (Thomson *et al*, 2011) from their own parents, to their children. Thus the emotional traces of the past leave intergenerational legacies which influence parenting practice (Thomson *et al*, 2011). Even when parents did not report feeling close to their own family or did not agree with their parenting practices and chose another path, by choosing to reject their past, they are still, in some way, making connections to that past.

While men do bring their own parenting histories with them into their new families, it is argued that this type of intergenerational ‘work’ is particularly important for mothers at their transition to parenthood. For maternal identity to develop, women need to make sense of their own upbringing and make decisions about what aspects they value and appreciate and which they decide to reject (Thomson *et al*, 2011). While full identification or dis-identification i.e. rejection, of their mother’s values and parenting practices were rare, ‘partial identifications’ and moments of connection and

disconnection were more common. New mothers are therefore described as ‘generational pivots’ acting as powerful trans-generational transmitters of family culture (Hollway, 2010).

It is argued that that mothers and daughters share an awareness of embodiment of the process of becoming a mother, a ‘bodily inheritance’ where women assume affinities between their own embodiment and that of their mothers (Thomson *et al*, 2011; Darvill *et al*, 2010; Henwood *et al*, 2010). As they approach first-time motherhood, the experience of intergenerational interconnection with their own mothers is enacted in conversations about pregnancy, childbirth and early parenting with their own mother. It is argued that telling and developing these trans-generational stories are part of the identity work of new motherhood and serve as ‘moral tales’ which locate mothering within family and local cultural narratives which, as such, reflect the weight of social norms (Thomson *et al*, 2011). This intergenerational relationship helps to explain the finding that the influence of the maternal grandmother appears stronger than that of her mother-in-law (Reid *et al*, 2010).

It is worth noting that fathers and other male relatives rarely feature in women’s narratives and that even very supportive grandfathers were often very much background figures (Thomson *et al*, 2011). This largely female dominated process has led to some fathers reporting that they feeling marginalised by female embodiment (Darvill *et al*, 2010; Barclay and Lupton, 1999).

There is therefore an emerging idea that helps to make sense of the differences in breastfeeding rates between women who were breastfed themselves and those who were not. This includes the stories or scripts from their families about how babies are cared

for and fed, particularly when that experience is embodied and shared between mother and daughter. It has been suggested that this may apply in a breastfeeding context and that there may be a number of ways in which a mother can influence her daughters feeding decision, consciously or unconsciously, and that daughters may reproduce their own childhood values experience (Ekstrom, 2003). This principle is reflected in studies which show that most breastfeeding mothers were breastfed themselves and most formula-feeding mothers had been fed with formula themselves (Andrew and Harvey, 2011). It has been argued that support is the other main way that family history and experience influences infant feeding. As asserted in Dykes and Griffiths (1998) 'A woman's mother is a major role model inevitably influencing her parenting style.' They continue by stating that;

'Many grandmothers of today will have either bottle fed their babies or breastfed in the regimented and unphysiological manner advocated by health professionals in the 1960s and 1970s. This will inevitably affect their advice to their daughters which may conflict with other sources of information provided'.

Therefore, the next important aspect to be discussed is the support offered by families, particularly grandmothers, which can influence women's experience of breastfeeding.

### **3.5 The Influence of Family Support on Breastfeeding**

It has been established that breastfeeding mothers considered families to be important in helping them succeed with their breastfeeding intentions (Barona-Vilar, 2009; Swanson *et al*, 2006; Ekstrom *et al*, 2003; Humphreys *et al*, 1998; Guigliani *et al*, 1994) often more so than health service support (McInnes and Chambers, 2008). This is a finding that holds across cultures, with a recent Scottish study suggesting that for some women,

family experiences and stories are as valid as or more valid than professional advice and research evidence (Hoddinott *et al*, 2010). It has been hypothesised that to be able to offer the required support to breastfeeding women, it may be important to have a network which is congruent with and supportive of the mother's breastfeeding intentions (McInnes and Chambers, 2008).

A UK study which specifically looked at family members (grandmothers, sisters and partners) views on breastfeeding, found that women, despite feeling the need for emotional support with breastfeeding, struggled to ask for support and families did not provide it (Lavender *et al*, 2006). In particular family members stated that breastfeeding no longer fitted with today's culture as it was no longer seen as the norm and was problematic to fit into daily life. Some family members were active in trying to dissuade women from continuing with breastfeeding and others did not feel able to offer any support, removing themselves from women when they were feeding and generally 'keeping out of her way'. Although no individual family members reported that breastfeeding was embarrassing or unacceptable, a number of those interviewed said that other family members did. Other studies have found that although family members said they were offering support, the research suggested that conflicting advice was common (Hall Moran *et al*, 2007) and many family members were actually undermining the mother's experience either overtly or covertly, often through non-verbal cues (Lavender *et al*, 2006). Women interpreted these messages by questioning their ability to breastfeed and whether something was wrong with their bodies (Hauck and Irurita, 2003; Dykes and Williams, 1999).

Reviews of research have suggested that while partners within the nuclear family have a role in influencing and supporting breastfeeding, female relatives (Hoddinott and Pill, 1999) and particularly the mothers' own mother, the baby's maternal grandmother, appears to be most significant (McInnes and Chambers, 2008). While relatively little research has been undertaken to consider the role of female relatives, it is clear that grandmothers influence breastfeeding across cultures. Given that the focus of this thesis is about the experience of breastfeeding women who have no family of origin breastfeeding experience, and because grandmothers are frequently identified as the most important influencer, the predominant focus in the following section will be about grandmother experience and support, and its impact. However, because of the potential impact of the role of male partners and their role in decision making and supporting breastfeeding, partners will also be considered, but in less depth.

### **3.5.1 Partner's Role in Influencing and Supporting Breastfeeding**

There is contradictory evidence about male partner's role in influencing infant feeding decision making. While a number of early studies suggested that partners were instrumental in their breastfeeding decision making (Pisacane, 2005; Bailey *et al*, 2004; Stewart-Knox *et al*, 2003; Arora *et al*, 2000) others suggest that the decision is made jointly (Laantera *et al*, 2011; Voss *et al*, 1993). More recent findings have suggested that although fathers were willing to support a mother's decision to breastfeed, they were not part of this process (Datta *et al*, 2012; Mannion *et al*, 2013). Once the breastfeeding decision has been made, partner support is considered to be important, with some studies (Mannion *et al*, 2013; Hoddinott *et al*, 2012) reporting that partners were either as influential, or slightly more influential, than women's own mothers.

It has been reported that fathers can feel unsure about how to provide support to their partners and as such were more likely to offer advice which undermined breastfeeding and supported the use of formula, in a context where their partners wanted to breastfeed (Datta *et al*, 2012; Entwistle *et al*, 2010; Bailey *et al*, 2004; Dykes and Williams, 1999). There is therefore a body of opinion which suggests that fathers should be included in antenatal education and training about breastfeeding, to provide assistance with breastfeeding difficulties (Rempel and Rempel, 2011; Sherriff and Hall, 2011). However, others argue that general supportive behaviours, such as positive verbal encouragement and preparing cups of tea, enhance maternal confidence and have a greater impact on sustaining women's efforts to breastfeed (Mannion *et al*, 2013).

### **3.5.2 Grandmother's Influence on Breastfeeding**

While it has been established that grandmothers are an important influence across cultures (McInnes *et al*, 2013; Grassley *et al*, 2012; Reid *et al*, 2010; Grassley and Eschiti, 2008, McInnes and Chambers, 2008; Guigliani *et al*, 1994), this varies depending on cultural and socio-economic factors. The influence of different relatives varies by social group with grandmothers' influence stronger in lower socio-economic groups (Brannen, 2006; Entwistle *et al*, 1982), non-Anglo-Saxon cultures (Baranowski *et al*, 1983; Bryant, 1982) and when the nuclear family live closer to the mothers family of origin (Reid *et al*, 2010; Lamm *et al*, 2008; Bryant, 1982). For example, urban mothers, who live at some distance from their family of origin, may depend more on networks of peers, professionals and the media, relying less on vertical transmission of culture and support from their own mothers (Reid *et al*, 2010). It is therefore particularly important to keep in mind the context in which any study was undertaken to be able to assess the relevance of the findings and conclusions of these studies to the

Scottish context. This includes not just the cultural context but also the very different levels of health service provision, which even across developed countries, may make up for to some extent, a lack of family support. For this reasons, research evidence from the UK will be prioritised in the following section and literature from other less comparable countries being used with caution with its origin clearly indicated.

Several, UK studies have established the importance of grandmother support for women. The infant's maternal grandmother was mentioned frequently by mothers as an important source of support and practical advice in the early days (Andrew and Harvey, 2011). Mothers indicated that practical support, empathy and approval were important, particularly when from the maternal grandmother (over that from husband's mother). Breastfeeding success was found to be associated with high level of approval from women's own mother (Dykes and Williams, 1999).

These findings were added to in a study with adolescent breastfeeding mothers where, while husband and health professionals were of some significance, the adolescent mothers' strongest source of support came from their own mothers and families. When the mother's mother had breastfed, this was particularly strong. Women were found to need support of different types, including direct practical support (instrumental support), emotional support, esteem support such as encouragement and positive comparison and informational support in the form of advice and feedback (Dykes *et al*, 2003).

Further studies have suggested that grandmothers' own experience of breastfeeding particularly influence new mothers' decisions to initiate and continue breastfeeding. Grandmothers who themselves breastfed were found to have significantly more positive

attitudes to breastfeeding than those who formula fed, and this difference persisted despite an educational intervention (Grassley *et al*, 2012). Grandmothers who had breastfed are thought to transmit not only their practical knowledge of how to breastfeed but also their confidence that breastfeeding is the normal way to feed an infant (Grassley and Eschiti, 2008; Dykes *et al*, 2003; Scott and Mostyn, 2003). This shows the inter-relationship of family and individual factors, as illustrated in the ecological model, and women spoke of how useful it was when their own mother shared their own breastfeeding experiences (Grassley and Eschiti, 2008). This was confirmed in a recent Scottish Study where grandmothers who had benefitted from positive breastfeeding experience themselves were an important source of emotional support for breastfeeding mothers, especially when they made practical suggestions, were non-judgemental, did not impose their views and listened and tried to allay their daughter's fears (Hoddinott *et al*, 2010).

While grandmothers play a key role, many report that they feel ill prepared to support their breastfeeding daughters (Grassley and Nelms, 2008; Ingram *et al*, 2004) and experience significant dilemmas in trying to support their daughters (Reid *et al*, 2010), especially if they did not breastfeed themselves (Grassley and Nelms, 2008). Indeed, grandmothers may actively encourage feeding methods with which they are familiar, suggesting formula and other unhelpful solutions which were not supportive of breastfeeding with, especially if the breastfeeding mother encounters problems (Grassley and Nelms, 2008; Lupton and Wheelan, 1998). Studies have found that the grandmother's advice was dictated largely by cultural beliefs (Grassley and Eschiti, 2008) and her own experience (Morrison *et al*, 2008; Lupton and Whelan, 1998). This

can have negative consequences for breastfeeding mothers who can be undermined by lack of knowledge in the social network or by negative attitudes and beliefs.

In order for breastfeeding mothers to have the family support they would like, it has been proposed that health professionals should intervene directly with grandmothers to give them accurate information and help change their beliefs about infant feeding (Grassley and Eschiti, 2008). Other researchers join them in suggesting grandmothers could learn to support women better (Lavender 2006; Ingram 2003) and some have designed interventions to test the acceptability of this to grandmothers (Grassley and Eschiti, 2007) and the effectiveness of interventions in changing infant feeding practices (Kerr *et al*, 2008; Aubel *et al*, 2004; Ingram *et al*, 2004). One randomised controlled trial conducted in the north of England questions the effectiveness of interventions with grandmothers, finding no increase in breastfeeding initiation or duration after an information meeting about breastfeeding for women and a self-selected female supporter, usually the mothers own mother (Winterburn *et al*, 2003). This was however, a small intervention and the supporter was not involved in all aspects of antenatal care as recommended by other studies (Reid *et al*, 2010).

### **3.6 Implications for Family Relationships**

Surprisingly there have been no studies about the impact of breastfeeding on family relationships or, more specifically, the impact of making a different feeding choice from your own mother on this relationship. Literature from other settings can be drawn on to contextualise this research and some implications can be tentatively drawn from other breastfeeding experience studies particularly those focussing on family and grandmother support.

Anthropologists describe the transition to motherhood as a particularly intense moment in women's lives (Thomson *et al*, 2011; Hollway, 2010). In addition to the intensification of relationships with families and in-laws when adults become new parents, couples themselves experience additional strain especially if those relationships were previously difficult or ambivalent (Brannen, 2006). This is supported by family therapy literature which identifies the transition to parenthood as a key stage in a family's life-cycle (Carter and McGoldrick, 2005). It has been suggested that when a new baby is born, centripetal forces occur within the extended family, pulling them closer together and potentially making relationships more intense (Combrinck-Graham, 1985). This may mean that previously non-problematic differences of views can take on a new intensity and meaning (Carter and McGoldrick, 2005).

Families may have strong views about breastfeeding (McFadden and Toole, 2006) including strong emotional responses to feeding such as disgust and the increased intensity of these relationships may expose these. Differences in belief and practice for example about breastfeeding routines, may also cause new tension and difficulties, or reactivate earlier ones, which may affect relationships (Reid *et al*, 2010). This Australian research by Reid *et al* (2010) has highlighted some of the earlier mentioned challenges and dilemmas for grandmothers supporting daughters and negotiating interactions with the new family, trying not to jeopardise relationships and access to grandchildren. Conversely some international studies suggest that when there are differences of views about feeding method, some women will follow grandmothers' wishes to avoid confrontation (Kaushal *et al*, 2005; Bentley *et al*, 1999).

### **3.7 Conclusion**

It has therefore been established that family history and support for breastfeeding is important for women influencing their infant feeding decisions and this shows through breastfeeding rates and women's subjective reports. Families are wider than the traditional definition of the nuclear family and grandparents are actively involved in their children's and grandchildren's lives and the influence of grandmother's appears to be particularly significant. This may act through intergenerational transmission of parenting norms and through the type of support that families can offer to their breastfeeding daughter. Where grandmothers are able to support their daughters, mother's feel more confident in their feeding and report better relationships with their mother, however, many grandmothers struggle to provide this support, especially if they have not breastfed themselves and have little knowledge or understanding of breastfeeding.

Some women, however, do not follow the trans-generational infant feeding patterns from their family of origin and have chosen to breastfeed their babies when they have no family history of this. The infant feeding culture and experience of the family is therefore potentially not congruent with her own. This informs the consideration of the research question, investigating what it might be like for women who have no family breastfeeding history.

Consequently, in the next chapter, consideration is given to several methodologies which might be suitable to investigate women's experience of breastfeeding when they have no family history of breastfeeding.

## Chapter 4 - **Investigating Breastfeeding Experience**

### **4.1 Introduction**

This chapter considers the various approaches which have potential to investigate breastfeeding experience when a woman has no immediate family breastfeeding experience. The rationale for using a qualitative approach will be outlined and two potential research methods, Grounded Theory and phenomenological approaches, will be defined. These will then be considered and critiqued to establish their suitability for answering the research question. Interpretative phenomenological analysis (IPA), the chosen methodology is then situated within the field and its use in this research is justified.

### **4.2 Rationale for Employing Qualitative Methodology**

Qualitative methods have increasingly gained in status in psychological and health research. Traditionally researchers in this area would have used hypothetico-deductivist methods (Popper, 1959) where hypothesis are generated from theory and tested largely through the collection and analysis of numeric data. The belief is that by identifying false claims and disproving the null-hypothesis, truths can be found. This is considered to be a nomothetic research approach which seeks generalisable findings which can explain phenomena. This is largely conducted within a framework of a positivism epistemology, where objectivity is sought and there is considered to be a direct or relatively direct relationship between the world and our perceptions of it (Lyons and Coyle, 2007), hence coming from a realist ontology.

In contrast, qualitative research is informed by a number of different assumptions about the nature of reality and our relationship with the world we inhabit, i.e. ontology, and of

knowledge and how we come to know what we know, i.e. epistemological frameworks, They have in common, however, an interest in the subjective experience of individuals, through the collection of rich, non-numeric data. As such, the data is considered to have primacy, is understood within the context in which it was collected and is related to the individual's history, setting and culture, meanings and understanding. In summary, it is argued that the qualitative researcher seeks to understand what it is like to be this person in their particular context (Willig, 2008). This often involves idiographic approaches where individual cases are considered in detail, before any tentative propositions are made about the generalisability of findings.

### **4.3 Consideration of the Approach**

There are a number of types of qualitative methodologies which could potentially be used, each coming from different ontological and epistemological frames and having different but also overlapping areas of concern and application. Grounded Theory and phenomenological approaches have potential to answer the research question, therefore these approaches are considered in further detail and, in doing so, justification for the most appropriate method is provided.

#### **4.3.1 Grounded Theory**

Grounded Theory has its origins in sociology, having been developed by Glaser and Strauss (1967). In their seminal work *The Discovery of Grounded Theory*, they argue that much sociological research methods had focussed on how theory could be tested, while their development, Grounded Theory, addressed how theory can be discovered from data through the systematic gathering and analysing data from social research. They saw their work as a means to generate theory which could then be empirically

tested and that the theory they generated by this means would be more successful than theories which are deduced from a priori assumptions (Glaser and Strauss, 1967).

Grounded Theory, as a method, consists of guidelines for the collection, synthesis and analysis of data, staying close to the data while developing more abstract categories and concepts that help make sense of the data collected. These tentative categories and concepts are then used to collect more data to refine and develop their properties and the relationships between them, so building theory that explains the data. Thus, Grounded Theory's focus is nomothetic and its intention is to generate theory from the descriptions elicited from data with further data collection being shaped by that which has already been analysed (Charmaz, 2008).

Fundamental to their endeavour was to develop written guidelines on how to conduct qualitative research and methods involve gathering data (Glaser and Strauss, 1967). Their methodological procedures have however been criticised as being vague and ambiguous (Payne, 2007). This was addressed by Strauss and Corbin (1990); however, Glaser and Strauss appear to have become divergent in their views regarding refinements to the method resulting in public critique of each other methods (Willig, 2008).

Early formulations of Grounded Theory have been considered to be based, epistemologically, in positivism or realism, with the implied straightforward relationship between perceptions of the world and reality, where 'truth' can really be discovered (Payne, 2007). This fits with their assertion that grounded theory can be used as a pre-requisite to empirical testing (Glaser and Strauss, 1967). Irrespective to their own developments or attachments to the original method, Glaser and Strauss urged in

their original work, for others to develop their method and this has occurred with constructivist (Charmaz, 2000; 2008) and postmodern (Clarke, 2003) versions being published. As Grounded Theory has demonstrated some potential to be used in this study and will therefore be further considered alongside phenomenological approaches.

#### **4.3.2 Phenomenological Approaches**

Phenomenological approaches are based on Phenomenology, a philosophical approach to the study of experience. There are a number of interests and emphasis among the various phenomenologists, but key to them all is what it is like to be human and to have experiences in the lived world. Of particular significance to this tradition are the philosopher Husserl and Heidegger with others following, for example, Gadamer, Merleau-Ponty, Ricoeur and Sartre. Although the phenomenological philosophers had no interest in research, a number of researchers have drawn on phenomenology to inform their methodologies. While a detailed consideration of phenomenology is beyond the scope of this thesis, an outline of the key ideas of two of the main proponents, Husserl and Heidegger will be given and related to the research methodologies which have been informed by them.

Husserl, who is a key member of the Continental Philosophy tradition, initially set out to establish a 'logical foundation for the sciences' by looking beneath disciplines to discover their 'essences', their key components and as such understand the foundations which lie beneath. This involved a process known as phenomenological reduction, a meditative process, where all of the individual philosopher's beliefs, assumptions and emotions which exist in one's natural state of mind, are set aside. This allows the philosopher to see the world afresh and gives one access to the 'essence' of the object or

experience to be studied. Over time, Husserl became particularly interested in human experience and how one might know one's own, pure experience of consciousness and identify its essential qualities, applying this to say something about the experience of others (Moran, 2010).

Heidegger was a student of Husserl who initially accepted Husserl's ideas but, over time, differentiated himself from them. His major work 'Being and Time' (1962) develops the concept of Dasein, which is directly translated as 'there-being', and is seen as a special type of entity or essential quality, of being human. He argues that Dasein, the aspect of the human that is aware of its own existence, is the fundamental essence which should be investigated. It is further argued that Dasein already understands some of its own nature, and is self interpreting, which allows it to interpret and mis-interpret itself and the world (Paley, 1998). Heidegger is therefore interested in the conceptual basis of existence, but from a 'worldly' perspective, wanting to know the world which is accessible to us, considered to be 'ready to hand' as an embodied, subjective person. Dasein is therefore embedded in a subjective individual, investigating a world which is immersed in language and culture and cannot be separated from it (Smith *et al*, 2009).

As such, one of the main differences between Husserlian and Heideggerian doctrine is ontological with different assertions about the degree to which it is possible to suspend existing knowledge and to be able to get direct access to an individual's experience.

Husserl's version of phenomenology is realist, with a belief that with the correct reductionist stance, the nature or essences of things can be discovered, if we can strip away the world. In contrast, hermeneutic phenomenology, as espoused by Heidegger,

focuses on describing and understanding a phenomenon from the more relativist and subjective ontological perspective of 'being-in-the-world'.

These differences have both ontological and epistemological implications for the stance of the researcher and practical implications for the application for research methods and, in particular, analysis of data. Consequently, when researchers use Husserlian inspired phenomenological methods, they aim to reveal essential meaning structures of a phenomenon and to do this, would 'bracket' their existing beliefs and biases to look at experience. This exists in various forms including the Husserlian approach as applied by Giorgi (1994). Giorgi's scientific phenomenology draws on Husserl's idea that existing knowledge can be bracketed and he describes a researcher stance called psychological reduction, which is intended to bracket researcher knowledge. From this stance, Giorgi argues that the meaning of an experience for a research participant can be found, by the application of his analytic method. Giorgi's method, as informed by Husserlian phenomenology, as will be later seen, does not easily fit with the epistemological standpoint brought to this research and will not therefore be considered further for use in this research. However, his critique of other phenomenological methods will be considered as part of the rationale for the use of interpretative methods.

In contrast, there is a fit between my own epistemology and those which inform interpretative phenomenological research methods, where the individual's subjectivity is accepted and valued as part of the interpretative process. There are a number of interpretative phenomenological approaches, such as those proposed by Gadamer (1989) and van Manen (2007), and Interpretative Phenomenological Analysis (IPA) (Smith *et al*, 2009). IPA is an increasingly frequently applied form of interpretative

phenomenology in the United Kingdom with a broad corpus (Smith, 2004; 2011a). As IPA has potential to answer the research question, has a clearly articulated analytic approach (Smith *et al*, 2009), and access to training and consultation with the researchers who developed it is available, it is considered to be a potential approach.

IPA is an approach that is concerned with the examination of participants' experience and how they make sense of that experience (Reid *et al*, 2005; Smith *et al*, 2009). It is phenomenological in its concern in that it investigates lived experience and the meaning made of this by the participant, as this is understood by the researcher and as such is a hermeneutic i.e. interpretative experience. Thus IPA recognises that the researcher's own cognitions are required to make sense of the experience being studied, through a process of interpretative activity (Chapman and Smith, 2002). It is therefore a double hermeneutic process where the researcher is seen as attempting to make sense of the participant's sense making activity (Smith *et al*, 2009). IPA is distinctive from many other qualitative methods in its commitment to idiographic analysis with the in-depth consideration of each individual's experience in addition to its interest in any shared meanings the phenomena may have for the entire group of participants (Larkin and Thompson, 2012; Smith 2011; 2007; 1996; Smith *et al*, 2009; Larkin *et al*, 2006; Chapman and Smith, 2002).

IPA draws on both phenomenological and hermeneutic theory, particularly the work of Gadamer (Smith, 2007; Gadamer, 1989). Smith (2007) argues that the hermeneutic circle is a key aspect of interpretative analysis within IPA. In IPA analysis, the relationship between the part and the whole, in a cycle, is a key feature, where movement back and forward between levels within the transcript and analysis help with

deeper understanding. This involves considering each utterance in the context of the whole transcript and in the context of all the transcripts, which in turn influences the analysis of each utterance in the transcript.

Within IPA there is a clear interpretive function, where the researcher's own cognitions are required to make sense of the experience being studied (Chapman and Smith, 2002) and her beliefs are therefore not seen as biases to be eliminated as they might, for example, in some forms of grounded theory, but rather as being necessary for making sense of the experiences of other individuals (Fade, 2004). The researcher brings her own pre-conceptions and existing knowledge to each contact with another, in this case the research and research participant. It is argued that one should acknowledge one's own biases and beliefs, and use reflexivity to make sense and record these, before attending to the participant's concerns, helping the researcher in the interview process to explore their participant's experience and world view. Having undertaken the interview and explored in detail the clients view, the interviewer then analyses the data, including using her prior experience and knowledge, but knowing that she is inevitably changed by the different perspective which has been offered by the participant. It is possible that only through this process of reflecting on what one believes and how this has changed, that we may become aware for the first time of pre-suppositions which we had.

IPA analysis is characterised by a set of common and systematic processes that are applied to the analytic task (Reid *et al*, 2005). As advocated in Smith *et al* (2009) an idiographic approach is used where the researcher will subject each participant's data to manual, close textual analysis before looking at further transcriptions with a similar level of detail. This involves examining and coding the participant's semantic content

and language use, identifying key words and phrases used, to begin to make sense of the participant's understanding of their world. This is followed by clustering of the identified codes into larger categories and the identification of emerging patterns of convergence and divergence for each single participant, before looking at further participants. IPA's focus on the idiographic, means that this close analysis is undertaken with each participant as well as the identification of themes and areas of convergence and divergence across a number of participants and takes the form of iterative and inductive cycles (Smith, 2007). Analysis is never considered to be finished, rather it is punctuated and ceases when it is considered good enough (Smith, 2007).

It has been argued that one of the reasons that IPA has been attractive as a method is because accessible guidelines have been published about how to use this approach (Larkin and Thompson, 2012; Smith *et al*, 2009; Smith and Osborne, 2003). Critics of the approach argue that this codification of the method allows analysis to be done in an unreflective way and without adaptation to the specific research project (Chamberlaine, 2011; Giorgi, 2010). He adds that by coding data in a mechanistic way, rather than exploring it phenomenologically and then looking for sub-themes and then larger themes or superordinate themes, means that the phenomenological idiographic aspect of the data is lost and, doubly damning, 'strong' interpretation cannot occur as this requires intellectual processing beyond the process of collection and summarising of data. However, Smith (2011) argues strongly that a 'cookbook' approach does not make good qualitative research and that the suggested analytic guidelines detailed in publications are there to be adapted as required by the analytic task. This is supported by the variation in different approaches advocated within IPA publications (Larkin and

Thompson, 2012; Smith *et al*, 2009) due to the researchers own particular philosophical interests and the area or nature of the research they are undertaking.

As IPA has potential to be used in this study it will be considered in relation to other methods.

#### **4.4 Rationale for the Use of IPA**

The aim of this study is to investigate the experience and meaning of being the first person to breastfeed in a family. This has a number of assumptions within it which are informed by ontological and epistemological concerns.

##### **4.4.1 Reflexivity Relating to Methodology**

It is important when considering which qualitative methodology to adopt, to ensure coherence between the researcher's ontological and epistemological position and that of the methodology selected. My systemic family therapy training led me to a world view that values the role of context, relationships, constructivism and social constructionism. Consequently, I was interested in the relationships between people, the beliefs they have about the world and how their use of language helped shape their internal world and external world view. Ontologically, I was unconcerned about the nature of reality and whether or not it existed as this could never be known, as we do not have a direct relationship with it. I would have argued that the use of language and socially constructed shared meaning was highly significant in our understanding of the world and how it worked, which probably positioned me as a constructivist with social constructivist leanings.

This world view was radically shaken by the births of my own children and the power of this embodied experience. The embodied nature of pregnancy and breastfeeding and my increased awareness of my hormones on my milk supply, mood and behaviour lead me to revise my beliefs to encompass the biological reality of my existence. This undermining of my world view led me to reconsider a number of other assumptions. At its heart was my reflexion on my beliefs about the existence of an independent, if changing 'self', which was not fully explained by social constructionism and set me off on some ontological and particularly epistemological revision. I began to believe that there actually could be something called 'the self', and something that 'was experience' which is influenced by and has a relationship with language and social interaction, but that could exist, at least in theory, independently of this.

I was given the ideal opportunity to explore some of this in relation to my research question and made the decision that I was interested to ask about people's experience of breastfeeding in a context. This was not only about how women used language, or how dominant discourse shape their beliefs and actions, it was a wider exploration about what the embodied experience was 'like', from a breastfeeding women's point of view. This fits with the assertions that breastfeeding is both an embodied experience and also comprises 'headwork' as we conceptualise and tell stories, mediated by culture and language, about breastfeeding experience (Bartlett 2002). These beliefs have consequences for the ontological and epistemological approach I judge are most suitable to investigate the research question, with those informed by a contextual constructivist approach being the best fit with my own evolving ontological and epistemological position.

#### 4.4.2 Comparison of the Approaches

Grounded Theory and IPA share a number of areas of interest including a focus on meaning and in phenomena of themselves, aiming to generate rich and nuanced descriptions. At a methods level, they both use categorisation to reduce the complexity of the data. There are however, a number of differences, which need to be considered when deciding on which method to use in this study. IPA embraces and maintains the individual as a mode of data collection and analysis and is less interested in theory generation or the application of grand narratives, as is the case in grounded theory. IPA is more idiographic and interested in talking in detail about the particular experience of the individual participants and the convergence and divergence of their and others' experience (Smith *et al*, 2009). Consequently, data collection differs between the methods, as Grounded Theory looks to a heterogeneous purposeful sample to try to reach data saturation about a particular area of interest (Glaser and Strauss, 1967), whereas IPA is keen to restrict the purposeful sampling to a group which shares a particular experience, making tentative claims for generalisability (Smith *et al*, 2009).

While both approaches value bottom-up, inductive approaches and could be applied to the investigation of experience, IPA acknowledges the deductive processes at work during analysis and is explicit about them (Smith *et al*, 2009). Therefore a researcher, at later stages of the analysis, may draw upon other theoretical frameworks or concepts to develop interpretations of the experiential accounts that have emerged, which is more interpretative and less emergent than in a traditional grounded theory approach.

Grounded theory has traditionally considered the researcher's experience and perspectives to be unhelpful biases to be 'bracketed out' (Glaser and Strauss, 1967).

However, more recently some researchers from a postmodern background (Luca, 2009)

argue the impossibility of ‘disembodied bracketing’ and demand an epistemological revision of grounded theory to include researcher hermeneutics which inevitably shape the interpretation of the data. The Situational Analysis form of grounded theory, which uses a post-modern approach, goes some way towards this (Clarke, 2003) as have constructivist versions as developed by Charmaz (2000) and Strauss and Corbin (1990). In these versions the role of the researcher is acknowledged and the theory developed only reflects one subjective version of the data. From its origins, IPA has been clear that the researcher’s beliefs and experience are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals (Fade, 2004).

One additional consideration is the context in which Grounded Theory and IPA were developed. Grounded Theory was originally developed to answer sociologically derived processes and to theorise social processes (Charmaz, 2000). Its applicability to answer questions about experience has therefore been challenged (Willig, 2008). IPA was specifically developed to investigate experience and evolved in a health psychology context and therefore has a fit with an exploration of meaning and experience in a health context.

IPA, while valuing the individual’s experience, has a secondary critical focus on language, meaning and context and their influence on the individual, their experience and meaning making. IPA, therefore, recognises that a participant's thoughts are not necessarily transparently available from their interview transcript. The focus of IPA is to analyse and comment on a participant's particular way of describing and thinking and is more interpretative in its interest. It shares some of this focus with discourse analysis

and IPA explicitly states that there is no direct access to a person's lived world, only mediated access through their meaning-making and their use of language to express and formulate this meaning in dialogue with the researcher. This means that epistemologically IPA takes up the phenomenological position that the meaning and nature of that reality is dependent upon our view of it and our involvement and engagement in it, it also suggests that there is some access, albeit limited, to a person's lived world (Merleau-Ponty, 1945). As such there is a focus on both getting close to the participant's experience, limited as this is, and making sense and interpreting their experience (Larkin *et al*, 2006).

IPA has been developed and applied to a number of areas within psychology, health and social sciences; for example, living with genetic conditions (Chapman and Smith, 2002), coping with Alzheimer's disease (Clare, 2002), sexual health (Flowers *et al*, 2006; 1987) and experience of mental health issues (Eatough and Smith, 2006). It has also been used in studies of women's experiences of breastfeeding in different contexts, including Shaw and Wallace (2003), Johnson *et al* (2009), Williamson *et al* (2012) and Williamson and Sacranie (2012) which supports its potential for use in this study.

Additionally, IPA offers applied researchers the opportunity to integrate research and practice (Smith, 2007; Duncan *et al*, 2001; Golsworthy and Coyle, 2001). An example of the difference IPA research made to practice emerged through in-depth interviews with gay men, exploring the emotional meaning of unprotected sex. This led to a new understanding of gay men's sexual health decision making, which had implications for health promoting practice and policy (Flowers *et al*, 1997). It has been argued that IPA should be applied to preventative health issues (Shaw 2011, Fade 2004). This is partly

because of its ability to explore an individual's unique making sense of their life and experience and that the application of this to decision making within preventative health behaviour, offers a realistic approach to investigating decisions as they fit within individuals lives and beliefs, as opposed to presuming that individuals make logical choices.

#### **4.5 Synthesis and Conclusion**

Having explored qualitative research methodology to establish the most suitable approach, it was decided that both Grounded Theory and IPA had potential to be used to investigate the research question; however, the most promising approach to analysing in depth descriptions of human experience is Interpretive Phenomenological Analysis (IPA) as described by Smith (2004; 1996) and Smith *et al* (2009). This is because of its explicit interest in: the experience and cognitions of the research participant, the cultural and historical context that this is situated in and mediated by, and the focus on the idiographic as opposed to theory generation. As Smith (2011) says, IPA believes in 'a chain of connection between embodied experience, talk about that experience and a participant's making sense of, and emotional reaction to, that experience'. This fits with the definition of breastfeeding as both an 'embodied experience and a discursive construction' (Schmied, 2001) and is therefore ideal to answer this research question. This choice of approach, where it is assumed that individual experience is mediated through wider cultural discourses, fits both with the aim of the study and my own epistemological and ontological beliefs. Further, it has been proposed that hermeneutic phenomenological approaches are the most appropriate methodologies to explore women's breastfeeding experience as these methods take into account the subjective, embodied experience of participants in a way that other approaches, informed by

differing ontological perspectives do not (Spencer *et al*, 2008). The use of IPA could therefore enable new understandings of women's experience and individual support needs to emerge which inform practice and the delivery of woman centred, individualised care by health and voluntary sector workers.

## **Chapter 5 -Study Methods**

### **5.1 Introduction**

The previous chapter provides an overview and rationale for the methodology to undertake this research. The strengths and limitations of a number of approaches were critiqued and interpretative phenomenological analysis (IPA) was selected. The current chapter outlines the research methods, informed by the chosen approach, used in the design of this research. This includes an outline of the research setting and the selection of participants, the collection of data through the completion of genograms and semi-structured interviews, the analytic process and the ethical issues which were considered. The final section details how rigour has been achieved by considering a number of indicators of quality in interpretative phenomenology analysis. The decisions are guided and contextualised by the methodological considerations of the previous chapter.

### **5.2 Participants**

#### **5.2.1 The Research Setting**

The research was undertaken in Ayrshire, a county which has concurrent boundaries with the area covered by NHS Ayrshire and Arran, in the West of Scotland. Ayrshire has an estimated population of 366,800 and Ayr is its main administrative town with Kilmarnock and Irvine the other principle towns. Ayrshire is predominantly rural, is agriculturally rich and used to have a number of industries such as coal mining and steel works, but these have largely closed. It has a higher level of unemployment than the Scottish average and has a number of areas categorised as being deprived (Scottish Neighbourhood Statistics, 2011). This is a region which has persistently had one of the lowest breastfeeding initiation and continuation rates in Scotland (ISD, 2013).

The majority of women who reside in the research area are from a Scottish ethnic culture (in excess of 90%) with a minority identifying themselves as ‘other British’ and fewer than 2% from other ethnic minorities (SCROL, 2011).

### **5.2.2 Participant Selection Strategy**

Purposeful participant selection was used to recruit to this study. As IPA requires detailed case-by-case analysis of individual transcripts to give a detailed interpretative account of the experience and understandings of the particular group studied (Smith, 2009) a small sample size is needed (Larkin *et al*, 2006). The number of IPA participants required for postgraduate study has been discussed across the IPA community (Smith *et al*, 2009; Reid *et al*, 2005). In a review of the IPA Corpus (Smith, 2011) the number of participants ranged from 1 to 40, with a mean of 14, however, this included studies with focus groups which raised the mean. Recently it has been suggested that there should be a maximum of ten participants in an IPA study (Reid *et al*, 2005) with Smith *et al* (2009) advocating a sample size of 12 for a PhD. Other key figures within the IPA field have argued for slightly larger sizes in studies with public health relevance (Flowers *et al*, 2006). As breastfeeding is an issue which has public health implications, it was decided that a suitable number of participants would be 12 – 16, with an ideal number being 14. This gives the opportunity to hear a number of women’s experiences, without an unacceptable compromise with the depth of analysis. Inclusion and exclusion criteria were developed to ensure an appropriate and homogenous sample, which is advised for an IPA study and is necessary to reveal what an experience means to a particular group.

### 5.2.3 Inclusion Criteria

In order to be eligible to be included in the research, participants need to be women who;

- initiated and sustained breastfeeding for at least eight weeks within the previous three years
- were not breastfed themselves by their own mother
- do not have a sister or other close female relative who has breastfed, for example step or adopted sister
- have regular contact with her family of origin
- are white Scottish, living in Ayrshire and speak English as their first language

The inclusion criteria were informed by a clear rationale. Participants were required to be breastfeeding or to have breastfed within the previous three years, as maternal recall of breastfeeding practice has been shown to be valid and reliable when recalled within three years (Li *et al*, 2005). Additionally, participants were required to have breastfed for at least eight weeks as my clinical experience suggested that these women were likely to have overcome initial breastfeeding difficulties. In order to be the first person who had breastfed in their family, participants could not have any close relative who has breastfed, including their mother or sister. Participants were required to have had regular contact with their family of origin, defined as fortnightly face to face contact and/or weekly phone contact, as a minimum, but could not be living with them.

Breastfeeding rates and attitudes are significantly affected by cultural variation and ethnicity (Baranowski, 1983; Condon *et al*, 2003) therefore only women who defined themselves ethnically as white Scottish and who lived in Ayrshire were included in the

study. Only women who spoke English as a first language were included in the study, because language and culture are intimately related (Mahadi and Jafari, 2012) and this could therefore impact on the family and cultural beliefs of the participant.

Although women's socio-economic backgrounds and their age have been shown to be factors which influence breastfeeding initiation and duration in populations (ISD, 2011), homogeneity in this area was not sought. There is precedent for narrowing the field of interest to the experience being investigated but not controlling other factors such as socio-economic status and age (Smith, 1999). Difference in perspective which may arise from these factors can be accommodated in the divergence of participants' views within themes which may emerge (Smith *et al*, 2009).

#### **5.2.4 Additional Exclusion Criteria**

- Women currently diagnosed as having post-natal depression (to avoid recruiting a vulnerable group).
- Anyone not capable of giving fully informed consent.

### **5.3 Recruitment Procedure**

#### **5.3.1 Recruitment Strategy**

In January 2011, a number of voluntary and community sector groups were approached to request permission to recruit participants through their contacts. This included:

- The Breastfeeding Network (BfN) is a national charity, registered in Scotland and a strong presence in Ayrshire.
- The National Childbirth Trust (NCT), a UK wide charity which supports families and has a branch in Ayrshire

- Social Networking sites, Mumsnet and Facebook
- Mother and toddler groups
- Family friendly cafes and play areas.

Potential participants became aware of the research by seeing fliers which briefly described the research being undertaken and which invited contact if they wanted to participate (Appendix 1). These were circulated by electronic means (BfN, NCT and Social Media) or by paper fliers in the case of cafes, play areas and Mother and Toddler groups. The Breastfeeding Network Board of Directors gave consent to members being contacted on the condition that requested that a letter was sent out to all local National Breastfeeding Helpline volunteers to let them know about the research This ensured that they were aware of the possibility that women may call the breastfeeding support telephone line if they were distressed as a result of the research interview (Appendix II).

Twenty seven women made contact as a result of seeing information about the research. Potential participants who expressed an interest but who did not meet the inclusion criteria were thanked for their interest and the reasons for their inability to participate were explained. In all but one case, this was because they had been breastfed themselves, but they were keen to participate and share their experience. One potential participant was excluded as she had no contact with her family. Potential participants (n= 21) who had expressed an interest in the research and appeared to meet the inclusion and exclusion criteria were sent the participant information sheet (Appendix III) and consent forms (Appendix IV) and were invited to return these, with their telephone contact details, or to contact the researcher by e-mail, if they wished to

participate in the research. Potential participants who returned the forms, or who emailed to ask to participate (n=18), were contacted by phone. During the call, it was established that they wished to take part in the study and any questions they had were answered. Their eligibility was checked using a specifically designed personal details and eligibility form which used to record demographic, personal and family information (Appendix V). Interview times and locations to suit the participants were arranged with 16 of the 18 participants, with 2 choosing not to undertake the interview due to their own time constraints. Two participants arranged but did not attend for the arranged interview and did not respond to a follow up email offering a further time. This resulting in 14 interviews taking place. A careful audit of the recruitment process was recorded and is presented in Figure 6.

In summary, of the 14 participants recruited and interviewed: four picked up a leaflet in Smalltalk Cafe; three through social media (one participant via Netmums and two through Facebook); two came through baby and toddler groups and five responded to a request sent out to mums who had previously expressed an interest in receiving news and updates from the Breastfeeding Network. The researcher did not know any of the participants.



**Figure 6 Participant Recruitment**

Recruiting through the voluntary sector as opposed to the NHS was chosen for both pragmatic and purposeful reasons. Recruiting women when in the maternity hospital and following them up for at least eight weeks was considered, but excluded, as a possible method. This was because the number of women in Ayrshire who initiate and continue to breastfeeding for at least eight weeks is small, with the number of women who breastfeed but who were not breastfed themselves, significantly smaller. Thus to recruit 12-16 women who met the inclusion criteria and had the required minimum of at least eight weeks of experience of breastfeeding, very large numbers of women would need to be initially recruited and followed up for many months, to their inconvenience, in order to generate participants. Recruitment through NHS health visitors was also rejected as this would have led to NHS staff selecting participants, whereas, recruitment via the voluntary and community sector would give access to the wider network of breastfeeding mothers in the community. Although women from a variety of socio-economic backgrounds were to be recruited, particular attention was paid to trying to recruit women from lower socio-economic groupings or living in deprived areas, as fewer of them breastfeed (ISD, 2011) and are more difficult to recruit and are thus under-represented in breastfeeding research (Hoddinott *et al*, 2010). This influenced the recruitment strategy and Mother and Toddler groups in areas of deprivation were approached as a primary source of participants. Secondly, the Breastfeeding Network was approached because: they were in contact with a significant proportion of all the breastfeeding women in Ayrshire; were contracted by NHS Ayrshire and Arran to work in areas of deprivation; and because proportionally more women from socially-deprived backgrounds were supported by them than would be expected from the normal breastfeeding population (Shennan, 2010).

### **5.3.2 Participants**

The following table describes the key characteristics of the recruited participants. As can be seen, the 14 participants had their first child between the ages of 20 and 39, but are now aged between 29 and 40. Eight of the women had only one child, and six had two or more children. At the time of the interview, their child that they were breastfeeding was aged between 5 months and three years and all therefore had breastfeeding experience within three years, as required by the inclusion criteria. Eight of the women were still breastfeeding at the time of interview.

**Table 1 Participant Demographic Characteristics**

Pseudonym	Age at first child Current age ( )	Number of children and feeding status	Age of youngest child	Breastfeeding duration for youngest child	Highest level of education	Received peer Support?
Kay	39 (40)	1, breastfed	10 months	10 months, ongoing	ONC/ College education	No
Heather	37 (39)	1, breastfed	11 months	11 months, ongoing	School	No
Susan	25 (27)	1, breastfed	22 months	4 months	HNC	No
Elsbeth	22 (38)	4, all breastfed	17 months	6 months	School	No
Mhairi	20 (31)	3 breastfed, 1 formula fed	18 months	18 months, ongoing	School	Yes
Tracy	32 (32)	1, breastfed	5 months	5 months, ongoing	Diploma	No
Debbie	26 (35)	2, both breastfed	3 years	3 years	School	No
Rhona	27 (29)	1, breastfed	15 months	6 months	Diploma	Yes
Aileen	23 (30)	2, both breastfed	3 years	3 years, ongoing	Diploma	Yes
Gemma	29 (32)	2, both breastfed	6 months	6 months, ongoing	Degree	No
Julie	27 (32)	2, both breastfed	5 months	5 months, ongoing	Diploma	Yes
Fiona	28 (32)	1, breastfed	3 years	3 years	Degree	No
Louise	33 (35)	1 breastfed	21 months	21 months and ongoing	Degree	Yes
Niambh	29 (31)	1 breastfed	16 months	8 months	PG Degree	Yes
Summary	Age range at first child 20 - 39	8 mothers with one child, 4 with two children and 2 with 4 children.	Age range of youngest child 5 months – 3 years	4 months to 3 years 8 still breastfeeding, 6 ceased.	School (4) Vocational (6) Degree (4)	8 No 6 Yes

## **5.4 Ethics**

### **5.4.1 Ethical Approval**

This study was approved by the University of Stirling School of Nursing, Midwifery and Health in January 2011, in advance of recruiting and interviewing.

### **5.4.2 Ethical Considerations**

Qualitative research can present ethical issues (Richards and Schwartz, 2002) and some were identified within this study. These included: potential risks for the participants when investigating a sensitive topic and safeguarding against this risk; potential risk for the researcher; ensuring participants give informed consent; the power of the researcher's role; that research is being undertaken into a sensitive topic; the maintenance of the participant's anonymity and confidentiality and the security of data gathered. These concerns will be discussed and a description will be given of the precautions and actions taken to minimise these risks.

#### **Potential risks for participants and safeguarding against risk**

The risk to participants when undertaking research interviews is small; however, the nature of one to one interviews exploring personal experience raises the potential of emotional distress and impact to the participant's mental wellbeing. Societal attitudes towards infant feeding in the media have suggested that there are negative perceptions associated with breastfeeding (Henderson, 2000), particularly because breastfeeding is sometimes related to sexuality (Stearns, 1999). This means that for some participants, breastfeeding could have been a sensitive area. Additionally, as family relationships

were also being explored, areas of past experience may be reactivated which may be affect laden which could have caused distress.

A number of precautionary measures were therefore taken to mitigate against any harm and to offer support should participants become distressed. The interviews were held in location of the participant's choice to assist with their comfort and to protect the participant's dignity if they were to feel upset. The participant information sheet offered an invitation to the participant to choose not to continue with a particular line of questioning or to terminate the interview. I was cognisant that a degree of self assertion would be required on the participant's part to be able to do this, therefore, attention was paid to the participant's external emotional state so that signs of distress could be responded to and the participant offered the opportunity to decide whether to take a break, move to another area of enquiry, or to continue. It felt important to allow participants the choice about continuing as it may be important for them to share this aspect of their lived experience, despite the upset it causes. Additional time after the interview was allowed for the participant to debrief the interview experience and to prepare themselves for re-entry into their usual activities. Participants were provided with the Breastfeeding Networks helpline number for follow-up support. No participant experienced distress during interviews and a number of participants expressed gratitude at being able to describe their experience.

### **Potential risks for the researcher**

In recognition of the risks associated with working as a lone researcher steps were taken to ensure my own safety. All potential participants were screened by phone prior to the interview and I informed my supervisor or other colleague of the time and location of

the interview, contacting the same person at the end of the interview to assure them of my safety.

### **Researcher's role**

There are two main aspects of the researcher's role which can impact on research. This includes the significance of the researchers own experience this might shape their understanding of and interactions with participants, and also the participants perception of the researcher.

As a researcher, I bring the professional experience of being a psychotherapist and a breastfeeding peer supporter and supervisor. Personally, I bring my experience of being a woman who has breastfed with the benefit of strong family support. Inevitably, this shapes my world view, however, my training and work as a psychotherapist means that as part of my professional practice, I am very aware of my own 'lenses' through which I view the world, and my potential influence on an interviewee's response during interviews. I am also conscious of how my existing beliefs may be shaping my understanding of other's experience both in the interview and in later analysis. It is recognised that acknowledging and reflecting on these roles and positions through reflexivity can help to reduce its influence in qualitative research (Hammarstrom, 2008) and a reflexive diary was kept to assist with this process.

Power associated with roles can influence both participant in an interview situation, and this may be of particular importance to participants who may have knowledge of my role as a breastfeeding support worker. While these potential influences and power differentials cannot be removed, I oriented the participant to my role as a researcher and clearly explained my part in the research process. Additionally, my experience as an

interviewer and ability to show non-judgemental acceptance and curiosity about the participant's experience (Ceccin, 1987) may have empowered the participant to express her own experience rather than any perceived expectation to conform to social norms.

Given my professional background where a therapeutic stance is my predominant position, attention was paid to the boundary between qualitative research and therapy.

Although it could be argued that there are similarities and areas of convergence (De Haene, 2010) they have different intentions and outcomes and could raise ethical concerns if there is confusion between therapy and care (Henderson *et al*, 2007).

Through professional registration with the United Kingdom Council of Psychotherapy via the Association of Family Therapy (AFT), I am bound by professional codes of ethics (AFT, 2008) and all aspects of the code were adhered to.

There were no conflicting interests that might affect the independence or integrity of the research. A statement relating to this regarding sources of funding specifically in relation to the International (WHO) Code of Marketing of Breastmilk Substitutes or its subsequent resolutions was included in the participant information sheet as this may be an area of potential concern for some participants.

### **Confidentiality and anonymity**

All reasonable steps were taken to protect anonymity and ensure shared data was unidentifiable. As qualitative research requires participant descriptions, aspects of participant's descriptions and life story were changed to protect anonymity. Legislation on the disclosure of information which may indicate serious risk to another, such as the Children's Act Scotland (2005), requires that the relevant authorities would be informed, but this did not emerge as an issue in the interviews.

### **Misrepresentation of participants**

A final risk which was considered was the misrepresentation of participants experience and views (Richards and Schwartz, 2002) as the analysis is interpretative in nature. This risk was addressed by keeping a reflective diary, by discussing the analysis of the data with my supervisor and at an IPA Interest group, as detailed in the Quality Issues section at the end of this chapter.

## **5.5 Data Collection**

Data was collected in a number of formats. This included the completion of the aforementioned personal details and eligibility form (Appendix V), the drawing of a genogram and conducting a semi-structured interview. The fourteen interviews were conducted between January 2011 and the end of March 2011.

### **5.5.1 Demographic Information and Genogram**

The personal details and eligibility form, which also served as a screening tool, as detailed in 5.3.1., (Appendix V), was used to collect a range of personal and family demographic data, including the participant's name, age, names and ages of children and breastfeeding information. A genogram, a pictorial representations of information primarily used to show individuals characteristics and family relationships, was also completed (McGoldrick and Gerson, 1985). Further information on genograms and their adaptation for this research can be found in Chapter 6. Some aspects of this form were completed by telephone at the time of planning the interview as part of the screening process; however, in practice the phone call was often brief, due to the presence of potential participants' children. The decision was therefore made to leave the gathering of the remainder of the demographic information until the interview, when it was completed alongside the genogram.

### **5.5.2 Development of the Pseudonyms and Genogram**

As qualitative data is full of clues to the participant's identity (Richards and Schwartz, 2002) the presentation of demographic and family information about the participant presents the risk of identification, however, as IPA values the stories and the idiographic aspects of the participants, it is important to be able to share some information about the participants to put them in context. This is provided in the Table 1, in the genograms in (Appendix VI) and as part of the analysis of interviews in the Findings in Chapters 8-12.

The original names of the participants and their families have been replaced by pseudonyms in genograms and any quoted material to protect the anonymity of participants. To reduce the risk of identification, the anonymisation of the genograms and interview transcriptions was undertaken in numerous stages. This process consisted of creating an accurate, non-anonymised genogram for the participant and their family. The genograms were then anonymised with pseudonyms replacing the names. The decision was made to substitute occupations or jobs with generic categories which represented the educational or vocational requirements and pay rates, so that the socio-economic background of the individual could be retained. For example, an electrician may be described more generically as a tradesman, while a fire officer would be an emergency services worker. Finally, any details which might make the participant and their family distinctive in their local community was removed or adapted, for example, identical twins or a relative in a same sex relationship.

The risk of this degree of anonymisation is that the contextual background is changed to such an extent in order to protect anonymity that the context becomes too different from

that of the participant and loses its idiographic value; therefore, a fine balance needs to be found.

### **5.5.3 Semi-structured Interviews**

This study was designed as a qualitative project using individual interviews to elicit in-depth accounts of women's experience of breastfeeding in a context where they have no family history. The one to one interview allowed for an in-depth exploration of the meaning of the experience for the participant and gave the opportunity to clarify and explore issues as the interview progressed (Smith *et al*, 2009; Kvale, 1996).

The semi-structured interview provides the benefit of exploring specific areas of interest to the study by means of the structure of the interview schedule, while having the freedom to further explore areas of interest raised during the interview by the participant or explore areas that appeared important to the participant (Chapman and Smith, 2002).

In IPA studies, it is recommended that the interview schedule is only a guide to be used within a semi-structured interview, not as a fixed protocol. However, it has been argued that developing a schedule is a critical part of thinking through how to approach an interview and also to become aware of one's own presupposed ideas and beliefs going into the interview through reflexivity (Smith *et al*, 2009; Smith 2004).

The first step in developing the schedule was to identify the issues to be explored in the interview as informed by my research questions. The content of the interview schedule was ordered to reflect the priority given in the research questions, therefore experience questions were written first, and then questions related to what sense participants made of their breastfeeding decision. A long list of potential questions was developed, for

example, ‘When did you first think about how you might feed a baby?’ and ‘How do most people you know feed their babies?’ As the questions were reviewed, they fell into a smaller number of categories and were able to be summarised by some broad open questions. During development of the schedule, the questions about family relationships were placed in a third section, however, these were so intrinsically related to the first two research questions, it was more useful to embed them within the first two sections as relational questions.

As part of the orientation to the interview, participants were informed that I was interested in her perspective of the views of other family members. This fits with IPA’s focus on the participant’s perceptions and beliefs about other views rather trying to identify the actual views of other family members, which would require me to ask other family members in person. Experience of practice as a family therapist has suggested that asking this type of circular question needs some explanation as it can feel different from ordinary linear questions (Tomm, 1998). In addition it was important that the questions should be open and expansive, to allow the participant to explore the issues rather than the risk of being inducted into a brief, closed answer.

Attendance at an IPA conference and workshop and peer discussions lead to a deeper understanding of the semi-structured interview in the context of research to be conducted using an IPA approach. This experience emphasised that that the nature of phenomenological inquiry was such that the meaning of experiences for the participant should be prioritised and that this should be reflected by starting with a question relating to the meaning of the phenomenon to the participant. As within IPA’s epistemology, the participant is considered the expert in her own lived experience,

priority is given to her areas of priority. The meaning of the phenomenon could then be further explored by following up the issues raised by the participant.

The final interview schedule, which can be seen as Appendix VII was consequently adapted so that it opened with one question, based in phenomenological methodology; ‘What has breastfeeding been like for you?’, giving the participant the opportunity to express their areas of importance and allowing a conversation to develop where further questions can be modified in the light of participants’ responses.

#### **5.4.5 The Interview Process**

As potentially sensitive topics would be discussed, it was important to interview in an environment in which the caregiver would feel comfortable and sufficiently relaxed to discuss freely and in detail, issues relating to caring (Smith, 1996). It was also important to accommodate the needs of mothers who have babies and young children. Twelve participants requested to meet in their own home while one suggested a library that she attended and the other wished to meet in a local coffee shop. When the meeting was to be in a public place and with some concerns for their privacy, I checked that the participant knew they were to be participating in an in-depth interview and if they thought that their chosen location would suit. In each case they assured me that their chosen location was suitable and this proved to be the case.

Interviews were anticipated to last around an hour with some additional contact time required for initial introductions, collection of demographic data including completion of the genogram and to provide any support required at the end. The interview duration across the participants, ranged from 35 minutes to 1 hour and 51 minutes.

Some of the interviews were conducted with babies and children present in the room. Interviews took place with minimal interruptions in all but two interviews, where there were some brief breaks while children's needs were met. Several of the women breastfed their babies during the interview sessions and the sessions were not interrupted by this.

At the start of the interview, demographic information was gathered which had not been previously supplied, including further relevant family information which was added to the genogram. The collection of demographic information and the interview itself were audio recorded on an Olympus VN-5500PC digital voice recorder. A digital recorder was chosen because of the high quality sound recording, because it is small and unobtrusive and because this allowed the data to be downloaded as a file onto a password protected secure computer.

Data was then converted into written format. The recorded data on the digital voice recorder was transferred onto a computer by a USB connector, saved in password protected files and then deleted from the recorder. My initial decision was to use a professional transcriber, who was known to my supervisor and who had experience of transcribing qualitative data, to undertake the transcription of interviews. However, reading (Patten, 2002) and conversations with fellow researchers lead me further consideration before finalising my decision. I therefore arranged for one interview to be transcribed professionally and I undertook the transcription of a second interview myself. In both cases, after the initial transcription, I listened to the recordings while reading the transcripts to check accuracy and to ensure there was consistent annotation when there were silences and paralinguistic features, as shown in the legend at Table 2.

Consideration was then given to whether there were any disadvantages associated with contracting a professional transcriber. I found that after listening to the transcription to proof check it for accuracy, meant I felt as close, if not closer to the data than when I had transcribed it myself. This may have been because of the very disjointed listening required for transcription, combined with distraction of the physical process of word processing, leading to distancing from the data. Given the additional time commitment required and the fact that few if any advantages seem to emerge from self-transcription, the decision was made to contract out all other interviews. The transcriptions were formatted to have wide margins to allow for analysis notes to be made on each side and lines were individually numbered using continuous numbering, before printing off for analysis.

**Table 2 Quotation Symbol Legend**

Symbol	Meaning
(...)	Material has been removed because it is irrelevant or compromises the participants anonymity
[ ]	Words have been added to clarify the meaning or describe non-verbal communication
...	Each full stop represents a seconds pause

## 5.6 Analysis

### 5.6.1 Analytic Approach

When analysing qualitative data it is argued that it is important to provide a detailed description of the process undertaken to extract meaning from the data. This should be clearly organised and transparent so that the reader can assess the plausibility of the interpretation (Larkin and Thompson, 2012).

There is common agreement that IPA is characterised by a set of common principles and processes (Larkin and Thompson, 2012). It is committed to trying to understand experience from the individual's point of view and personal meaning making in their own context (progressing from phenomenological understandings to interpretative understanding), before moving to those which are shared by the group. IPA's processes and principles can be applied flexibly according to the analytic task (Reid *et al*, 2005) using both iterative and inductive processes (Smith, 2007).

A number of papers have been published describing the analytic process which can be used within IPA (Larkin and Thompson, 2012; Smith *et al*, 2009; Flowers *et al*, 1997; Eatough and Smith 2008). This over-arching process is clearly articulated in Smith *et al* (2009) which is summarised in Table 3, and this structure was used to guide the analysis and subsequent thesis development.

**Table 3 The Analytic Approach**

IPA analysis begins at the level of the *individual case*, with close, line-by-line analysis (i.e., coding) of the experiential claims, concerns and understandings of each participant (see e.g. Larkin *et al.*, 2006).

- Identification of the emergent patterns (i.e. themes) within this experiential material emphasising both *convergence* and *divergence*, commonality and nuance (see e.g., Eatough & Smith, 2008); usually first for single cases then subsequently across multiple cases.
- Development of a ‘dialogue’ between the researchers, their coded data and their psychological knowledge, about what it might *mean* for the participants to have these concerns in this context (see e.g. , Larkin *et al.*, 2006; Smith, 2004), leading in turn to the development of a *more interpretative* account.
- Development of a structure, frame or gestalt which illustrates the relationship between themes.
- Organisation of all this material in a format that allows for coded data to be traced right through the analysis – from initial codes on the transcript, through initial clustering and thematic development, into the final structure of themes.
- Use of supervision or collaboration, to *audit*, to help test and develop the coherence and plausibility of the interpretation and explore reflexivity.
- Development of a narrative, evidenced by detailed commentary on the data extracts, which takes the reader through the interpretation, usually theme-by-theme, and often supported by some form of visual guide (simple heuristic or table).
- Reflection on one’s perceptions, conceptions and processes should occur through the process and is usually captured in a systematic fashion by keeping a reflexive journal (see e.g., Smith, 2007)

List from Smith *et al.*, 2009 p. 79-80, my italics.

Within this overall structure, it is argued that there is room for flexibility in how analysis is done in practice (Larkin and Thompson, 2012) and they argue that it is more appropriate to consider IPA as an analytic ‘stance’ from which to approach analysis rather than simply a set of techniques.

### **5.6.2 Analytic Process**

First, free coding was undertaken, to ensure that the participant is the focus of analysis and to reduce the chance that the powerful thoughts and pre-conceptions one might

have following the interview do not take centre stage (Smith *et al*, 2009). This was done by reading the transcript and jotting down initial thoughts and reminders of theory or previous reading. This free coding is part of the process of being transparent and reflexive about what is brought to the analysis. Its intention is to allow engagement with the data from the participants' point of view, having noted the 'lenses' or 'noise' I might bring to make sense of others ideas and prevents them from intruding on the subsequent process of idiographic coding and analysis. These notes were put aside but retained and were reviewed when developing recurrent themes across participants.

The next stage was the detailed, line-by-line analysis which summarised and captured the essence of what is being said by the participant. The aim was to try to imagine what it is like to be the participant and to identify the main phenomenological ideas in the participant's words. This is described as trying to 'stay close to the participant's explicit meaning' (Smith *et al*, 2009; p83).

Initial coding was broken down into three stages. This included descriptive coding, where the main issues and summarised content of interviews was noted.

The second stage was linguistic coding and focused on how content and meaning were presented through the participant's use of language. It is the beginning of interpretative activity and leads to comments on the specific use of language by the participants and considering how this might help to reveal meaning.

The third level of coding was interpretative in nature, capturing an understanding of what the participant has said and what it means to them from the researcher's subjective perspective. This means that there is some movement away from the participant's explicit claims and the beginnings of drawing on one's own early understandings about

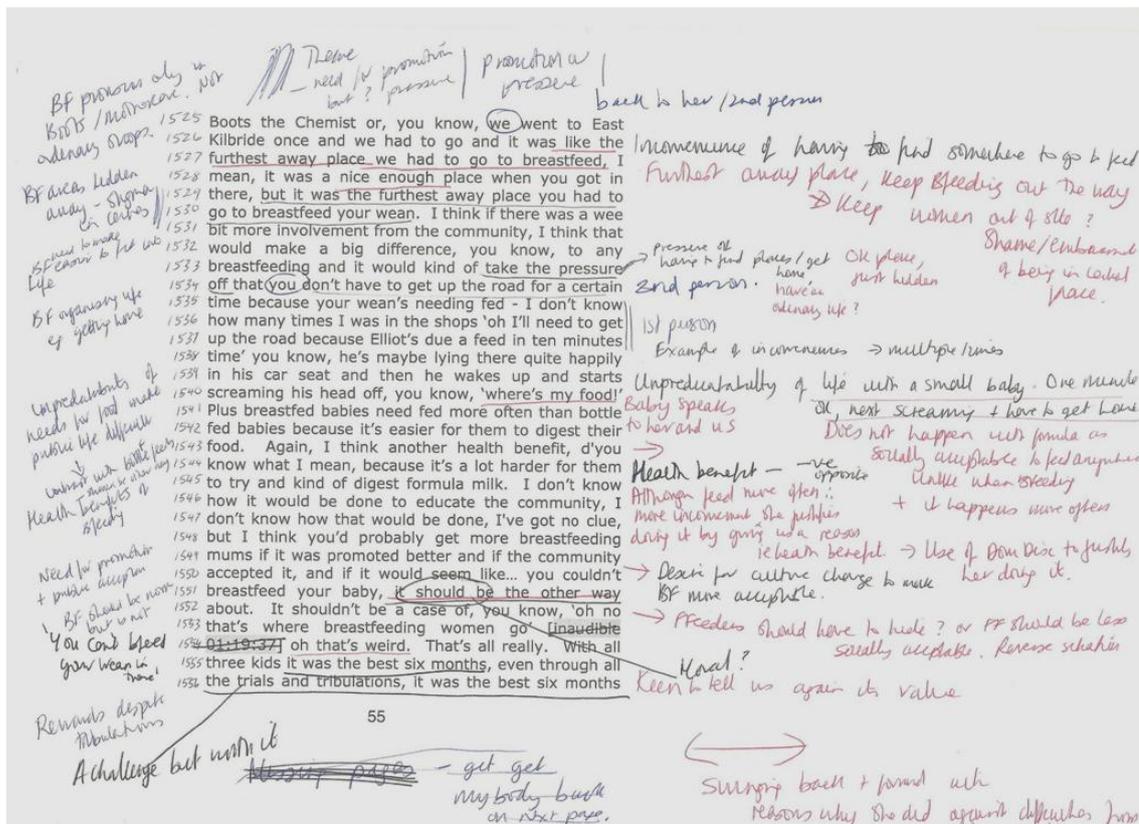
the participant and their world view. With increasing analytic experience, these three stages did not need to be undertaken separately, rather they became ‘lenses’ which were kept in mind while analysis was undertaken, over multiple readings. Participants’ genograms were referred to at this stage to assist with understanding the participant’s family relationships and context.

The next stage in the analysis was the development of emerging themes. This involved organising and summarising the analysis, reducing the volume of comments while retaining the complexity in the transcript and notes (Smith *et al*, 2009) and undertaking further analysis (Larkin and Thompson, 2012).

The analysis focused on both the participant’s transcription and the coding already undertaken. This much larger data set was then reduced in the volume of the detail but without the loss of complexity of understanding and interpretation. This process is described in Smith *et al* (2009) as the production of a ‘concise and pithy statement’ which represents the essence of the analysis done thus far. In the analysis, I found it difficult to commit to the tight, conceptual phrases, as was concerned that it would lead to a loss of complexity and nuanced detail at an early stage of the analytic process. I was aware that this approach allows for revisiting transcriptions and recoding as part of the hermeneutic circle, and that the richness of the data would be reintroduced when the participants’ quotes to support the themes were reintroduced; however, I felt that this method led me to premature and incomplete description and understanding of the participant. I therefore undertook further reading and participated in additional training in the approaches to analysis used within IPA. This included attendance at a number of workshops run by Paul Flowers, Virginia Eatough, Michael Larkin and Jonathan Smith. This resulted in a deeper understanding of IPA as an approach and an understanding

that different researchers within the IPA tradition vary somewhat in their method depending on their experience and the nature of their data.

As a consequence, when developing emerging themes, I decided to use the ‘looser labels’ described by Larkin and Thompson (2012), rather than the ‘tighter’ more concise phrases advocated by Smith *et al* (2009). The opportunity to undertake interpretation in a more gradual manner and to have less tightly framed themes seemed to fit better for my data and my more conservative approach to analysis. This looser descriptive labelling, where the themes meaning could be easily understood, felt important to retain in my research so that there could be flexibility later on the analysis process when I looked across participants. I therefore decided that my data and my initially more cautious approach to analysis, indicated that analysis is a gradual process where deeper levels of interpretation occur in an iterative fashion, as part of a larger hermeneutic cycle (Smith *et al*, 2009; Smith, 2007). An example of the coding for Elspeth, whose transcript was the first to be analysed, can be seen in Figure 7.



**Figure 7** Example of Analysis

To organise the themes, I transferred the emerging themes from the coded paper transcription into an electronic format by typing them into a Word document. As this was done, I further developed the themes, reconsidering their fit with the data and whether they could be adapted to better capture my interpretation of the participants meaning. This ongoing refinement of themes is supported by the approach used by Larkin and Thompson (2012). The individual themes were then cut, pasted and reorganised until they began to come into a more concise format. This proved to be time-consuming and frustrating because of the requirement to move back and forward through the document; however, a process of printing the themes onto paper and moving between paper and electronic formats assisted with this. Gradually, this led to

the development of a smaller number of more abstract, summarising themes, with a cluster of sub-themes sitting below each one.

At a conceptual level a number of processes were used (Smith *et al*, 2009) which assisted with the organisation of themes. Examples of how these processes were used to help develop Elspeth's themes are given.

- Abstraction- This involves putting similar themes together and finding a new name which describes the cluster. This is a higher level description of the themes. This process was used to bring the themes; 'Breastfeeding and the good mother', and 'I am not better than anyone else, but I did the best thing (so what does that make me) together under the new superordinate theme of 'Breastfeeding and Identity'.
- Contextualisation – This is using narrative or contextual elements, for example pulling together themes around key life events or stages as a way of organising themes in time. For example, 'Breastfeeding: the mothers choice' became the superordinate theme for a collection of themes which account for the breastfeeding decision making and continuation process and included the themes; 'Brought up to bottlefeed', 'I've earned the scar so have the decision' and 'Your mind has to be set'.
- Polarisation – This is where opposites emerge and are linked because of their difference, for example, love and hate can also be categorised in a superordinate theme of 'strong emotions'. In the super-ordinate theme, 'It was only me' the themes 'As long as I was there', 'I was all that mattered', 'Breastfeeding as a proximity regulator', 'Breastfeeding as time together', 'We had something special no-one else had' and 'But it was only me...' were pulled together

because of the tension between them, representing opposite sides of the same issue and detail the joy and overwhelming feelings of responsibility of being the baby's predominant carer.

- Subsumption – This is an analytic process where one theme in the cluster acquires a superordinate status by being of a higher level of abstraction. This occurred with the theme, 'Your mind has to be set' which became the higher level superordinate theme for a collection of themes about breastfeeding continuation despite challenges and includes a theme of the same name, alongside 'Avoidance of guilt and regret as motivators', 'Limitation of what can be overcome' and 'Other things that get you through it'.
- Function – This focuses on the function of the language used in the themes and draws on ideas from discourse and narrative analysis. For example there may be a theme where the role of hero or survivor is important. A number of themes clustered around the role of being a mother and feelings of pressure and guilt about infant feeding choices. Hence, the theme 'Breastfeeding and the good mother', at one stage of the analysis, brought together the themes: 'I am not better than anyone else, but I did the best thing (so what does that make me?)', 'Breast is best and so am I?', 'Breastfeeding as status raiser' and 'A Breastfeeding role model'.

With each stage, themes become of a higher order, as emergent themes coalesce to form higher order themes and these themes begin to show connections and relationships to form superordinate themes. The themes were then brought together in table which summarised the themes for each participant. Elspeth's table of themes is included below as an example.

**Table 4 Superordinate Themes and Themes for Elspeth**

**Breastfeeding and identity**

*Breastfeeding and the good mother* – Breastfeeding as certainty in the uncertain world of parenting, Importance of knowing you have done the right thing, A sacrifice, but worth it, I've done my time

*I am not better than anyone else, but I did the best thing (so what does that make me?)* – Breast is best and so am I?, Breastfeeding as status raiser, A Breastfeeding role model

**Breastfeeding: The mother's choice**

*I've earned the scar so have the decision* – I've earned the scar so have the decision, what 'support' means, Breastfeeding means fathers miss out

*Brought up to bottlefeed* – The invisibility of breastfeeding, Making a different decision: I wonder if I could? It is scary being the first, no-one to turn to, managing feelings about making a different choice: the unasked question

*Your mind has to be set* – Determination and commitment, avoidance of guilt and regret as motivators, limitation of what can be overcome, other things that get you through it

**Breastfeeding and society**

*Breastfeeding as taboo* – Breastfeeding culture in Scotland, Tension between public health message and societal attitudes, Breastfeeding as a 'touchy' subject, Breastfeeding as a private versus public activity, the 'yuck' factor

*Pressure of external expectations*- Following the recommendations, tension between public health messages and societal views

*Natural but within limits* – Nothing more natural, universal or timeless, Breastfeeding as an extension of pregnancy, and birth, breastmilk is there so should be used, But only natural to a certain age when it 'crosses the line'

**Breastfeeding: The double edged sword**

*It was only me*- As long as I was there, that was all that mattered, Breastfeeding as a proximity regulator, Breastfeeding as time together, we had something special no-one else had, breastfeeding as a proximity regulator, but it was only me...

*The pain and the pleasure* – Nobody really kind of tells you, you just need to get past the pain, an experience of extremes and a clash between expectations and reality, but the rewards... if you believe them, the risks of trying too hard

As part of ensuring rigour in this research, this process was carefully recorded and an analysis audit trail was kept, from numbering participants lines, through coding, emergent theme development to the theme and superordinate theme, thus allowing each theme to be connected to the participant's words.

Once analysis was completed for each participant, connections across participants were sought (Smith *et al*, 2009; Larkin and Thompson, 2012). They suggest that as different interpretative ideas come together, different emerging themes will begin to look like they can be arranged in more efficient and meaningful patterns with areas of convergence and divergence within themes.

The initial method of bringing the various idiographic themes into cross participant themes was to lay all the tables beside each other and look for connections across cases. This led to a list of themes which appeared to be significant to a number of the participants. Due to the high number of participants in this study, by IPA standards, and the consequent large number of themes, a more systematic approach was needed and I decided to use some of the techniques from the idiographic analysis to help bring together the themes for all participants. Therefore the themes which emerged from the initial cross participant tables were used as an organising structure and this was used to move themes which looked like they belonged together into clusters. This then allowed the remaining themes to be considered and either moved into existing theme clusters or to form a new theme which could then attract other related themes. This was done until it appeared that the most common recurring themes had been identified. The resulting reconfiguration and renaming of themes lead to new superordinate themes with as connections and relationships emerging across cases. This was an iterative process which took place over a number of months and involved a variety of processes, including writing the themes on post it notes and moving them around on a wall and exploring the different fit between them. It also involved revisiting the notes from the initial free coding and the integration of my thoughts which emerged during the interview stage. A variety of arrangements were tried out, until an overall structure

emerged. As part of this process, some of the original themes were brought together, while other sub-themes were expanded to become themes on their own. During this process, a file of transcribed extracts for each participant's interview was developed in a Word document, to support each of the emerging themes. Additionally, genograms and vignettes for individual participants were referred to as a means of staying in touch with each participant, while simultaneously developing the cross participant themes.

Throughout these processes additional analysis was undertaken, with further development of the themes for each participant then informed the emerging themes. A circular process emerged where the analysis of the whole, i.e. the cross participant themes, lead to a new understanding of the part, i.e. the individual participant's experience. This then informed the development and arrangement of the themes, going round the hermeneutic circle, as recommended in the literature (Smith *et al*, 2009; Larkin and Thompson, 2011).

## **5.7 Quality Issues and Conclusion**

While this creative, interpretative process is valued in IPA studies (Smith *et al*, 2009), as outlined in the methodology, there is an increasing focus on ensuring quality within qualitative research. Key measures of the quality in qualitative research have been identified by Yardley (2000) and include commitment, transparency and rigour. Additional measures specifically for IPA research have been published recently (Smith 2011). These include: embracing the key theoretical underpinnings of IPA, a transparent method, a clearly structured, interpretative analysis and thoroughly evidence themes, with each theme requiring sufficient space for in-depth elaboration including divergence and convergence within the themes. The recommendations from these studies informed the design and analysis of this research.

Commitment within qualitative research refers to the requirement for extended engagement with the subject area; the development of the methods used, and prolonged immersion in the data. Transparency can be assessed by detailing the data collection and analysis process to the reader can assess for themselves the quality of the research. It can include triangulation of data, where this has an epistemological fit with the method, or as is more appropriate for an IPA study, an independent audit of the analytic process. The extent to which quality has been achieved in this research can be assessed in the description of the methods used, which is detailed in this chapter.

A number of additional measures were undertaken to ensure quality in this research. Regular attendance at an IPA supervision group gave the opportunity to discuss research development and to take extracts of analysis to peers and the group supervisor. An extract from the first participant's interview was submitted to an IPA workshop I co-facilitated and was subjected to idiographic analysis by all participants, with the group developing emerging themes and then themes from this data, under the supervision of Professor Paul Flowers. This allowed the comparison of my own analysis with that of all the workshop participants and allowed me to explore my coding and theme development, to ensure I was not blind to major themes, or constructing them without evidence from the participants accounts. While this did not make significant changes to my analysis, it confirmed that a number of the early emerging themes, as they appeared to other analysts to be present in my participants accounts, as opposed to constructions emerging exclusively from my own beliefs and assumptions. Of particular importance at this stage was my interpretation that participants were judgemental about other women's feeding choices, but were self-conscious about

expressing this, and that their beliefs had implications for their feelings about their own mother's infant feeding decision.

A further measure of quality can be assessed through the transparent detailing of the analytic method, with excerpts from the data collection process presented in this chapter and through participant's extracts being presented in the findings chapters which follow. Additionally, to ensure transparency and coherence of the analysis, the analytic process subjected to independent audit by the first supervisor (RM), to ensure that the themes had a comprehensible basis in the participant's accounts. In detail, three idiographic analysis theme tables were examined and the process of the development of the themes from the emerging themes and back to the original transcript was undertaken. The supervisor had oversight of the development of the themes and superordinate themes from the participant's idiographic themes and regular discussion of emerging findings aided a deeper level of reflection into the meaning of the themes.

The rigour can be assessed from the suitability of the data collected, for example, in phenomenological analysis, the depth of the analysis. It is argued that evidence of interpretative activity, rather than just descriptive analysis is significant in assessing the rigour aspects of quality. This, the convergence and divergence within themes, can be assessed in the analysis chapters of this thesis. The rigour of the analytic process within IPA can also be assessed by whether there is recurrence of themes in more than 50 percent of the participants (Smith *et al* 2009). Therefore, Tables 3 – 6 in Chapter 7, which introduce the superordinate themes and themes, show the recurrence of the themes noted for each participant.

As recommended, attention has been paid at all stages of this research to the congruence of the philosophical background, epistemology and methods used (Yardley, 2000), with the required commitment to the philosophy which underpins IPA (Smith, 2007)

In conclusion, this chapter has outlined the research design, transparently detailing the analytic approach and methods used, including highlighting dilemmas and focussed on quality issues. In the next chapter, further information on the use of genograms in this research is provided, demonstrating their novel use in this research context.

## **Chapter 6 -The Infant Feeding Genogram: A Methodological Development**

### **6.1 Introduction**

The purpose of this chapter is to present the genogram and demonstrate its use as a research tool and potential application in practice contexts. The genogram, in its generic form, will be introduced and its usefulness within this research context will be demonstrated. The use of genograms in infant feeding research appears to be novel and an adaptation of the genogram, in the form of an Infant Feeding Genogram, will be proposed as a methodological development. Its use in this research as a data gathering and rapport building tool will be detailed, and its additional potential elucidated.

### **6.2 The Evolution of the Genogram**

Genograms evolved within systemic family therapy and have been largely developed and popularised by Monica McGoldrick (McGoldrick and Gerson, 1985; McGoldrick *et al*, 2008). They are visual representations of information, which show family characteristics, relationships and important life events across generations and have been used extensively as a data gathering and therapeutic tool.

Genograms consist of symbols representing family structure and relational information. Symbols usually represent individual characteristics, such as gender and culture and can be used to record medical information. They are also used to represent the nature of people's relationships with each other, for example indicating closeness or conflict. Genograms record information about families over a three generation period and they offer the opportunity to explore family history and their stories over time. They allow for an individual to be seen in their wider family context, allowing for the evaluation of

the role of the wider family in difficulties and solutions (McGoldrick *et al*, 2008). Their graphic representation allows complex information to be summarised and easily recognised by practitioners with basic training (Puskar and Nerone, 1996).

There has been some variation in use of accepted symbols and structure when compiling genograms with variation between those used in the United States of America (USA) and Canada and in the UK. In the USA a standard format was agreed for the basic genogram in the early 1980s and published in McGoldrick and Gerson (1985) however there have been a number of adaptations proposed since and McGoldrick *et al* (2008) describe the format as a ‘work in progress’. In the rest of the world the structure of the genogram developed independently but shares a large number of similarities with those from North America. Examples of the format most commonly used in the UK, Australia and New Zealand can be found in Journals such as The Journal of Family Therapy (for example, Miller *et al*, 1994) and The Australia and New Zealand Journal of Family Therapy (for example, Stagoll and Lang, 1980).

While historically genograms have been used as instruments that help with building relationships between the professional and client in a therapeutic context, they have been developed for use in variety of contexts and with different client groups (McGoldrick *et al*, 2008). As such they have been adapted, including the development of new symbols, to show: cultural variation (Hardy and Laszloffy, 1991); socioeconomic factors (McGoldrick *et al*, 2008) and sexuality (Feinberg and Bakerman, 1994; Hof and Berman, 1986). They have been developed for use in a family healthcare context in North America, where they are sometimes referred to as ‘family pedigrees’ to include medical history and health risks to allow the repetitive patterns which can occur within families to become easily visible and to help clinicians keep family issues in

mind (Alexander and Clark, 1998). This includes considering cardio-vascular risk (Wimbush and Peters, 2000), genetics (Dudley-Brown, 2004) and chronic illness (Penn, 1983). One Canadian paper argued for the use of a genogram with post-partum families with the goal of increasing fathers involvement in post-natal care (Holtslander, 2005), but despite a search of the published and grey literature, no use of genograms in an infant feeding context were found.

### **6.3 Completing a Genogram**

To complete a genogram, several key stages are usually undertaken: mapping the family structure; recording family information such as dates of birth and death, significant other dates, occupations; delineating family relationships including recording strong family bonds or conflicts and finally any additional specialist information can be added. As previously described, at each stage, symbols are used to represent the data.

Mapping the family structure usually starts with the individual family member, or members, who are compiling the genogram and expands to include the others who are not present. This would include the individual and their significant others, such as current and past marital or cohabiting partnership relations, then children from any of these relationships. Then the individual and their current partner's parents and other relatives from their generation, however, often only the most significant relatives would be included. Then paternal and maternal grandparents and their significant others are added. Relevant dates and other information are then added, as appropriate.

The next stages would depend on the purpose of the genogram but often and particularly in a therapeutic context, symbols to represent the nature of the relationships

are added, with symbols for different types of relationships, for example close or conflictual relationships. Finally, any additional information, specific to the genograms purpose can be added in writing on the genogram, for example, cultural or health related indicators. At the end of the completion of a genogram, the participant is asked if there was any other relevant information they would like to add giving them an opportunity to mention more distant relatives or significant others who were important to them, but who did not yet feature on the genogram.

#### **6.4 Genograms and Research**

It is argued that despite the widespread use in clinical practice, genograms have been slow to be adapted in a research context, which is surprising given their usefulness as an information gathering tool (McGoldrick *et al*, 2008).

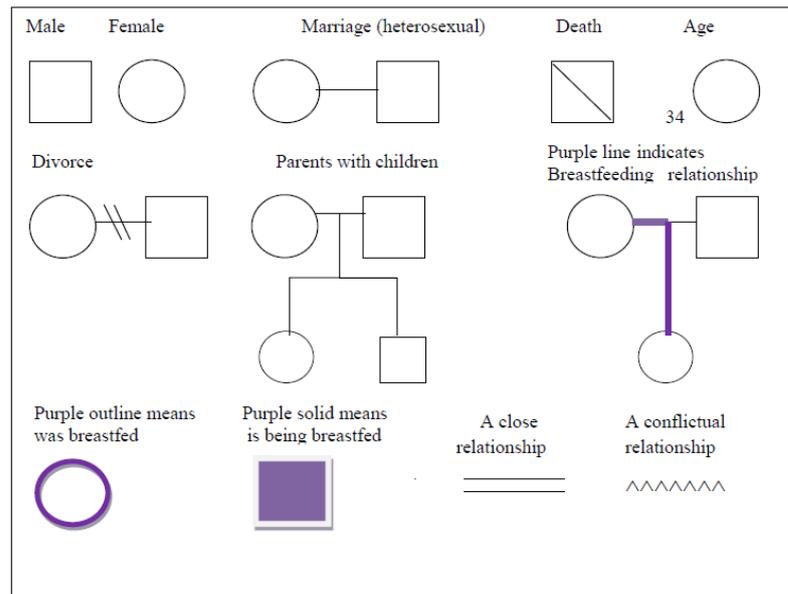
Of key significance to the development of the genogram as a research tool is its reliability and validity. The psychometric properties of a genogram have been recently tested (Platt and Skowron, 2013) in a therapeutic context. The researchers developed a theoretically based standardised protocol and assessed inter-rater reliability and construct validity. The latter assessed the ability of the genogram to predict scores on another validated emotional relationship test. They found that the genogram had good inter-interviewer reliability, with different interviewers eliciting almost identical information from participants. They therefore argue that the inter-interviewer reliability would allow for the data collected using genogram interviewing to be accurately replicated. Construct validity was not as strong; however, this aspect is less relevant to the current research as Platt and Skowron (2013) were testing this against psychotherapeutic theory. They conclude that the genogram is a tool which can be reliably used across users and has as yet unfulfilled potential.

There are a number of reasons for genograms being useful in a research context. The first is that it provides a useful structure to gather demographic information about an individual and their family. Additionally, the completion of a genogram offers the opportunity for rapport building at the beginning of an interview. As the completion of a genogram requires asking for factual information that does not require large amounts of reflection, it allows participants to begin a conversation with the researcher, before being asked more challenging experiential or reflective questions. It also shows to the participant that the interviewer is interested in them in their wider family context and sets the questions within this frame. Finally, the completion of the genogram can be referred to during the analytic process, as they were in this research, as an orienting tool to remind the researcher of the family structure and members and to help retain an idiographic focus. This has applications therefore for a number of qualitative research methods which value idiography, including other phenomenological approaches.

These assertions are supported by McGoldrick *et al* (2008) who argue that genograms have a ‘good fit’ with qualitative research contexts. For example genograms have been used in conjunction with semi-structured interviews in a phenomenological study with sex offenders (Petry, 2006), in investigating family post disaster resilience (Beitin and Allen, 2005) and to consider the flow of information through a family following genetic testing (Smith *et al*, 2011).

## **6.5 Developing the Infant Feeding Genogram**

Some adaptations were required to use the genogram in an infant feeding context including the development of additional symbols. These can be seen in the legend presented in Figure 8.



**Figure 8 Infant Feeding Genogram Legend**

The use of a purple outline around the symbol identifies those individuals who have been breastfed and a solid purple shape represents a child who is currently being breastfed. A purple line connects those who have experienced a breastfeeding relationship. This allows for the easy observation of infant feeding experience through families.

The decisions about which symbol/s should be used to represent breastfeeding are embedded within the wider debate about how breastfeeding should be represented in health promotion. It could be argued that as breastfeeding is the biological norm and formula feeding is the deviation, breastfeeding should be unmarked on the genogram, being the presumed feeding method, while formula feeding should be marked on as the deviation and ‘health risk’. This would however mean that where infant feeding history was unknown and no representation of breastfeeding was made on the genogram, the genogram would appear to suggest that breastfeeding had occurred. Therefore due to the predominance of formula feeding in this study, and in the community more

generally, the marking of breastfeeding avoids a potentially misleading situation and ensures the genogram is uncluttered and legible.

The use of symbols to mark breastfeeding does not allow for the representation of breastfeeding duration or the quality of the experience. For example, breastfeeding for three weeks and having a very negative experience would be indistinguishable from a year long positive experience. This can however be easily rectified with additional comments written beside the symbols, as is done with other relevant information such as names and occupations. Further adaptation of the existing symbols to represent difficulties is possible, for example, a difficult or conflictual relationship is represented as a zigzag line and the purple breastfeeding line could be adapted in this way to represent a difficult breastfeeding relationship that was unresolved.

In this study, genograms were completed with the participant at the beginning of the research interviews to collect relevant family information and to set the context and build rapport. The genogram was also used to record something of the nature of their relationships, but this was not done to the same extent as would occur in a therapeutic interview. The completion of the genograms with the participant was audio recorded along with the interviews to allow for listening back to confirm details. Thus the length of time they took to complete could be assessed with the quickest completed in 8 minutes and 16 seconds (Heather) and the longest 17 minutes and 43 seconds (Julie) giving a mean of 12 minutes and 12 seconds. All participants helped to complete the genogram enthusiastically and did not express any reservations about the process. All participants' genograms are included as appendix VI and Louise's genogram is shown as an example at Figure 9.

As can be seen from Louise's infant feeding genogram (Figure 9, see next page), she is married and has one son, who is 21 months and is still being breastfed. Her own parents are divorced and neither in a new relationship. She has a brother who is not in a serious relationship and has no children. Louise was not breastfed by her mother and has no sisters. Louise's husband was not breastfed and there is no wider family history of breastfeeding. He has a younger sister but she is not in a serious relationship and has no children. Both of her husband's grandmothers are still alive but his grandfathers are deceased. Other potentially relevant information such as their occupations is noted, as is her closeness to her own grandmothers who are now deceased. This was information which she volunteered when asked if there is anything else that she wanted to share about her family. For ease of interpretation, only the structural symbols are included and not the lines which indicates the nature of the relationships.

As a contrast, my own infant feeding genogram is included as Figure 10. This is clearly different, showing the strong breastfeeding history in my family of origin, but a more mixed picture in my husband's family.

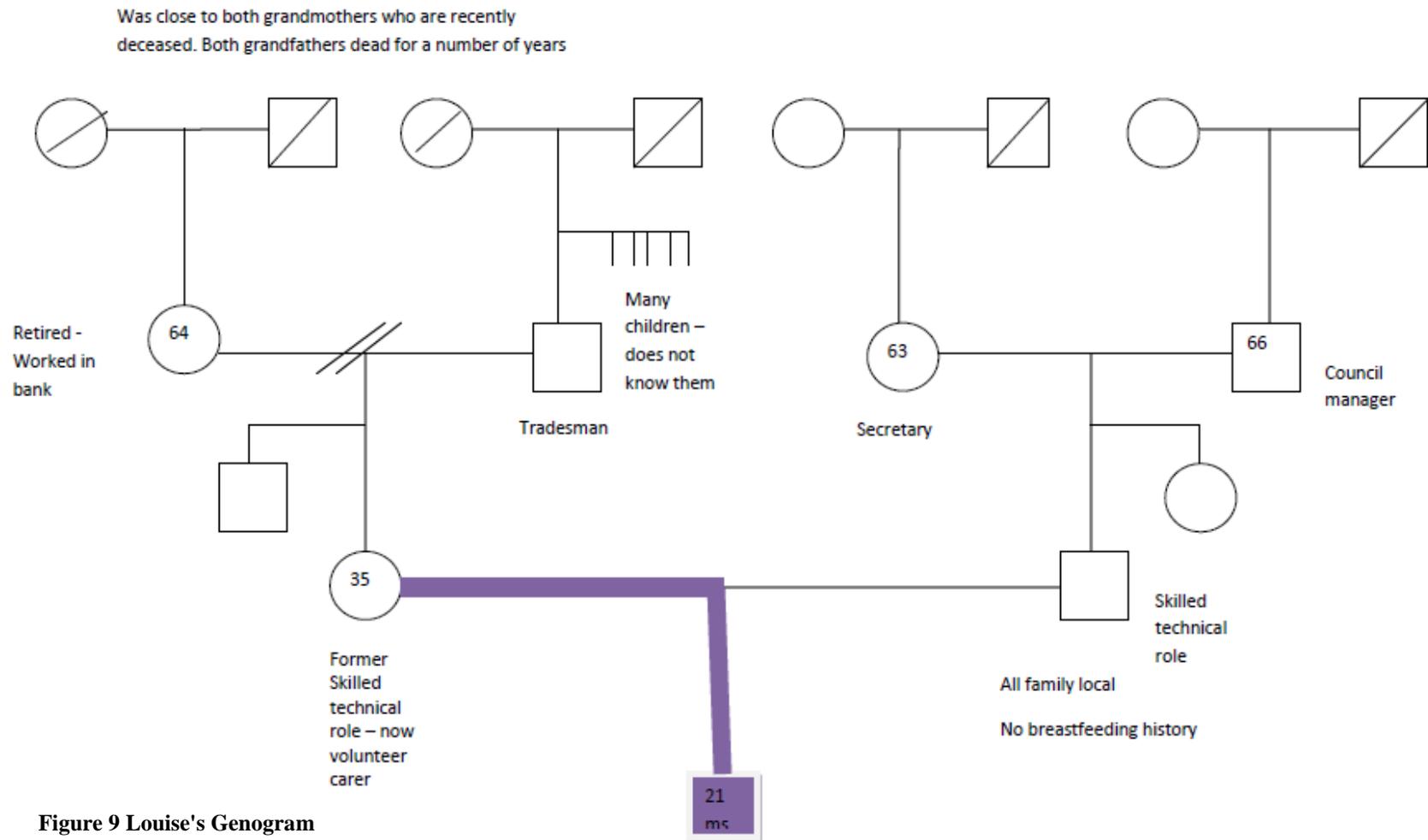


Figure 9 Louise's Genogram

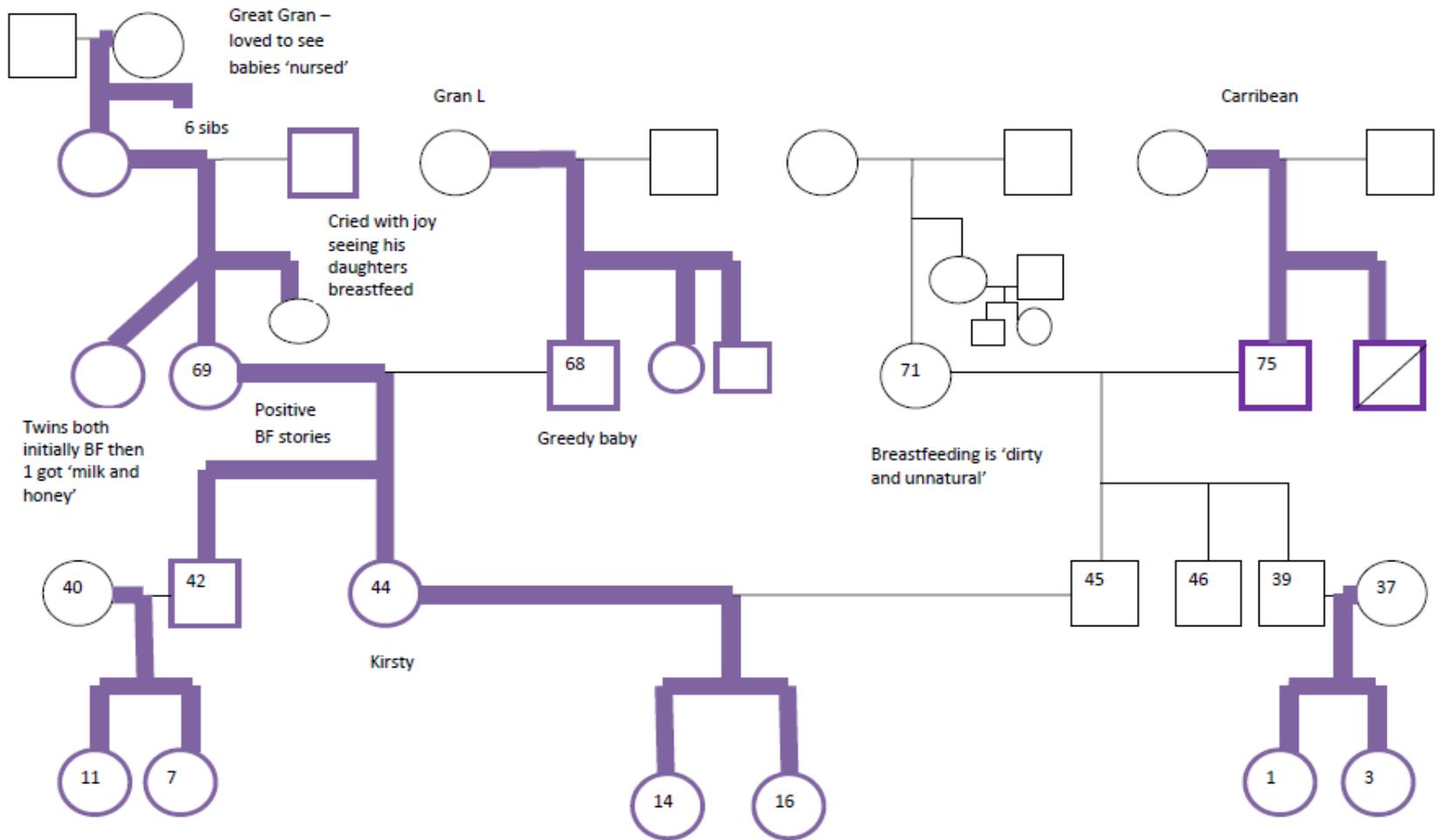


Figure 10 Kirsty's Genogram

## **6.6 Conclusion**

This paper proposes the development of a simple pictorial device, the genogram, which can be used to begin a conversation about women's infant feeding history, stories and culture. This has value in a research context due to its data gathering and rapport building aspects and its potential has only just begun to be explored. The genogram's potential for use in a practice context is demonstrated in the Recommendations for Practice section in Chapter 12.

## **Chapter 7 - Introduction to Findings**

### **7.1 Introduction**

In this section findings are introduced and there is an explanation about how these are presented in the subsequent chapters. Women's voices will be given primacy, without reference to the literature to allow their experience to be considered without becoming entangled in academic discourse. Consideration of the themes in relation to the literature will be undertaken in the Discussion section which follows in Chapter 12.

### **7.2 Presentation of Findings**

An overview of the findings, including the superordinate themes and themes are presented in Figure 11 and the tables below. The next four chapters go on to present the findings from the Interpretative phenomenological Analysis. The superordinate themes found were: Breaching Societal and Family Norms (Chapter 8); Volition and Imperatives (Chapter 9); Unprepared for the Challenge (Chapter 10) and Worth the Sacrifice (Chapter 11).

Within these chapters, participant's experiences are brought together with an examination of the superordinate and associated themes which cross over the interviews. Participant's quotes link themes directly to the data and elaboration of these illustrates the commonalities and divergences across interviews.

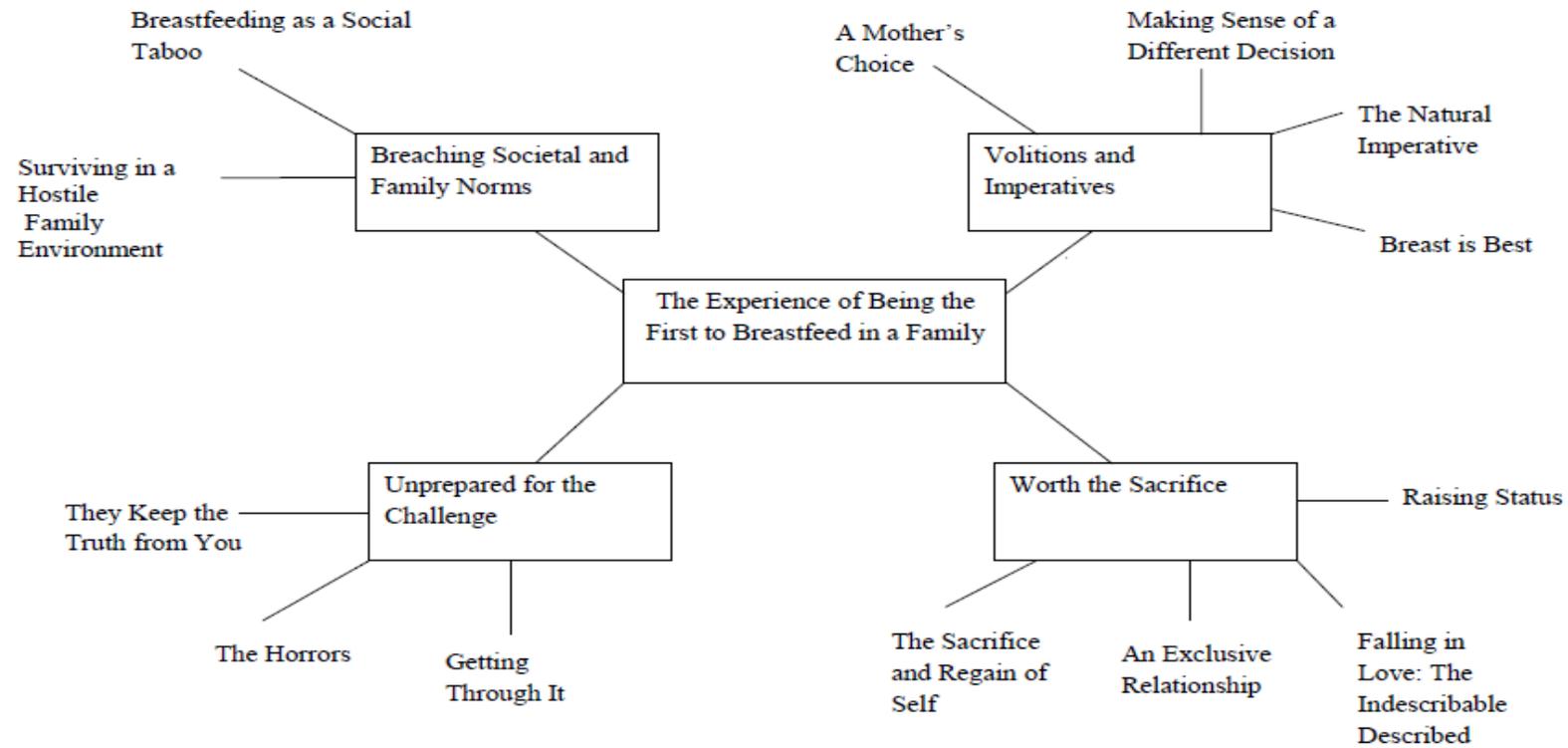


Figure 11 Map of Superordinate Themes and Themes

## 7.2.1 Tables of Themes

**Table 5 Superordinate Theme: Breaching Societal and Family Norms**

Superordinate Theme - Breaching Societal and Family Norms		
Theme	Theme Description	Participants Contributing to the theme
Breastfeeding as a Social Taboo	This theme explores the experience of breastfeeding as a taboo activity and the implications this had for participants' feelings and behaviour.	All except Louise and Fiona  Fiona made no mention of societal views and Louise only mentioned the taboo at breastfeeding an older toddler
Surviving in a Hostile Family Environment	This theme details the participant's experience of the culture of their family of origin and in-laws. Family culture was overtly critical of breastfeeding and had implications for their behaviour and relationships.	All except Julie, Niambh and Tracy  All participants, except Julie, Niambh and Tracy received criticism from either own family or in-laws, with most experiencing this from both

**Table 6 Superordinate Theme: Volition and Imperatives**

Superordinate Theme - Volitions and Imperatives		
Theme	Theme Description	Participants Contributing to the theme
A Mother's Choice	In this theme the ownership of the right to make the infant feeding decision is explored.	All  All participants reported that they were the exclusive or dominant decision maker
Making Sense of a Different Decision	This theme elucidates process and experience of making a different infant feeding decision from one's own mother is detailed. Participants' sense making of their own mother's	All  This is a broad theme with all participants identifying formula feeding as the family norm. with participants reflecting on timing

	infant feeding decision and how this impacts on their relationships is explored.	and influencers which challenged this
The Natural Imperative	In this theme, the assertion that breastfeeding is the natural and therefore right or required way to feed a baby is detailed and the significance of this for the mothers making sense of the infant feeding decision.	All except Kay  Kay refers to her body being ‘designed’ for breastfeeding but does not refer to it being ‘natural’.
Breast is Best	In this theme, the influence of this dominant discourse on women’s infant feeding decision and its moral implications for other women is explored.	All except Susan  Susan refers to potential benefits of breastfeeding but not the ‘breast is best’ discourse in the same way as other participants

**Table 7 Superordinate Theme: Unprepared for the Challenge**

Superordinate Theme - Unprepared for the Challenge		
Theme	Theme Description	Participants contributing to the theme
They Keep the Truth from You	In this theme, the dissonance between women’s personal breastfeeding experience and the dominant narrative of the healthcare system is explored. The personal implications of facing breastfeeding difficulties in this context, is considered.	All except Rhona, Susan, Fiona and Gemma  A theme for the majority but Rhona, Susan and Fiona made no mention of this theme. Tracy found breastfeeding easier than she expected but subscribed to ‘if it hurts you are doing it wrong’ aspects of theme. Gemma is contra-case who felt well prepared
The Horrors	In this theme, participants tell their story of feeding difficulties and the implications this has for their judgement of women who do not breastfeed.	All except Fiona, Heather and Debbie  Fiona and Heather did not describe any ‘horrors’. Debbie had a difficult experience but felt this was

		ordinary and not horrible.
Getting Through it.	In this theme the personal attributes of participants and their support mechanisms which assist participants in continuing to breastfeed are explored.	All except Susan  Only Susan made no mention of the need of things to get through the experience, all other mentioned internal factors and support mechanisms

**Table 8 Superordinate Theme: Worth the Sacrifice**

Superordinate Theme - Worth the Sacrifice		
Theme	Theme Description	Participants contributing to the theme
The Sacrifice and Regain of Self	In this theme the sacrifices women make including their bodies, lives and aspects of themselves for their babies and their feelings about this are explored, before detailing how a new self is recovered.	All except Julie and Louise  Julie and Louise did not use the language of sacrifice in their extracts, despite describing challenges
An Exclusive Relationship	This theme narrates the double edged sword of the exclusive relationship which develops between mother and baby is considered.	All except Julie  All participants experienced both aspects of the exclusive relationship, except Julie
Falling in Love: The Indescribable Described	In this theme, the attempts and difficulties expressing the joys of breastfeeding are discussed.	All  All participants spoke of the strong feelings of love, attachment and bonding associated with breastfeeding
Raising Status.	In this theme, the enhanced status awarded to participants due to the rareness of their breastfeeding activity is revealed.	All except Tracy  All participants except Tracy reported feelings of raised status from their own perspective and/or that of their family or community

## Chapter 8 -Breaching Social and Family Norms

### 8.1 Introduction

The first superordinate theme details participant's perceptions of societal, community and family norms around breastfeeding. In both public and family contexts, breastfeeding was seen as a counter-cultural activity. In the community context this led to participants fearing a negative response if they were to be seen breaching the taboo by breastfeeding in public. For most this was managed by avoidance of breastfeeding in public places, while those who did breastfeed in front of others focussed on the importance of being 'discreet', including using devices to conceal any exposed parts of their bodies. Within their families, participants discovered that formula was seen as the default, or presumed, infant feeding choice and infant feeding more generally was not discussed.

Following initiating breastfeeding, participants experienced both overt and covert criticism of their breastfeeding decision and activities. This affected their relationships with their relatives and their ability to interact in the usual way with their families, leading to not being able to feed in front of family members, or even their own homes. Despite this, women found ways to adapt to and make sense of their family's response and to maintain positive relationships with them.

This superordinate theme comprises of two themes: Breastfeeding as a Social Taboo and Surviving in a Hostile Family Environment.

## 8.2 Breastfeeding as a Social Taboo

Within the interviews, participants described their experience of the breastfeeding culture in Scotland and its impact on their feeding experience and behaviour. This was dominated by a perception that breastfeeding was seen as a counter cultural, taboo activity and that there was widespread disapproval of breastfeeding. This was informed by their experience talking to community members, particularly women, who described breastfeeding in very negative terms. This often featured revulsion where the term 'yuck' was used. This was compounded by women's perception of media representations as breasts as having an exclusively sexual function and that any other function was unacceptable, particularly in public. A number of participants felt that by making the decision to breastfeed, they were challenging these rules and participating in a somewhat subversive activity however, the extent to which the participant's felt comfortable doing this varied. Many participants were ambivalent about society and family disapproval of breastfeeding and while railing against it, were also considerate of others discomfort, not actively challenging their stance. Consequently, many were unable to participate fully in the world while breastfeeding. The majority of women avoided breastfeeding in public places and those who did emphasised the discreetness of their feeding or used specialised clothing, such as breastfeeding capes to conceal their feeding.

Among most of the participants there was a perception that their breastfeeding went against what was considered acceptable. They describe others perceptions of breastfeeding most commonly as 'disgusting', but a number of other descriptions are used such as 'eugh', 'alien', 'stigmatised'. They expressed that other people felt 'uncomfortable' around them when they breastfed, with some participants describing

other people ‘freaked out’ by it or that it made them feel ‘queasy’. This discomfort and disapproval was expressed overtly through conversations with friends and other community members, when talking generally about breastfeeding, but was also experienced through interactions with people they did not know in their communities, through direct comments and covertly through perceived ‘looks’. Mhairi was one participant who had received direct negative comments when breastfeeding.

*Oh it was horrible, so it was. Boots had a wee baby room in there but if I went into town, I used to sit in there nearly the full time I was in town feeding him. But to feed in a restaurant, I mean I had an old couple come up to tell me that that was disgusting and I mean, I was younger then, so em, I just, it was horrible, like we tried the covering up and stuff and em, it was just embarrassing.*

Mhairi’s story, while a little disorganised due to the memory of the embarrassment, tells of her different feeding practices and her experience of this. Despite an effort to ‘cover up’, in order to hide any exposed parts of herself, she experienced direct criticism and was mortified as a consequence. Her comments show the impact that this criticism had on her, leading her to adapt her feeding behaviour and go to private, designated spaces like the ‘baby room’ in order to be able to feed. With the frequent feeding often required with a small baby, she felt she could hardly get out of this room to go about her ordinary life in the town.

While few of the participants had personally received a negative public reaction, the fear of a negative comment had a powerful impact on participants and stories of public confrontations heard from others, impacted on their breastfeeding confidence and meant they were defensive, actively anticipating difficulties. Julie recounts:

*It’s a shame, I heard one of the girls saying that the other night, she had somebody come up to her and said one day ‘that’s disgusting’ and walked away, and you think well in this day and age when everything else is so accepted, how can people have that view? (...) I think you’ve always got in the back of your mind that you’re kind of prepared for people being defensive about it or maybe saying something negative about*

*it, so you've always kinda been prepared for people maybe coming up with those kinda comments, so you've got to be a kinda stronger person to be able to stand up to that, although I never have. I've heard other people have but I personally haven't.*

Some participants, despite not personally experiencing any direct public criticism believed that others had strong negative views of breastfeeding. As Elspeth expressed, 'some people just find it disgusting, you know, it's not nice.' This had a profound impact on her feelings about breastfeeding in public and subsequent behaviour. Her mixed feelings are further illustrated in her next extract where while she denies any feelings of shame, she feels the need for privacy and concealment.

*It just felt as if people were kind of looking at you. And maybe that was wrong for me because I was only going by documentaries and things that I'd seen, so maybe I was prejudging people thinking that they would be judging me. But I think that because I've never seen anything good on the television, there was nothing to balance the argument. So I think because it was always something negative that I saw, that I just thought no. (...) I was never ashamed of breastfeeding and I'll tell anybody, best thing I ever did, breastfed all my children, you know, fantastic, I would recommend it to anybody but I would never sit out and do it. And I'm not ashamed but I always made sure that we were... wherever we were going there was somewhere or made sure we were home in time for a feed, you know... (...) I definitely would not have sat in a café or anything like that, I would've went into a mother and baby bit and got a chair or down to Boots or somewhere where I knew that there was, like, chairs for you to sit and there's maybe a little curtain, that's what I would've done.*

In Elspeth's extract it is evident that the messages from the media, which she perceived to be critical of breastfeeding, influenced her perception of the response she would get to breastfeeding in a public place. This led to her feeling the need to only breastfeed in an area designated for mothers and babies, but even then she suggests she needs more concealment, with a 'curtain'. Choosing to go to baby centred places to feed, however, did not guarantee a peaceful feeding environment. Although these places are specifically designed for baby care, they are also used by community members, largely other mothers, who may hold societies critical views. Unfortunately Aileen had experience of this and recounts:

*Once I was in Mothercare feeding Natasha and there was another lady in, this was in the change area, there was another lady in, she was bottle feeding her baby, and she actually said to me 'oh I don't know how you could do that, why don't you just put her onto a bottle?'*

While not actively critical of Aileen, the woman's repulsion at the idea of breastfeeding and suggestion that bottle feeding would be a more acceptable alternative, clearly shows the taboo around breastfeeding in all locations, even those specifically designed for mothers and babies and not just in public places.

A small number of participants felt more able to challenge societal taboos and had made the transition to breastfeeding in public places. Rhona persisted in breastfeeding in public places; however, she felt that society was unaccepting of breastfeeding and lined this to others associations with sexuality. In her extract, she suggests that other women might perceive her as a sexual rival, as breastfeeding makes her seem sexually available to other women's husbands.

*Some women outdoors if you were going to coffee shops, I found they were probably the strangest, they gave you the strangest looks, you know, as if you were about to shove your nipple into their husband's mouth or something like that, that was the insanity of it, it was like 'how dare you do this in public' and I was surprised that that still happened. I almost expected it just to be a breeze out and about, but women were definitely odder about it, as if you were a prowler after their husbands, it was just bizarre [laugh] 'I'm feeding my baby, get over it!'*

For a number of participants, the awkwardness of others led them to adapt their own behaviour. Aileen, a health professional, reflects the perception that a breastfeeding mum might be challenged, or face opposition to feeding in public, and in anticipation of difficulties; she adopted the practice of feeding 'discreetly'. She expressed pride in succeeding in doing this, managing to achieve her own aims of being out and about with her baby without directly challenging societal taboos.

*People have asked me 'oh did you get any... have you had any problems, has anybody asked you to stop feeding?' but I never experienced any problems like that. I managed*

*to... it's really sad, but I managed to practise at home how to breastfeed discreetly [laugh] so I think whenever I was out, some people didn't even notice that I was feeding, I used to go on trains with Natasha quite a lot up and down, and people would say to me 'oh my goodness, I didn't realise you had a baby there'.*

This pride in being able to feed discreetly, and the assertion that discreet feeding is required in public, was widespread in accounts. Elspeth asserts:

*It's not as if you undo yourself and you're sitting there, you know, it's so discreet and whenever I fed any of mine I always had like a blanket that I put over their head so it's not as if anybody can see anything anyway, but I don't understand, some people just find it disgusting, you know, it's not nice... I don't get that.*

Despite Rhona's earlier assertions, her knowledge that what she was doing was considered unacceptable still impacted on her confidence, and led to her adopting the 'discretion' idea, adapting her clothes and environment to make less impact on others.

*I remember my first time doing it in public though, that was quite... that was daunting. I do remember being full of confidence and thinking 'I'm going out and I'm going to feed my baby in public!' and then I got there and thought 'oh right, what do I do now?' [laugh] the whole learning how to uncover without uncovering [laugh] that was certainly an experience... I got quite good at it in the end though, and I knew what to wear and how to sit and to position yourself, it was quite good.*

It can therefore be seen, that even for those women who challenged societal taboos by breastfeeding and feeling empowered enough to do so in public places, they had still internalised aspects of the taboo by feeling they needed to conceal themselves and make feeding invisible. The complex relationship between dominant breastfeeding discourses reveal themselves in this theme, with ideas about societal taboos and the shame of bodily functions conflicting with others such as 'Breast is Best' and 'The Natural Imperative', leading to the ambivalent position where women are pleased to be breastfeeding, but reluctant to be seen doing it, or if they choose to be seen they feel the need to emphasise their discretion. The challenges participants face are further

explored in relation to their own family context, which was in large part actively hostile and unsupportive of breastfeeding as an activity.

### **8.3 Surviving in a Hostile Family Environment**

In the interviews, a majority of participants described their experience of breastfeeding in the immediate family culture which was unsupportive or actively hostile to breastfeeding. In a number of families there was overt, frank criticism of breastfeeding as an infant feeding choice. This involved open criticism about women's decision to breastfeed and undermining of their confidence in breastfeeding and their ability to parent. In other families, and sometimes alongside the more open criticism, there was covert criticism of breastfeeding with ordinary parenting difficulties being attributed to the infant feeding decision. This family opposition influenced the relationships between family members and breastfeeding women and impacted on their behaviour around their families. For many women this meant they could not breastfeed in family member's homes or even in their own home, if certain family members were there. Relationally, the criticism often affected women's ability to seek support from family members and affected how they felt about them. When it was an 'in-law' who was particularly critical, this could also impact on their marital relationship. Despite this, participants developed a number of ways of coping with this experience and largely managing to maintain positive relationships with their family.

Mhairi's experience was one of the most difficult as she faced widespread hostility and opposition to her breastfeeding decision from all members of her family. As she lived close to most of her relatives and was in frequent contact with them, she was bombarded with negative and undermining comments, right from the start of her breastfeeding journey. This includes expressions of revulsion:

*Even like just in my mum's house with family about, because I got the 'Eugh, can you put that away, its gads [revolting] and stuff, put that baby on a bottle and stuff' and it was 'nae nice.*

She found this negative response particularly distressing when the lack of acceptance was from her mother and father. Mhairi details:

*Cause I can remember my dad coming into the hospital just after Gary was born and em, I was feeding him, and I was sitting there all proud and my dad walked in and he was like that 'Put that away before I come and look at this baby' like he could'nae come and see the baby, which I understood because they had not see them, anybody breastfeeding or anything, but I thought as time went on they would get used to it, but it took a wee while, but. When Chelsea turned about six months it all kind of changed, if I fed her or that, like they did not bother as much, because they were used to seeing it so they did'nae bother.*

Despite her hurt at this experience, Mhairi tries to make allowances for her father's harsh response, understanding that this was a new experience for him. While her parents did not ever come to accept or support her decision, their response to it weakened. However, her early days were marred by an incident with her own mother:

*I had fall outs with people in my family, once I had Chelsea, so I did, I fell out with my mum because she was needing fed at my mum's work when I was out showing the baby off and my mum tried to hide me. She stood in front of me and tried to hide me and told me to hurry up because there was folk coming in and that is a council run area so I know it was breastfeeding friendly, so I fell out with ma mum for oh, we did'nae speak for a couple of months because it was my choice to feed, she was mine, so it is my choice, but once again, I never had any support, em, because like you expect support off of family, but my mum never done it so she could not understand why I was doing it. It's weird (uncomfortable laugh). It is horrible to think back.*

Even now, many years after this first incident, Mhairi's distress is palpable and she feels the need to assert her right to have breastfed her own baby, even recounting the location was breastfeeding-friendly, to support her actions. Her disappointment at not receiving the support she felt she needed, when she was really struggling to feed her first baby (whom with very great regret, she stopped feeding after only a few weeks), remained long after the incident and she felt her parents never really accepted her

decision or changed their negative views about breastfeeding, rather she just 'puts up with it'. Her use of the phrase 'once again' suggests that this was not the first time she felt let down by the lack of support she received from her family.

While Mhairi's family were particularly overt in their disapproval, almost all the participants experienced criticism from either their own family or their in-laws. In Gemma's case, the criticism was covert and sometimes perceived rather than spoken. With her own mother, with whom she has a somewhat strained relationship, she recounts her mother's response when her cousin breastfed sometime before she did.

*At that time definitely there was an air of disapproval from my mum, quite disgusted at the idea of Rachel breastfeeding, Rachel breastfeeding in public and Rachel feeding him beyond a conventional look of a baby, you know, into toddlerhood sort of, which is interesting cause she's never ever said anything to me about disapproving of me breastfeeding.*

Although her own mother's feelings are left unspoken, Gemma assumes that 'she's still pretty not really into breastfeeding'. Her Gran on her father's side, who largely brought her up due to her own mother's personal difficulties, had been openly critical of Gemma's decision to breastfeed, but by the time she was breastfeeding her second child, was largely covert in her undermining of her breastfeeding decision, suggesting that it is in Gemma's interests to allow formula to be given so that she can rest.

*My gran's been slightly negative about it... again, more so when Angharad was wee. I think this time round they just know I'm going to do what I want to do, but she would sort of put it in different terms, she would say 'oh, to give you a break', 'I don't see why you're feeding so long?' 'you must be feeding quite often, d'you not want a break from it, why don't you just give her formula?*

Gemma has challenged her Grandmother about her negative views and tried to get support from her, but without success.

*I'll say to her 'well this is the recommendations, you know, they recommend you don't start weaning until six months' 'ocht nonsense, you read too much!' she always thinks she knows better than anything that's any way scientific or coming from an education*

*background, she kinda doesn't want to endorse it or recognise it. I think she just thinks that she knows best.*

For a number of participants, the lack of family support impacted on their confidence to feel comfortable breastfeeding. Susan's mother was generally supportive of Susan's right to make her own infant feeding decision, saying things like it's up to you, it's your decision' and Susan felt her mother was supported in her decision by her, but at the same time, she appeared to covertly undermine Susan's commitment by talking about the positives of formula feeding. While she helped her daughter to feel comfortable breastfeeding in front of her, this was not however the case with Susan's father, as she details:

*I think because when I was at my mum's house, my mum's never breastfed any of us, so my dad's never been there when my mum's been breastfeeding so it's totally alien to him, so maybe he just... like, I don't know if my mum was very aware of that as well but I was always aware of it anyway that although I was doing this natural thing that it wasn't natural to my immediate family, so I was always aware of getting out the road or, like, going somewhere private to do it. () I would always make sure he wasn't there or I'd go out the room if he came in from his work, just because I didn't want to put him in an uncomfortable position. Other than that, but I mean, he never bothered, he was never bothered, he would just go in the kitchen or he would go to the bathroom or something, if I was already there.*

Although, 'not bothered', there was clearly an agreement, spoken or unspoken, that breastfeeding in front her father was unacceptable and she did everything she could to accommodate this concern and it remained unchallenged. This adaptation of behaviour to accommodate others sensitivities was common, and Kay also accommodated her parents in law's feelings. In this case it appears to be because of her mother-in-law's perceived old-fashioned, prudish attitudes.

*RES: When we go to Gary's mum's I always go sit on the stairs.*

*INT: Okay.*

*RES: Because I don't want to make them feel uncomfortable in their house.*

*INT: Right.*

*RES: I think it's more because his parents are that much older...*

*INT: Okay.*

*RES: ...and I know his mum's views on breastfeeding.*

*INT: What are his mum's views on breastfeeding?*

*RES: She couldn't do it, there was no way that she would let anyone near her boobs because they were just too sensitive and she can't even talk and say the 'N' word!  
[Nipple]*

*INT: But your mum, it's different with her?*

*RES: I don't really talk about it with my mum either, it's just something I do and they just come out.*

*INT: Right.*

*RES: You know, if my boy needs feeding he gets fed and if anybody has a problem with that then they can bog off really.*

Despite Kay's assertion that others can 'bog off' if they do not like her feeding, she is making the decision to feed out of the room when at her mother-in-laws home, facing discomfort on the stairs. Despite knowing that her own mother is unsupportive of breastfeeding, Kay does feed in front of her, but distances her breasts from herself, saying 'they come out, which might suggest that despite her assertions of confidence, Kay is reluctant to assert that breastfeeding is a choice she is making, rather it is something that happens involuntarily.

Negative attitudes about breastfeeding, did not only impact on relationships between the critical family member and the breastfeeding women, in her extract, Debbie tells of the strain her mother-in-laws criticism has put on her own marital relationship.

*To be honest with you, Douglas's mum was quite old school and quite kinda... she was like 'oh you don't know what he's getting' 'oh you don't know this/you don't know that', more so with Peter, and I was younger when I had Peter and I used to think 'but so what?' and then I think I said to Douglas, I was quite angry with her one day, she was*

*like 'can you not just give him a wee bottle?' and Douglas said 'well my mum's just dead old school' and I said 'but Douglas, see the thing is, your mum doesn't... I wouldn't sit and watch your mum eating her plate of mince and tatties and say that's disgusting, Peter's only getting a feed, there's nothing hor...' I says 'it's her problem if she's uncomfortable with it, it's not mine and I'll not go down there and feed Peter then if she doesn't want me to... if she's uncomfortable with it, but I'm only giving him what he needs, and it's out my breast and not out a bottle and I don't see the problem with that.*

Debbie describes how her expressing anger and seeking support from her husband, to help her cope with this criticism, appears to have placed him in a position where he felt split loyalties, feeling the need to explain or possibly excuse his mother's behaviour.

Debbie continues:

*He was to an extent supportive with his mum as well, I think he found that a wee bit difficult 'what do I say when my mum's...' you know, I was a first time mum and his mum had like five kids, you know... and fostered, and you think was he sitting there thinking 'well maybe my mum's right?' and I had to kinda say 'you know, we do know what he's getting, he's putting on weight, if your mum's not happy with it then that's her problem not mine, it's nothing...' so he... he was very supportive.*

Here we can see Debbie working to understand the position her husband is in, given his loyalties and the fact that his mother is very experienced as a parent and foster-carer, while they themselves are new parents. Debbie asserts her confidence as a good mother, assuring her husband that she knows what is working for their baby and reiterating that this is an issue for her mother-in-law and trying not to let it affect her. Her final comments suggest that she feels her husband was able to demonstrate his loyalty to her rather than his mother, and support her.

Despite Debbie's crossness and frustration with her mother-in-law, she makes a significant effort to accommodate her, by not breastfeeding in front of her, and additionally by trying to make sense of her objections and to make allowances for this. By accepting her mother in laws views and that she is not likely to change, Debbie

appears to be able to move on from feeling angry and accept that it is a cultural difference between them due to her mother-in-laws age and attitude, and not take it as a personal criticism.

*I think just mainly because she's quite old fashioned and she's quite... (...) Things have changed and she's still kinda living the way things used to be, you know, we're much more open about things and stuff now and she doesn't see it that way. So I don't think anything will change with her.*

While relationships with mothers-in-law appeared to be put under significant strain by the lack of support for breastfeeding, participants appeared to be better able to maintain positive relationships with their own mothers, despite overt criticism and their lack of support for their infant feeding decision. In this series of extracts, Aileen tells of her experience of criticism, but the maintenance of her relationship, revealing some of the processes that help her stay connected:

*My mum, who is my closest ally, you know, was saying to me 'what are you doing that for, I couldn't do it?' even like, she would screw up her face if... she said to me for example 'so d'you think you'll continue feeding Anya for a year?' and she's like 'errgh' you know, she's like repulsed almost by it.*

This lack of support for feeding choice meant that Aileen, who was very close to her mother, was unable to rely on her mother for support with this aspect for their parenting. As Aileen says:

*I would go to her [participant's mother] for a lot of things, but for breastfeeding absolutely no way cause she's already said to me 'when are you giving up this breastfeeding thing? (...) With the breastfeeding, like you say, she's not for it, I'm sure she would rather I bottle fed, but she's always been in with the both births, it wasn't my husband that was in, it was my mum and I had difficult times both times, so she's seen me in a lot of pain, she's seen all that. Then I think when she sees me when apparently I'm struggling with feeding and things, I think in her head she's just thinking 'well why doesn't she just bottle feed, why does she not just do that?' Yeah, so maybe that, but at no time has she ever... I think I'm going to contradict myself here, she has questioned my breastfeeding but at no time has she questioned, you know, my love for my children and what I'm doing is the best for my children. ...If you can understand that, she knows*

*that I think what I'm doing is the best, she might not think it but for me it's the best and she's happy with that.*

Aileen has managed to separate out her mother's specific criticism of her feeding choice, from other aspects of their relationship and does not generalise from the specific criticism and experience it as a more general critique of her as a person. Initially she starts to say that 'at no time...' has her mother questioned her breastfeeding but before saying this pulls back and corrects herself, saying that her mother, while not supporting her actions, accepts that this is important to her daughter and that she is doing what she thinks is best, allowing Aileen to see her mother as generally supportive of her and her intention, if not her actions. While this seems very limited support, this is something Aileen clearly values and is able to focus on so that she can maintain a positive view of her mother, despite criticism and undermining of her infant feeding decision. There is some sadness on Aileen's part that this is an area that she cannot receive support in, but she is pragmatic and has accepted that she cannot influence her mother's views, despite their very close relationship. In the extract, her laugh is one of discomfort and there is poignancy in her words.

*I feel sorry that my mum is maybe, you know, not as positive towards the breastfeeding because I'm closest with my mum and I think on that matter we'll always agree to disagree I guess [laugh]! I don't know if there's anything ever that will change her mind and nothing really that'll change my mind, so it's one thing that we'll never really agree on which is strange.*

While the majority of participants experienced and had to cope with a lack of support or hostility from a range of family members, there were one or two fortunate exceptions who felt approved of in their decision. While Heather's parents-in-law were actively critical of her breastfeeding decision, regaling her with stories which implied a lack of support for the sustainability of her decision, her mother offered respect for her daughter's right to make her own decision.

*I think she's [her mother] always encouraged everything, like, she would always, she would never ever voice her opinion. Because she couldn't breastfeed she was like.... I suppose opened up the wee questions 'what's it like?' 'how would she have managed?' 'how would it have been?' and she's never said 'oh well I didn't breastfeed so you're better using the bottle' that's the most natural thing to do. She's always been kinda straight down the middle, like, try everything and whatever you feel's easiest for you.*

From the interview, it is not clear what Heather's mother's own views of breastfeeding are, and it appears Heather is unaware of them, but she appears to credit her mother with an open mind. Regardless, Heather experiences unconditional esteem from her mother, and feels valued in the decision she had made.

It can therefore be seen that, in addition to experiencing the societal taboo that breastfeeding women experience, participants in this study were additionally found to experience a hostile and unsupportive response within their own families. Given these challenges, it could be considered surprising that participants made the decision to initiate and continue breastfeeding. Of some significance, might be the fact that many, although not all, of these negative views were expressed only after the women were already breastfeeding, by which time other rewards and influencers may have compensated. The processes involved in decision making are explored in the theme 'Volitions and Imperatives' which follows, which explores in detail other aspects of participants families' beliefs about infant feeding and some of the contrasting societal discourse which impact on women in their decision making.

## Chapter 9 - **Volitions and Imperatives**

### **9.1 Introduction**

In this superordinate theme, participants detail their infant feeding decision making process and the major influences on it. Most participants describe the lack of discussion of infant feeding within their family of origin and discover when making their own breastfeeding decision that formula feeding is their family's default position. Although many participants were keen to credit their partners as joint decision making, on exploration it becomes apparent that the infant feeding decision is the mothers, with partners being involved in supporting her decision, whatever that is. Participants detail their experience and making sense of making a different decision from that of their family culture, including the timing of the decision and the various influencers on them. This includes vicarious experience and contact with health professionals opening up the possibility of breastfeeding for them, however, the most powerful influencers, coming from a number of sources, appears to be dominant discourses within society, which shape their thinking about breastfeeding and what it is to be a good mother.

This superordinate theme comprises of four themes: A Mother's Choice, Making a Different Decision, The Natural Imperative and Breast is Best.

### **9.2 A Mother's Choice**

In the interviews, participants reported that they were the main infant feeding decision maker. Many of the women strongly voiced their belief that this was their exclusive decision as they were the person who had been pregnant and giving birth. Several women initially described the decision as one made jointly with their husbands or partners, however, when this was explored they went on to describe a process where

they made the decision and then invited their partners support for them in this.

Participants described their husband as supportive of their breastfeeding, however, the interviews describe how the support appeared to be for their partner generally and for her decision, rather than that they were supportive of breastfeeding as their infant feeding choice.

In her account, Elspeth clearly articulates experience of, and her views on, who should make the infant feeding decision, not only in her own case but also for other mothers.

*Well I think because the mother carries the child for nine months, I mean, I don't know what a man's perspective's like on that because I've always been the one carrying the children and I know it's life in me and I do think that when you're having a child the father feels differently than the mother does. (...) So I just think that because you carry the child, I think that the father really kind of leaves it to the mother to kind of make that decision, you know, I mean, choosing the names tends to be both of you, you know, choosing what they wear tends to be both of you, you know, but I think the way that the child is fed I think tends to be the mother's choice because if the mother wants to breastfeed she'll breastfeed. () So I definitely think something like that it's up to mum because the mum's just carried the child, the mum's just given birth to the child, so the dad kind of tends to feel like a spare part at that point anyway, and because you feed your child so soon after you have them, I think really it's the mother that tends to decide and I think that's probably the right decision. I don't think that any father should take that away from a mum when she's carried the child for nine months, gone through however long a labour or whatever to have that child – I mean, I was a c-section with Mark and Ryan, got the scar – in fact I say that to Michael all the time when he's in with the lads 'd'you want to see the scars!' 'Do you want to be reminded of the scars?' he's like that 'no!' you know, so whatever way you're damaged and whatever way you have the child, you know, so I don't think any man can take that away. I think it's the woman's choice really.*

In her account, women by carrying a baby, and experiencing the pains and 'damage' of this experience have clearly earned the right to do the majority of the decision making.

Elspeth expressed shock at the idea that a partner, who has not, in her view, put up with the inconveniences and made the sacrifices of pregnancy, should not get to influence a woman's decision. Her strong belief that this is a woman's entitlement leads her to

struggle to understand why a woman would make consideration of her partners views and she is fortunate in having her husband's full support for her decisions. While Elspeth was the most outspoken supporter of this position, the view that the mother, having been the one who was pregnant, should be the person with the majority decision was commonly expressed amongst participants. Debbie, in her account, articulates both her belief that it is her decision by merit of pregnancy, expressing, in a similar way to Elspeth, that any challenge to her primacy would not have been expected or welcomed. As a father and partner, his role was to be supportive of her decision.

*I think Michael just kinda... you know, I would say 'I'm going to breastfeed the baby' I think Michael just kinda... well I'd carried the baby, d'you know, I think kinda seen it as very much 'well you've got to do what you want to do'. (...) He was very supportive of that, but he didn't... we just never really talked about it, it was just like 'I'm going to breastfeed' 'right okay' that was it, it was like 'well it's your choice'. I think he kinda felt 'well, you've done all the hard work here, it's up to you what you do after it, I'll be there to help you but I've got to really go with what...' and probably if he'd turned round and said 'well I don't want you to, I want you to...' I would've said 'well, wait a minute here, I've carried this baby, I'll do what I want!' [laugh] so aye, he would've... he was really supportive.*

Although Louise also made the infant feeding decision, she holds a slightly different position where she does not argue for entitlement, rather she is keen to decide and keep her husband 'on board' with her decision.

*Yeah it was like, I kinda made the decision but just checked that he approved really. It wasn't like we'd discussed the possibilities and came up with the decision together, I'd already kinda made my mind up and just wanted to make sure he was on board really, which is probably the way [laugh] we operate in a lot of areas! He's quite happy with most things, he's quite laid back probably and I'm the planner and think about things well in advance, so I just bring him up to speed [laugh]! 'Here's a small range of options!'*

Although in all participants' accounts, it appears that the mother is the primary decision maker, initially when asked about who had made the infant feeding decision, some mothers reported that it was a joint decision. Upon further exploration however, a rather

different picture emerges. Niambh, who in a number of themes has expressed a desire for shared parenting between herself and her husband, reported initially that it was a joint decision. However, when the detail is explored the situation is more complex.

Despite Niambh saying that breastfeeding was a joint decision, it appears that Niambh actually made the decision and her husband agreed with it, offering her support.

*INT: How would you describe the way that decision was made?*

*RES: Joint decision I would say. Only because neither of us had thought about it and it was brought up to us at the same time and so we both considered it and both made a decision. I had no kind of... previous desire already to breastfeed and I don't think Doug had considered it either, it's just the decision was well we want to have a baby and we're ready to have a baby, so as all these things were coming to us we were just making our decisions.*

*INT: I want to bring you back to something you said, just because I'm interested in it, and that it sounds like it was the first time you thought about it was when the midwife spoke to you and then it sounds like you spoke to Doug about it, and then there was the bit about when things were tricky in the hospital and you were asking him what he thought and he said 'you wanted to breastfeed', can you talk a wee bit about that?*

*RES: Well I think he just... I think he was like 'well, ultimately it's you', you know, I think he maybe realised the whole 'we' in the situation's got to kind of maybe be adjusted because at the end of the day it's 'you' and I think he was just willing to be there for me.*

A phrase which recurs within this theme is that her husband was 'supportive' of her breastfeeding. This could be understood to suggest that partners were supportive of breastfeeding as a feeding choice; however, this does not appear to be the case. Mhairi, in her extract shows that her partner actually has no particular view on infant feeding as such, rather he wants to be supportive of his wife more generally.

*He was so supportive, about it and he always said, whatever you want to do, that's fine. So if I had'nae managed I mean he would be, I mean, that happened with Gary and Sean and he never ever once said, 'Oh for god's sake', why are not no doing it, breast is best, blah, blah, blah, if they need to go on a bottle, they need to go on a bottle' he is easy oasy, so he is but when I managed with Chelsea and Jack, I could not have asked for better support, because he was always, ken, 'You are doing great' so it made you feel good, so it did. Na, I did speak to him about it but he was'nae to bothered what I done, whatever made me and if the baby was happy, he was happy.*

The complexity of what women mean by the phrase ‘support’ is exemplified in Susan’s account. In her extract there appears to be a split between support for breastfeeding as an act and support more generally for one’s partner. Susan perceives her husband as highly supportive of her and of her decisions, including her breastfeeding decision, however, his purchase of formula, when she is saying she wants to breastfeed, could appear to be undermining of her and her breastfeeding decision. It is not however interpreted by her, who only sees his benevolent intentions.

*I think Steve was really supportive as well. He was really encouraging, he just said ‘we’ll try it’ and then we were out shopping and I was in pain and I said ‘I still want to try it’ and he actually bought one of the wee Aptamil cartons of milk just to say ‘well that’s there if we need it, you’re doing really well, that’s there if we need it, though don’t worry, don’t feel pressured into it but obviously I’m here to support you if you need it, if you can express milk I’ll feed her and you can get a wee break’ but he was really, really helpful and he was really... I don’t think I could’ve done as well without him, he was a really, really good help with it, even although none of us had been breastfed ourselves.*

It can therefore be seen in this theme that the ownership of decision making is complex with nuanced meanings appearing for phrases like ‘joint decision’ and ‘he was so supportive’. Despite initial ambiguity women perceive themselves as the infant feeding decision maker with their partners playing a supportive role, supporting them in their decisions and providing emotional support and succour for their efforts. In the next theme, timing of and process of making the decision to breastfeed is explored along with how women make sense of making a different infant feeding decision from that of their family of origin.

### **9.3 Making Sense of a Different Decision**

In the interviews, participants described the experience and process of making a different decision from that which is most common in their family. They recounted that formula appeared to be the default feeding position in their family, with no or little

discussion of infant feeding as the presumption was that babies were formula fed. Participants often struggled to tell a coherent story about how they made their decision and the sense they made of it; and the timing and process by which this was decided is complex. It appears however, that with a couple of notable exceptions, participants had not considered breastfeeding as an option for themselves, until shortly before they had to make their own infant feeding decision. The process by which they decided to make a different feeding decision varied considerably and there were interacting influencers, but two main ones appeared to be related to the input of midwives and the participants' vicarious experience, where they saw other women breastfeeding, often for the first time. Given that all the participants had made a different infant feeding decision from their own mother's, making sense of their own feeding history seemed to be important and the way they did this appeared to help to protect their relationship with their families, particularly the breastfeeding woman's own mother.

Participants recounted that formula appeared to be the default feeding position in their family, with no or little discussion of infant feeding as the presumption was that babies were formula fed. Because of the lack of conversation about infant feeding, family culture is therefore largely inferred by participants. Formula feeding therefore appears to be the unspoken family norm. Participants suggest that the decision to breastfeed, rather than formula feed, challenged their family's norms, as recounted by Debbie:

*She would've maybe just assumed that the baby's going to get a bottle. It was like when I fed Peter 'Oh you're breastfeeding?' so maybe there was an assumption in there with my mum that that's... I don't know if it changed their way of thinking cause, I mean, we were bottle fed so I don't know if it was a wee kinda switch of her opinion of just 'oh you can do it differently' don't know?*

Debbie suggests that by doing things different she may have challenged the family norm, but it is apparent from her extract that this was not discussed between mother and

daughter. A lack of discussion of infant feeding and breastfeeding in particular, was widespread across participants.

For the majority of participants the decision to breastfeed was made only once they were pregnant. The exceptions were: Aileen who decided when undertaking health professional training not long before her pregnancy and whose reasons were largely influenced by the 'Breast is best' and 'The Natural Imperative' themes; and Kay, Mhairi and Rhona, who felt that they always knew they would breastfeed and had decided to breastfeed at some undefined point, long before they became a mother. The process by which participants decided to breastfeed when they were pregnant will be explored shortly, but as the exceptions to the rule, the more unusual counter cases of women who decided long before they were pregnant, will be accounted for first.

For the participants who felt that they had 'always known' they would breastfeed, it was difficult to get a cohesive account of how they made sense of their own decision making process. For Kay, she said 'I always thought, 'Oh yeah, I'll breastfeed' and this was supported by the 'Breast is Best' theme but she was unsure about where she had heard this message or when, she felt she had just 'picked it up'. The only key moment she can identify is the change from, 'I will breastfeed' to 'I must breastfeed' because of her feelings of guilt about taking prescribed medicines during her pregnancy, which she feared might have harmed him. Making the decision to breastfeeding, with its consequent health benefits was perceived as rectifying some of that perceived damage.

Rhona was also unclear about her own decision making processes, being sure that she intended to breastfeed before her pregnancy and acknowledging, that she may, like

Aileen have been influenced by professional training, however, she was confused about her own reasoning, describing it repeatedly, as 'Bizarre'.

*It actually does confuse me though cause I don't understand where it did... where the original thought came from cause it wasn't until I had spoke to some of the girls at the Breastfeeding Network I had started to wonder why was it that I chose to do this? I had no real explanation as to why I had done it (...)I don't know how that happened, I couldn't even attempt to give you an answer for that. Just that, that's what I was going to do. Bizarre. The more I think about it the more I'm confused by it! I've no idea, the natural probably process to it would've been that I would've bottled fed, you know, from what I knew, but it wasn't to be. I can't honestly remember thinking about it other than having a steriliser just in case, but that was to help... that wasn't to put formula in, that was to help along with breastfeeding. Bizarre, I'm odd [laugh]!*

Mhairi was both confused, and at time had been distressed, by her own feelings about infant feeding. From very early on in her childhood, she appeared to feel that breastfeeding was the way to feed babies and her struggle as a child to understand her own desired actions, were perturbing for her. She says:

*'I felt as if it was one of thay [those] things, like see when I was a wee girl and see when I played with my dollies, I didn't play with bottles, I always just lifted my baby up to my breast, but I used to think I was weird, because, I'd had never seen anybody doing that, like I never seen anybody being breastfed, neither I had so I used to think you are weird, why are you doing that yersel [yourself], it felt wrong, but also felt as if that it was just natural, but then when I was pregnant with my eldest, I never thought about bottles, I never even bought bottles or sterilisers, because that was what I wanted to do, it was always in my mind that that was what was going to happen and that that was what I was going to do.'*

Further exploration in the interview did not clarify this any further for her.

*Int: Can you tell me a bit more about that because it sounds a bit unusual, what do your think was going on for you?*

*Res: I don't know, I mean I must have seen it on the TV at some point, or that, but I was not, even as I got older, I like, I know wee girls stop playing with dolls at an early age, I was always maternal and I always remember playing with my dolls and bathing them and the urge to, ken, (laughs) put them on my breast. No like, my sister would sit with her wee bottle and feed her dolls, but I never, but I would not dae it in front of anybody, it was weird, but I felt dirty for doing it. But noo that I have my babies, I think that must have been maternal for me to be doing that, but it's weird.*

*Int: What do you think the dirty bit was about?*

*Int: Because I had never ever seen anybody doing that and I did'nay know what I was doing. But I mean I have obviously seen it somewhere that it has been in my mind. Eh, but that, I mean, I mean, I used to do that and then burp the baby, ken, even although had never seen, well I must have seen it on the TV at some point, and I thought to myself at an early age, well that's what I am going to do.*

*Res: So it sounds like from very small, that is how you thought you would feed your babies?*

*Res: Aye, but I never knew that up until, I just used to think that I was weird, up until I was pregnant and then I thought, now that is just what I am going to do.*

For Mhairi, it was not until she was pregnant that things began to make sense for her.

While for Mhairi, pregnancy was when her decision suddenly made sense and crystallised, for all the other participants, it was pregnancy that was the exclusive time for decision making, having not considered infant feeding before this point.

All other participants reported that they decided to breastfeed, at least provisionally, during pregnancy with an occasional confirmation of a tentative decision at the moment of birth. The dominant influencers of participant's infant feeding decision are articulated in the themes 'Breast is Best' and 'The Natural Imperative' which were highly influential for all participants. There were, however, some additional informers, which were important to the sense participant's made of their decision making. These appear to have been midwives influence and vicarious experience, particularly from within their own extended family. Elspeth had not considered breastfeeding as an option for herself, presuming she would formula feed. It was not until she was asked directly by a midwife at her antenatal appointment that she considered breastfeeding, and even then, it was not so much a decision, but a potential consideration, to be decided later. Elspeth goes on to describe the decision making journey she made, which

culminates in some influential vicarious experience which opens up breastfeeding as a real possibility for her.

*When I was first asked about how I wanted to feed the child by the midwife, and I'm thinking 'mmm, breastfeed?' kind of thinking like that, but as the months got on, as I was getting near the end I was starting to think 'well, maybe I could...?' and then I started to kind of say, you know, 'I'm thinking about breastfeeding' and actually my cousin – my mum's sister's daughter – she had a little girl three months before I had Jordan, and she breastfed her child. So at that point I was like six months pregnant when she was born and I'm thinking 'Lillyanne's breastfed' and I'm thinking 'I wonder if I maybe could?' (...) I think that if you're in an environment where nobody else has done and that just doesn't just relate to breastfeeding, anything where nobody else has done something, then just the fact that you hear somebody within your family has experienced that it makes you think 'well, if they can do it...' because you know somebody personally. It's a bit different on somebody down the road but if it's somebody kind of within your family that has done somebody, I think then you're more likely to think 'well, you know, I could maybe do that, you know, if they could do it?'*

From Elspeth's account, it can be seen that vicarious experience is important to her, but the fact that it was a family member, someone whom she identified as being somewhat like her, was more significant. This led to Elspeth to say to others that she was 'thinking about it' but because she had said to the midwives that she would breastfeed, her birth plan recorded that as her intention, even though she was not yet sure.

*When he was first born she said 'you can feed him in a little while' and I went 'aye okay' and it kind of went out my head because it was a new baby, I'm a first time mum, you know, and when she said I was kind of like 'aye okay', she goes 'do you want on here that you want to breastfeed?' obviously the birth plan, I'm going 'aye okay'.*

This interlocking of different influencers, with it feeling difficult to determine which was more important or whether the decision would have been different if either were not present, is common across participants and the apparent repeated influence of midwives and vicarious experience are found across participants, and are further exemplified in Mandy's account. When asked about when she had first begun to consider how she might feed a baby, she explained:

*I had honestly never thought about it until we started thinking about trying for the wee one... and had never really thought properly about it until actually we found out we were pregnant and then I was like 'right, what are we going to do?' and obviously the midwife's saying to you when you go and they tell you all about it and give you the leaflets and what not, and you think about it and you read about it, then read a wee bit more and then, as I say, seeing Katie (a friend) having fed her two as well, made me think 'well aye, I could maybe manage this'. And then obviously my other friends have all had kids before me and then starting off feeding as well. I thought 'well we'll give it a go, we'll do it, that's the way that we want to do it.*

Having made the decision to breastfeed their baby, participants recounted how they now made sense of their own feeding history, which for most was very fragmented due to lack of discussion of this with their families. This lack of discussion translated into participants having little knowledge of their own feeding history and while a number of participants knew they had not been breastfed, they had not discussed the reasons for this with their parents. In the absence of an explanation as to how their mothers decided on their infant feeding decision, participants constructed an explanation for themselves, trying to make sense of their different decisions. These reasons varied, and some are explained in the extracts below, but a common theme appears to be that they are quite sympathetic/empathetic constructions which allow them to continue to see their own mothers in a positive light. Given that many of the participants were critical of women from their communities, including friends, who did not breastfeed; this suggests that they were constructing these understanding reasons to help protect their positive view of their own mothers and their commitment to themselves as children. Niambh, in her extract, makes it clear in her extract that she does not know the reasons why she was formula fed, or much about the immediate peer or cultural her mum was in, but she finds personal and cultural reasons which might explain her mother's decision.

*Maybe she thinks... 'maybe I could've....' you know, she was very young... she was married when she was 19, she had me when she was 21, she's from a small village... I*

*don't know if many of her circle of friends or even in the eighties if it was the done thing to breastfeed.*

Although the reasons for the participants mothers' infant feeding decision were often undiscussed. Participants used the knowledge of the circumstances of their own babyhood, for example their or their siblings births, as the basis to construct an explanation, in an absence of a comprehensive story. Heather recounts:

*RES: And my mum... what happened with my mum... my oldest big brother he was quite unwell when he was born and I think she would've loved to breastfeed but it just... and my mum was so ill when she had my big brother, so I think she missed out on that and maybe didn't get that closeness that I thought oh it just seemed so natural, and she always said, you know, because my mum... I think she had to get taken straight in for an operation, I think she haemorrhaged, so it meant that she couldn't be there at that instant, and I thought I just grabbed it with both hands and thought that would be really lovely. We're all close as a family, and I think she felt a wee bit missed out, because she'd such hard pregnancies, the four of them she was quite ill after it and it was like 'I couldn't care less' kinda idea...*

*INT: Yeah, once she's managed to get through it.*

*RES: And I think it was just that somebody else would be there and she'd be in hospital a wee while and I think she felt 'oh d'you know, I would loved to have tried that' but she couldn't. And it was always in the back of my mind thinking 'oh I wonder if I'll be able to do it?' because my mum couldn't do it.*

In Heather's account, she prefaces most of her statements with the phrase 'I think' suggesting that she is not certain about the accuracy of the story she is recounting. This can particularly be seen when she describes her mother's feelings and intentions with phrases like 'I think she would have loved to' seem to tell us about Heather's feelings, which she attributes to her mother. Woven through her description of her mother's feelings are some of her own thoughts and feelings about breastfeeding, suggesting that this is not Heather recounting something she knows from her mother and is rather an imagining about how it might have been for her mother, with the assumption that her mother shared her positive feelings about breastfeeding.

For Elspeth, whom we met earlier in this theme, breastfeeding was such an unspoken issue that, in common with several other participants, she was not sure how she was fed herself until after she had made her own infant feeding decision. It was only when she considered taking part in their research that she asked her mother about her own feeding history.

*I got asked at the mother and toddlers and they said 'did your mum breastfeed?' and I went 'oh I don't know?' and I asked her and she went 'no because your brother was premature', that was the answer she gave.*

Elspeth's final phrase suggests a lack of satisfaction with the response she received, struggling to make sense of it given that it did not actually refer to her. Later in the interview Elspeth works to understand and make sense of her mother's decision by describing her understanding of what happened for her mother and brother, but also shows some more of her feelings about the explanation she has received. Elspeth recounts:

*Yeah, but see I think my mum as well, my brother was five weeks early and at that point... at that time, 40 years ago, your child was kind of taken away, you know, the child wasn't with you, you know ( ), but I don't know whether in my mum's mind it kind of gets her off the hook for her not doing it – I don't mean that in a... off the hook like, as if she done something wrong, but in her mind it justifies, 'well no because your bother was premature and he was first' so she just never breastfed me.*

While expressing empathy for her mother's situation in some parts of her extract, Elspeth also through her use of phrase 'off the hook', despite her self-correction, suggests that she is expressing judgement of her mother's decision. This is compounded by the idea that her mother might need to 'justify' the decision she made not to breastfeed her. Given the strong feelings Elspeth has about her mother's decision, despite her best efforts to be understanding, it is possible that not discussing infant feeding decisions within their family serves to avoid conflict and protect relationships.

The dilemma of how to maintain a positive relationship when faced with a difference of view about infant feeding is explored in Aileen's extracts. Aileen has a close relationship with her mother, describing her as her 'mentor' with feelings about infant feeding being reported as the only one area that they have different views on. Aileen tries to make sense of her own infant feeding history, from a basis of little or no knowledge. To try to understand her mother's perspective, she uses what she knows of her own mother's personal history to try to understand what might have been informing her mother's decision:

*I think maybe, I, she didn't have a mother, she grew up with her grandparents, yeah, she didn't have an easy upbringing at all, she didn't have an easy life – you know, sent from Australia on a boat that took weeks, you know, when she was six months with her other brothers and sisters, yeah, it wasn't easy for her, she felt a lot of abandonment, she never ever contacted her father again although he had been trying to contact them, she never really knew about her mother until recently, what actually happened. Yeah, so I think maybe just a hard life, it was something that she never felt that she could do for her children and, you know.*

She continues to try to make sense of this, being clear that this is all her own inference, drawing on a number of potential cultural explanations, suggesting that the culture 'forced' formula feeding, removing any culpability from her mother for having made the decision she did.

*Who knows, whether it was just that sort of era, I don't know whether they were quite sort of forced almost to bottle feed or... I don't know, I'm really not sure. It could be the whole that because she was quite a strong Christian she thought that her breasts, it was almost like a sinful thing, I really don't know, I'm only guessing here.*

While infant feeding may not have initially been discussed in families because it was the default position and therefore was accepted and unchallenged, the continued lack of discussion feels like there are other processes underpinning it. Many of the participants had acquired during pregnancy and more particularly once they were breastfeeding, strong moral discourses about infant feeding, as explored in the 'The Natural

Imperative' and 'Breast is Best' themes which follow, and these beliefs may have implications for women, including their own mothers, who made a different decision. It could be argued that in order to maintain their positive relationships with their mother, in the absence of being able to discuss the reasons for their mothers decision, they had to find a story which helped them resolve the dissonance that while 'the best mothers breastfeed', their own mother did not breastfeed them. This may have been important to them both to help keep positive, non-conflictual relationships with their mothers, but also because the absence of a positive explanation could be seen to reflect badly on their mother who could be seen as not doing 'the best' for them.

#### **9.4 The Natural Imperative**

Within the interviews the idea that breastfeeding was the natural way to feed a baby was highly significant. The idea that breasts are there for the purpose of feeding babies and that milk is produced automatically, without any will of the mother was important, with breastfeeding being perceived as an extension of pregnancy. Because nature has providing this specially designed food for a baby, it was seen as the optimal way to feed a baby, with formula being a lesser product. The power of this discourse meant that as nature has provided it, it therefore should be used, and becomes a moral imperative. This extended for some to the idea that it would be wasteful not to make use of the milk which was being produced.

For Elspeth, the fact that your body produces milk, and there is no conscious decision required, indicates to her that this is a natural process, like pregnancy, and it is therefore the body's intention.

*This is what your body's set to do, just like your body's set to carry the child, you know, when you have your child it's amazing how the body works, but when you have this*

*child and your body knows you've had the child and all of a sudden milk gets produced, I mean, you just think... 'I mean, I never switched a button, how does it even know?' And that's why I think it is the most natural thing.*

Louise develops this theme stating her belief that as a species we evolved both to breastfeed and to parent in a particular way. She contrasts this with formula, which is man-made and therefore not natural and is, as such, an inferior product and choice.

*I think just because... it's what nature intends you to do for one thing, you know, we've evolved to breastfeed our babies, it's nature's way of keeping your baby close by you, you know, they need to feed frequently and it's the natural thing to do. (...) It was part of the reason I wanted to breastfeed in the first place, you know, I just can't imagine why you'd want to give your child a manufactured product rather than mother's milk which is tailored to your baby's needs, you know. I know formula milk probably comes fairly close but it's not the same, they don't get the antibodies and things like that, so yeah it's... it seemed liked you're giving your baby the purest thing, you've nourished them inside your body for nine months so it just seemed like the natural progression to nourish them through your body once they're here; so it just felt like the right thing to do.*

For Gemma, the artificial versus naturally made argument holds significance, stating:

*It's almost like the man-made formula versus what is naturally pumping through your body in order to feed your offspring, you know, it's there, it's there on tap.*

She develops this idea in the following extract where she argues for the natural advantages of breastfeeding, contrasting formula with man-made, stigmatised foods, from commercial fast-food outlets.

*I just see it as something that's there in your body and, you know, all the research seems to be telling me that, you know, your body filters out the negative thing, you know, you're getting the most nutritious and the right vitamins, you know, and your body's breaking it all down naturally to get rid of the bad stuff and your baby gets... it's like your placenta, it gives it the best of what you eat and even if you eat crap it'll take whatever's good out of your McDonald's and give you that and get rid of the crap. And I just feel like it's such a natural process and, you know, the research that I seem to have read on it is telling me that, that it's healthy and I just see that it must be healthier and I think that's why it means so much to me as well, cause it's there already in my body to be used and experts are telling me it's healthier than formula, my brain's telling me financially it makes more sense, relationship wise it makes more sense (...) I*

*just feel like all the signs seem to be pointing that this is the natural, the best thing for you to possibly do.'*

The contrast between 'natural' being good and formula being 'unnatural' appears to be associated with judgement of others choices. As Debbie says:

*You've got the equipment and the resources to do it, so just do it, it's, no... I don't see anything, it's just the most natural thing in the world. And I would probably say I think it's a wee bit more unnatural to see a bottle getting... I do, I just... it's like plastic... I'm really sounding as if I'm down on people that don't, but I'm not...to me that's... I would say it's more natural to see a woman with a baby close to her and breastfeeding than a bottle. So I just think it's the most natural thing in the world. Your body's working all this time to have a baby and that's what it's there for.*

It is a very slight move to the idea that was commonly expressed, that as breastmilk exists for the purpose for feeding a baby, it therefore *should* be used, as articulated by Niambh:

*I just thought 'well nature has given me milk, that's the best thing, right I'll breastfeed and the fact that my body has done that must mean that I should do it'.*

While she is stating that she thinks she should do it because her milk is produced naturally, others move slightly further, with breastfeeding becoming an imperative not just for oneself but for others, as Fiona says:

*RES: I think it just seems the natural thing to do, you should therefore do that which, again, not everyone wants to or can, but aye.*

*INT: Can you say a bit about what you mean by it's the natural thing to do?*

*RES: It's just... it's just what should happen, that's why you produce milk. It's... I don't know why I feel guilty about this cause you do, obviously not everyone chooses to, but yeah I just feel it's... actually quite strongly feel it's the best thing for a baby and I do think the milk's there for a reason, you may as well use it and... aye, yeah, sorry I'm a bit kinda vague [laugh].*

Fiona starts by talking in the third person, saying 'you' should do it and initially appears to be referring to herself; however, as she continues it becomes clear that she is also referring to others. While Fiona feels somewhat uncomfortable with the idea of suggesting that breastfeeding should be done, and that others who do not breastfeed are

not doing what they should be doing, she persists with her view. It becomes evident that although women talk about what they did, there are implications for what they think other women should do.

Debbie develops this in her extract where she articulates her feelings to her friend, about how breast milk should be used, expressing her moral feelings about a product which was produced for a baby not used for its intended purpose, therefore being ‘a waste’.

*Your body makes a baby, it makes milk for a baby, that's what it's there for. I mean, my friend's just recently had a baby and didn't do it [breastfeed] and then she's like that 'I'm still leaking' and the baby was nine weeks old, and I kept saying to her 'what a waste, what a total waste that you just didn't do that' you know.*

The moral context around the natural imperative extends into the clearly articulated idea that breastfeeding is the ‘right’ choice with contrary position that formula feeding is therefore the ‘wrong’ choice. As Julie says:

*It's [breastfeeding] the most natural thing to do and you should try, you should try to achieve that, but as I say, you don't want to pressure people as well so... cause people get defensive and think they're doing something wrong then they will get defensive.*

Julie highlights a key issue, as the implication of breastfeeding being natural and therefore should be done, being the right way to feed a baby has the opposite implications that formula feeding women are not doing what they should and are making the un-natural, wrong decision. Julie is aware, that the moral imperative to breastfeed does impact negatively on those who formula feed. Niambh goes further in her interview and clearly expresses her beliefs about the moral context of breastfeeding.

*If you choose to bottle feed without trying breastfeeding I think you're not embracing fully what it is to be a mum. And I've never really thought about it [laugh] and I don't know, I'm maybe being... I hope that didn't sound prejudiced or anything, but that's just my feelings.*

Her laugh and disclaimer about not wanting to sound prejudiced shows her discomfort at expressing her views, which she appears to be articulating for the first time. Niambh goes on to offer a glimpse of some of the processes that might be used to be able to better manage the feelings of moral failure a mother might experience if one does not breastfeed when you hold or are affected by the natural imperative. She says:

*I remember the very first feed in the hospital and they were really struggling to get the milk to... and I thought 'oh maybe I can't, maybe my body's just going to decide that I can't do it' and that would've been fine. Or maybe Lizzie's just not going to get the hang of it and Lizzie has decided that she can't breastfeed from me, so that would be fine. But the fact that yes the milk came and yes Lizzie was showing the signs, well then that was me, I was committed then, it had to be done then.*

Niambh suggests that if nature decides whether you can or can't breastfeed rather than it being a persona choice. By saying 'Oh, maybe I can't' she removed volition meaning that for Niambh, if nature decides for you that you can't breastfeed, you can be absolved of the imperative and cannot be held responsible for failing to meet her own moral standard if she does not breastfeed. This puts her in a bind where she is dictated to by her body as opposed to expressing a choice, which may have other psychological consequences.

Thus there are moral aspects of breastfeeding implied within the 'natural imperative' with breastmilk being seen as optimal which 'should' be used with formula a lesser product. The moral and judgement aspects of breastfeeding are further explored in the 'Breast is Best' theme which is the other major influence on participants' decision making.

## **9.5 Breast is Best**

Within the interviews, the theme 'Breast is Best' was widely used and was influenced by participants' decision to initiate and continue breastfeeding. The dominant reason to

explain why breast is best was related to the health advantages associated with breastfeeding and scientific evidence was often used to explain the use of the phrase. As breastfeeding being seen as doing the best thing for your baby, there was the covert and sometimes overt implication that not breastfeeding was a lesser action. Associated with this were narratives about the inferiority of formula feeding and associated with this is the judgement of women who do not breastfeed. Although those who were seen not to be able to breastfeed were judged less harshly than those who 'choose' not to, there remained the idea that they had 'copped out' or had not persevered to the required extent.

Mhairi, in this extract, illustrates a number of aspects to this when she says:

*It's no' a big thing to some people and I try no' to let it bother me, but you want to give your kids the best start in life, so you do and that was, tae me, being pregnant and then feeding your baby yourself, that what should be done. It is hard to put into words how I feel about it, so it is, em, but I just, I don't have very strong views on it, but I do still don't understand why people can give birth then not try and feed their baby in the natural way, yet they say they are doing the best for their baby and stuff.*

Mhairi clearly has adopted the 'breast is best' message and believes that breastfeeding is the best way to feed a baby, giving them 'the best start in life'. In her opening line, she shows that she appreciates that this is not necessarily a commonly held view, but it is one she feels strongly and concerns her. The reference to 'I try and no let it bother me' appears to be referring to her feelings of distress because she did not breastfeed her first two children, despite desperately wanting to. The moral discourse in her extract is shown with the use of the word 'should' when talking about how not only her baby should be fed, but by her repeated use of the word 'your' she suggests this is generalised and applies to all babies. Although she says she does not have 'very strong views' on the subject this appears to be a 'softening' phrase before she goes on to

express a view which she finds uncomfortable, i.e. that she cannot understand women not 'doing their best' for their baby by not breastfeeding. A number of the aspects expressed in this extract will now be explored in more detail.

The dominant reason for participants believing that breastfeeding is the best thing to do for their baby is because they believe that it brings health benefits for their babies, and to a lesser extent, to themselves. The idea that breastfeeding increases a baby's immunity and increases their antibodies was frequently mentioned in participant's accounts, although there is often not a clear understanding of what these benefits might be. Kay suggests this was a major reason for her breastfeeding, but her use of the term 'all sorts of things' suggests the limits of her knowledge:

*'Yeah, uh huh, it's the best thing for him, it's.. you know, full of immunity and all sorts of things like that, so I always thought 'yeah I'll breastfeed'.*

Mandy in this extract reiterates and expands on some of these beliefs:

*RES We want to do it just to give her the best start possible, cause that's what it's all about, it's all about her [laugh].*

*INT: And what made you think that breastfeeding would be the best start possible?*

*RES: Just for her to get the immunity and things from myself that she gets... and hope that it gives her less chances of having the colds and ear infections and everything that they tend to pick up and how it's actually a good benefit for me as well for things for later in life, like, your reduced chances of cancer and what not, and hopefully that helps with that as well.*

Mandy's subscription to the belief that breastfeeding will enhance her baby's immunity does not however, necessarily lead to a direct impact on her baby's health, rather she hopes it might. She is slightly vague about the exact health benefits that might be for her, suggesting that there is a link with a reduction in cancer rates, but she does not mention which type although she seems to know that there are other benefits which she cannot recall, by the use of the phrase 'what not'.

There is a conviction across participants that health benefits are the most significant reason to feed, however, the degree of certainty about the outcome of the biological advantage breastfeeding might give, varies. While Mandy has an idea that there ‘might’ be a health benefit for her baby, others are more certain about the individual benefits breastfeeding might bring to their baby directly. This is as illustrated by Elspeth who is much more concrete in her belief that breastfeeding will guarantee health and wellbeing outcomes for her children and provides her with a feeling of certainty in the uncertain world of parenting:

*It's definitely made me think, you know, no matter what else happens, if my kids grow up and they fall out with me, you know, whatever happens in life, I know that I breastfed them for six months and I now that, you know, they might not want to talk to me when they get older but at least they'll be healthy! At least they'll live long happy lives because they're healthy.*

The source of the information that informs women’s beliefs about the health benefits of breastfeeding are diverse, with midwives and reading research on the internet being frequently cited as informers. The multiple sources of this message are demonstrated by Gemma when she describes her exposure to the message:

*All the research is saying it's healthier for your children, you're waiting in your doctor's surgery and you see 'breast is best' and everything's there. (...) The research that I seem to have read on it is telling me that, that it's healthy and I just see that it must be healthier.*

Exposure to research studies is widely listed, usually sourced on the internet, but sometimes through the participants’ professional training, for example on nursery nurse courses. While many of the participants do not retain much content of this training, rather just the key message that breastfeeding is healthier, Aileen retains some of the details, for example the place of the study, and integrate this with their own personal hypotheses, as she recounts:

*I know there's an ongoing study in Dundee I think it is, yeah, the big one () there was one thing, the sort of negatives of formula reading that really, really drove it home to me, the fact that by bottle feeding – I don't know whether you agree with this or not but I'm going to say it anyway...with bottle feeding you can actually knock off some of the insulin receptor cells in babies, so your baby may be more likely to get diabetes. The fact that bottle fed babies tend to just feed, feed, feed, guzzle, guzzle, guzzle, don't know when to stop, can lead to an increase in childhood obesity, and obesity later on in life. The benefits to me about bone cancer, you know, osteoporosis and things...yeah, so I would say those things really drove it home to me, the negatives of bottle feeding.*

What is apparent in Aileen's account, is not just that she believes that breastfeeding is healthier, but that formula feeding is directly associated with negative health outcomes such as obesity. Amongst participants, the use of infant formula, or bottle feeding, as it is usually referred to, is seen as a lesser product. Kay clearly states this when she says that 'There's all sort of rubbish in formula' and goes on to use a metaphor for the contrast between formula and breastmilk:

*I suppose if you're going to have a baby you've got to give it the best, you've got to give it the best start. What's the point of giving them chips and cheese for lunch when you can have something a wee bit more substantial and healthy?*

Later in her interview, she describes breastfeeding as 'mince and tatties' and sees this traditional Scottish meal as representative of breastfeeding, while chips and cheese, with their unhealthy connotations fits for formula feeding. Her use of the pronoun 'you' implies that her suggestion refers to all babies and not just her own, with the phrase 'got to' again implying the moral imperative that babies should be breastfed and not formula fed because of the products qualities and health implications.

In participants' extracts, it is not, however, just that formula is a lesser product, it is also seen as a poorer decision to make and with that, there is a direct judgement of women who are not breastfeeding and are using formula to feed their babies. Rhona, in her extract initially talks of her own decision to use the 'best milk' and shows the

connection between the 'Breast is Best' theme and the 'Natural Imperative' theme. Her concern not to use anything 'processed' fits with her enthusiasm for breastmilk as a natural product, and her struggle to understand what anyone would not agree with her position. She goes on to make the connection for her between doing what is best for her baby, and being the best kind of mum:

*I think that was the box that really had to be ticked because I was going to give her everything that she needed, and that was very much in my mind that this was the best milk for her and I didn't want to give her anything processed – we eat very well at home and I couldn't understand why anybody would want to give their baby something that was in a box, that could sit there for months and that kind of always got to me. So it was I had to be this number one mum and do this, what was best for my baby.*

Therefore, for participants, it is not just that breast is best, but also that breastfeeding mothers are the best. As Niambh says: 'I wanted to be the best mum and I was told that the best mums breastfed so that's why I done it'. Niambh had experienced significant breastfeeding challenges but persisted, feeling she 'had to keep going'. This is explored in her extract:

*INT*      *What was that about do you think, prompts you to say that you had to keep going?*

*RES:*    *Because if I... I would've been actively not being the best mum. Because to me breastfeeding is doing the best, and if I had then said 'no I'm not doing it' I would've been letting everyone know I was choosing not to be the best.*

*INT:*    *You knew it was the best?*

*RES:*    *Uh huh. If I had just bottle fed and never tried to breastfeed then to me and to everyone else well I was never trying to be the best anyway, I was just going to bring up my child and give them the food that they needed, but the fact that to me breastfeeding is the best way, I couldn't be seen not to be trying to do it, I think is the crux of the whole thing [laugh]!*

*INT:*    *And what made you think that breast is best? What was the forming of that?*

*RES:*    *Midwives and the breastfeeding network. You know, everything I was reading, everything I was hearing was telling me that breast milk without a... you know, there*

*was no ifs or buts, there's no well maybe, they were telling me it was the best and I was understanding that it was the best and so that's what had to be. It had to be done*

Her strong belief in breastmilk being the best, with this information being suggested to becoming from a variety of sources, meant that she formed a clear idea that the best mums breastfeed, and that she therefore had to continue with this, or face her own judgement. Her laugh when she realises that this is what she is saying, leads to an uncomfortable realisation and an awkward laugh, but she goes on to confirm that this is what she believes.

The idea that the best mothers breastfeed and the obverse, that mothers who do not breastfeed and instead formula feed are somehow lesser, is present in almost all of the participants transcripts, however the overtness of this and the extent to which participants feel comfortable expressing this view varies. Debbie, for example, makes her position clear, but she feels uncomfortable saying this, with a number of starts and stops and a reflection on how 'terrible' what she is saying sounds, even to her own ears.

*When I see, like, my friend as I say and she has a bottle for her wee boy, maybe there is a wee bit in me that thinks 'oh I didn't do that and I gave my baby what...' that's terrible '...what they're meant to get' but that's the way I felt, that's what they're meant to get. But it didn't... I wouldn't... I couldn't say 'oh no it made me think I was a...' I think I've done better by them in terms of feeding, but I don't think of myself 'oh I'm a better mum' or anything because I done that for them. But I think I've gave them the best possible start that I could give them rather than a bottle.*

Her discomfort is clear as she goes on, but it does not change her belief:

*It kind of cements the fact that you are kind of properly a mother now, which I don't mean that people that don't do it aren't, obviously that's horrible, but sort of... aye...*

Participants widely express judgemental views of women who do not breastfeed and use similar reflections such as Niambh's: 'I hope that didn't sound prejudiced or anything, but that's just my feelings'. Others are more sophisticated in their expressions, with Louise fronting her sentence with a statement which suggests she is

respectful and not judgemental of others, continues and expresses a covert judgement of women who do not 'at least' try breastfeeding.

*While I always respect anybody's opinion to not do it and to bottle feed instead, I think it's a shame in a way if you don't at least try it.*

There appears to be a spectrum of 'acceptableness' of not breastfeeding, with those who do not try receiving the harshest judgement and women who have tried to breastfeed but not managed to continue escaping somewhat. While there appears to be a degree of sympathy for women who try to breastfeed but who do not continue, usually after facing breastfeeding difficulties, this is however, conditional, as some are seen as not trying hard enough. This appears to be particularly the case when the breastfeeding women has herself experienced significant breastfeeding difficulties and had managed to 'persist' and continue to breastfeed despite them. Gemma recounts:

*Cause a lot of friends that I've had that say they've tried breastfeeding and then they say 'oh it didn't work for me' or 'they wouldn't latch on' and I thought I had to struggle so much with him and Megan, for the first few weeks it was absolutely torture and sometimes I felt it was more painful – a totally different type of pain – but to me more painful than labour at times, I mean, the feeling of them on your nipple when they're not on right is an incredible amount of pain, and to persevere through that, I mean, women had to persevere through that for a long time, you know.*

Louise, who in her previous extract was covertly critical of women who do not try to breastfeed, is less covert in her judgement of women who do not persist with breastfeeding through difficulties. She reflects on the stories of other women who report that they have not been able to breastfeed, and as such may escape some judgement as this was not by their own volition, seeing that position now as 'false' because she believes that they have not persisted, as she did, and continued through pain, in order to keep breastfeeding.

*I think I had probably quite a false impression really that for a lot of people it doesn't work, but I think it's just that they probably give up too soon while it's sore, cause it would be easy just to say 'oh stuff this, it's nipping like hell here, give us a bottle'.*

It therefore appears that the 'Breast is Best' message, while being important in influencing women to breastfeed, has a number of consequences for participants' perceptions of other women's decisions, some of which are pejorative. The narratives about the inferiority of formula feeding appeared associated with this, as is the negative judgement of women who were seen to make a lesser choice, by not breastfeeding. This social comparison is explored further in the theme 'Raising Status' within the 'A Sacrifice but Worth It' superordinate theme in Chapter 11.

## Chapter 10 - **Unprepared for the Challenge**

### **10.1 Introduction**

In this superordinate theme, participants described feeling entirely unprepared for the challenges of breastfeeding. Most had positive expectations for breastfeeding, predominantly derived from antenatal classes and contact with health professionals, and had expected it to be largely problem free. This was in contrast with their experience where many of them faced a number of initial and ongoing breastfeeding difficulties. Combined with the previously articulated idea that breastfeeding is natural, and therefore instinctive, women consequently often attributed their struggles with breastfeeding to be their own personal inadequacies rather than the intrinsic challenges of breastfeeding in the current culture. Even when initial physical difficulties were overcome, most participants continued to feel very challenged by their experience of breastfeeding. The unshared nature of breastfeeding meant that their exclusive responsibility for feeding and comforting their baby lead to them reporting feeling overwhelmed by the demands of their baby and their own feelings of responsibility. Women attributed their breastfeeding success to internal factors such as determination and perseverance, and developed a number of mechanisms, including sourcing support, to help them cope with these multiple challenges.

This superordinate theme therefore comprises of three themes: They Keep the Truth from You, The Horrors and Getting Through it.

### **10.2 They Keep the Truth from You**

Within the interviews, there was a widely articulated view that health professionals, and to a lesser extent other women who have breastfed, keep the truth about breastfeeding

from women when they are making their infant feeding decision. This results in a mismatch with women's expectations and the realities of breastfeeding. Difficulties with breastfeeding were therefore perceived as 'doing it wrong', because breastfeeding was reported to be natural, easy and pain-free, if doing it 'right'. As such, difficulties experienced when breastfeeding were seen as signs of personal failure as opposed to breastfeeding being difficult in the current culture. Aileen, who was a health professional, exemplified this theme saying;

*I think midwives and other practitioners who say it's not painful, I don't think they're telling people the truth because I think it is on many levels, so it is painful, you will have to push past a lot, you will have a lot to deal with.*

The lack of information shared with women about the variety of different feeding experiences, particularly the challenging ones had significant consequences for women's experience of breastfeeding. Consequently, participants reported that their expectations for breastfeeding were unrealistic resulting in them feeling unprepared for the experience they had. Niambh expressed that; 'It would never have crossed my mind that it could've been anything other than straightforward.' This led to her being rather confused about the antenatal preparation she received. She states;

*Me and my friend went to the breastfeeding workshops and I couldn't understand why they were giving us the video and they were giving us the doll and telling us how to hold it 'right how many of you are going to do it?' 'how many of you really think this is for you?' and I'd be like 'yeah, uh huh' and I remember saying 'why d'you keep on asking and telling us how to do it and showing us the video, am I not going to be able to do it?' and they just said 'some people can/some people can't' and I wasn't really prepared for how difficult it would be. And I don't really think they tell you. If somebody was to say to me 'breastfeeding's going to be the most difficult thing, possibly the most difficult thing, and you're really going to have to struggle, you know, you'll have given birth to the baby and that won't be it over, breastfeeding will make it difficult for quite a while' I would go 'okay, right well now that I know I'll brace myself for that'. But I felt that people just went 'oh so you're going to breastfeed, okay, well you just hold the baby like this and you'll see that... there's a little diagram here and that's how they'll feed and then that'll be you' and I'm like 'oh right okay, dead easy'. I feel like if people had only*

*been honest, maybe if I had had family that could've been the honest person for me rather than just health professionals who were trying to make me do it anyway.*

This confusion about why there was breastfeeding instruction was associated with her expectation that breastfeeding was a straightforward, natural process. Her expectation for trouble-free feeding meant that she could not make sense of the fact that she was being 'taught' how to do it correctly. She clearly expresses that she believes an unrealistic picture is presented by midwives, which means that the antenatal teaching did not make sense and as such was ineffective in preparing her. Combined with her lack of family experience of breastfeeding, she feels entirely unprepared and this is a shocking experience for her, whereas she argues that had she known that you needed to 'brace' yourself for breastfeeding, she could have coped better.

The description also suggests that the health professional input was entirely focussed on the physical tasks associated with breastfeeding and not the emotional and psychological ones, which Niambh particularly struggled with. Midwives may have implied that breastfeeding had challenges by suggesting that 'some people can, some people can't' but by omitting any detail, Niambh's dominant narrative of trouble free feeding remained. Inferred in Niambh's extract is that the reason for the midwives not being clear about the challenges often encountered with breastfeeding was because they were 'trying to make me do it', so omitted any potentially challenging reports. She later comments that; 'It was all breastfeeding, breastfeeding, breastfeeding – as soon as I said 'yes I would try it' that was it, that was what they focused on.' This suggests that there was an active promotion of breastfeeding, possibly at the expense of supporting women to think through the decisions they were making. This is confirmed when she continues:

*[The midwife asked] did I know they would test me on what the benefits of breastfeeding were, did I know that it would reduce my risk of ovarian cancer? Did I know that it would be the best thing for the baby? Did I know that it would reduce their*

*chance of becoming ill? You know, all of those things and do you understand about how the baby would latch on?*

The 'they' in this extract is likely to be the assessors for the UNICEF Baby Friendly Initiative. Their information giving and questioning appears to be informed by the midwives concerns about the woman giving a positive result for them when being tested, as opposed to the needs of the mother.

Niambh's, like others, unrealistic expectations were compounded by the lack of information sharing by other women about the challenges of breastfeeding and early parenthood.

*And I think maybe, you know, just the kind of friends that did it, weren't the kind of people that would share that kind of information, because at the very beginning I'm like quite open with saying 'oh it's so difficult, I'm exhausted, it's changed my life, I can't believe how much it's changed my life' and, you know, my other friends would say... I'm like 'well why are other people managing and I'm not managing?' and they would say 'no Niambh you're just saying that you're not managing, that's the difference – everybody will struggle, it's just you're choosing to say that you're struggling'.*

Mhairi had a similar experience of antenatal classes and reported that;

*I went to a wee breastfeeding class, it was only on for an hour, but I did'nae feel as if it was, I mean they told you, this is the position you put the baby on but they did'nae tell you about how the baby might feed lots during the day like, because, like when you have a baby you think it is going to be fed every four hourly, they never told you about, they don't call it block feeding at night, at teas time, like cluster feeding, nobody told you about that.*

This had different consequences for her as she attributed the difficulties she had to her own personal failings.

*I thought there was something the matter with me, because I thought it was so easy to breastfeed, I thought it would just come so naturally, that I thought there was something the matter with me, why was I not able to make milk*

Her experience of antenatal education informed the widely articulated beliefs that if breastfeeding was painful or difficult it was not the nature of breastfeeding, rather it was your own lack of skill or inability to do it correctly. As Mhairi says;

*I was obviously doing it wrong, cause now I know that if you are feeling pain then you are not doing it right (...) I did not realise there were so many, no' rules, but so many different ways, wrong ways, of doing it.*

Louise very clearly articulates the dominant narrative that breastfeeding is straightforward, and that pain is a side effect of not doing it correctly:

*That [breastfeeding] was very different to my expectations, and I don't think any of the health professionals I'd spoken to during pregnancy gave me a very realistic picture of what it could be like. I think for first time mums it would be good if you could get a more realistic picture of the practical things you might need to be aware of and the difficulties you can have, cause you're kinda told that it's just going to be all wonderful and if you're feeling any pain the technique's wrong but, you know, you should be able to sort that out. So it would be good to just be put in the picture more realistically so you're going into it with your eyes open I think, and for me that would've reduced a lot of the stress in the first few weeks when you're already knackered from having given birth and you're sleep deprived anyway, so if you just knew that this phase will pass and things will settled down, that would've been good to know.*

She argues strongly that a more realistic picture, 'prior warning' as she describes it, would be helpful to mothers and would allow them to know that their experience was not unusual. She goes on to make recommendations as to how she would like new mums to receive information.

*If I had a friend who's thinking of doing it, I would just make sure she was more aware of some of those things rather than just saying 'oh it's all wonderful, it's all brilliant' because it's not always all brilliant.*

One of the dilemmas of giving prior warning to women about how challenging breastfeeding might be is because breastfeeding experiences vary so much. For two of the participants, breastfeeding difficulties were not an issue. Heather's experience was in contrast to that of the others when she says;

*I would say it's been a lot easier than I expected, I thought it would be... quite*

*demanding in, like, different ways. I thought I'd be sore and it would be quite agony and it would take a while and maybe it wouldn't be right, but it just seemed natural which has been great, so I don't... I suppose it's been better and easier than what I imagined it to be like.*

This might in some part be due to the preparation she received antenatally and the conversations she had with her midwife which appear to have reflected a wide variety of potential experiences;

*My midwife at the surgery was, like, honest but never ever gave their opinion, just honest but 'well I've had people this and I've had people that' so it was almost like positiveness but just keep your mind open cause you don't know...*

Gemma had a somewhat contrasting experience to other participants as she had a friend who helped her prepare for her breastfeeding experience. In their conversations;

*She was saying to me 'when you breastfeed, I'll tell you [the] truth, it is painful and it is sore and you feel like giving up...' and she says '...but see if you set in your mind that you're going to give it six weeks, see by the end of the second week it's fine.*

This knowledge, that early breastfeeding difficulties were normal, and transient, was incredibly helpful to Gemma when she was struggling in the early breastfeeding days.

Because this advice had been so helpful to her antenatally, Gemma wanted to be involved in supporting other women to know what to expect from breastfeeding and she offered to be involved in breastfeeding classes, talking with other expectant mothers:

*I had that opportunity to speak to those women, just to be honest and say it's definitely not the easy option in the early stages, it is the easy option once you get that bit out the way.*

Despite wanting breastfeeding women to have a more realistic picture, participants also had the same tendency to want to protect women from their negative experiences. Kay very clearly objected to not being given accurate information saying:

*Cause everybody tells you 'oh it doesn't hurt' and it's like 'you just lie! Big fat lie!' [laugh]*

However, when thinking about what she would say to other women, felt the need to modify her experience to protect others.

*RES I wouldn't tell them about the pain, yeah it hurts a little bit but not that much!*

*INT: So you would play down a wee bit about the practicalities based on your experience?*

*RES: Yeah, uh huh, yeah because to tell somebody how much pain and agony I've been in for the last nine and a half months it just wouldn't be fair and it would put everyone off. So I'd play the pain down a bit, 'yeah we had a couple of difficulties at first but we both had to learn how to do it*

She therefore articulates the dilemma both women and health professionals face about helping to prepare women for an experience which may or may not have some fairly negative aspects, while not putting them off trying. The dilemma is compounded by the fact that that antenatal preparation is about trying to prepare women for an experience that is not only unpredictable but to some extent beyond their imagining, as it is so very different from experiences they have had before. Julie articulates this by saying;

*I suppose it was a bit different because never having done it you never really totally know what to expect. I would say it's... nothing really prepares you for how you feel about it, I think.*

As such, preparation may always feel somewhat inadequate, as breastfeeding and early motherhood is difficult to imagine without actually experiencing it. However, the strength of the women's feelings that others actively tried to prevent them from being fully informed, suggests this alone does not explain the lack of feelings of preparedness.

### **10.3 The Horrors**

Within the interviews, participants describe in detail the physical difficulties they faced with breastfeeding. For many breastfeeding was a shocking experience and did not fit at all with their expectations of problem and pain free feeding. Phrases such as 'agony' were frequently used and many reported crying with the pain they were experiencing.

As breastfeeding is a repeated activity, they came to dread feeding times. Although for some this was overcome in the first six weeks, a number continued to experience pain and other difficulties for much longer, or had new breastfeeding problems well into their breastfeeding experience. For some participants their experience of pain and difficulties helped them empathise with others who may have difficult breastfeeding experiences and consequently move to formula feeding, however for others, their experience of persisting through difficulties lead them to expect others to do the same. The judgement of others which can potentially arise from their experience is described in 'Breast is Best' in section 9.5.

When Kay was invited to describe what breastfeeding had been like for her she was emphatic that it had been 'horrible'. When asked to say more about that she continued:

*RES: ...it's been horrible. He's... when we finally got the hang of it, he had a tongue tie which they discovered 'oh yeah he's got a tongue tie that's why he's not latching on properly' and things like that, so we got that sorted, and my nipples were permanently bruised...*

*RES: ...and I've got really sensitive boobs [laugh]. We maybe had a good month or two...*

*INT: Was that right at the beginning or?*

*RES: No about halfway through, just before he got his teeth, and now he's got teeth and it's proper agony again [laugh]! So it's been a horrible experience really!*

*INT: Right, so right from the beginning there was the tongue tie issue, weight loss...*

*RES: The latching on problems.*

*INT: ...latching on right from the beginning, and then there was a wee bit in the middle once you... how long did it take you to get that kinda sorted and organised?*

*RES: Probably about four months before we got... I mean, people say about toe curling pain, I know toe curling pain, it's like... and there was times I cried cause he wanted feeding and I just didn't want to, it was so sore. And we had a couple of months maybe when he got to about four months that it was great, and then he got teeth and discovered biting, and he sort of... he's never come off properly, he always comes off sharply, so as he comes off now he jags his teeth down and it's like... it's horrible.*

Kay's strength of feeling about this is confirmed by her strong language, describing her experience as 'agony'. Her recurrent difficulties persisted despite her finding a number of causes and potential solutions to the problems, for example the diagnosis and snipping of a tongue-tie. It is clear that she feels the difficulties she is experiencing are to do with her baby and her personally, rather than being attributed to the nature of breastfeeding itself, an area which is explored in more detail in the theme 'They Keep the Truth from You'. Not surprisingly, Kay came to dread each breastfeed, crying in anticipation of the pain she was going to experience. The repeated nature of breastfeeding, means this is a trauma to be faced time and time again, often with little recovery time, as confirmed by Gemma:

*I suppose you're feeding them so frequent, I mean, sometimes it's hourly and you're going through that agony and then you're getting over it and then you're back on it again.*

In Gemma's transcript the horrors are placed within a time context. Gemma had been told by a friend to expect difficulties for the first six weeks of breastfeeding, so felt she was somewhat prepared for the early days to be tricky, however, despite this, the reality was still very challenging.

*I thought 'what's six weeks of my life really?' at the time it's a bloody long time I'll tell you [laugh] because see when I think of the pain and then, like, I look at the wee book, you know, their wee red books and I think God the feeding problems I had with him. I mean, that was chronic because of the blood and everything, but it was day 14 that the health visitor signed us off saying 'I'm not coming back, it's sorted' and I remember thinking 'good' and that was the longest 14 days of your life, you know!*

Gemma's documentation of her experience gives permanence to her memory of the difficulties, and the process of recording them in her Red Book (the NHS mother-held Child Health Record), validates the experience as a medical condition. She uses the word 'chronic' not just to suggest the ongoing nature of the difficulty but also perhaps to reflect the perceived severity, emphasising this by referring to 'the blood and

everything'. This phrase both tells of the seriousness, with her nipples bleeding but the follow up 'and everything' suggests that there were even more difficulties without her going into the gory detail. The power of the health professional 'signing her off' seems to have been an important marker that the worst of the difficulties were over and she had permission to move on and see her breastfeeding struggles as being over.

For a number of participants, however, the difficulties persisted well past the early weeks, as exemplified in Kay's earlier transcript. This was also the situation for Mandy, who initially had difficulties with her baby latching and had a slow start with the baby at the breast requiring cup and then naso-gastric feeding, however, the physical challenges for her came later. Mandy's extract was not unusual in that she tells with some expressiveness of the awfulness of her experience, while at the same time, minimises it, saying that she did not have a 'bad case' of mastitis, and suggesting that it may even have been a blocked duct, which is considered to be more minor, or an earlier stage of mastitis.

*Now it would've been before that actually I had the mastitis... aye, 'cause my check was at eight weeks, we were a fortnight late with the check and our injections, I had... I forgot about that, I had mastitis about six weeks, it wasn't so much a bad case of mastitis, it was more she had decided to have a full night's sleep and didn't wake up. I woke up the morning and was totally engorged, I could not believe it, I had never felt like that before, I was like 'oh my goodness, what on earth's happened here?' We felt fine, I remember it being a Sunday morning... hubby had went to his work and left us and I felt fine, I was up and about and doing whatever, and then all of a sudden I felt like I had the flu. It was really horrible, I felt really shivery, roasting, sweaty, you name it, looked and my left... aye it was my left breast, no it wasn't it was my right, it had a big patch of red and I think it was obviously just... I think it was more a blocked duct than anything*

For some, the pain and difficulties experienced helped them empathise with others who may have difficult breastfeeding experiences and consequently move to formula

feeding, however for others, their experience of persisting through difficulties lead them to expect others to do the same.

In Elspeth's extract she both shows her empathy for others, but by stating that she understands why others give up, she also emphasises the extent of the challenges she faced and suggests that she is able to endure better than the majority of others, who in the same circumstances would not have been able to persist.

*I can totally understand actually that is the point where women give up because it is very painful and very uncomfortable and even just something brushing past you can be excruciatingly sore. () I can understand why women give up. And it's easy to say, you know, 'you'll get through it, you'll get through it' but I know the pain, I've been there three times and it is very, very painful and that's one of the things that's not the joy of breastfeeding, you know, and that's why maybe there's not a lot of people in this country breastfeeding because they go 'oh no, no that's agony, oh no I'm not doing that' you know, it's easier to bottle feed.*

For others, however, the extreme nature of what they had to persist through appears to raise their expectations for others. Gemma contrasts herself with a 'lot' of her friends who stopped breastfeeding when facing challenges, ones which, by her phrases 'absolute torture' and 'more painful than labour', she suggests were less difficult than hers.

*A lot of friends that I've had that say they've tried breastfeeding and then they say 'oh it didn't work for me' or 'they wouldn't latch on' and I thought I had to struggle so much with him and Megan, for the first few weeks it was absolutely torture and sometimes I felt it was more painful – a totally different type of pain – but to me more painful than labour at times, I mean, the feeling of them on your nipple when they're not on right is an incredible amount of pain, and to persevere through that, I mean, women had to persevere through that for a long time, you know*

Aileen adds a moral context to this, which is explored more fully in the 'Breast is Best' theme. She compares herself with other mothers, who say they would do their best for their children, but whom, in her view, do not. The repeated nature of this pain adds to

the idea that she has gone ‘beyond the call of duty’ for her children, potentially raising her own feelings about herself but perhaps at the expense of her empathy and esteem for others.

*I would say that I would do anything for my children because... you know, well I know most mothers would say that, but I think when you hear other mothers saying ‘oh yeah I couldn’t breastfeed because it was too sore’ you know, ‘I had some blood coming out my nipples’ and you’re thinking ‘yeah, five weeks I had that’, you know, it was really painful, every time putting... especially with Natasha, every time putting her on it was like ‘oh my goodness I’m going to have to do this again’ or ‘oh I need to rest that one so I can go onto the other one’ cause it was just so sore, but I pushed passed that and I think for the absolute best of our children.*

These graphic descriptions were not widely shared with others by the participants in this study; however, such stories did circulate in the community. Rhona’s contribution to this theme is as a counter case as she heard about the horrors but did not experience them.

*People were saying to me, you know, ‘oh it’s so painful, it’s like shards of glass and you’ll have to toughen your nipples using scrubbing brushes’ and we were thinking ‘do I really want to do this, this sounds horrific! How can that be so nice if...’ and it wasn’t like that at all for me [laugh] I don’t know what these people were talking about, but I don’t remember it... well, maybe I’d say uncomfortable possibly for the first couple of times.*

She distances herself from the women who tell these stories by using the phrase ‘these people’, but does reluctantly acknowledge that she did share some of this experience, expressing that it may have been ‘uncomfortable’.

#### **10.4 Getting Through It**

In the interviews, participants described a number of internal factors and support mechanisms that helped them face the challenges of breastfeeding and early motherhood. The most widely reported internal factors were their own determination and perseverance. Also motivating mothers was the avoidance of negative feelings

increasing their commitment to continue to feed, so they could avoid the feelings of guilt and failure they believed they would experience if they were to stop. Connected to this were beliefs women had about breastfeeding being the best feeding method for their baby, which is fully explored in the 'Breast is Best' theme. Within their own families, women reported receiving support from their husbands/partners and this was highly valued. This often was not support about continuing to breastfeed but was rather focussed on emotional support and reassurance of their mothering skills. Women sometimes sought out assistance from voluntary sector groups and most women either looked for or received unasked, interventions or support from health professionals. While the sought out support, particularly from voluntary sector group was reported positively, there was a thin line between what was perceived as support and what felt more like pressure when health professionals were involved

Most of the participants used internal factors such as their determined nature to explain why they continued with breastfeeding despite facing difficulties. Central to their account was that when the decision to breastfeed had been made, it was binding on them and they were then committed. To not continue in these circumstances would be seen as failure to meet their own objectives. When asked about what kept her going through the difficulties she had experienced, Elspeth responded:

*Just determination. I've got a very, very determined nature and when I say I'm going to do something I'm going to do it and nothing distracts me from that. And because the day I had Adam and I decided, you know, when they said 'do you want to feed him?' and I said 'yes', and at that point I'd made the decision that I was going to breastfeed, I was never going to give up because it's just my determination, I would've been kind of fighting against myself and I probably thought I would've regretted it later on if I hadn't of done it.*

The assertion that determination is required was widespread amongst participants, but for some the determination to succeed was underpinned by other motivators. In a

number of cases this was the commitment to be doing, and sometimes to be seen to be doing, the 'right thing'. The other side of wanting to do the 'right thing' is the concern of the feelings you will experience if you are not able to do what you think is right or best, and that is the fear of experiencing guilt and regret. Aileen clearly articulates this:

*I would feel really guilty cause I think it's the absolute best for them and it would... yeah, I would feel really guilty if I was not to do it. Guilty because I knew it was the absolute best for them.*

For one of the participants, Kay, this was a particular concern because she had pre-existing feelings of guilt due to her perception that her baby had not had an optimal start due to taking medication during pregnancy.

*It was the... the determination really that's kept me going because, I mean, it's painful, even now it's painful but it was the guilt, the determination and like 'he's had that really bad start so I'm going to give him the best' and my husband keeps saying 'if it's so bad give it up' and then when I'm not feeding him it's like 'well, we'll just keep going, he's nearly one' you know, it's not long now.*

While internal factors were by far the most commonly reported motivators, women additionally reported that what helped them to 'get through it' was support from others. This included support from midwives, peer supporters and their husbands or partners, while friends and family were much more rarely mentioned. As was explored briefly when considering partners role in decision making in breastfeeding, the meaning of support is not always clear. This support was not support for breastfeeding as an activity, and they had neither any practical assistance to support her in feeding, nor necessarily any particularly positive feelings about breastfeeding, rather it was support for his partner's decision and emotional and moral support for her. As Aileen says:

*Whenever I'm tired and stressed and things, I've got that support in him that he's actually saying 'it's alright, you know, they will sleep through the night, you're not always going to be feeding them'. Yeah so I've always got that support that he's saying 'it's not going to be forever, it's short term' because there are certainly times and there*

*have been times during the night that I'm almost in tears thinking 'I can't go on, I can't do this anymore'. Yeah, so to have that support is great, you know.*

While most participants spoke of their husbands support of breastfeeding being important to them, only two spoke in anything other than the most general terms. While participants use phrases like 'he was so supportive' there is little evidence of their accounts of what they actually did. Heather and Niambh are the exceptions to this and while they gave very different accounts of the support and what it meant to them, it was a factor, alongside their own determination and perseverance (and in Niambh's case her perfectionism and fear of guilt) that helped 'get through it'.

Heather's experience of support from her husband is very gentle and he is the only partner who is reported as either waking or getting up in the night when his baby is being fed.

*He's always been encouraging and when I was up during the night he would kinda sit and hold my hand or 'd'you want a cup of tea or d'you want a wee drink or d'you want water?' he would be very, d'you know, in the middle of the night he would be very supportive. Whereas you didn't feel as though it was always you, or he would go through and get her and then settle her or wind her, so it was that. I suppose that really did help, that you had somebody there constantly just egging you on as such 'ocht you're doing great, you're fine, she's fine'.*

The combination of his emotional support and the offers of care and support during the night were greatly appreciated by Heather and the shared act of being up in the night, contrast with reports from other women who experienced night feeding and the consequent tiredness very challenging and reported feelings of resentment of their partners who 'snored on' while they were breastfeeding. Niambh's husband was one of the partners who, despite reported efforts to wake, did not do so leading to resentment and some stress in their relationship, however, he was able to offer encouragement

when she felt herself weaken and this was highly valued by her as she had a real fear of not being able to succeed and meet her own standards. As she says:

*I couldn't have done it myself, I would've given up if it hadn't of been for the people around me... you know, that's quite... I mean, Alex and I can go for a bike ride and I'm like 'oh I can't go any further I'm exhausted' and he's like 'come on, just round the corner then we'll be home' and I'm like 'oh no I can't, it's not just round the corner' but he forces me – well he doesn't force me to do it, he encourages me to do it and I do it and I'm like 'oh thank goodness I did that'. So it's the same kind of thing with the breastfeeding.*

One of the issues that might have been expected to be found, given that most participants lived very close to their families and all were in frequent contact, might have been a mention of family support. As reported in other themes, such as 'Surviving in a Hostile Family Environment' many families were not supportive of breastfeeding and actively undermined it, but some did manage to offer general emotional or practical support to their daughters in their struggles with early parenting. Aileen, who described her mother as her 'mentor' was able to access support from her mother.

*INT: What d'you think made the difference with it [breastfeeding] being better?*

*RES: I think having family support round here, not support of breastfeeding but just general family support.*

*INT General support.*

*RES: Yes, uh huh, you know, I knew my mum would come in and she'd help me out with the dishes and... you know, I had the usual sort of three day week kind of lapse and 'oh my goodness this is just hideous, what am I doing?' you know, and I'm looking round the house and thinking 'everything's a mess, I can't do anything, I'm feeding all the time'.*

A number of participants had asked for professional advice to help to try to cope. The people most often spoken to were midwives, who would be coming in to visit most days in the first 10 days after the baby was born, and the health visitor. Also approached was the Breastfeeding Network, a voluntary sector peer support organisation, with which a number had had contact with through their antenatal classes. In her extract, Mhairi

contrasts her most positive recent experience of health professional support with her experience feeding her first child:

*The whole attitude of the midwives and the health visitor and stuff was totally different, like they were, 'Here is a number, ring this if you need help, there is a wee breastfeeding centre, look up this website and stuff' so that is what I done. (), The support was totally different within the healthcare, it was total, totally different, like they were all for it. Like Chelsea struggled to put on weight the first two weeks, em, but the health visitor did'nae once turn round and say to me, 'If she does not put on weight next week, we'll need to think about a bottle', whereas that happened with Gary [her first baby]*

While Mhairi experiences this support as being very positive, this is not because of any specific or particularly effective advice that she was given, as there was none, but rather because they had not sought to undermine her confidence in breastfeeding. This is in stark contrast to her earlier feeding experience where they had insisted she supplemented with formula and she had stopped breastfeeding.

Elsbeth initially asked her midwife about ‘any kind of creams?’, ‘anything I can do to protect myself?’ and had used these religiously to try to help with sore nipples, but when she continued to struggle she approached the voluntary sector.

*I was crying with pain. I phoned the Breastfeeding Network or whatever it was, the support team, I phoned them/spoke to them and they said you need to try and up your feeds so that with every feed he gets he gets, you know, the fast flow. Well, of course, you're in absolute agony because he's pulling away and you're getting told you have to up your feeds! Yeah, any time he kind of wakes, any time he does anything, latch him on, get your milk and I did do that and it helped didn't it, it did help.*

A number of the participants were recruited into this study through their connection with the Breastfeeding Network and had receiving peer support. Several of them specifically referred to the support they had received, for example Tracy whose extract appears below, and how it helped to keep them going. It appears that in the absence of

community and family support, the role of peer supporters becomes particularly important.

*I've got to say definitely going to the group every Monday is a great support so it is, cause you can just talk to other people, see how they're doing and realise that, you know, you are doing the right thing. ( ) The support's there if you need it from any of the helpers and the other mums that are there. I do find they've been a better support than what the professionals have been. If I hadn't known about the breastfeeding group I would've come out of that six week check, well eight week check, and probably just given up.*

For Tracy, the support from peer supporters and other breastfeeding mums was more significant than that from health professionals, who all the participants had been in contact with. There were wide differences in how helpful the mothers had felt that health professionals were and none specifically attributed their ability to continue feeding to contact with them, however, two participants reflected on the difference she had experienced in the support she received with different babies, and attributed this to the passage of time between them and improved training and support for health professionals.

It is therefore clear that in the absence of family support, peer supporters and health professionals did have a limited role in supporting breastfeeding women through their unexpected struggles with breastfeeding. The far greater attribution, however, was to their own internal resources and women crediting themselves with the key attributes needed to succeed with breastfeeding, particularly determination and perseverance. It can be seen that this had consequences for their feelings about other women and their breastfeeding continuation decisions, feeling that women who had not persisted through difficulties as they had, had perhaps not persisted to the required level, with associated moral judgements about the level of their efforts. The esteem consequences of participants' efforts are further considered in section 11.4.

## Chapter 11 - **Worth the Sacrifice**

### **11.1 Introduction**

In this superordinate theme, participants recount their commitment to their babies and their breastfeeding relationships, telling of the personal sacrifices of their body and aspects of their selves. This sacrifice was described sometimes as willingly done, but others felt compelled, and were pleased when their breastfeeding time was finished and they were able to get their old selves back. While there were some challenges associated with this including exhaustion and feelings of being always at their babies call, the rewards were more powerful and they were able to enjoy the specialness of being in an exclusive relationship with their baby and take credit for their growth and development and an enhanced sense of themselves as a good mother. Participants tried and sometimes managed to describe the intense emotional feelings they experienced when feeding their babies and being in that exclusive relationship, but struggled due to the limitations of language. As a consequence of the extent of the sacrifice they had made to be breastfeeding mothers, combined with overcoming significant challenges and the rarity of breastfeeding in their environment; participants experienced a perceived raising of esteem and status in their own eyes and that of their families and communities.

This superordinate theme comprises of four themes: The Sacrifice and Regain of Self, An Exclusive Relationship: the double edged sword, Falling in Love: The Indescribable Described and Raising Status.

## 11.2 The Sacrifice and Regain of Self

In the interviews participant spoke of the sacrifices they had made to breastfeed their babies. This involved putting the baby's needs before their own and feelings of guilt if they did not do this. Breastfeeding meant sacrificing many aspects of their lives, bodies and identity for the baby and involved feelings of loss and disorientation. While the sacrifice was described as being done willingly, the experience was very challenging for many of the women, it was the time limited nature of breastfeeding which made the sacrifices more manageable, where it was seen as a 'shift' or 'sentence' which had to be served. The rewards of breastfeeding, including those identified in other themes such as 'The Indescribable Described' and 'An Exclusive Relationship: The Double Edged Sword' combined with the new sense of self and purpose which emerged later in the breastfeeding relationship was seen to compensate for the sacrifices and losses. For some the breastfeeding experience acted as a catalyst to re-evaluate what was more important to them and led to a new, more confident self, who was better able to challenge society's norms and follow their own instincts and parenting path.

The first area to be considered is the widespread view from participants was the requirement to make sacrifices for your baby. Elspeth who faced multiple challenges with breastfeeding was clear that what the baby needed from her was more important than the pain and sacrifice she had to make to provide this:

*This is what I'm going to do and I've got my mind on it and I'm doing it'. It doesn't matter the pain I'm going through as long as he's getting what he needs.*

For Elspeth the main challenges were physical ones such as pain when feeding, but she felt a wider sacrifice of having to give up her body more generally for her baby. Despite the joy feeding gave her, the need to share her body with someone else, in fact give it

over to someone else, was a real commitment and she was pleased when she was able to reclaim her body for herself.

*With all three kids it was the best six months, even through all the trials and tribulations, it was the best six months ever and I wouldn't change a thing. But d'you know, at the same time, especially with Adam [most recent baby], I was glad to get my own body back to myself because by that time it had been like months that my body wasn't mine... (...) I was glad to finally kind of get my body back to myself again, yeah, I was ready for that. But I wouldn't change a thing, definitely not.*

Another aspect of sacrifice was the compromising that participants had to make in their participation in society and social life. This led to participants feeling that many aspects of their lives had been taken away from them. Aileen reflects on this:

*One thing I would say is that I'm not able to go out at night, not that I was a party animal or anything like that, but I would restrict myself, yeah, so things like that, so I've been restricted I would say that I can't just, at night time because it's not like my husband can put her down to bed because she's breastfed to go to bed, and that's always been important (...) So that I would say, so maybe if somebody said to me 'oh we'll go out for a drink' or 'd'you want to do late night shopping' or something, I would have to say 'no I can't do it'.*

This sacrifice was keenly felt and even lead to reconsideration about whether this was a sacrifice that would be willingly made again. As Debbie says;

*If I was to have another baby I would do it again, although there was at times you think 'this is so tiring, it's so...' you couldn't have a drink, you know, I went out to my friend's 30<sup>th</sup> birthday party after I'd had Rebecca, I had to be in the house for ten o'clock, I felt as if I was back at my mum's, I'm like 'no I need to go now because I know she'll be wanting a feed soon'. It does kinda take away your life a wee bit, but then if you can put your life on hold for however long, you get it back. So no it was definitely the right decision and there was times, as I say, I did think 'God I'd never do this again, it's so tiring.*

The feeling that their baby's needs had to come first and that as a mother they were expected to make the required sacrifices had a powerful influence on normal activities.

In Fiona's extract she tells of her decision to have a drink at Christmas, but in order to avoid exposing her baby to any alcohol that might be in her milk, she prepared in

advance by expressing her breastmilk. Despite this care and commitment to preserving exclusive feeding, she still experiences guilt because her baby's preference was for milk from the breast and not from a bottle and wishes she had not ever tried to have a drink in the first place.

*I think it was kind of... Christmas Eve and Christmas Day I didn't feed him at all, I had expressed in advance so that was fine, and I had to kind of express at the time cause it was agony, but when I finally was deciding 'my system's clear now of all the alcohol' which probably wasn't even that much but you're quite paranoid in the early days [laugh] and then when I finally did I was like 'oh God' I felt really bad for not having just done it, you know. (...) He was never really into taking bottles, he would but it was never, you know, he obviously wouldn't starve himself but he wasn't madly keen on it, and I think I almost felt guilty that I hadn't just not had a drink.*

In addition to practical changes and losses in their lives, a major issue for participants was the impact of breastfeeding on their sense of self and their identity. A number of metaphors were used to describe themselves when feeding, including 'a cow' and 'a vending machine'. Many lost a sense of themselves entirely, which was a deeply distressing experience. This sense of loss of who you are is keenly experienced by Niambh, who is profoundly affected by the change in her identity and the compromises she had to make in her life, feeling she 'just I couldn't be anything other than Lizzie's mum'. She expands:

*I just felt my whole life had kind of slipped away and I was just... I was no longer Niambh, I was Lizzie's mum' and just the pressure of that. I mean, I can't even... I remember thinking... you know, really I was completely lost. (...) Just giving my body... like, I'm quite... you know, I wear black and I don't wear skirts, my body's not something that I'm particularly... you know, pay any attention to really, but to have your body on show for the whole world to see when you're giving birth and then to get help with breastfeeding, I was just like 'I've lost my identity, I've lost control of my body, I'm just being violated [laugh] all over the place almost' even although breastfeeding is what I wanted to do, but just to... in a very quick space of time to just have everything stripped away from me so quickly, I think was what I struggled with. (...) Just... like, the loss of who I was, like...*

In this powerful extract she details the multiple sacrifices she made in her life, from her style of dress, her preferred activities and her loss of her feelings of ownership of her body and her own identity. This was unexpected and over-powering for her. Although breastfeeding and its demands had an impact in the sense of loss of self for Niambh, she did manage to ‘turn the corner’ and ‘came full circle’ while still breastfeeding, integrating her baby into her life and reconstructing a new sense of who she was. However it is not so surprising that she was quite relieved when she was able to stop breastfeeding. This is reflected in others contributions with Kay being pleased to be able to report that ‘I’ve nearly done my shift’ and Elspeth saying;

*At six months with Ryan I was ready to say ‘pew, that’s it!’ ‘that’s it, you know, and I’ve done my time’. It’s the only time I’ve been thinking ‘oh thank God that’s that six months over.*

The phrase ‘doing your time’ with its connotations of prison sentences functions as a ‘gem’, shining light not only on her experience, but that of a number of others. It is particularly relevant in Elspeth’s case as she had made the commitment to herself that she would breastfeed for six months, which she believed was the optimal time based on her understanding of public health recommendations. Rhona undertook a similar commitment but in her case, her understanding of health recommendations meant that she wanted to breastfeed for a year, as this meant she did not have to use formula and could instead give her baby cow’s milk.

This relief at stopping was not shared by all participants, many of whom had fed for far longer than they had intended to, and who managed to integrate their breastfed babies into their new lives and had permanently constructed a new sense of themselves and their priorities. Louise says:

*I feel much better able to just put Cameron’s needs first and to hell with what society in*

*general says, you know, western society it's all about keeping your child at a distance/at arm's length, making them as convenient as possible early on, you know, having them weaned and in their own bed and toilet trained, you know, that's all signs of being a good mother. Whereas I think my parenting approach has been quite different to that, and I wouldn't have necessarily thought I'd be that way before I had Cameron, but it's kind of evolved and I'm much better able to just go on my own instincts now and not be so influenced by peer pressure and what's generally acceptable.*

Louise asserts her new confidence in finding her own way to parent and to pay attention to what she wants to do, and be less influenced by societal norms and peer expectations. She somewhat surprises herself at how much her own views have changed as a consequence of breastfeeding.

### **11.3 An Exclusive Relationship: The Double Edged Sword**

In the interviews, participants described the exclusive relationship that developed between mother and baby due to breastfeeding. While initially participants wanted to involve their partners in infant feeding, the extent to which they wanted them to be included varied widely. Although there was a stated desire from mothers that they wanted to share feeding their baby, many had mixed feelings about this and exclusive breastfeeding appeared to serve as a proximity regulator between mother and baby with the frequency of feeding and the difficulties others had settling the baby meaning that other family members, including the fathers, could not look after the baby for any length of time, thus ensuring that the mother remained the exclusive carer, a role which was often cherished. This was particularly powerful when there were difficult relationships with the family of origin or in laws, where from the women's reports, it appeared that breastfeeding was perceived by some extended family members to be responsible for them not being able to be as involved in the baby's life as they would have wanted.

There were both challenging and highly rewarding aspects to the relationship which developed between the mother and the baby, with the exclusive dependence being described as a 'double-edged sword'. On the negative side, participants experienced significant demands with being the parent who was almost exclusively involved in a baby's life and they described being isolated and of feeling overwhelming responsibility when breastfeeding. They detailed the frequent feeding of their babies and feeling that they did not get any break from their babies' demands. This led to reports of exhaustion and that feeding was an endless process, pushing them to the edge of their ability to cope, particularly in the early weeks and months. It was not only the act of breastfeeding itself that made them feel isolated, but the fact that the close relationship they developed as a result meant that they were the only person who could comfort and settle their baby. This responsibility often felt overwhelming as they did not feel they could ever get a break from their mothering role. There were, however, a number of rewards and advantages associated with the exclusivity of the relationship. The special relationship which developed between mother and baby meant mothers felt privileged and that they could take all the credit for the baby's growth and development, which was important in establishing their new role and sense of self-worth.

The dilemma around sharing feeding and responsibility with their partner was central to the accounts of almost all the participants. The first issue there was that women wanted their partners to be involved in feeding their babies, to some extent, but the extent varied widely, with most wanting them to 'have a shot' with only a minority wanting a larger degree of involvement, with feeding being more shared. Women were concerned that their partners would be 'missing out' if they did not feed their babies, but this

appears to be a concern for the women, not one expressed by their partners and when offered the opportunity to be involved in feeding, many were not particularly interested. For many of the women, the experience of expressing to provide the milk for their husbands to use when feeding was too difficult for them to persist and for all but one participant, formula use was not considered and the partner involvement in feeding fell rapidly by the wayside. Despite their desire to have their partners involved, for all but one participant, they were content with this outcome, perhaps more so for those women who had more mixed feelings about sharing feeding in the first place. The nature of the exclusive relationship meant that there were implications for the woman's partner (the baby's father) and their relationship with the baby. For some, feeding practices leading to uneven levels of parenting had implications for the marital relationship too.

In the following few extracts the range of desire for involvement and feelings produced by this is explored. Heather was at one end of the spectrum and did want her husband to be involved, so he could experience some of the positive feelings she associated with feeding her baby, however, the baby expressed its preference for feeding method.

*I think he would've loved to have had that wee shot at feeding her and I did express but she was a bit funny with a bottle, so we tried all that and tried it with a cup, but she was just having none of it. Didn't like it at all.*

It appears that Heather's desire to allow her partner to have some involvement was quickly quashed by the babies reluctance to cooperate and therefore their exclusive relationship continued. The practical difficulties with expressing, which made it more difficult to involve partners in feeding were commonly reported, however, it was not always clear how well motivated women were to persist through difficulties to include their partners. In addition to difficulties with expressing, and with the baby not being keen to take milk from anything other than the breast, the father's perceived

enthusiasm for being involved in feeding was also influential. As Gemma says:

*My plan when Angharad was born was I wanted to breastfeed but I didn't have it in my head that it was exclusive. I kinda thought that I would express and I wanted Chris to feed, well the baby at the time, you know, that was kind of the plan before she was born. So at that point I would've been happy enough with other people occasionally feeding, but Chris didn't seem interested once she was born (). He definitely didn't seem particularly interested in feeding and I did express quite a bit... as it happened, Angharad, you know, refused dummies, refused the bottle when we did express the milk anyway, but Chris wasn't particularly interested in feeding her.*

In the interviews, Niambh was the participant who most wanted her partner to be involved in feeding. She was clear that she saw parenting as an equally shared task and found that breastfeeding did not allow for this to be the case.

*I wanted Lizzie to be our baby, like Alex and mine, the baby that we both now have. She had been mine when I was carrying her for so long, that I just wanted to then share her, share the responsibility of her, but I still wasn't able to do that because of the feeding and even, you know, the feeding would then kind of make putting her to sleep easier or to pacifier her easier – Alex couldn't do any of those things, so even... although it's not necessarily directly feeding, it's still she'd fall asleep on me so then I would have to put her down or if she started crying Alex couldn't pacify her, it had to be me, it had to be putting her on the breast. So, you know, other than changing nappies and taking her for a walk, it was all the biggies, all the big things were still my responsibility and mine alone and that's what I found difficult. Because I realised from other people that if we just stopped the breastfeeding she would become ours and not just mine.*

The close exclusive relationship which feeding gave her and her baby was an additional burden and unwelcome responsibility which she really struggled with. This led to some resentment in their relationship:

*I think Alex just took the brunt of it from my frustration and his own frustration that he couldn't... I knew he couldn't do anything to help me and he knew he couldn't do anything to help, I think was maybe a wee bit of a strain.*

Niambh, with high expectations of sharing feeding, was by far the most affected when this did not appear to be possible. Interestingly, Niambh was one of only two participants who commented negatively on the impact breastfeeding and the exclusive

relationship had on their marital relationship. This may be because they were trying to present breastfeeding and their early family life in the best possible light, however, it is also possible that the exclusive relationship actually suited many of the participants well and was sufficiently rewarding for them to be accepting of the unshared nature of the work. For some participants, the fact that they could not share feeding, despite their original intentions was a relief, or at the least they had mixed feelings about having to share their baby with anyone else, even their partner or other children. Gemma illustrates some of this ambivalence about how willing or able to they were to share feeding with their partner. She says:

*So I find that kinda interesting about myself, because although I feel like I enjoyed being the only one, I didn't feel so selfish that I didn't want them to be part of it (...) it's funny cause I just... although I've enjoyed feeding... I'm quite pleased with myself from that fact that I wanted to share it with them cause sometimes you do wonder are you being kinda greedy in wanting to do it all yourself.*

She shares the concern of others at sounding selfish, but is pleased with herself that she is able to share, but there is an underlying idea that this is an act of generosity on her part, rather than something he could expect to have as a father. The use of the word 'them' refers to her partner and young daughter and the importance of the power of the bond with her baby, is visible given that she is pleased at being able to share with them, and almost suggests that she contemplated not letting them into the relationship at all.

Debbie was one of the participants who liked the idea of her partner being involved but the emotional implications of sharing were much more difficult.

*I mean, I don't know how I would've felt if I'd put Rebecca on a bottle and she took to it, you know, it would've been... I probably would've been soul destroyed. I would've, mm hmm.*

This feeling of being needed appeared to be reassuring to Debbie and the thought of having to share this with someone else, even her own partner somehow could have felt

like rejection. Thus breastfeeding appears, at least for some participants to serve other psychological functions for them, providing reassurance that they are still loved and needed.

Breastfeeding served other psychological functions for participants, particularly around the reduction in anxiety levels when they were separated from their babies, as they knew that the separation was of a limited duration. Breastfeeding appeared to act as an invisible umbilical cord between mother and baby, providing a feeling of control or containment. Elspeth articulates this in her extract, showing both how breastfeeding served as a means of keeping her baby closer to her and avoiding prolonged separation.

*I kind of like to feel in control a wee bit that I kind of think, you know, 'well, at least it's not a case of that he's suddenly going to be...' you know, and I feel a wee bit kind of insecure, where is he and, you know, you can stay away for longer than four hours, that kind of thing, I like to kind of have him close because... I mean, I know the girl over the back door again I fell back to her, she said all of a sudden her partner's mum said 'oh I'll take the wean away for the night' and she said 'no, I want the wean with me' and it was harder for her to say that because maybe, you know, she was bottle fed. I mean, it was never questioned that Elliot would always be here at nights, you know, so I think that is... I was able to see other people getting enjoyment out of him but ultimately he still had to come to me because I was feeding him.*

This reluctance to share appears to be much more powerful when it comes to in-laws.

For Gemma, who experiences her in-laws as intrusive, breastfeeding acts as a proximity regulator, allowing her to have access to her baby when other family members are 'baby hogging'.

*When Angharad was a baby they would pass... they just take the baby [Angharad] off you, as soon as they come in the door and then you get her back when they leave, so for me breastfeeding was great because I could walk over and get my baby back!*

This was particularly important over time when parents-in-law, in common with other participants' families wanted to have a greater degree of access, including overnight stays.

*When Angharad was born, within, you know, weeks, she was only weeks old and Karen [mother-in-law] wouldn't direct her comments at me, she would direct them to her [the baby], it would be 'when are you coming to nana and grandpa's house to stay over?' and you just had this feeling that they wanted the kids, you know, not so much with Marcus cause they've not seen him maybe as much as they did Angharad, but they certainly wanted to... it was always questions about overnights and babysitting and because I was feeding that seemed to always, you know, put a stop to that which I think increased their, you know, kinda not liking it [breastfeeding].*

The fact that exclusive breastfeeding meant that it was difficult or impossible for babies to spend any length of time away from their mothers sometimes lead to tensions, however, this may have lowered the personal animosity between daughter and (usually) mother-in-law as anger was focussed on BF and not on the daughter in law being unwilling to allow them more access to the baby. This is explored in more detail in *Surviving in a Hostile Environment*.

While breastfeeding meant that mothers could have the reward of keeping their babies close, always coming back to them, this also meant that the baby was exclusively dependent on the mother for food. Louise, while describing many positive aspects of the relationship she developed with her baby also recognised its negatives:

*I suppose that's a double edged sword really because I knew it would mean that it would be me that would be up for the night feeds and everything and David or anybody else couldn't really help out with the feeding aspect anyway.*

For some of the participants the demands of frequent feeding became quite overwhelming. They described feeling like they were permanently 'on call' and that their baby was 'sellotaped' or 'clamped' to them day and night. Mhairi describes her experience of this demand and the consequences for herself, pushing her to the brink of her ability to cope.

*Chelsea was terrible, so she was, em, she fed every hour, honestly, she just, all she wanted to, she did just want to feed, I was her comfort, so I was. I did not get mastitis till about 5 months, she was quite old, and I was so stressed because of the feeding,*

*there were so many times I wanted to give up, but I did'nae, but I felt as if I never got a break from feeding her constantly. She just fed and fed and fed, but you would not think it because she was a tiny wee thing, so she was, she did not sleep, I lost so much weight I was like a skeleton and I was not sleeping so I was not eating what I should have been, it got to the point where some nights she would just latch on and she was just feeding all, well she would not be feeding, just on, latched on, all night long, so I was not sleeping or anything like that. I would'nae say I was an emotional wreck, but looking back I think, Oh my God, why did I keep doing that.*

As Mhairi hints, it was not only food that her baby sought but also comfort. The nature of the breastfeeding relationship, because of its role in comfort and reassurance, meant that mothers soon became the main source of care and comfort for babies. This meant that they felt compelled to care for their babies, as they were the best or only person who could effectively comfort them and that a strong sense of attachment to them meant they struggled to let anyone else, even their partner assist with caring roles.

Louise describes an incident when she was exhausted and struggling and her husband tried to help:

*I remember a time when David insisted that he would settle him because I was so exhausted, and he said 'you just go into another room, I'll comfort him' and apart from the fact that I thought the best thing would actually be to just sit down and feed Cameron, I actually almost lost the plot with David because he wouldn't let me take him, it became a really overpowering urge to pick him up, and David... I don't think he realised how strong I felt at the time, cause he just kept saying 'no, you go into the other room, close the door' and I got really angry with him and just almost, like, pushed him aside and picked Cameron up and 'no I can't leave you, this has been going on...' five minutes feels like a lifetime in a situation like that and I couldn't emotionally cope with it any longer, I had to do something about it, and I knew all it would take would be for me to pick him up and he would be fine. So despite being so exhausted I still couldn't switch off that feeling, you know, it's still... it was always Cameron first no matter how knackered I was [laugh]. So I probably didn't expect that either, I probably... prior to having him, imagined that I'd be quite happy to let David do 50/50, you know, and the sort of comforting stuff, but I just felt 'no he needs me, it's me he's crying for, I'm best placed to comfort him, I've got what he needs' and it's true, you know, the minute I picked him up that's all he wanted, so why fight it [laugh]!*

On the positive side, however, mothers argued that breastfeeding built a special unique bond that was highly rewarding. In her account, Mhairi reflects on the fact that breastfeeding is an activity that is exclusively hers, as opposed to shared, and makes her baby 'all mine' and more closely connected to her than to her husband. Mhairi was in an interesting situation because she had experience of both breast and formula feeding and central to her account is the difference between these experiences.

*Anybody can cuddle her and change her nappy and that but it is only me who is feeding her. Every wee bit of weight she put on, that couple of ounces, I was so proud of myself because that was me that was doing that. It is weird because she never bonded with her dad like the boys [who were not breastfed] did, she never had a bond with her dad until she was about 18 months and I feel bad about that but they have got it now, but, she was just mine and all mine, ken, it is something that naebody else could share and she was just all mine and it just felt really, really nice, so it did. I don't know what else to say. I am sounding really weird, you don't really think about it until you are in this position and you are thinking, cause some folk just see it as 'Oh I am just feeding my baby' but there is that difference so there is. Like with the other two, we took turns at feeding them, me and Tony and when I went back to work, but naebody could do that with Chelsea or Jack. It was just me, they needed me just that wee bit more. I am sure that is what it was - maybe I am just needy (laughs). But it was totally different.*

For Mhairi, there is something special about the additional dependency her baby has on her and that as the sole source of food and comfort; she can personally take credit for her baby's development, with the primary focus for her on weight.

*I just see, I always see it is the next step after giving birth, it is just, it is hard to explain, so it is. (Pause) There is, I don't know if it is selfish reasons, when your baby is growing and you know that it is you that have done that, for six months of their lives you have been their only source of nutrients. So I don't know if that's it. I find it hard to put into words. I know in my head what I am trying to say. Aye, for the first six months, I helped them grow, I helped, em, the way that I, that was all down to me. All me.*

The idea that as a breastfeeding mother, you can take all the credit for a baby's development and outward signs of health is one that is reiterated by participants. One way of getting objective confirmation of the impact of breastfeeding and its contribution to a having a healthy baby was to take the baby to the baby clinic for

weighing. This formed part of the claiming exclusive credit for this sign of being a good parent. Fiona, who knew her baby was thriving, still took her baby to the weight clinic, so see objectively the impact of her breastfeeding.

*You take them in weekly and they get weighed and the health visitor comes out, and it was just really quite...(...) You were quite kinda pleased to know that you'd kinda done that yourself with no help from anyone else [laugh] which is maybe a statement more on me than anyone else.*

In their extracts above both Mhairi and Fiona, express self-consciousness in their accounts through reflections on the 'weirdness' of their statements or through nervous laughter. This self-consciousness at how their feelings might be perceived was shared by participants, who were aware that their enjoyment of the exclusive relationship they'd had might be seen as 'selfish' and excluding. Aileen however defends her position, arguing that she is able to be selfish because her baby is more hers, because of the extra responsibility she has by feeding her and carrying her through her pregnancy. Her closeness and feelings of exclusivity impact on her desire to share her baby with others and she seems to struggle somewhat with the idea of allowing other to enter into a relationship with her baby, even if it is 'just' for a 'hold' but is better able to separate briefly from her baby, because she knows her baby is going to come back to her for feeding. This suggests that breastfeeding functioned as a proximity regulator, which is explored later in this theme,

*I feel an overwhelming love, you know, it's something that I can give and no other mother can give my baby. I might, you know, pass my baby over to someone just to hold but I know that they'll always want me... when you say it out loud you think 'well I actually sound really selfish' but I guess it is a selfishness cause they're mine and I want them and I've done this for them, you know, you've carried them for nine months and you continue to have that closeness with them.*

Kay in her account, spends time focussing on the look which passed between her and her baby which she has tried to capture and is described in the 'Love' theme. In this

extract she articulates the looks significance to her in allowing her to feel pride in her achievement of making her baby. The idea that Bf is an extension of pregnancy places the mother in the primary role and demonstrates the idea that having an exclusive relationship is the biological norm, as it is in pregnancy. This acts to justify and protect the dominant maternal role in child-raising. For Kay, this is highly rewarding.

*There is nothing that can take away that look when he's laid there looking at you. When he's latched onto your boob and he looks up at you and you think 'I made that' not just the whole growing inside me process, but from being born to being five and a half months old, I made that. Everything that he is has come from me and it is just the most fantastic feeling.*

The power of this exclusive relationship brought mixed feelings for a number of participants. In Debbie's account, which follows, she shared with other participants the pleasure in the feelings of achievement obtained from the exclusive relationship, getting esteem rewards and congratulating herself, however she also feels the sense of responsibility that accompanies this and the potential for this to make her feel overwhelmed and potentially angry with her partner that she was carrying more parenting weight that he was. She recounts:

*RES: I know myself, I think 'oh God it's only me that can do this' but it didn't make me resent it and want to give it up, you know, because there was plenty other things that other people could do, you know, so that was the kinda reasoning behind mine. But I suppose there was times I thought 'only I can do this though'.*

*INT: And how did that feel?*

*RES: Good. It was. Aye it was good, I can't say it wasn't anything cause it was just something that I think I can say 'well I done that and nobody helped me to do it, that was me'.*

*INT: Yeah.*

*RES: So it did, it felt good. Aye, cause anybody can give a baby a bottle. So no I would say it felt good, mm hmm.*

It can therefore be seen that breastfeeding serves a number of functions for participants including helping to keep their baby close to them, allowing them to feel special and

needed by their baby and by rewarding them with the exclusive credit for the baby's growth and development. The other side of this exclusive relationship is the overwhelming feelings of responsibility and dependence they sometime felt by not being able to share parenting tasks. On balance however, the transient nature of this exclusive demand appeared to be able to be compensated for by the ongoing rewards that breastfeeding brings, something that will be explored further in the next theme, which elucidates some of these emotional rewards in more detail.

#### **11.4 Falling In Love: The Indescribable Described**

In the interviews, participants described breastfeeding as precious time together. While they struggled to find words to describe the feeling they were experiencing when feeding their baby, they talked about the look the baby gave them as they gazed into each other's eyes when feeding and the feeling of connectedness it gave them. This feeling of intimacy compensated for the many struggles and challenges they had or were experiencing with breastfeeding and helped them feel a growing attachment or bond with their baby. The temporary nature of this relationship added to the poignancy of many of their descriptions

For these mothers, breastfeeding was a time where the ordinary distractions and demands of parenting and housekeeping could be put to the side. Breastfeeding has enough status as a good parenting activity, that it is able to 'trump' other tasks and allow mothers to sit, rest and spend time with their baby, getting to know each other. Breastfeeding becomes the mother's priority and appears to allow them to relax and feel care-free; ignoring other distractions and the experience becomes timeless. Heather, in

her extract, reflects on the timelessness of the experience when she is entirely engrossed and focussed on the moment.

*I suppose it was just that it was me and Gemma, that was it, it was only the two of us and nobody else could get involved. So there's something, you know, when you sit down and you think 'oh I've got this to do/I've got that to do', breastfeeding you were just like that was your one priority and that's all you thought about, and it was that wee closeness time where you could just stroke her hair and nobody else really... time stands still, nothing else really mattered, cause I didn't answer the phone, I didn't go up and get the door, you just kinda... whereas now you'd be like 'oh there's somebody at the door', you would be... I think it would just be that kinda 'ocht well, tough, everybody else can wait' everything stopped I suppose, like, time just stopped because your priority was making sure she was fed and quite happy.*

Part of the 'time together' aspect appeared to be about having an opportunity to gaze at and get to know their babies and experience intimacy with them. Elspeth, who had breastfed three of her babies really valued the time with her baby, to the extent that she recorded the time she spent in a little book so she could look back on it and remember the time. She described what she actually did when she fed, with sometimes breastfeeds feeling more intimate for her than others.

*Just having him lying there and I would look at his fingers and, you know, play with his wee feet and I could feel his wee toes curling when I was touching his feet and, you know, he'd be like all snuggled up and he'd be lovely and warm and he would smell lovely and I would love playing with his hair. I just loved the time that we got and sometimes I would sit and think, you know, 'I hope he feeds for ages'.*

While describing what they did when feeding seems quite straightforward for some mothers, expressing the meaning of breastfeeding and their feelings while they were doing it posed more of a challenge. Heather compares breastfeeding with other intimate signs of love like cuddling and kissing, but this does not have the same level of intimacy and connection as breastfeeding had for her and she argues that nothing in the future ever will.

*I suppose nothing will ever be... nothing will ever compare to that and you would never get that time back, you're not going to... you can hug and kiss and whatever, but just*

*that... this wee person needing you for that amount of time and maybe if she's crying the only thing that'll settle her, so it's just that nice... nice... it's just a special time that you can't... I suppose you can't describe it.*

In her extract, Heather struggles to find the words to express these feelings, falling back on the rather bland 'nice' in her attempt to express the difficult to express, which in her case seem to also feature poignancy and a degree of loss for the changing relationship. Her words also show the connection between the love felt when feeding and the feeling of reward she experienced from her baby's dependency on her and their special, exclusive relationship. Sometimes participants commented on the struggle they had to express their experience of breastfeeding, as Niambh does in the extract below.

*It's like how do you say what love is? You know, it's just a feeling... you know, there's no words for that and I don't think there's any words for how breastfeeding your child and being happy with it is. If you were asking me... if I was breastfeeding her right now and you were to ask me what it feels like I might be able to say something, but looking back on it I just remember, you know, it's just a happiness... a comfortable, at ease... natural thing. Maybe you don't have too many kind of natural moments, you know, I can only say, you know, if you've not seen your husband or anybody for a while and you suddenly go 'oh, oh there you are', you know, I don't have, you know, when I was putting Lizzie on I'd go 'oh' but it's still... it's just a kind of at ease-ness that's there.*

Niambh, even as a highly articulate participant, struggles somewhat to express herself and describe how she experiences breastfeeding. Her starts and restarts suggest a desire to try to capture and articulate the feeling of breastfeeding. For her, she compares this experience with feeling with love, but it does not appear to have a perfect fit for her, in fact it appears to have more complexity than love, with the naturalness of the experience also appearing to be important, as is explored in more detail in other themes.

For Niambh, breastfeeding appears to be about connectedness as is illustrated with her comparison of the breastfeeding experience being like being reunited with someone you love having been parted for a while. This is a rare feeling, not commonly found in life

and is more precious for that reason. Describing this feeling of connection was a common occurrence, which for Kay, focussed on the 'look' which went between her and her baby when feeding, which she found intimate and rewarding.

*RES: It's really indescribable. I mean, I've taken photographs of it on my camera phone and I still couldn't describe it and the camera doesn't catch the look and the feeling, but it's... I don't know?*

*INT: What's the feeling like? If you can't describe what the look looks like, what's the feeling like?*

*RES: [Sigh] it's a whole satisfaction and just complete love and knowing that I would do just anything in the world for him. I mean, I suppose all mums say that whether they bottle feed or breastfeed, but it's... I don't know, and it's something that only me and him have because it is so indescribable. It's ours, it's like a really special moment that's mine and his, and you can't photograph it and you can't describe it and explain it and it's just... I don't know.*

*INT: Has anyone else, have you ever told anyone else about that, whether it was Alan or anyone else about what that means, that important bit?*

*RES: Not like I've just told you, no.*

*INT: And is that because of... why d'you think it would be that you... cause it sounds like that's really important to you?*

*RES: Because you can't describe it, it's really hard explaining it to somebody so... because I know that Gary won't grasp what I'm trying to say there's not really any point telling him [laugh]! But it's... I don't know, it's a perfect moment. Not had very many. One of them I had in Scarborough and I went just after my tonsils were out, and I sat on a bench overlooking the sea and I thought 'if I died now I'd be really happy, I'd go knowing that everything's right with the world' and that sort of feeling, just that perfect moment, and that's what it is when he looks up at me and he's feeding.*

In this extract, Kay illustrates a number of aspects of this theme. Central to her account is her struggle to describe what breastfeeding means to her, finding it difficult to find the words which accurately describe her experience and her feelings about it. This includes the elusive nature of the 'look' she sees on her babies face when they are experiencing an intimate connection through breastfeeding. She shows her desire to capture and record the intimacy, which is so difficult to describe, but not surprisingly,

the camera cannot 'catch' the moment as she would like. Despite this experience being important to her and one of the reasons she was able to persist with breastfeeding through a multitude of challenges, she had not discussed this with anyone before, not even her partner, as she does not think he will be able to understand her experience.

Interestingly, part of what makes the experience so special is its exclusiveness and its unshared quality and that if another person were able to understand or experience what it was like, it might seem like some of this specialness would be lost. In trying to help me understand the significance of her feelings, she recounts an episode, one of only a few, when she experienced a moment of existential significance, which had a similarity to the power of the look which exists between her and her baby when feeding. The contributing role of the natural setting seems important in her description, as does the fact that she was recovering from an operation, and some potential parallels could be drawn between her descriptions. In both cases she was recovering from a difficult physical experience, in the former, some surgery from which she was now recovering and the latter, a difficult birth and a challenging early breastfeeding experience. The particular significance however, is in the fact that the close intimate feeling is so powerful that it provides her a feeling of wellbeing that allows her to feel that, at this moment, 'everything is right with the world'.

Participants reflected on the myth of the instant bond that mothers have when they have a baby. In her extract, Fiona expresses her initial anxiety about becoming a mother and her disconcertion when she did not experience an instant connection with her baby. For her breastfeeding served a very specific function in 'forcing' her to take time out to get to know her baby through feeding.

*When I got pregnant obviously I was pleased but also a bit kinda... a bit hesitant about just the whole idea of it and too... when he was born I certainly didn't feel like the instant... you know everyone says that you have a baby, then you look at it and you totally fall in love, I actually felt really detached from him the first couple of days just cause labour... actually mine wasn't that bad, it is quite unpleasant and it's just not... it was such a big disruption, you know, no sleep, no anything, but I think even kinda forcing myself to sit there quietly and do something with him for quite a long time, like, at first it really... I think it really, really kind of sped up bonding where maybe it wouldn't have happened as quickly if I wasn't'*

This focussed concentrated time, looking at each other and feeling connected appeared to assist with relationship building and in Tracy's situation, help heal the difficulties she experienced in their first few days together where there were a number of medical interventions. Tracy, did not experience the sometimes reported initial rush of feelings for her baby at her birth, in large part because of a difficult birth, early separation and a delayed start to breastfeeding.

*I actually think it's been good for me personally because of what happened at the birth and cause we didn't get the time, so the feeding in the very early days helped me with my bond with her cause I hadn't got that time at the very, very beginning (.). So I think it's definitely brought my bond with her closer and made it a lot better than what I think it might have been if we hadn't have fed.*

In Aileen's extract, which follows, she recognising the connections between love and dependency, the idea that breastfeeding is an intimate activity where you spend time with your baby, looking and connecting, and the temporal nature of the relationship. This is something she recognises both in her own breastfeeding and when she watches other women. She invites me, with her repetition of the word 'you know', to share in this understanding.

*I love seeing other mums breastfeed as well because there's just that... the eye contact, the fact that this little thing actually wants you and needs you, and that you're... you know, I've thought so many times this will not last forever, you know, and it doesn't, you know, they grow up so quickly, I can't believe it's almost seven months already and you think, you know, I've been able to have that closeness and... you know time together.*

The fleeting nature of breastfeeding is expressed by other participants and is poignantly captured by Kay who spoke earlier about her perfect moments of experience. In this final extract, she also is aware that the decision to end is not fully within her influence, with her baby choosing to feed differently, while she anticipates the inevitable loss of the breastfeeding relationship.

*It's like 'how can I ever give that up?' We're coming to a point now where he's cutting down on his feeds and he's drinking out of cups and things, and it's like it's going to be so difficult for me to just give that look up, to give that moment away, which I'm going to have to do.*

Thus the transient nature of the feeding experience, combined with its intimacy has a feeling of 'first love' about it, a love which eclipses and excludes all others. The exclusivity is almost enhanced by the difficulty of describing it, as this means only those who have experienced it directly can know it. The rarity of breastfeeding in the community is further explored in the next theme, where the challenging nature of breastfeeding and societal dominant discourses about its value as a feeding method, lead to women having enhanced feelings about themselves and their status.

### **11.5 Raising Status**

Women who breastfed their babies knew they were a minority group both in their communities and that they were doing something unusual and perceived as challenging. The rareness of this activity in their families and communities and the significant challenges which they had to overcome, raised the value of breastfeeding for the participants and with it, their self-esteem and pride in their actions and their perception of their status. Breastfeeding was seen as a way of showing that you are a good mother, as associated with the 'Breast is Best' message'. This was moderated however, with a

self-consciousness at the negative social comparison, which was implied about women who did not breastfeed.

In this theme there are a number of areas where women's esteem appears to be enhanced. There is the pride and esteem they feel for overcoming the challenges they faced and the fact that few others manage to overcome them. There is the enhanced esteem in the family or community as someone who has been seen to manage to breastfeed, which then enhances the individuals esteem when they hear reports of this. And finally, there is a sense, related to the 'Breast is Best' message that they have managed to do something which has a high status or value.

For Elspeth, there is a real sense of achievement at managing to reach the goal she set herself of breastfeeding for six months. She is unself-conscious about her feelings and is happy to share this with anyone who asks.

*I just always feel really proud to say I breastfed all of them for six months. Whenever you get asked the question, you know 'breastfed?' 'yes, all of them for six months' and I'm so proud to say that, you know, because it's not very common I don't think for women to breastfeed let alone breastfeed all three children for six months, you know, I think that's quite kind of rare in this day and age.*

The rarity of Elspeth's activity makes this special, and although she did face significant challenges in managing to undertake her commitment. Aileen, in common with Elspeth, is able to express unself-conscious pleasure in her achievement, in this case in reference to her success in managing to overcome breastfeeding challenges.

*I actually feel really good about what I've done. I feel really good about myself that I've been able to do this, that I've challenged myself cause I've pushed past a lot of things. I always thought I was an absolutely, to use a better word, an absolute woos [wimp], that I wouldn't be able to push past pain, but I've been able to do it and when people say to me 'oh but it's so sore, I can't go on' I'm able to say to them 'you can and you will'.*

Aileen's esteem for herself is raised as she discovers that she has a tenacity or perseverance that she did not know she had and this positive quality she finds in herself, leads her to reflect on herself and her personal qualities and strengths. The raised esteem through facing her own challenges was added to when she found she was able to offer advice and support to others, for example a friend who was struggling with breastfeeding. This gave her a role as 'expert' in her community and raised her status.

*So I feel positive in myself that I've done this, I can help others, I can be a good example, you know, and for myself I feel good about myself for that.*

Elspeth found herself inadvertently in a similar position, being seen as an expert, but in this occasion it was her own mother who had changed her view of her daughter's status. This enhancement in her mother's eyes seems to lead to feelings of increased status for Elspeth, although she tries to suggest she is not better than anyone else, the pleasure she has in recounting the story suggests an increase in her own self-esteem too.

*I think actually some people have maybe kind of... well my mum, she's kind of... like, I know she's really pleased and I remember she was in the street one day and she said to me 'oh this woman just came up to me and...' she went no, she goes 'I was talking to this woman and she said that her daughter was breastfeeding and she was having real trouble and she's trying to get the child onto formula and bla, bla, bla' and she goes 'oh I wish my daughter was here because she's already breastfed, she'll be able to give you some advice' and I thought my mum was obviously really... you know, she was wanting me to be there to give this woman advice. (...) I know my mum was really, really... dead chuffed [proud], so I suppose actually it's not so much for me because I don't feel as if I'm better than anybody, but I think for other people have thought, you know, 'Elspeth's got experience there' and if there's anybody that they come across that needs any... I'll be the person that they would turn to.*

For Rhona, there is the achievement of being able to manage to overcome difficulties and achieve a goal she set herself and do something which is perceived as 'tricky' and that others had not thought she would achieve. Additionally she can take the credit from the positive outcomes she believes she has given to her daughter.

*I feel quite... I set out a goal and I managed to do it. I'm not sure, that's quite tricky, haven't really thought about that... smug [laugh]! 'I did it, they all told me you wouldn't!' Don't know... I'm so glad I did do it, I'm so glad I managed to do it and I see what I believe as being all the benefits to Niambh every day really and I think 'I'm so glad I did that' you know, cause she's turning out so well and I do put a lot of it down to that and I give myself quite a lot of credit I suppose [laugh]! Possibly not telling everybody this [laugh]...but I do to myself 'it's cause I breastfed her'. My friends and I, we quite often have a bit of a giggle about it kind of behind closed doors of 'that's cause we breastfed ours, they're better' [laugh] it's terrible! No I think that I do, I feel kinda proud of myself, it's an achievement.*

Talking about raised status raised a number of contrasting feelings for participants, as Rhona exemplifies. While willingly admitting to feeling proud of their achievements, they were often aware that this might sound boastful or smug and that their pride in their perceived achievements might suggest that they were comparing themselves with other women who did not breastfeed. They then felt self-conscious at potentially being seen to look down on or judge these women and being seen as suggesting that they were 'better' than them. This can be inferred from Rhona's extract above where her uncomfortable laughs and confession that she would 'possibly not tell[ing] everybody this', and only saying it 'behind closed doors' shows the awareness that her own pride in succeeding is also associated with a negative social comparison with others who have not breastfed. In her extract, Debbie articulates some of these feelings while she wonders about whether breastfeeding gave her babies advantages, her self-conscious laugh and reiteration that she does not compare herself to others, highlighting some dissonance in her words and feelings.

*I don't think of myself as a better mum or anything but I just think I've gave them the best start and the two of them are clever and I don't know if that's got anything to do with it either, but they come away with some things that just amazes me and I think 'd'you know, is that cause you were breastfed?' [laugh] and maybe...I just feel there's a wee sense of achievement in that for me, maybe it was me/maybe it wasn't, maybe they were always going to be clever but in my mind it was me [laugh]! Well that's just the way I feel, I don't know if that's... but I don't think... I don't compare myself...*

Despite some of this self-consciousness, however, participants retained and articulated a belief that breastfeeding and high esteem, successful or 'proper' mothering, were intertwined. Niambh, who had struggled psychologically with some overwhelming feelings early in her breastfeeding relationship, saw breastfeeding as a sign that she had 'made it' as a good mother. This was important to be able to announce publically, in order to get that sense of external validation to shore her esteem up.

*I felt that it was quite an empowering thing to see myself, I felt it was a sign of being a successful mum, the fact that look at me I'm out, I can drink a cup of coffee, I can breastfeed my baby and I can have a conversation at the same time, look at me! (...) It just made me feel like more of a complete mum. I don't have any... if people want to bottle feed that's absolutely fine and, you know, Maggie was given a bottle, but just to know myself that I breastfed and to have it be seen...*

The assessment of others and its impact on esteem, featured in a slightly different way for Mhairi, who was from a solidly working class background. Mhairi's contribution to this theme was of interest as she was the only participant who openly referred to issues of class in her interview. She is also the only participant who had formula fed a previous child. She can therefore compare how she felt while undertaking each method and her feelings about herself and expectations of the community.

*I dae feel a wee bit more, no a better mum than some folk, that is the wrong way to put it, I feel proud of myself because I have achieved something. I mean, it is something to feed your babies, I don't know. I do feel different this time from what I did when bottle-feeding, from what breastfeeding, but I always put that down to being older when I had them, I don't know how I see myself. That is a question, so it is. Sometimes I always think like, I come from a council estate, there is nae a lot of people round here breastfeed, so I always feel, when I am out and about, folk would just assume that I was going to bottle feed my baby and folk they look at you different because you breastfeed. I was once called a hippy mum, aye, I was once called a hippy mummy and that was fae [from] one of the other mothers. (Pause) I don't know how I see myself.*

Mhairi goes on to describe the apparent change in social status in the community due to her breastfeeding. The infant feeding decision she made appears to have influenced others and her own socio-economic status i.e. class. As such it appears to have directly

affected her social mobility, performing an activity which is more prevalent in more affluent groups.

*I feel as if I have got more in common with different people noo, like when I go to the breastfeeding bit [group], there are some people there that I would'nae normally speak to and they normally would'nae speak to me, but because we have got something in common it is different so it is, and it has opened my eyes a wee bit more, that there it is more than just 'here', more than this place, if you know what I mean. It is different, I feel as if, em, when people do see you breastfeeding they have a wee bit more respect for you, so they do.*

It can be seen that despite the societal taboos that have been identified in the superordinate theme 'Breaching of Social and Family Norms', the rarity of breastfeeding as an activity, the challenges which needed to be overcome and the societal discourses about the value of breastfeeding as an optimal feeding method, lead to feelings of enhanced status and esteem. When reflecting on the superordinate theme, the connections between the themes emerge, telling a story of the emotional and esteem rewards of the sacrifices made in the exclusive relationship that forms when breastfeeding a baby.

## Chapter 12 - **Discussion of Findings**

### **12.1 Introduction**

This study provides an original contribution to knowledge by offering new understandings of the experience of women who have breastfed when they are the first to breastfeed in their family. Further, it gives insights into how women make sense of their decision making and the impact of their decision on their relationships with their family. As might be expected from an IPA study, it identifies aspects of the experience which are phenomenologically focussed and embodied, and socially constructed, reflecting discursive aspects of the experience.

It has been established that infant feeding experience and decisions are embedded in complex social structures with embedded norms and values, and have been so throughout history. In previous chapters, it has been outlined that families bring their own history and culture to parenting decisions, including breastfeeding, which influences the initial breastfeeding decision and the support families can offer the mother with her breastfeeding experience. An understanding of having feeding intentions which are not congruent with that of one's family and the impact of feeding choice on their family relationships is likely to be an important consideration for providing effective breastfeeding support to be able to give woman centred, individual care to breastfeeding mothers. Therefore, in this chapter, the findings from the four previous chapters are considered in relation to the research questions and the literature and the implications for practice are explored. The limitations of the study, along with recommendations for practice and suggestions for areas which would benefit from further research, are also discussed.

## **12.2 Synthesis of Findings**

In this synthesis, the interpretative themes generated from the interviews are related to the research aim and questions. Thus, this synthesis provides an account of the experience and meaning of being the first person to breastfeed in a family considering: women's experience of feeding when they have no immediate family history of breastfeeding; how women make sense of their decision to breastfeed; and their understanding of how their decision has affected their relationships. The boundaries between these three areas are not always distinct and there are a number of connections between the sections which follow. While aspects of the breastfeeding experience appear to be shared with women in other studies of breastfeeding experience, there were several areas of difference and a number of original findings.

### **12.2.1 Experience**

Participants in this study who breastfed when they had no immediate family history of this, faced a number of challenges. Once breastfeeding, women found they were exposed to the critical views of others. This included facing the consequences of breaching social, community and family norms which led them to feel that they were undertaking a stigmatised or counter culture activity. Consequently they adapted their behaviour, becoming limited in their ability to participate in daily life: having to find private places to breastfeed or conceal their bodies. Although some railed against this, most accepted the stigma and put other people's feelings above their own, feeling that they were the ones who had to be accommodating. They were even able to take pride in their ability to adapt, emphasising their skill in being able to breastfeed discreetly (Surviving in a Hostile Family Environment and Breastfeeding as a Social Taboo).

To add to this, participants found themselves unprepared for the difficulties they would face with breastfeeding (Unprepared for the Challenge). This included physical challenges (The Horrors) and emotional demands (negative aspects of An Exclusive Relationship). This appeared to be due to their lack of experience of breastfeeding in the family and community and the unrealistic picture they were given by health professionals and other women (They Keep the Truth from You). This led to a mismatch of expectations and reality and as a consequence, women ascribed breastfeeding difficulties to their own personal lack of skill or competence. Having faced a number of breastfeeding challenges, women attributed their ability to continue breastfeeding and overcome difficulties to their own perseverance (Getting Through It).

As a consequence of their decision to breastfeed, women found they had to make very significant personal sacrifices but they felt well rewarded for their efforts (Worth the Sacrifice). This involved putting the baby's needs before their own and feelings of guilt if they did not do this. Breastfeeding meant sacrificing many aspects of their lives, bodies and identity for the baby and involved feelings of loss and disorientation. While the sacrifice was described as being done willingly, the experience was very challenging for many of the women, but in the end they were able to redefine themselves (The Sacrifice and Regain of Self).

This sacrifice, however, also brought rewards. This included an exclusive relationship which developed between mother and baby where the mother could see herself as a good mother, in a special relationship (An Exclusive Relationship) where they could take credit for the baby's development. The second aspect included the joy of having time with their baby, prioritising it over other domestic activities, and the feelings of love and adoration they felt and received from their baby (Falling in Love: The

Indescribable Described). This allowed them to see themselves as a complete mother, with raised status in their own eyes and in those of others (Raising Status).

### **12.2.2 Making Sense of the Breastfeeding Decision**

Participants reported little if no discussion of infant feeding in their family of origin or with in-laws, with formula being the implied family default position. In this context, few participants had considered what their infant feeding options might be until they were pregnant. Without exception, women saw themselves as the infant feeding decision maker (The Mother's Decision).

The possibility of breastfeeding was reported to be opened up for them by the input of midwives and from vicarious experience, including contact with peer supporters, but the decision making process was unclear and did not appear to be consciously available to women (Making Sense of a Different Decision). The predominant reported influencers on these women's decision to breastfeed were that they believed that they were going to do the best thing for their baby, often the basis of their understanding of health benefits, and because this was the natural thing to do (Breast is Best and The Natural Imperative). The combination of having made the sacrifices and overcome the challenges associated with breastfeeding and the esteem consequences of the 'Breast is Best' discourse had implications for their attitudes towards mothers who did not breastfeed, who were seen to have made an inferior decision and were judged to be lesser mothers (Breast is Best and The Natural Imperative).

### **12.2.3 Relationships**

Making the decision to breastfeed had significant impacts on family relationships.

Women became aware of their family's strong negative feelings about breastfeeding. In

some cases this was directly hostile while in other families the criticism and undermining was more covert. By breastfeeding, women breeched family norms, and challenged the family's default infant feeding position, which sometimes lead to strained relationships. This meant that they could not look to their families for support or assistance with infant feeding or early parenting concerns (Surviving in a Hostile Family Environment). To try to maintain relationships many participants adapted their behaviour, for example not feeding in front of family members to avoid overtly challenging their views. Despite this, there were some 'fallings out' with their family, largely their own mothers; with some feeling their relationships might not fully recover (Surviving in a Hostile Family Environment).

Breastfeeding also appeared to serve a function in protecting the mother-child relationship from intrusion from parents and parents-in-law. The need for frequent feeding, day and night meant the mother could refuse to be separated from her baby because of the practical need to breastfeed and this appeared to assist women in being able to be assertive about refusing to separate from her baby. This may have served to protect relationships with the extended family as grandparents could hold breastfeeding responsible for this restricted access to grandchildren, rather than it being seen as the daughter-in-law being withholding (Surviving in a Hostile Family Environment).

Having made a different infant feeding decision from their own mothers by breastfeeding, participants tried to make sense of their own mother's feeding decision. Women had little knowledge or understanding of their mother's decision making, as this was not something they had discussed, possibly to avoid conflict and awkwardness given the participants strong feelings that breastfeeding is the best way to feed a baby. This functioned to protect their relationship and their positive view of their mothers, as

did the positive constructions they formed to explain their mother's decision (Making a Different Decision).

Women's relationships with their partners were also affected. The relationship they developed with their baby, which was protectively guarded, meant that their partner was less involved than many had imagined or had originally planned as a couple. While at times this was highly rewarding for women, often the feelings of sole responsibility left women feeling overwhelmed by their baby and resentful and angry with their partners. The different parenting styles of fathers and their perceived less attached relationship meant that women could not ask for or receive help to care for the baby and rest themselves (An Exclusive Relationship)

## **12.3 Discussion of Findings**

### **12.3.1 Breastfeeding Experience**

The experience of women who participated in this study appears to have been impacted on by a number of contradictions. These included both contradictory societal discourses about breastfeeding and also conflicts within their embodied experience, which was both very challenging and highly rewarding.

The challenges of contradictory societal discourses will be considered first. On one side there is the taboo about breastfeeding, particularly in front of others (Battersby, 2007; Harris *et al*, 2003; Mahon-Daly and Andrews, 2002). This appears to be informed by the perception of the breast as a sexual object; and by the idea that breastmilk and breastfeeding are regarded with disgust and revulsion, possibly because of being associated with body fluids. This fits with participant's experience of their family's response, which was characterised by the words 'yuck' or 'gads'. Both of these

onomatopoeic phrases are expressions of disgust, and reflect dominant societal ideas about breastfeeding as 'dirty work' (Battersby, 2007). In contrast are the dominant discourses about breastfeeding being the best and most natural way to feed your baby (Wolf, 2007; 2010; Dykes, 2006a). This places women in a position of tension where their desire to do what they believe is the right thing for their baby exposes them to criticism and isolation and they consequently 'sit at a juncture between affirmation and marginalisation, highlighting a significant dissonance between statistical, ideological and cultural norms' (Faircloth, 2010, p.357).

The conflict between breasts being seen as the natural way to feed a baby and participants' awareness that others often perceived breasts as sexual was widely reflected on by participants. A small body of research has explored breastfeeding's status as a stigmatised activity, with a number of cultural taboos related to breastfeeding bodies and their dual functions as sexual and nourishing objects (Battersby, 2007; Mahon-Daly and Andrews, 2002; Stearns, 1999). The meaning of breastmilk has also been explored with breastmilk being seen as 'matter out of place', with associations with pollution and perceived dirtiness (Battersby, 2007; Bramwell, 2001; Schmeid and Lupton, 2001).

It appears that participants have internalised the cultural messages about breastfeeding, as explained by objectification theory. This suggests that individuals adopt the messages around them and attempt to conform to them in an effort to maximise rewards and avoid negative consequences (Fredrickson and Roberts, 1997). This stigmatised status led to reluctance to be seen participating in this activity, which persists despite public health campaigns and legislation in the Scottish Parliament which protects

women's right to feed their babies in public places (The Breastfeeding etc. (Scotland) Act 2005).

The concern at the public response to breastfeeding resulted in participants becoming limited in their ability to participate in daily life: having to find private places to breastfeed. Despite the Infant Feeding Survey suggesting that the vast majority of women in Scotland were aware of their right to feed in public (73%) further detail in the survey suggests that only 12% felt comfortable feeding anywhere other than a 'special place' with 8% reporting being stopped from breastfeeding or being made to feel uncomfortable (McAndrew, 2012).

For women in this study, this reluctance to feed in front of others applied not only to public spaces but also within spaces which might be considered to be private, such as with family members, and even their own homes. This reflected the taboo that women in this study experienced not only within society, but additionally within their own families where they received a hostile or unsupportive response. Women in this study actively avoided feeding around potentially critical family members and also those they thought might be uncomfortable around or opposed to breastfeeding. This appeared to be both about a concern with breaching social and family taboos and the response they might receive, but also about wanting to be considerate of the feelings of others. This fits with other research which has shown that breastfeeding women are sensitised to the responses of others around them (Murphy, 1999). It is argued that, as a society, we should be questioning why the feelings of others should be prioritised over a woman's right to feed how and where she wants, and over infants' health and wellbeing (Williamson *et al*, 2012).

A few participants challenged the taboo and did breastfeed in public, however, this was accompanied by an assertion that any breastfeeding in public was being done 'discreetly', so that no one would know they were doing it. Participants in this study appear to attempt to manage the stigma associated with breastfeeding through concealment (Breikopf, 2004) and took pride in being able to feed discreetly, not feeding anywhere in public until they could do this. It has been argued that this use of discretion to make breastfeeding more acceptable appears to be the only culturally agreed way to breastfeed, both in the UK (Boyer, 2011; iBreastfeeding, 2010) and more widely in a Western international context (Lane, 2014; Bartlett 2005) with other studies having found that women will not feed in front of anyone unless they can feed discreetly and looking as if it is without effort (Sheeshka *et al*, 2001; Stearns, 1999). This appears to be confirmed by the widespread popularity of breastfeeding tops and capes which aim to conceal the act of breastfeeding from public view (Netmums, 2014; NCT, 2013).

One of the consequences of breastfeeding being delegated to the private sphere, or feeding having to be so discreet that it is un-noticeable, is its lack of visibility in the community. This continues the myth of breastfeeding as trouble free, silencing the early difficulties and efforts which are required to attain trouble free breastfeeding. This precludes women from having a realistic picture of early breastfeeding and adds to their lack of preparedness. Additionally, this invisibility compounds the lack of community familiarity and/or acceptance of breastfeeding, reducing vicarious experience and continuing to keep breastfeeding as a marginalised activity.

A further challenge for women associated with contradictory discourses was the clash between the 'natural' construction of breastfeeding, held by women, which led them to

expect non-problematic feeding, when their embodied experience was highly problematic. It is argued that the experience of breastfeeding is romanticised (Hall and Hauck, 2007; Mozingo *et al*, 2000; Bottoroff, 1990) and that many women had idealised expectations of breastfeeding, particularly when they had no knowledge about breastfeeding other than their antenatal education (Grassley and Nelms, 2008). Indeed, many of the participants in my study found themselves unprepared for the physical difficulties they would face with breastfeeding. For the majority of participants, the embodied act of breastfeeding was painful. This is consistent with the literature from a range of studies in different contexts (Williamson *et al*, 2012; Kelleher, 2006; McBride, 2004; Chapman *et al*, 1985). For many participants, as in other research, this led to a dread of the next feed and undermined them in their confidence that they could continue breastfeeding (Williamson *et al*, 2012; Larsen *et al*, 2008). The intensity and severity of the pain was shocking to many of the participants who described it as ‘torture’ and ‘agony’ and this is consistent with other studies (Williamson *et al*, 2012; Kelleher, 2006; Schmeid and Barclay, 1999). As an embodied experience, pain, according to Merleau-Ponty (1981) always has meaning and for participants in this study, pain acted to signal that something was ‘wrong’ with breastfeeding, which on occasion facilitated women to seek help, but more often it led to feelings of self blame and inadequacy, as has been found elsewhere (Grassley and Nelms, 2008).

Women who participated in this study not only believed they had received an unrealistic picture of breastfeeding, they further asserted that the truth about breastfeeding was actively kept from them by health professionals and sometimes other women. This dissonance between expectations and lived experience may have been compounded by their lack of experience of breastfeeding in the family and community.

While it could be argued that it is difficult to ever prepare for an embodied experience such as childbirth or breastfeeding, it has been proposed that current antenatal education which focuses on positives to try to encourage women to commit to breastfeeding (Wall, 2001), contributes to a clash of expectations and reality (Lavender *et al*, 2005) In Scotland, antenatal breastfeeding preparation is specified in a national core syllabus (NHS Health Scotland 2011) which is informed by UNICEF's '10 Steps' programme and '7 Point Plan' (UNICEF 2014). This requires that antenatal education should include the benefits of: breastfeeding, particularly exclusive breastfeeding; feeding on demand; and keeping a baby close including the importance of skin-to-skin contact. The programme includes: explanation of the risks of artificial feeding including formula feeding and pacifiers; reassurance about how to know your baby is getting enough milk; and information on how to position a baby at the breast, with a focus on the idea that with appropriate 'technique' the experience will be problem free (the teaching of which is usually done with a doll).

Consequently, participants in this study did not feel this prepared them for the difficulties they experienced with breastfeeding. Given that the participants had a belief that breastfeeding was instinctive, natural and problem free, they struggled to understand why health professionals were offering training in how to breastfeed, and why they were given a doll to 'practice' feeding. The lack of realistic explanation about potential breastfeeding difficulties, which many women experience meant that women therefore attributed difficulties to themselves and doing it 'wrong' as opposed to getting it 'right' and using the correct methods. Similarly, an interpretative phenomenological analysis of women's early breastfeeding difficulties (Williamson *et al*, 2012), found a tension between the 'natural' discourse and women's experience of difficulties which

threatened their emerging maternal identity and lead to them feeling that their difficulties were their failures regardless of the contextual constraints. This threat to maternal identity could potentially have implications for women's mental health and wellbeing. It has been suggested that not managing to meet your own breastfeeding intentions has implications for maternal wellbeing (Redshaw and Henderson, 2012) with one study showing that a 'failed' breastfeeding attempt due to breastfeeding difficulties is associated with depression (Edhborg *et al*, 2005).

A significant and original finding from this research is the reluctance of participants to share their breastfeeding difficulties with others. This appears to be both about not putting other women off breastfeeding and also because they do not want others to know that they had not matched the blissful perception of motherhood, and that they were feeling like they were failures. The participants therefore found themselves colluding with the conspiracy of silence which they had suffered from themselves. This lack of honest discussion undermines and isolates women in their breastfeeding experience, and leads to a vicious circle where hiding the reality of breastfeeding continues to fuel the unrealistic expectations of motherhood and breastfeeding.

In addition to the physical challenges, women found themselves emotionally and psychologically unprepared for the challenges they faced. This included emotional suffering and feeling psychologically overwhelmed and disoriented, having to give up of many aspects of their lives, bodies and identity for the baby. While the sacrifice required was described as being done willingly, the experience was very challenging for many of the women and it has been suggested that this experience of loss can increase the risk of postnatal depression (Edhborg *et al*, 2005). Feelings of loss of self and identity are not unique to breastfeeding mothers and have been reported to be important

for many mothers at the transition to motherhood, irrespective of feeding method (Oakley, 1980). There do however seem to be some differences between formula feeding and breastfeeding mothers' experience, which are associated with having the exclusive responsibility for feeding, as breastfeeding usually requires. Primarily this is related to women feeling that they were unable to get a 'break' from parenting responsibilities. This includes both being able to rest, but also being unable to have any time to themselves to do non-mothering activities, with the loss of their social life being particularly important. The loss of independence for breastfeeding mothers, for example not being able to go out on their own, or go to parties and consume alcoholic drinks, has been documented elsewhere in the literature (Andrew and Harvey, 2011).

In this study, women coped with this challenge in several ways. The time limited nature of breastfeeding made the sacrifices more manageable for some of the women, where it was seen as a 'shift' or 'sentence' which had to be served. Others tried to create a break for themselves by expressing their milk for others to use to feed their baby. It has been argued that expressing milk can be a solution to managing the competing demands of breastfeeding and maternal independence by allowing the continuation of breastmilk but avoiding the allegations of not providing optimal mothering (Johnson *et al*, 2012). However, participants in the current study found the efforts of expressing outweighed the rewards, particularly because their partners did not appear to want to be involved in feeding.

When making sense of what 'got them through' the highly challenging experiences participants had faced and allowed them to continue to breastfeed, participants provided a number of explanations, which included their own perseverance and determination. Attributing their continuation to their own determination and perseverance fits with

other research findings, describing women's motivation for breastfeeding as a test of perseverance (Dykes, 2005; Hoddinott and Pill, 1999; Bottorff, 1990) and determination (Hauck *et al*, 2002). Believing that intrinsic factors were the predominant reason for being able to continue and overcome difficulties allowed women to credit themselves with achieving the outcome, which has positive esteem implications.

There were additional esteem and identity issues for this group of participants. Mothers in this study, in common with other new mothers (Laney *et al*, 2014) found that, while they felt they temporarily lost their identity, breastfeeding and the narratives which surrounded it appeared to give her a new, but somewhat fragile sense of identity. For all women in this study, breastfeeding was extremely important, and was considered an intrinsic part of mothering, taking priority over other aspects of their lives. It has been argued that breastfeeding appears to have become intimately linked with 'good mothering' with implications for women's sense of self and feelings of personal esteem (Marshall *et al*, 2007; Hauck and Irurita, 2003; Schmied and Lupton, 2001; Murphy, 1999). There is a positive side to this narrative as mothers, by feeling that they were sacrificing themselves for their babies, including experiencing pain and giving up aspects of their lives, appeared to be affiliating themselves with the 'good mother' narrative. This has affirmative implications for their new maternal identity and sense of self. Alongside this, however, is an implication in participants' narratives that while babies have needs, women have wants, and as such women need to be willing to give up their desires for their baby and breastfeeding, in order to retain their status of 'good mothers'. This reflects the more difficult side of this narrative; and introduces the idea of 'total motherhood' which acts in a more punitive manner (Wolf, 2007) and involves mothers committing every aspect of themselves to their children and is considered to

start in the womb and is continued by breastfeeding. Women are therefore expected to provide optimum mothering, irrespective of the consequences for their lives, identity and autonomy. Any lesser commitment is considered dangerous and irresponsible (Wolf, 2007), exposing ones children to risk, which is not considered to be acceptable (Knaak, 2010). There is evidence that participants in this study had subscribed to this concept, and they acutely describe the feelings of guilt they experienced if they did not put the baby's needs before their own at all times.

Some powerful, positive constructions of breastfeeding were found in this study. Positive aspects of breastfeeding have been found in other studies, with a focus on feelings of 'connectedness between mother and baby (Burns *et al*, 2010; Schmied and Barclay, 1999). It has, however, been investigated far less than the negative aspects of breastfeeding and this study offers a rich description of the more pleasurable and affirming aspects of women's breastfeeding experience. Women in my study strongly argued for the rewards of breastfeeding which made all the challenges 'worth it'.

An aspect which was identified in this study is the reward of the exclusive relationship which developed between mother and baby, where the mother could see herself in a special relationship, where she could take credit for the baby's development. A highly rewarding aspect of breastfeeding included the joy of having time with their baby, prioritising it over other domestic activities, and the feelings of love and adoration they felt and received from their baby. The fact that this intimate experience was not present with every feed seemed to make it more precious, where the difficulties and pain of breastfeeding, made the moments of intimacy more precious. It is possible that these moments are important in helping women persist through various difficulties and that women who do not experience this joy may be less motivated to continue.

Despite the very positive feelings associated with breastfeeding, often women struggled to find words to describe the intimate side of breastfeeding. This suggests that this embodied experience of breastfeeding is, as described by Ryan (2011), ‘pre-logical, pre-articulated’, which existed as an experience before language and therefore defies it. When women tried to describe this experience the most commonly used descriptions were that it was ‘time together’ and they tried to describe ‘the look’ their baby gave them at this intimate time. When describing this growing intimacy, there was a resonance with the language of romantic fiction, describing a new couple’s relationships. While this feeling of interconnectedness and intimacy was also found in other research (Burns et al 2010, Schmied and Lupton 2001; Bortoff, 1990), only a small number of studies have examined this in depth. In the few examples found, breastfeeding has been previously described as ‘being with’ and ‘linking as one’ as women came to know their babies (Dignam, 2001; 1995) and feeling that they were giving their babies milk as a ‘gift’. Alternatively this experience was named ‘fulfilment’ (Ryan *et al*, 2010) but none of these seem to be able to fully capture the experience that women in my study tried to describe.

Over time, therefore, breastfeeding became less of a means to feed a baby, with difficulties to be overcome, and moved towards being an intense, rewarding relationship. Women in this study described a closeness that developed through time spent together, which became a mutually rewarding exclusive relationship. Through breastfeeding women became confident in their skills to soothe and care for their baby. There were clear links between bonding, feeding and caring for a baby, with the participants clearly associating these activities with the mother’s role, in some cases jealously protecting the exclusivity, often excluding others to the extent that they could

not assist with baby care. The exclusive nature of the relationship has been found in other studies (McBride-Henry, 2004; Dignam, 2001; Schmeid and Barclay, 1999). The exclusive, rewarding relationship meant that participants experienced themselves as a 'complete mother', with raised status in their own eyes and in those of others. This perceived raise in status can be explained by social comparison theory (Festinger, 1954) as breastfeeding can be seen as a rare, high status activity, allowing women to compare themselves with others who are seen to make a lesser choice. This is considered to be a downward comparison, which can elevate self-esteem and regard and increase one's subjective well-being (Suls *et al*, 2002).

While it could be argued that the intimacy and esteem rewards of breastfeeding were sufficient to compensate for the difficulties women face, it could also be argued that the cognitive dissonance they were experiencing, where they were willingly participating in an activity that meant they suffered, compelled them to find an explanation which made sense of this suffering. Cognitive dissonance can exist when there is a conflict between beliefs or beliefs and experience and can occur when someone undertakes an activity which they feel they are obliged, but not forced to do (Festinger, 1957). This can lead to feelings of discomfort where individuals try to make sense of their actions in order to reduce the dissonance whenever possible. One way of doing this is by increasing the value of the activity, hence justifying the discomfort and inconveniences of the actions. It could be argued that this process occurs in women experiencing breastfeeding difficulties and increases their attachment to the idea that breastfeeding is good for their baby, is rewarding and has high status.

### **12.3.2 Making Sense of the Breastfeeding Decision**

Participants reported little if no discussion of infant feeding in their family of origin or with parents-in-law, with formula being the implied family default position. The family norm appears to be so dominant that it has become the invisible backdrop for early child rearing, and is not even relevant for discussion. It appears that in these women's families and communities, breastfeeding is invisible. It is therefore not so surprising that, in this context, few participants had actively considered what their infant feeding options might be until they were pregnant. This fits with Scott and Mostyn's findings (2003) in Glasgow and suggests that despite the numerous healthcare interventions and public health campaigns in the last ten years, attitudes towards infant feeding do not appear to have changed in families and communities in the West of Scotland. They also suggest that women who do breastfeed in this context are highly committed to breastfeeding, which appears to fit with the findings in my study.

Without exception, women saw themselves as the infant feeding decision maker and expressed strong feelings about their right, and the right of other women, to make the decision. While a number of women initially suggested in their interviews that breastfeeding was a joint decision, more detailed exploration revealed that this was not the case. Diverse views about the relative role of parents in influencing decision making have been found in the literature. Several studies have found that fathers are influential in decision making (Scott *et al*, 2006; Littman *et al*, 1994) with some suggesting that fathers were fundamental to this (Pisacane, 2005; Arora, 2000). However, most have suggested that fathers may have a limited role in influencing breastfeeding decision making, with women feeling the decision was actually theirs (Andrew and Harvey, 2011). Of particular interest is a recent Scottish study, where couples had a variety of

levels of involvement, from the ‘share everything’ approach, to the women as a ‘one man band’, where the woman’s perception was that fathers were not at all involved. (McInnes *et al*, 2013). In general however, fathers were found to be ‘not really bothered’ (Hoddinott *et al*, 2012) and would support his partner in whatever decision she makes (Sheehan *et al*, 2013; Avery and Magnus, 2011).

Of significance in the current study is the use by participants of embodied arguments to support women’s entitlement to make the decision. The assertion by a number of participants that breastfeeding is an extension of pregnancy appeared to be particularly resonant for these participants. However, publications considering partners’ views on breastfeeding decisions support this finding suggesting that many men believe it is really the woman’s choice given that it is her body (Barona-Vilar *et al*, 2009; Rempel and Rempel, 2004)

The process of how women made sense of their decision to breastfeed is not a straightforward one. Participants did not appear to have full access to their own decision making processes and few were able to give a coherent account, at least when first asked during the interview. This fits with the idea that this may be a non-cognitive process (McInnes *et al*, 2013), akin to ‘fast’ decision making which is unconscious and informed by emotions, as opposed to a ‘slow’ rational process of decision making (Kahneman, 2011). When explored in more detail and from ‘side’ angles, women constructed explanations about their decision making process, often appearing to articulate them for the first time during study interviews. The flexibility of the semi-structured interview and analytic method used allowed the depth and richness of these explanations to be expressed, clarifying women’s meaning.

A number of factors were given by participants to make sense of their breastfeeding decision. A primary explanation, which will be considered first, was that the possibility of breastfeeding was opened up through contact with others. This included the impact of seeing others breastfeed, which may have been a number of years before they themselves made any decision to breastfeed, and advice from midwives and to a lesser extent, peer supporters during their pregnancy. Across all participants' accounts was the influence of the idea that breastfeeding is the best thing to do for your baby and, as previously detailed, that it was 'natural'. These dominant discourses, which are clearly reflected in participant's accounts and the emerging themes, also have implications for those women who do not breastfeed, and these aspects will be discussed later in this section.

While witnessing others breastfeeding was a rare event, and not always positive at the time, on reflection, participants reported that this experience was significant for them. It has been argued that seeing breastfeeding, i.e. vicarious experience, provides an 'embodied' knowledge' of breastfeeding for women and that this can influence breastfeeding decision making by increasing their confidence that breastfeeding might be possible for them (Schmied, 2013; Hoddinott *et al*, 2009b; Dykes, 2006a; Hoddinott and Pill, 1999). It appears that vicarious experience through a relative, is even more powerful, as although no participants in this study had any immediate family members who breastfed, aunts and even distant relatives in other countries (who had not been witnessed breastfeeding) were cited as important, opening up the possibility that 'I could' breastfeed. This fits with a key finding from a vicarious experience study where seeing feeding by a female relative was particularly influential (Hoddinott and Pill,

1999) and fits with social learning theories which suggest that vicarious experience is most powerful when it is being modelled by someone ‘like yourself’ (Schunk, 1987)

A network supportive of breastfeeding is thought to be important for breastfeeding continuation (McInnes and Chambers, 2008). In the absence of support from the extended family network, a number of women in this study appeared to seek their network support from peer supporters and credited some of their ability to continue to breastfeed to their relationships with them. The peer supporters were part of a local, funded service and had significant breastfeeding training and experience, at a level which is higher than usually found in health professionals (Darwent and Kempenaar, 2014). Women in my study highly valued peer support and felt that peer supporters understood them like no-one else, because as breastfeeding mothers themselves, they had ‘been through it’. It is not possible to assess from this study whether this is specific to the study population or reflective of the usefulness of peer support to all breastfeeding women (Ingram, 2013). However, findings in this study fit with the literature which suggests that a women who do not have a supportive family, cope better when they are able to build a network of support which is congruent with their feeding intentions (Hauck and Irurita, 2002).

A further significant influence in making breastfeeding a possibility was through women’s contact with midwives. With limited family and wider community knowledge and experience, midwives became a very important source of information on which to base a decision. As has been found in other studies (Earle, 2002; Hoddinott and Pill, 1999; Schmied, 2013), midwives were respected as authorities on the health benefits of breastfeeding. While women were critical, on reflection, of how poorly they felt they were prepared for their breastfeeding experience, they accepted uncritically the

information midwives offered about breastfeeding and midwives appeared to be powerful transmitters of the 'Breast is Best' and 'The Natural Imperative' Discourses.

Without exception, the 'Breast is Best' discourse was at the forefront of decision making. Women in this study reported that their awareness that breastfeeding was the recommended method of feeding babies because of the benefits it brings, with particular attention being given to the health benefits for their baby. Combined with the idea that breastfeeding 'should' be done because of its 'natural' qualities, a powerful moral context for participant's breastfeeding decision making emerges. The power of the 'Breast is Best' message has been identified in numerous studies, most recently in Sheehan *et al* (2013) who 'deconstructed best' to assist in the understanding of breastfeeding decision making in an Australian population. The idea that breastfeeding is the 'best' way to feed, gives rise to an underlying assertion, that any 'good mother' would want to give her baby the best, and would therefore breastfeed. The existence of this moral context has already been touched on in earlier sections of this discussion where the 'good mother' identity appeared to assist women in their recovery from the disorientation of early mothering and breastfeeding. It has been argued that concern about being a 'good mother' shapes not only behaviours but also the way that women make sense of and account for their behaviour (Lee, 2011; Miller *et al*, 2007). The power of dominant discourses in this context is that a number appear to tie in with each other creating a context where women feel under pressure to fit with dominant ideas about good mothering or judged by others, including health professionals, family and community and even strangers. The idea that how babies are fed is a measure of how good a mother one is, also poses the risk that it will also be used as a means to judge others (Avishai, 2007).

The 'good mother' discourse was found in this study to have implications for participants' attitudes towards mothers who did not breastfeed, who were seen to have made an inferior decision and were usually covertly, but sometimes overtly, judged to be lesser mothers. It can be argued that the language used around breastfeeding continuation both reveals and reinforces this moral context with the widespread use of the terms 'success' and 'failure', for example in the 'The Ten Steps to Successful Breastfeeding' (UNICEF, 2014) and this may contribute to the 'moral baggage' around infant feeding (Shaw, 2004). Although there is not an active policy to make women feel guilty or shamed by not breastfeeding, the implications of the 'Breast is Best' message is that formula feeding is a lesser choice and that therefore women making this decision can be judged as lesser by the community of those who do breastfeed.

These influencers appeared to reduce the choice for women in this study, motivating them to continue breastfeeding, and instead appeared to be moral discourses that they were obliged to conform to or else face feelings of guilt. Guilt can be seen as a mechanism for encouraging moral behaviour (Manion, 2002), and functions as an adaptive mechanism that serves to discourage transgression and encourage compliance (Ranganathan and Todorow, 2010). It has been further argued that mothers who do not breastfeed do not just feel guilt, a feeling that a particular action or inaction caused harm, but there is something more, a feeling that they are somehow deficient as mothers, a failure, and that it is shame they experience, falling short of the expected standards of motherhood (Taylor and Wallace, 2012). Women who formula feed appear to be aware of this discourse and are concerned that other women would think less of them for not breastfeeding (Andrew and Harvey, 2011). This led them to feel the need

to defend their decisions to try, but fail, to escape this negative experience (Miller *et al*, 2007).

### **12.3.3 Relationships**

Making the decision to breastfeed had a significant impact on most of the participants' interpersonal relationships within the family, particularly between the mothers and grandmother. In a number of families, mothers used a number of strategies to try to overcome or offset the impact on their relationships, but this was not always successful and there were some long term impacts on relationships. This reduced the sharing of experiences between mother and grandmother which are part of the transition to motherhood and grandparenthood. This affected the emotional and parenting/practical support available for the mother with a consequent lower level of grandparental involvement in the new generations' upbringing.

Initial difficulties in family relationships were largely due to women's awareness and experience of their family's negative feelings about, and lack of understanding of, breastfeeding. In some cases this was directly hostile, while in other families the criticism and undermining was more covert. This has been previously found in UK and Scottish studies, where some very negative views were expressed (Lavender *et al*, 2006; Scott and Mostyn, 2003). This suggests that attitudes have not moved on in the last ten years and that by breastfeeding, women breached the family's understood ways of doing things, challenging the default infant feeding position.

These relationship difficulties can be understood by using the concept of the family script. Family scripts act as a trans-generational guide for how to parent (Byng-Hall, 1985). When a family member's actions do not fit with the expected script, it is argued

that this is noticed and attempts can be made by the family to try to get the person to adapt their behaviour. If the family member does not conform to the script, tensions can occur, particularly at periods of transition, when families may become closer and relationships more intense, due to centripetal forces (Carter and McGoldrick, 2005; Combrinck-Graham, 1985).

The complexity of family life is highlighted by the variability in the impact that making a different feeding choice had on their relationships. Almost all participants in this study report that choosing different feeding method did appear to increase intergenerational tensions and there were some 'fallings out', with consequent feelings that their relationships might not fully recover. This is not previously reported in breastfeeding research, but the experience of having to renegotiate and restructure relationships over other aspects of parenting have been described (Luescher, 2002). It is also possible that in the families most affected by intergenerational conflict, previously underlying tensions were exposed by the increased intensity of the relationship associated with the transition to parenthood (Combrink-Graham, 1985), with breastfeeding receiving most focus as a point of difference.

Other mothers, however, managed to find ways to sustain relationships with their families and remained close. It appears that participants, in the main, found a number of means of coping with the different expectations about infant feeding and hostile attitudes towards breastfeeding. For example, participants adapted their behaviour by not feeding in front of family members, to avoid overtly challenging their views, and avoided discussions about breastfeeding or other aspects of early parenting to avoid conflict or criticism. Some managed to mentally turn family members' criticisms into a joke, finding positive constructions for negative comments that were made.

One of the consequences of having a different approach to infant feeding from their families was that this group of mothers were not able to approach their own mother to ask for emotional or parenting support. This was because their families' views did not fit with their own, and requests for assistance or advice led to undermining comments about their breastfeeding. It has been argued (Thomson *et al*, 2011) that at the transition to motherhood, women experience an intergenerational interconnection with their own mothers which is enacted in conversations about pregnancy, childbirth and early parenting with their own mother. As such, the telling and developing of these trans-generational stories are part of the identity work of new motherhood and that being able to share an embodied experience, such as breastfeeding, with one's mother, can form an important role in cementing women's relationships (Darvill *et al*, 2010; Thomson *et al*, 2011). Because they cannot share their experience women, both mothers and daughters, therefore miss out on this important transition (Thomson *et al*, 2011).

In families where there were differences about parenting styles and different levels of desire for involvement between mothers and grandparents, significant tensions could arise. A number of grandparents wanted to be involved taking the baby out and 'introducing' him/her to their friends and the wider world, but the need for frequent breastfeeding, day and night meant the mother could be assertive about refusing to be separated from her baby. There were some negative consequences for relationships with grandparents who wanted to be actively involved both in the care of their grandchild and struggled with their lack of contact with the baby. The mothers reluctance to relinquish their infants for extended periods of time could be perceived by grandparents as a challenge to their competence and to their new identity as grandparents, impacting on their wellbeing (Reitzes and Multran, 2004) There is some

evidence that grandmothers found breastfeeding to be a barrier to bonding with the grandchild as they were not able to feed the baby or have overnight stays (Grassley and Estichi, 2008). However, the fact that grandmothers blamed breastfeeding for this perceived deprivation, may have served to protect relationships within the extended family, as grandparents could hold breastfeeding, rather than the mother, responsible for restricted access to grandchildren.

Although the impact of making a different feeding choice from your own family is an under-researched area, there have been several studies which have considered how grandmothers try to negotiate the relationships with their breastfeeding daughters (Reid *et al*, 2010; Grassley and Eschiti, 2008). Grandmothers in these studies had some experience of breastfeeding themselves, and are therefore not directly comparable with the current study, however, despite good intentions, these grandmothers struggled to support their daughters and were sometimes seen, by their daughters, to be undermining. This was confirmed in further studies which found that some women felt unsupported by their mothers, particularly those whose mothers did not have breastfeeding experience and who brought their own practices and beliefs with them in the advice they gave (Grassley and Eschiti, 2008; Morrison *et al*, 2008; Lupton and Whelan, 1998), rather than thinking of their daughters' needs and intentions (Grassley and Nelms, 2008). This undermining has been found elsewhere in the literature where grandmothers could be quick to suggest formula milk and other interventions not supportive of breastfeeding (Grassley and Nelms, 2008; Tarrant *et al*, 2002).

It has been recommended that classes offering information about infant feeding could be offered to facilitate expectant grandmothers support for their daughter (Grassley *et al*, 2012; Grassley and Eschiti, 2007), especially for those who had not breastfed

themselves (Grassley and Nelms, 2008). This has been tried in a UK based randomised controlled trial (Winterburn *et al*, 2003), where the maternal grandmother, or other close female confidante of the mothers' choice, met with a midwife on one occasion to discuss breastfeeding. The intervention did not increase breastfeeding initiation or duration of breastfeeding; therefore, the effectiveness of intervening directly with grandmothers has been questioned (Winterburn *et al*, 2003). This was however a brief information session based on a fairly standard public health information giving approach, which is unlikely to have addressed underlying attitudes or explored ways of behaving differently. A different approach therefore needs to be taken which addresses family beliefs, rather than just offering information which may not fit with the family culture.

Having made the decision to breastfeed, participants tried to make sense of their own mother's feeding decision. This previously un-researched aspect of infant feeding offers some interesting areas for discussion. Surprisingly few conversations occurred between mothers and grandmothers about the rationale for grandmothers' infant feeding decisions. While infant feeding choices may not have initially been discussed in families because bottlefeeding was the accepted norm, and therefore was the accepted and unchallenged default position, the continued lack of discussion once breastfeeding was initiated appears to suggest that the topic was actively avoided, suggesting that there may be some complex family dynamic processes involved.

It is possible that conversations about the grandmother's feeding methods may not have taken place as it is too sensitive a subject. As many families, including grandmothers, had expressed their actively hostile or undermining attitudes to breastfeeding, it is possible that mothers did not want to initiate any conversation about infant feeding, to

protect themselves from criticism. An alternative explanation; however, may reflect the mothers' fear of being perceived as critical of their own mother and further testing the already strained relationship. Many of the participants had acquired strong moral discourses about infant feeding, as explored in the 'The Natural Imperative' and 'Breast is Best' themes. It is therefore possible that because of the participants' strong feelings that breastfeeding is the best way to feed a baby, which identifies them as 'good mothers', they did not want to raise the subject in case they appeared critical of their own mother who did not breastfeed, and who is implicitly therefore not a 'good mother'.

In the few instances where women had some knowledge about their mother's feeding decisions and experience, incoherent, partial and sometimes contradictory narratives existed. It could be argued that, in the absence of being able to discuss the reasons for their mothers decision, they had to find a story which helped them resolve the dissonance that while 'the best mothers breastfeed', their own mother did not breastfeed them. It appears that some participants' are constructing empathetic explanations for their mother's decision, from the few bits of information which some of them have, to allow them to continue to see their own mothers in a positive light, thus protecting their relationship.

In addition to their relationships with their own mothers, participants' relationships with their partner were affected by breastfeeding. The relationship they developed with their baby through breastfeeding was protectively guarded, and meant that their partner was less involved than many had imagined or had originally planned as a couple. This reflects some of the findings of other studies (McInnes *et al*, 2013; Jordan and Wall, 2000). This exclusive relationship functioned as a double edged sword, bringing huge

rewards in feelings of specialness and esteem, but also meaning that the majority of care, emotionally and practically fell to them, with accompanying feelings of being overwhelmed, as previously discussed in 12.3.1 and identified in others studies (Kelleher, 2006; Wall, 2001).

While it has been suggested that breastfeeding can lead to complementary parenting task allocation (Epstein-Gilboa, 2009) with father doing the nappy changing, bathing, comforting and other basic needs, rather than feeding the baby, the women in this study did not often describe this behaviour. Rather, fathers were involved in few aspects of baby care, and were largely excluded or excluded themselves. This meant that the responsibility of childcare rested almost exclusively on the mother, with early parenting tasks being segregated along gender lines. It is of interest that a number of women did, at least initially want their partners to be involved in shared parenting and expressed breastmilk to enable this. However, without exception, men did not appear to be interested in offering their baby bottles of expressed milk and this quickly ceased. This fits with the finding that while mothers may worry that their partners may ‘miss out’ by not being involved in breastfeeding, partners were not concerned (Hoddinott *et al*, 2012).

It has been argued by feminist thinkers that breastfeeding actively interferes with equal parenting task functioning, which they consider to be important for healthy relationships, and this has led to some feminists to criticise breastfeeding (Blum, 1999). However, it appears that the men in this study rejected opportunities to participate in feeding and other caring tasks, suggesting that unequal parenting roles pre-exist breastfeeding rather than being created by it.

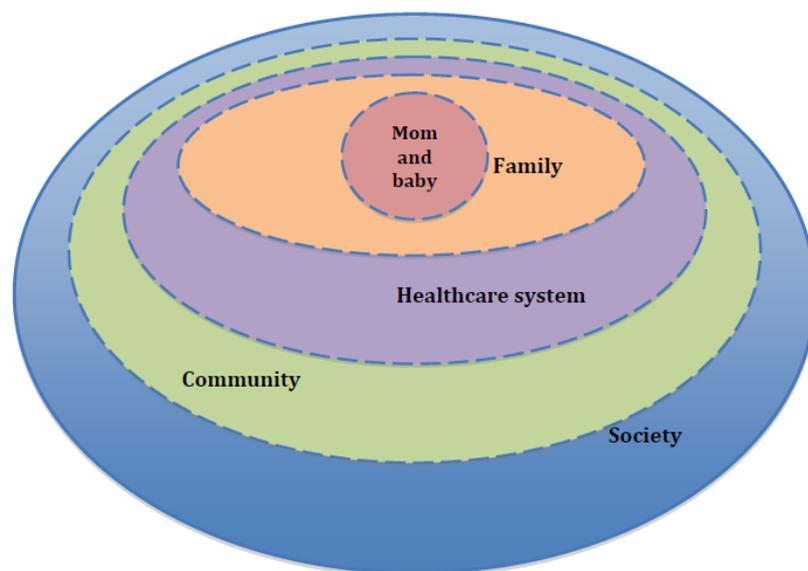
The extent of the practical support received by women was not apparent in their accounts; however, without exception, women experienced their partners as 'supportive' of their breastfeeding. This was not supportive of breastfeeding per se, rather it was supportive of them and their autonomous decision making, whatever the outcome of this might be. While it has been found that women who had partners who were supportive of breastfeeding were more confident about breastfeeding (Mannion, 2013), the description of what 'supportive' of breastfeeding meant in their study, was very different from what is described by my participants. For example, Mannions's mothers described men who were actively supportive as 'sponging the mother's breasts', being with her when breastfeeding or bringing the baby to her. This description fits only one participant in this study, Heather, whose partner would sit up with her during night feeds and bring her tea. Other participants' descriptions of their partners as being supportive fit better with definition of Mannion's 'ambivalent' fathers who would say it was their partner's choice, or would covertly undermine breastfeeding, which may reflect new fathers own sense of uncertainty about their role (Barclay and Lupton, 1999). My participants, however, perceived their partners as supportive, by telling them that they were good mothers, irrespective of their decision. This unconditional, emotional and esteem support was highly valued by women and it has been argued that this is important to continuation of breastfeeding (Dykes, 2003).

#### **12.4 Summary of Implications for Practice and Future Research**

There are a number implications for practice which have emerged from this study, which could improve the experience of women who breastfeed in the context of being the first to breastfeed in a family. Primarily, there needs to be a fundamental change in approach which sees women in their wider familial, community and societal context,

embracing an ecological view of breastfeeding. This has consequent implications for health service practice and education, breastfeeding policy and society more widely. Many of these implications also have potential applicability for all women who are breastfeeding or are making their infant feeding decision.

The ecological approach, as used in my literature review (Chapter 2) and re-visited in Figure 12, recognises the complexity and inter-relationships between the levels of context and influences on breastfeeding (MacKean and Spragins, 2012). The mother and baby and her family are at the centre of this model, with the healthcare system, community and society levels all exerting influence. It is therefore essential that due consideration is given to recommendations at each level, to bring about the fundamental changes which are required to improve women's breastfeeding experience. The ecological model is therefore used to structure the recommendations that arise from this research, with an acknowledgment of the relationships between each level.



Source: MacKean and Spragins (2012)

Figure 12 The Ecological Model for Breastfeeding Revisited

### **12.4.1 Mother and Baby**

#### **A more realistic portrayal of breastfeeding is required**

Women's experience of being the first to breastfeed in their family meant that they felt they were 'going in blind' to breastfeeding and this has a number of implications for practice. The argument that there is a need for a realistic portrayal of breastfeeding, with an acknowledgement of the initial difficulties that are commonly experienced, as opposed to romanticised representation of breastfeeding, has been strongly made (Williamson *et al*, 2012). This appears to be of great importance to women in this study who have no family and little vicarious experience of breastfeeding. This more realistic picture can normalise the breastfeeding difficulties that women in this study and others experienced and could reduce the self-blame that women feel, believing their bodies or breastfeeding abilities are abnormal.

#### **Supporting women's resilience**

When faced with these unexpected breastfeeding challenges, women drew on their own resources and determination in order to persevere with breastfeeding. To support these internal resources and help women cope with the challenges of early mothering and breastfeeding, it is recommended that women are offered psychological interventions which draw on aspects of cognitive therapy, such as challenging unhelpful beliefs and positive self-talk, developing problem-solving skills and the practice of mindfulness (Hegney *et al* 2008, O'Brien *et al*, 2009).

#### **Acknowledgement of the emotional and relational aspects of breastfeeding**

It has been argued that the current approach to breastfeeding support is reductionist, with the dominance of physical and health related aspects of feeding over the wider emotional and relational aspects. While becoming a mother is acknowledged to be an

important period of transition for women irrespective of their feeding choice, breastfeeding increases the impact of this transition because it is associated with wider life adaptations than other feeding methods (Andrew and Harvey, 2011). The feelings of being overwhelmed and disoriented that women in this study experienced, associated with the lack of opportunity to share their experience with their families, mean they potentially have a greater need for emotional support from other sources.

It has been argued that women need to experience an ‘authentic presence’ from those supporting them, knowing that they are empathising with their distress and struggles (Thomson *et al*, 2014). The acquisition of listening and counselling skills which can facilitate this stance is therefore important. Significantly, it has been suggested that this empathetic approach equally applies to non-breastfeeding mothers and their relationships with their supporters, which would also benefit from a new approach that focuses on individual and family needs (Thomson *et al*, 2014).

Encompassing a more psycho-emotional and relational approach, and the more realistic representation of breastfeeding which was requested by participants, will require significant changes to breastfeeding policy, healthcare training and practice, The nature of these changes will be developed in later section.

#### **12.4.2 Family**

##### **A family centred approach to breastfeeding support**

This study extends previous research advocating a family centred approach to supporting breastfeeding (McInnes *et al*, 2013; Schmeid *et al*, 2013; Hoddinott *et al*, 2012; Williamson *et al*, 2012). This study builds on this approach by recommending that

women and families are actively involved ante-natally, looking at their family history and stories which support or undermine their breastfeeding intentions.

Given the dilemmas grandmothers have reported in supporting their daughters, (even when they have breastfeeding experience themselves), and the lack of success of traditional information based interventions, it has been suggested that a more psychological and relationally based intervention should be tried. This could include offering support to explore and confront grandmothers' beliefs to assist them to think about their role in supporting their daughters (Reid *et al*, 2010; Grassley and Nelms, 2008). Although conducted in a USA and Australian context, these appear to have potential for use in a Scottish and UK context. Most recently, it has been argued that exploring family history of breastfeeding to allow women time to discuss their concerns and fears and/or a group consultation with other family members might be useful (Schmied *et al*, 2013).

There may, however, be some difficulties in applying this approach. The first is the caution about the effectiveness and feasibility of offering interventions with grandmothers. In a UK context, Ingram and Johnston, 2004, found significant difficulties in recruiting grandmothers to their intervention study, which appeared to reflect the negative cultural beliefs about breastfeeding in this group. A number of the grandmothers recruited to Ingram and Johnston's study, particularly those who had formula fed, had negative views about breastfeeding and did not think that a breastfeeding intervention with other grandmothers would be feasible, suggesting an unwillingness to try to change their beliefs. Although there was an increased breastfeeding rate in the daughters of those grandmothers who did attend sessions, the methodological flaws, including very low numbers of participating family members,

who self-selected to be in the study, mean that the results need to be interpreted with caution.

It is therefore possible that some families may be reluctant to engage with services which offer support to the extended family. One way of adapting to these circumstances is to adopt a systemic psychotherapeutic approach, where the family can either be present, or can be ‘kept in mind’ when working with an individual woman, couple or wider family (Boscolo and Bertrando, 1996). There are clear implications of adopting this approach for the healthcare profession and this will be expanded in the next section.

### **12.4.3 Healthcare System**

#### **The Role of the Infant Feeding Genogram in developing family centred support**

The Infant Feeding Genogram, which was developed as part of this research, could be an innovative tool to assist healthcare and supporters who are engaged with women and families. It can be completed with an individual woman, allowing the family to be ‘kept in mind’ or with chosen family member/s, and could have a place in bringing more family centred antenatal preparation for infant feeding. Currently, family history and experience of breastfeeding are not routinely recorded or explored in antenatal visits in the UK, therefore limiting the ability of health professionals, or other supporters, to provide the tailored information and support which may be needed by women when feeding their babies. Given the importance of family infant feeding history and attitudes in both the initiation of breastfeeding, and the limited ability of families to provide support, it is proposed that the infant feeding genogram would be a useful tool to build rapport and begin a conversation with women alone, or with their families, to explore their infant feeding intentions and support needs.

The application of the genogram in this context is novel, however, the genogram has proven its value as a practice based tool in a number of health contexts (Dudley-Brown, 2004; Hockley, 2000). The impact and acceptability of the genogram has been established (Martinez *et al*, 2007) and it is time efficient as, once familiar with the symbols, a genogram can be conducted in 15 minutes to 20 minutes (Wright and Leahey, 1999; Rogers and Durkin, 1984). The genogram could therefore be used as a framework to collect information by midwives, and others involved in women's care and discuss women's infant feeding history, stories and culture and begin to challenge these. It would give the opportunity for women to consider their family support networks and encourage them to begin conversations with their family about breastfeeding and identifying their breastfeeding support needs. If family support was not forthcoming, it would allow women to think about seeking early relationships with community peer support services, to build a network of social support which was coherent with their feeding intentions. It would also help health professionals to prioritise support for women who have little support and who may need assistance to succeed in meeting their own breastfeeding ambitions.

With the increasing focus on the need for a more person and family centred approach to supporting women (McInnes *et al*, 2013; Hoddinott *et al*, 2012), but with increased pressure on health professionals time, the infant feeding genogram could provide a time efficient and useful tool for the development of tailored interventions and support.

Although the Infant Feeding Genogram would need to be tested in a practice context, both for acceptability and effectiveness, the established effectiveness in other contexts, and the growing interest in family history and familiarity with family trees, which share

some features with genograms, mean that this is likely to be an acceptable, mother friendly way to open up breastfeeding conversations.

### **Up-skilling of Healthcare Professionals**

There are a number training implications which emerge as a consequence of this research. It is clear that midwives and other health professionals are a major and valued source of information and support for women, particularly for those without family breastfeeding experience. However, this is countered by arguments that health professional training in breastfeeding is inadequate preparation for health professionals to support mothers (Wallace and Kosmala-Anderson, 2007; Renfrew *et al*, 2006).

Further it has been identified that the health service workforce is in ‘urgent need of [a] skilling up’, to be able to deliver even the current antenatal education recommendations (Healthcare Improvement Scotland 2011).

In addition to the training required to deliver current approaches to supporting breastfeeding, an additional range of knowledge and skills will be required. The need for woman and family centred conversations and the focus on offering an ‘authentic presence’, where midwives can ‘be with’ women, empathising with them (Thomson *et al*, 2014) requires training which encourages a higher degree of ‘psychological mindedness’ and supports the development of listening and therapeutic skills. This goes well beyond the recently developed UNICEF requirement to be able to have an antenatal ‘conversation’ about how breastfeeding might fit with a woman’s life circumstances (UNICEF, 2014). The implications for training policy will be discussed later in the relevant section.

#### **12.4.4 Community**

##### **The importance of vicarious experience**

A major barrier to breastfeeding at the community level is the discomfort and embarrassment many women feel about breastfeeding in public, including feeding in front of family members. Embarrassment appears to be about the breach of community cultural norms, which are influenced by dominant ideas in society, which appears to shame women (Thomson *et al*, 2014). The rarity of breastfeeding and the marginalisation of breastfeeding in public, due to fear of public response, combine to increase the lack of visibility of breastfeeding. This means that women do not have the vicarious experience that women in this study said was important to their decision making and which is supported by research (Hoddinott *et al*, 2009b).

##### **Developing breastfeeding role models and peer support**

Given the importance of vicarious experience and the absence of a breastfeeding culture; women who do not have family experience of breastfeeding, and potentially other women, could benefit from visible breastfeeding role-models. This would offer the opportunity for women to see breastfeeding, both in its earlier more challenging times and the ongoing, rewarding, intimate aspects. By observing women breastfeeding in public, and struggling, as well as feeding with ease, the dominant idea found in this and other studies, that breastfeeding in public needs to be ‘discrete’ would be challenged. Women could therefore see that breastfeeding is often not trouble free, and that breastfeeding difficulties, are a normal part of breastfeeding for many, if not most women. It would also directly challenge the taboo which leads to the marginalisation of breastfeeding (Boyer, 2010).

Breastfeeding peer support organisations have been key advocates for breastfeeding and have championed women's right to breastfeed in public spaces. Developing breastfeeding peer support in Scotland would therefore be a way to increase breastfeeding visibility in a community, by supporting more women to breastfeed and to build their confidence to breastfeed in public. Although peer support programmes do currently exist, many previous interventions involve them delivering information to women via a curriculum designed to fit with UNICEF and health service requirements, where they are required to toe the NHS's 'party line'. This makes no opportunity to capitalise on their peer supporters' embodied breastfeeding knowledge and personal experience of breastfeeding, which appear to be important to women (Ryan *et al*, 2011; Dykes *et al*, 2003). This shared experience with other women can build confidence and improve women's breastfeeding experience, even if it does not increase objective measures of duration, which so often received the predominant focus in breastfeeding interventions. This could help women reclaim ideas about what breastfeeding means for them in the context of their own family and what success might look like for them, rather than success being defined in policy terms by the number of women in a population who meet nationally set breastfeeding duration targets, as expanded on in the following section (Hoddinott *et al*, 2012).

#### **12.4.5 Society and Policy**

##### **Moving towards woman and family focussed, not policy focussed, priorities**

Recently it has been proposed that adopting idealistic policy goals is experienced as being unhelpful by women (Hoddinott *et al*, 2012). This study supports this position and argues for a woman and family-centred approach to infant feeding as opposed to a policy and breastfeeding target centred one. While breastfeeding stopped being a

Scottish Government HEAT target in 2011, it remains as a local target for NHS Boards. There is an ongoing focus on breastfeeding rates as a measure of the success of the NHS's breastfeeding support outcomes. I propose a radical change from using breastfeeding rates as a measure of breastfeeding support services, and move instead to qualitative measures of how well supported women felt they were to meet their own breastfeeding ambitions. This shift begins the move from policy focussed outcomes to person and family centred ones, and could begin to challenge some of the breastfeeding 'success verses failure' narrative that appears to be dominant in the field, which will be expanded in later in this section.

### **Changes to national guidance on breastfeeding education and support**

The existing major deficits in knowledge and skills across the professional healthcare workforce have been recognised (Renfrew *et al*, 2006; Wallace and Kosmala-Anderson, 2007). The current approach includes a focus on the messages about the health benefits of breastfeeding and the physiology of breastfeeding, including the ante-natal teaching of 'positioning and attachment' (which made little sense to participants). To be able to address these and to be able to meet the recommendations for the change in approach by healthcare services, there is a requirement for a major revision of healthcare training policy.

A number of additional knowledge sets and skills need to be encompassed into the training curriculum for professionals delivering of ante-natal training and support. This needs to better prepare women for their breastfeeding experience, acknowledging the physical and emotional challenges women often report. Additionally it needs to support midwives and other supporters to acquire the psychological mindedness, emotional sensitivity and counselling skills that would be required to implement the approach I am

proposing. To facilitate this, changes will need to be made to the initial training of midwives and health visitors, as determined by the Nursing and Midwifery Council, and supported by continuing professional development. This, and other recommendations might be best taken forward as part of the revision of the Scottish Government's Maternal and Infant feeding Nutrition occurring within the Compassionate Connections project currently being undertaken by NHS Education Scotland (Scottish Government, 2014).

### **Promotion of breastfeeding and health messages**

Underpinning the current approach to supporting and promoting breastfeeding is the UNICEF Baby Friendly Initiative (UNICEF, 2014). It appears that, despite best intentions, this approach is not delivering on its intended outcomes, at least in a Scottish Context. It is also possible that UNICEF's influence on national policies and practices, could be unintentionally contributing to women's emotional distress, by focussing on policy and breastfeeding rate led outcomes and not family centred ones. The 'Breast is Best' and 'Natural' messages which were predominant in earlier public health messages and feature in mainstream breastfeeding advocacy, have been internalised by women and were highly motivating for many participants in this study. However, they are also associated with a number of negative outcomes, including for women who do not breastfeed. These include moral discourses about what it is to be a mother and the personal sacrifices required, and also the judgement of other women who make different decisions. I argue that there is a need to critically review ideas about 'good' and 'bad' motherhood and the assumptions which lie under them, as these have implications for all women, whatever their feeding method as these appear to be related to societal norms of 'acceptable' infant feeding practices. There is a delicate

balance between protecting and supporting breastfeeding, recognising its health and other benefits for breastfeeding mothers and babies, and elevating breastfeeding to have ‘special status’ which relegates women who do not breastfeed to lesser mothers who experience hurtful judgement.

It has been emphasised that women should be enabled to provide their own definition of ‘good mothers’ (Taylor and Wallace, 2012). It has been suggested earlier in this section, that the positive, authentic relationships with professional supporters, which are women focussed and respectful and which assist women to define and meet their own infant feeding ambitions, could encourage maternal-led definitions of ‘good motherhood’, and prevent perceptions of judgement and promote positive maternal health (Thomson *et al*, 2014).

There is still, however, a clear need for further research in this area and how the importance of infant feeding can continue to be taken forward in a less judgmental manner. I join with other researchers in proposing further study of this area (Shakespeare *et al*, 2004) to support a more holistic mother, family and community centred approach, assisted by interventions at policy and societal level, which shape social discourses.

## **12.5 Strengths and Limitations of this Study**

The reported influences that participants used to describe their experience, decision making and relationships are open to the criticism that they are post-hoc rationalisation, rather than a reflection of someone’s ‘real’ intentions. However, within the ontological and epistemological framework, it is accepted that all participant accounts are attempts to make sense of their experience and actions, with a further level of interpretation

through the interpretative phenomenological analysis undertaken by the researcher. This is described as a ‘double hermeneutic’ (Smith *et al*, 2009) as there is no ‘objective’ true story which can be understood, only the attempts by the researcher to make sense of the participants’ experience, which the participant themselves are trying to make sense of and articulate.

A key issue in qualitative studies is the quality of the approach and analysis, therefore, particular attention was paid to this by applying the principles articulated in Yardley (2000) and Smith (2011). The various means by which this was achieved are detailed in section 5.7, Quality Issues in Chapter 5. .

There are several areas which have been further reflected on during this study.

Participants in this study self-selected and as such may not be representative of the wider group of women who could have been included this study. This is partly mitigated by the range of different recruitment paths used. One of the strengths of this study is that it recruited a wide range of women, including some women with lower levels of education and who are employed in low status work. Given that health services are particularly keen to support breastfeeding in women with lower socio-economic status (Scottish Government 2011), who are often under-represented in breastfeeding research (Hoddinott *et al*, 2010), this study may be particularly useful for informing practice.

While no assessment was made of the quality of participant’s relationships with their families, one of the inclusion criteria was regular contact with their family of origin. This may mean that only those who had fairly close relationships with their family participated. This inclusion criterion was not included in the initial advertisement for

participants, however only one participant was excluded from participating due to low levels of family contact, which suggests that being in close contact with one's family when children are small, is common in this area of Scotland. This is supported by the Growing up in Scotland study (Bradshaw *et al*, 2008) which suggests that almost all women in Scotland have frequent contact and support from their families. This may not however be the situation for women in other parts of the UK and may mean some of the results of this study are less applicable.

Finally, qualitative methods, including approaches informed by phenomenology which value idiographic experience, have limits to their applicability when extrapolated to wider populations and as such, this should be done tentatively. This is countered by the depth they can provide in the understanding of participants experience. It is argued that small samples can be particularly problematic when considering how findings might be applicable to a wider population, and for this reason, a larger number of participants, at the edge of that recommended for an IPA study was selected as this can assist when there might be public health recommendations as a consequence of the study (Flowers 2007; 2006).

## **12.6 Conclusion**

This chapter has explored how an interpretative phenomenological analysis can consider the breastfeeding experience and sense making of women who have no family history of breastfeeding. It has enabled the emergence of new understandings which has relevance for the healthcare and public health systems, encouraging a change of practice which moves from a population based approach based on health benefits to an individually and family focussed approach.

This thesis shows that breastfeeding is impacted on by a variety of cultural and family influences. It is both an embodied experience and a socially constructed and discursive issue. Therefore IPA and the use of a methodological development in the form of an infant feeding genogram are ideally placed to investigate breastfeeding experience.

Women's experience of breastfeeding in this context has been explored and from the superordinate themes: Breaching Family and Social Norms; Volitions and Imperatives; Unprepared for the Challenge; and A Sacrifice but Worth It and the subthemes within them, a synthesis of how women experience this context, make sense of their decisions and the impact this has on their relationships has been developed and discussed.

This has shown that far from being a straightforward process, breastfeeding is impacted on by a range of powerful influences including dominant discourses, i.e. 'Breast is Best' and 'The Natural Imperative'. Women also had conflicts within their embodied experience, having both powerful moments of joy and connection, and times of pain and distress. Their experience led to raised self esteem and a sense of oneself as a mother, but this had implications for women who formula fed. Although formula feeding is perceived as less stigmatised by society, this study confirmed that through the moral discourse of motherhood, formula feeding mothers were judged by breastfeeding mothers for making a less acceptable decision, which did not fit with the 'good mothering' discourse.

In order to improve the breastfeeding experience of women in this context, and potentially women more generally, several issues need to be considered. Public services and policy-makers need to examine the implications of the dissemination of the dominant messages of 'Breast is Best' and breastfeeding as 'natural', as although they

do appear to be influential in women's decision making, they have implications for all women in propagating the idea that infant feeding is a moral decision.

While the implementation of the Breastfeeding etc (Scotland) Act (2005) in Scotland and the Equalities act (2010) in England and Wales has set the legal framework for change, societal attitudes are yet to follow. A wider conversation is also required to challenge the conflicting ideas about breasts within society that leads to stigma and breastfeeding women having to restrict their lives for fear of public criticism. This decreases the visibility of breastfeeding thus perpetuating it as a marginalised activity and hiding the reality of breastfeeding from women and the rest of society.

I argue that public health organisations such as UNICEF, the governments which are influenced by its policies, and the regulators who determine the content of health professional training, such as the Nursing and Midwifery Council, need to consider how well current education programmes for health professionals is preparing staff to support women for the experience of breastfeeding. This is to not only review whether the current approach is working, but also to reflect on whether it is causing unintended wellbeing and mental health issues for women who do not manage to breastfeed in line with their expectations.

Finally, it is asserted that a shift away from policy based outcomes such as valuing an increase in breastfeeding rates, to a more holistic focus on improving women's breastfeeding experience and meeting their own ambitions, would respect women's autonomy to make the best decisions for them and their family, improving the support she feels she receives from the health service, her family and community. As a consequence, breastfeeding rates may increase as a parallel process, but this should not

be the only infant feeding ambition we have for women, their families and communities. Therefore it is recommended that the health service needs to take a women and family focussed approach to breastfeeding which allows these wider expectations and support needs to be explored. The infant feeding genogram would be an ideal tool to start these discussions. This can be used flexibly with individuals or families to raise issues in a non-judgement way that focuses on, genuine choice and women's support needs.

## Appendix I Research Flier

### Breastfeeding Research

Hi there,

I am a post-graduate researcher and I am looking for the help of breastfeeding mums.

I am interested in talking with Ayrshire mums who were the first to breastfeed in their family. This would mean that they were not breastfed themselves by their own mum nor have sisters who breastfed before them.

If you are breastfeeding or have breastfed in the last three years and might be interested in taking part, contact me at [kirsty.darwent@btinternet.com](mailto:kirsty.darwent@btinternet.com) and I can send you one by e-mail. You can also ring on 01292 264023 and find out more. The study has ethical approval from the University of Stirling.

Thanks  
Kirsty



## Appendix II Research Information Letter

Dear Supporters and Helpers,

I am undertaking a piece of research with the University of Stirling exploring women's experience of breastfeeding when they were not breastfed themselves.

This will involve me interviewing mums, all of whom will be from Ayrshire in Scotland and asking them about their experience of breastfeeding and how they made their decision. There is a small risk that some of them might feel a bit upset talking about this so I am giving them the Supporterline number as a resource for them to call if they feel the need to talk after the interview. The Breastfeeding Network Directors are supportive of this plan and very sensibly suggested I should let Supporters who answer the phones know that there is a slim chance that might pick up one of these calls.

If anyone would like to know more about the study in case they receive a call or for their own interest I am happy to answer questions or send details off-list.

Thanks in advance for any help you might give

Kirsty

BfN Supporter/Supervisor/Tutor based in Ayrshire

## **Appendix III Participant Information Sheet**

### **The Experience of Being the First to Breastfeeding in your Family**

Version 1 – January 2010

*You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.*

#### **Why is this study being carried out?**

This study is designed to try to better understand women's experience of breastfeeding when they were not breastfed themselves. I am interested to know what this is like for you, how you make sense of the decisions you have made and if this affects your relationships with others.

#### **Why have you been approached to take part?**

You have been chosen to participate in this study because of the experience you have as a breastfeeding mum. It is anticipated that around twelve to sixteen breastfeeding mothers in total will be involved in the study.

#### **Will I be paid for taking part?**

Unfortunately I cannot offer any payment or reward for your participation.

#### **Do you have to take part?**

No. Taking part in the interview is entirely voluntary and you do not need to take part. If you decide not to take part, there will be no negative consequences and it will not affect any services you may wish to access in future.

#### **What happens if I change my mind?**

You are free to stop the interview at any time and there will be no negative consequences. I will destroy any recordings or transcripts of the interview.

#### **What will happen if you take part?**

If you decide to take part, you will be asked to sign a consent form. Once you have signed the consent form I will interview you about your experience of breastfeeding, in the context of having not been breastfed yourself. As I am trying to get a full understanding of what this is like for you, I will ask a number of questions about your life and your relationships. You are free to choose not to answer any questions that you do not wish to.

I would like to make a digital recording of the interview so that I can have an accurate written record of it. I may also occasionally take notes so that I do not forget any thoughts I might have

**How long will it take?**

The interview is likely to take between an hour and an hour and a half.

**What will the information from the interview be used for?**

I will be using the information to try to understand both your individual experience and also the similarities and differences between your experience and that of other participants. Before sharing this information with anyone else, including in any written papers, I will remove your name and any other identifying information so that you will be anonymous.

**What will happen to the information gathered?**

All the information provided will be securely stored. The written transcripts of the interviews will be stored securely in a locked cupboard. The consent forms will be secured in a separate locked cupboard, in compliance with data protection legislation. All electronic data will be kept on a password protected computer. All data will be destroyed seven years after collection.

If you wish to withdraw from the study, I will delete any electronic records and destroy any paper copies within 14 days of receipt of a request.

**Are there any risks in taking part?**

Although I do not anticipate that the interview will put you at any personal risk, some of the questions are quite personal and you may feel a little emotional. Please let me know if do not wish me to continue to ask questions about any specific area. If you do not wish to continue with the interview, you are free to withdraw from the study at any time. If the interview raises issues which you would like to discuss in confidence, you can contact the Breastfeeding Network's Supporterline on 1300 100 0210. You can also receive support by e-mailing in confidence on [breastfeedingsupport2010@breastfeedingnetwork.org.uk](mailto:breastfeedingsupport2010@breastfeedingnetwork.org.uk)

**Will you benefit directly from this research study?**

You will not benefit directly from this study, however, I hope that the information gained from this study may help me and others to better understand your experience and this may help provide better support to breastfeeding women.

**Who is organising and funding the research?**

The research is being undertaken for the purpose of PhD at the University of Stirling. I am not receiving any funding from the manufacturers or distributors of breastmilk

substitutes or any product covered by the International (WHO) Code of Marketing of Breastmilk Substitutes or its subsequent resolutions.

**What to do now**

If you would like more information before you decide about taking part, please ask me any questions you would like and take time to decide if you wish to proceed. If you would like to take part please read and complete the consent form.

**What should I do if I am unhappy about any aspect of this research?**

If you have a problem or complaint about any aspect of the research, please contact Professor William Lauder at the Department of Nursing and Midwifery at The University of Stirling, University Road West, Stirling, FK9 4LA

**Researchers Contact Details**

Kirsty Darwent, Postgraduate Research Student, [kirsty.darwent@btinternet.com](mailto:kirsty.darwent@btinternet.com),  
01292 264023, The Department of Nursing and Midwifery, The University of Stirling,  
University Road West, Stirling FK9 4LA.

Thank you for taking time to read this information.

# Appendix IV Participant Consent Form



UNIVERSITY OF  
STIRLING

DEPARTMENT OF  
NURSING AND MIDWIFERY

## The Experience of Being the First Person in your Family to Breastfeed Version 1 – January 2010

### CONSENT FORM

*Please initial boxes*

1. I confirm that I am aged 18 or older
2. I confirm that I have no impairments which might prevent me from participating
3. I confirm that I have read and understood the information sheet dated Jan 2011 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily
4. I understand the nature and purpose of the study and give permission for the information I provide to be used for research purposes (including reports, presentations and publications) with strict preservation of my anonymity.
5. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason. There will be no negative implications as a result of withdrawing.
6. I consent to the audio recording of the interview. I understand that this information will be treated as detailed in the participant information sheet.
7. I agree to take part in the above study.

\_\_\_\_\_  
Participant's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

#### Researchers Contact Details

Kirsty Darwent, 5A Racecourse Road, KA7 2DG, [kirsty.darwent@btinternet.com](mailto:kirsty.darwent@btinternet.com), 0292 264023  
or The Department of Nursing and Midwifery, The University of Stirling, University Road West, Stirling FK9 4LA.

## Appendix V Personal Details, Eligibility Criteria and Genogram Form

### The Experience of Being the First to Breastfeed in your Family

#### Personal details and eligibility criteria:

1. Name:	Participants Contact Details:
2. Age:	
3. Baby's date of birth and age	
<p>4. Eligibility criteria;</p> <p>Participant</p> <ul style="list-style-type: none"> <li>• Was not breastfed</li> <li>• Is breastfeeding or has breastfed her own baby in the last three years</li> <li>• Does not have any sisters who have breastfed</li> <li>• Is in regular contact with her family of origin i.e. contact at least weekly in person or by phone</li> <li>• Does not live with her family of origin</li> <li>• Lives in Ayrshire and speaks English as a first language.</li> <li>• Does not have a diagnosis of post-natal depression</li> </ul> <p>Was mum supported by the BfN -</p>	
<p>5. Ages of your children:</p> <p>Child 1:</p> <p>Child 2:</p> <p>Child 3:</p> <p>Child 4:</p>	

6. How long did you breastfeed each child and current feeding status e.g. exclusive

Child 1:

Child 2:

Child 3:

Child 4:

10. Genogram – 3 generation in each family of origin (if woman has a partner)

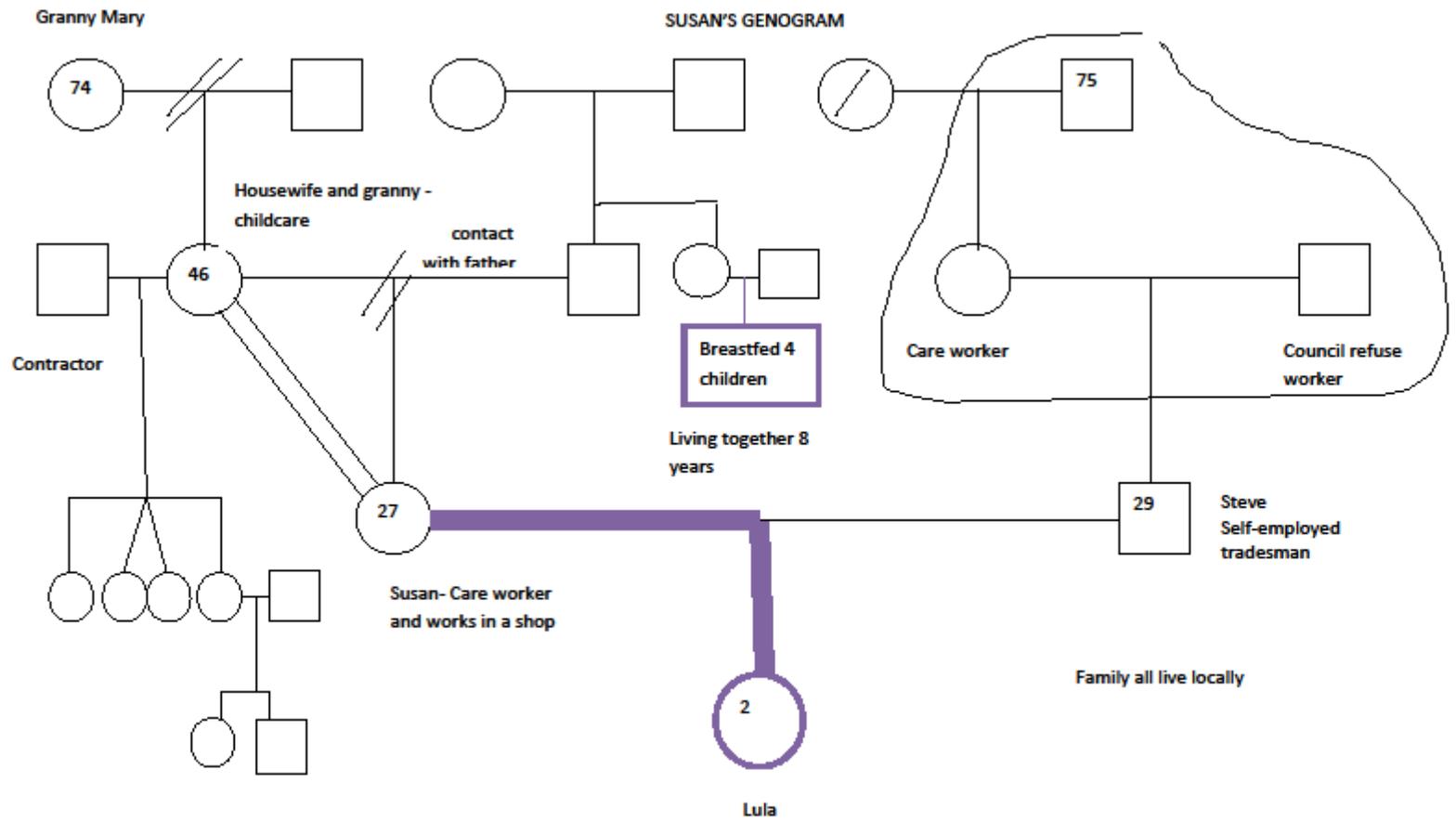
Areas to be completed before or at interview;

- Dates of birth and death
- Infant feeding histories
- Demographic data including work and educational history
- Major life / family events
- Other information identified through the question ‘Are there any other things I should know about you or your family just now?’

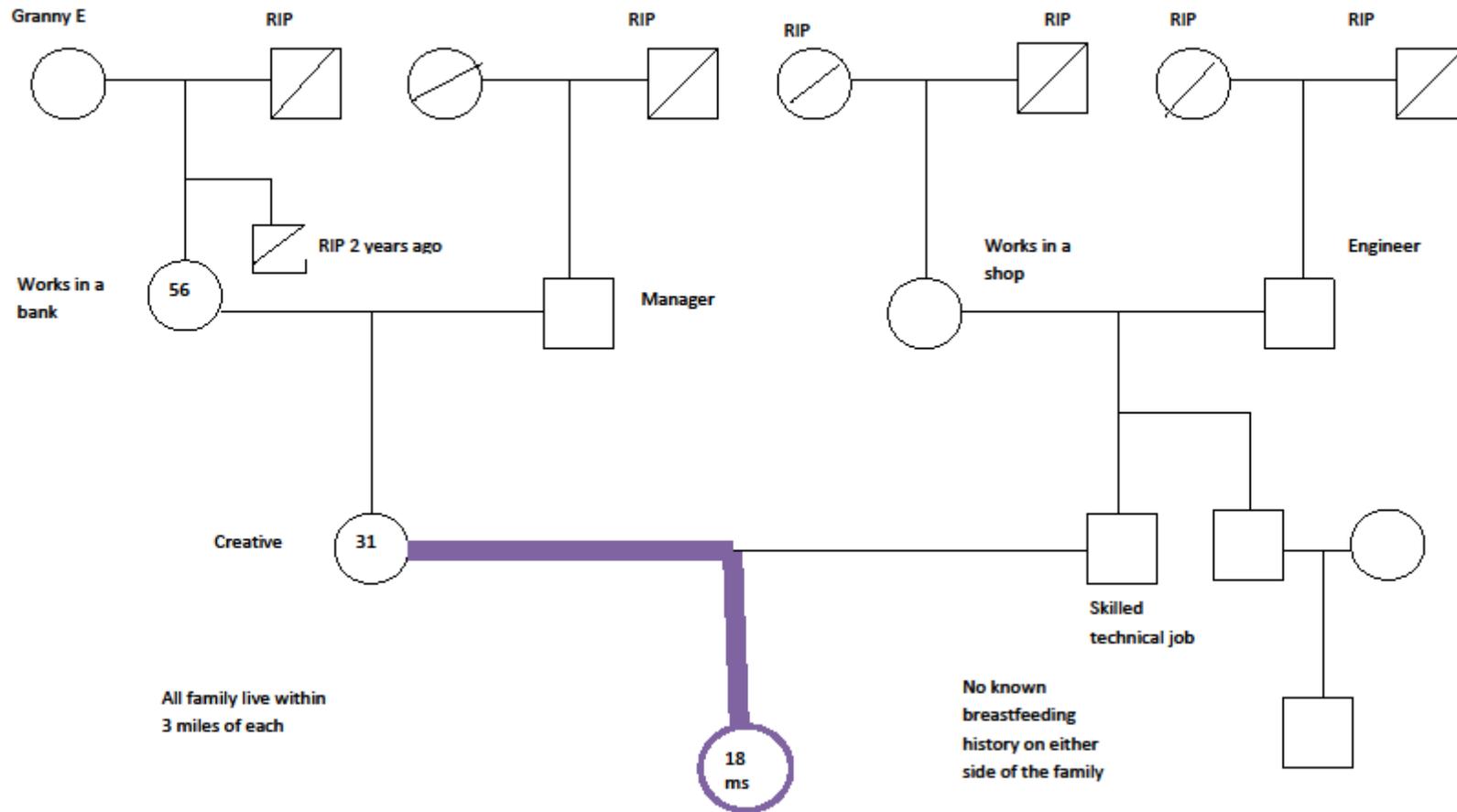
## **Appendix VI Participants Genograms**

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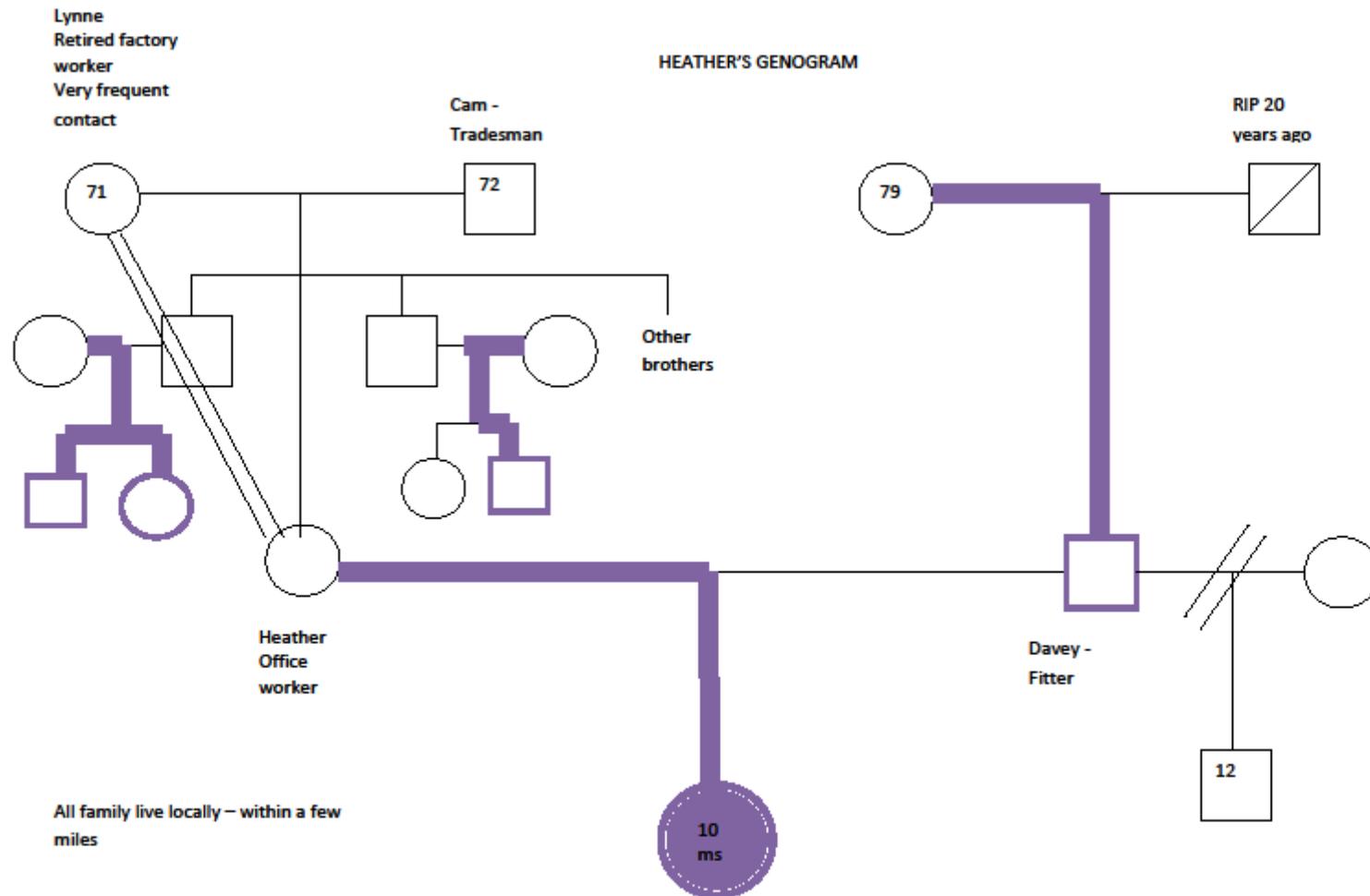




NIAMBH'S GENOGRAM



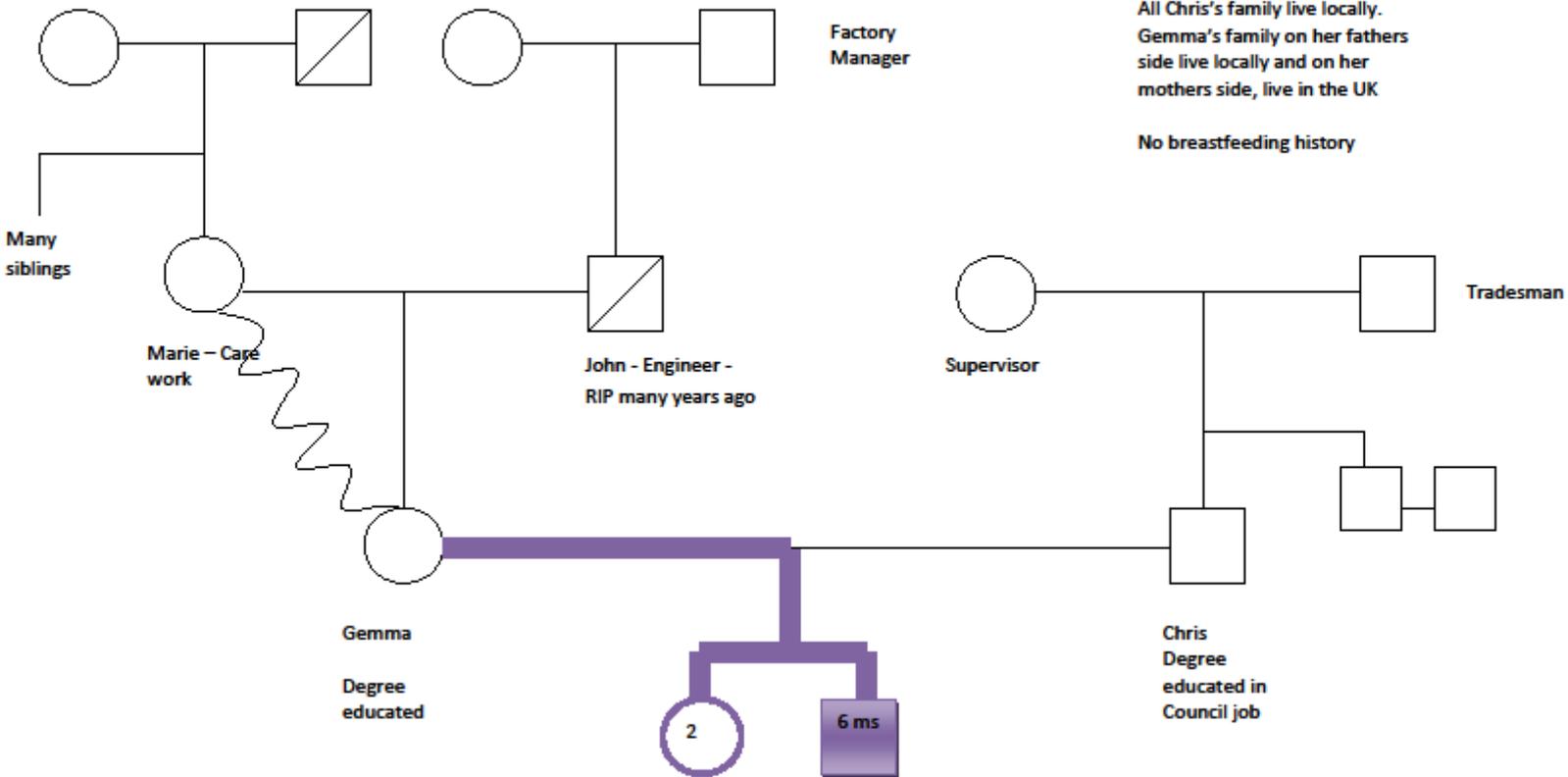
HEATHER'S GENOGRAM

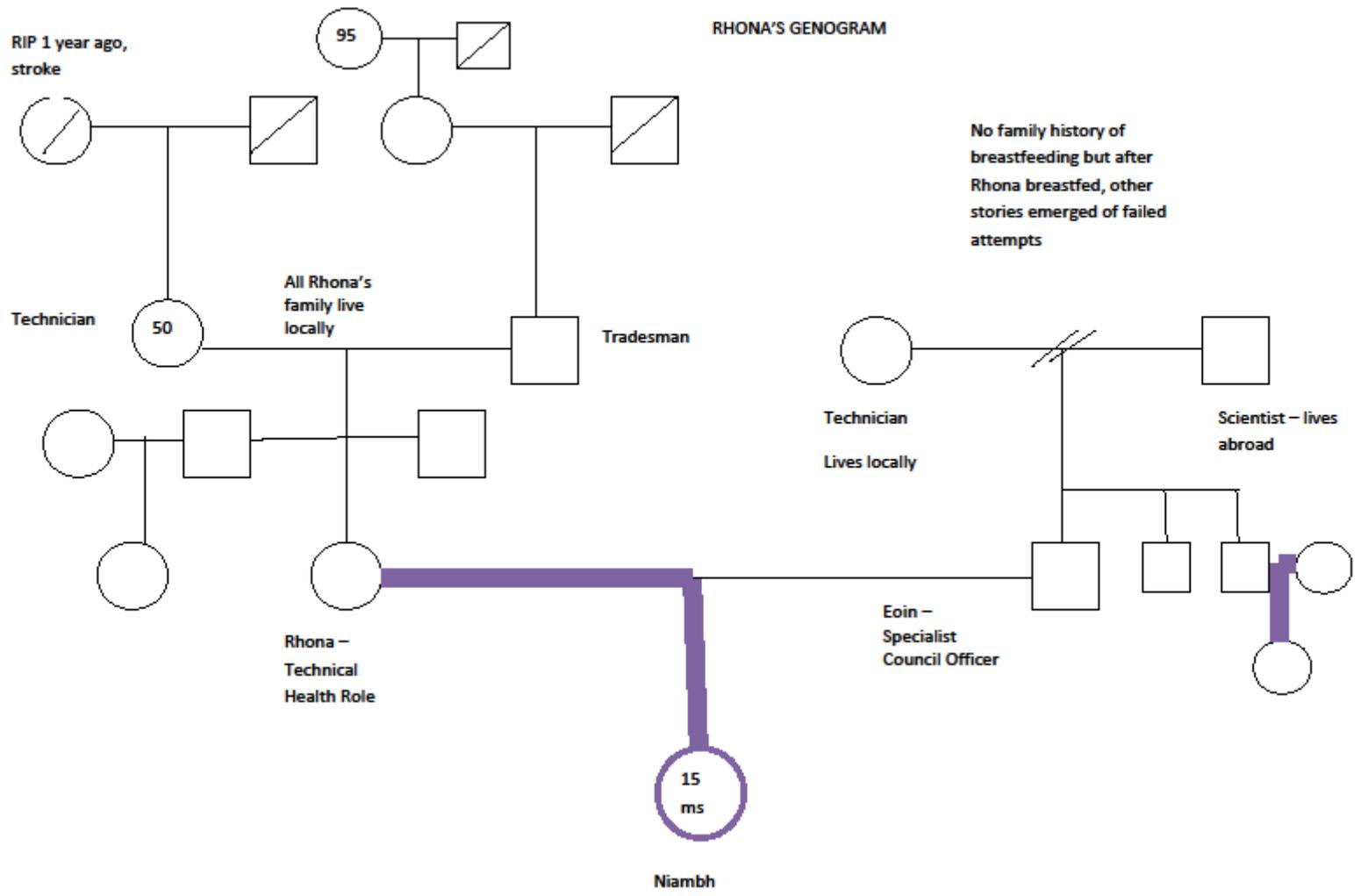


Faith -  
Auxilliary

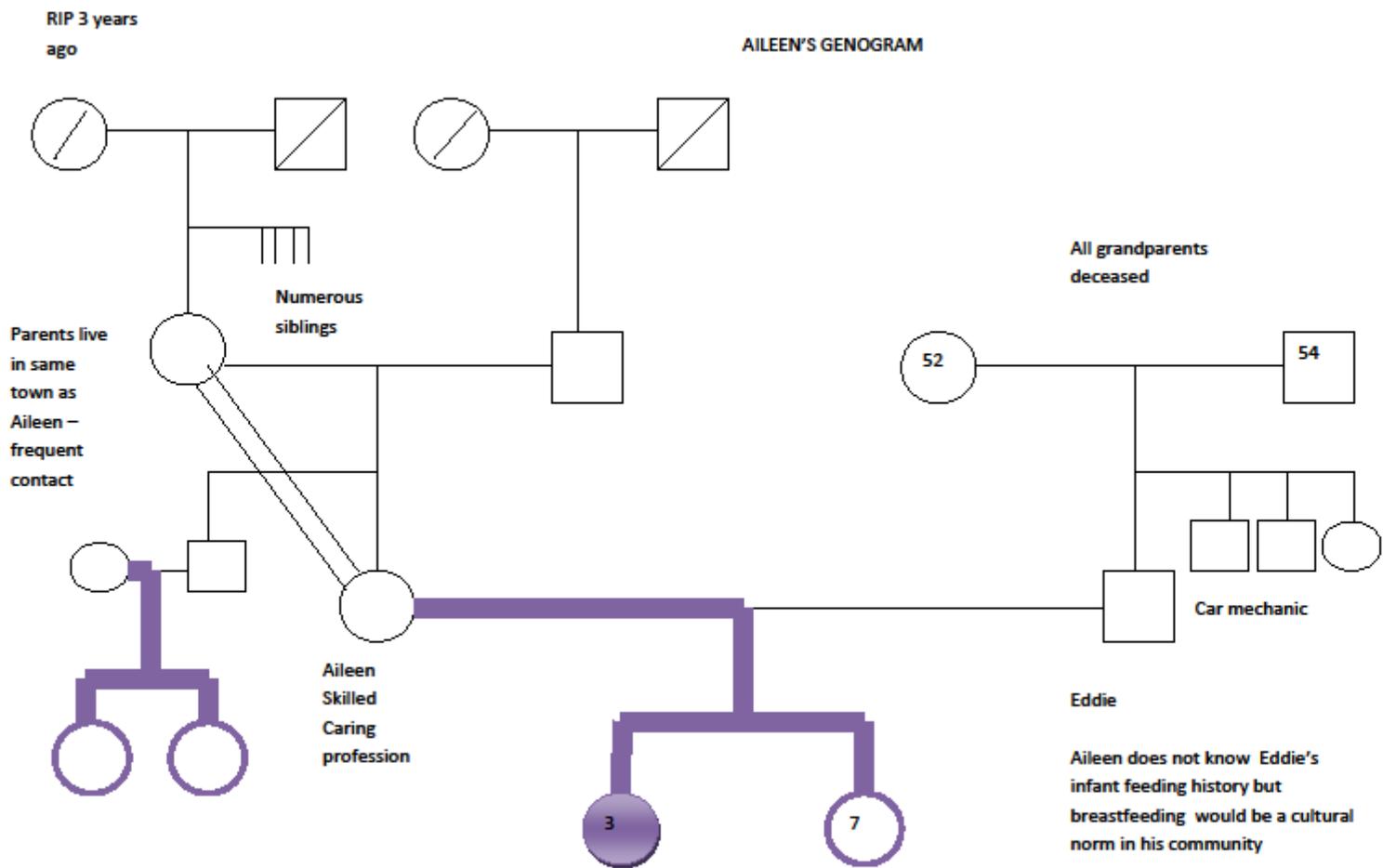
Avril  
Matriarch of  
family

### GEMMA'S GENOGRAM



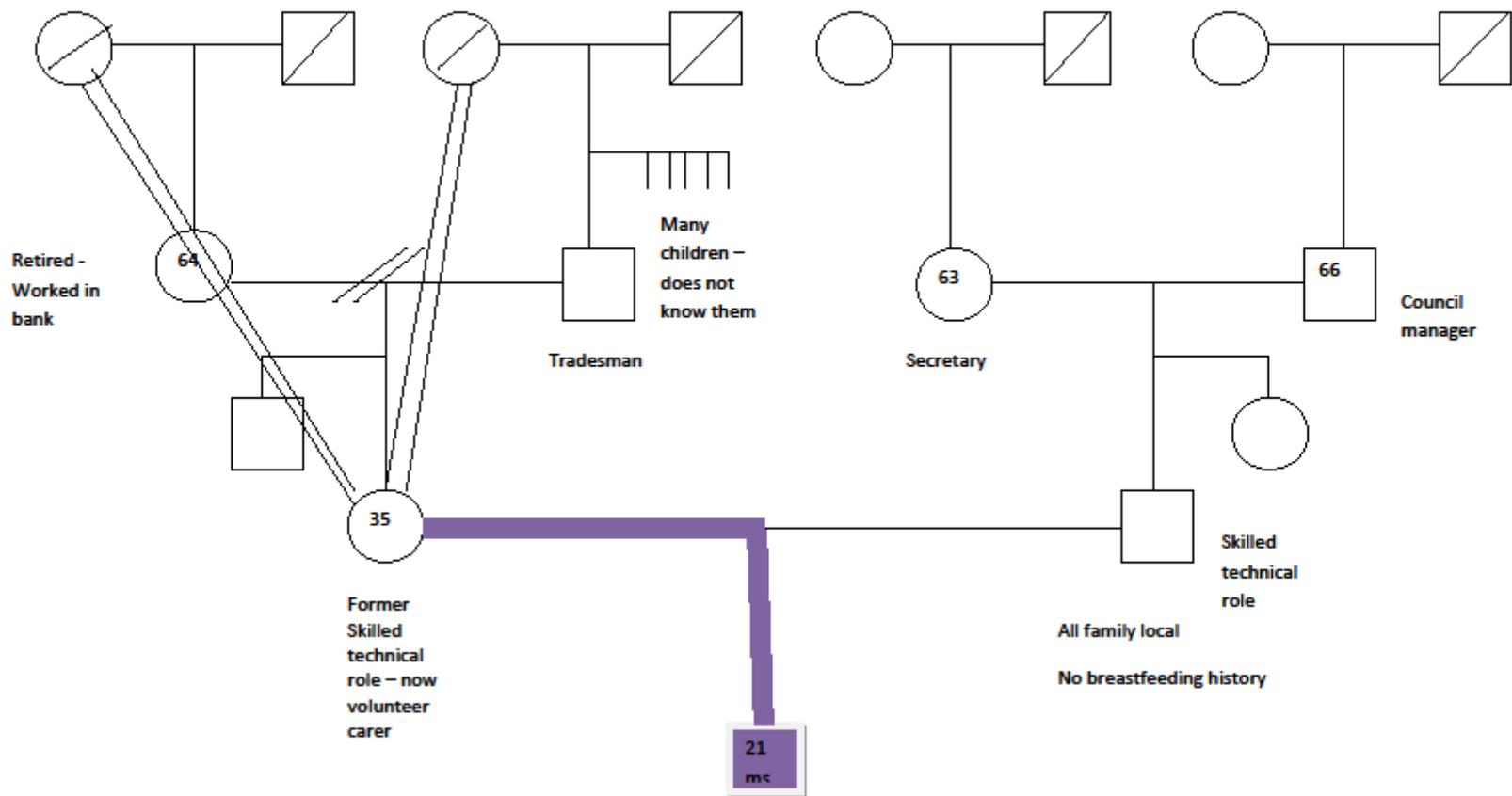


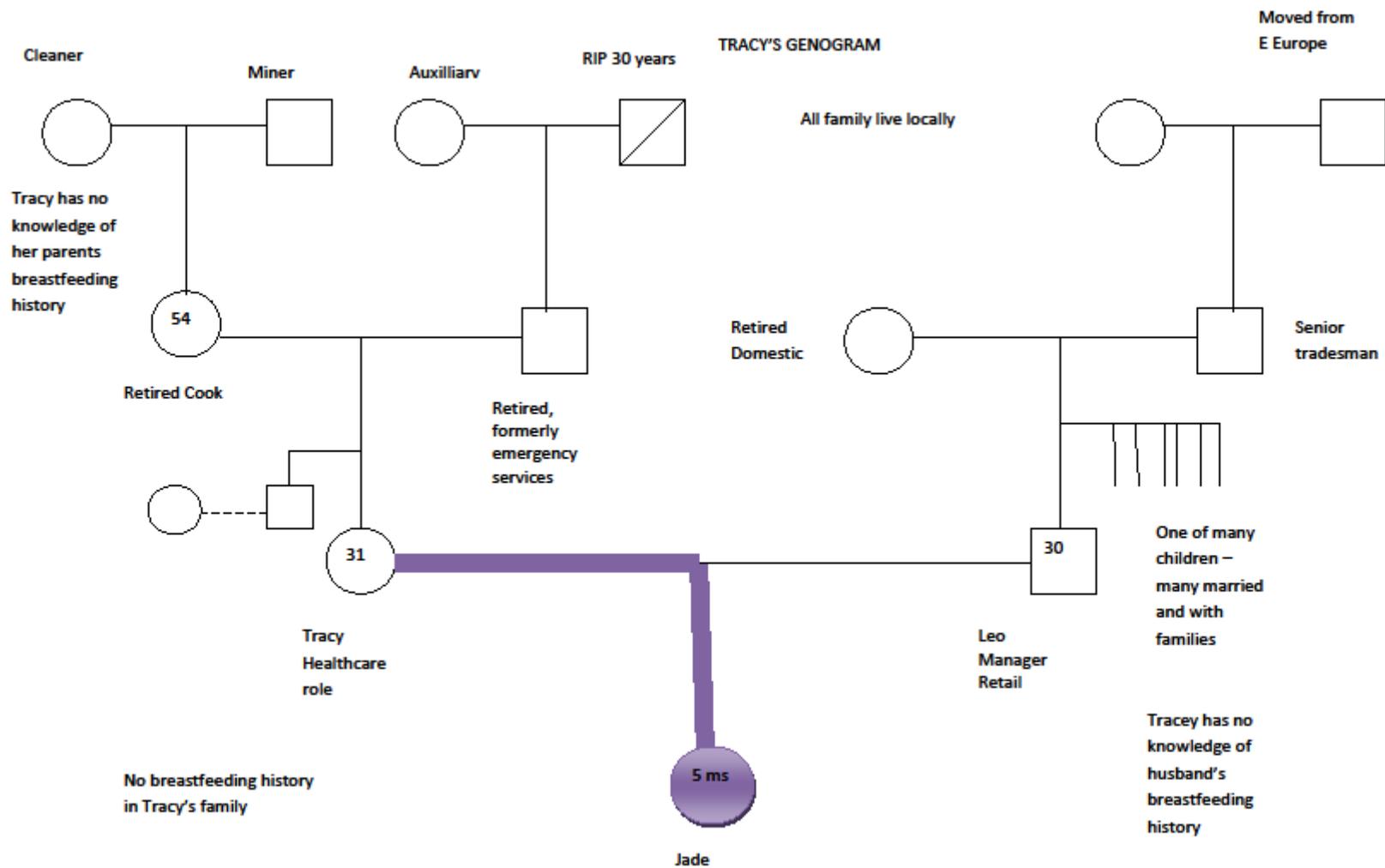


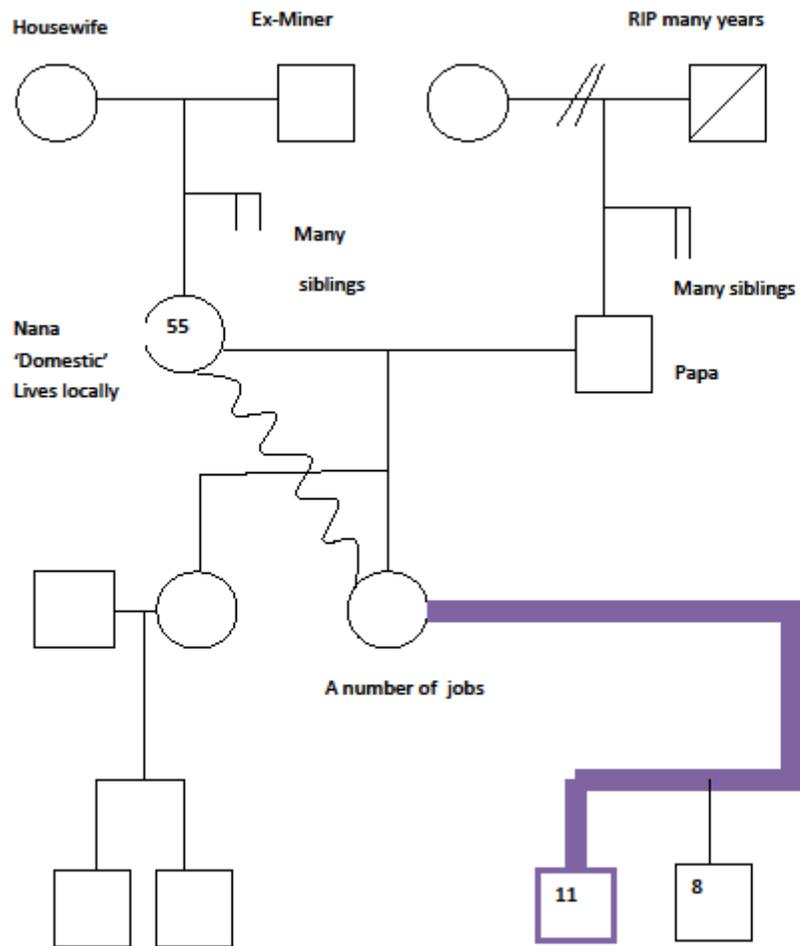


Was close to both grandmothers who are recently deceased. Both grandfathers dead for a number of years

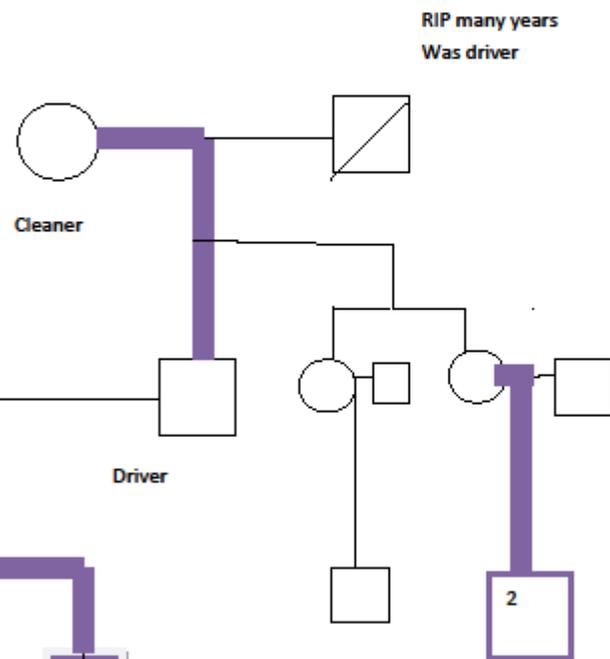
LOUISE'S GENOGRAM

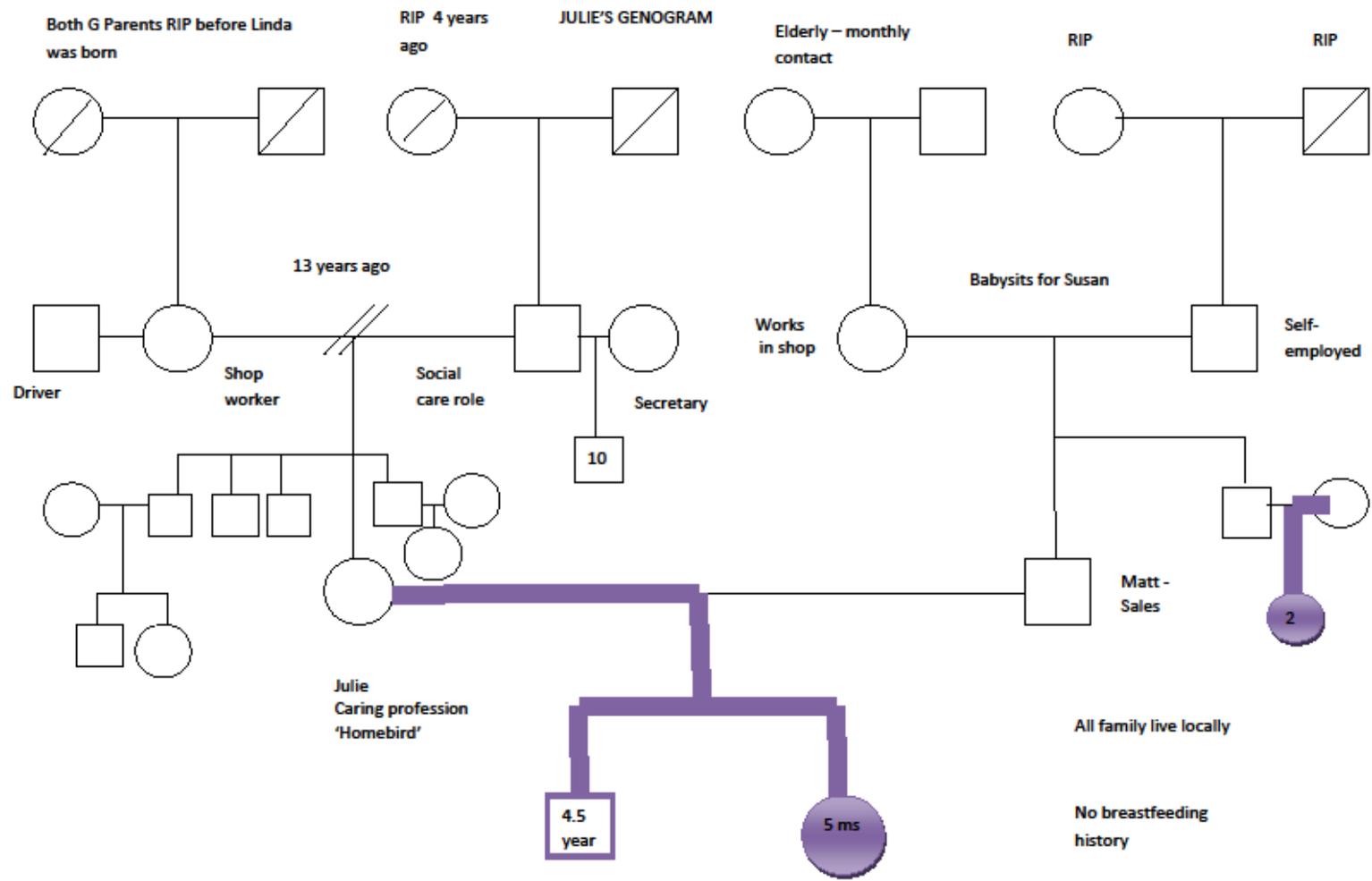






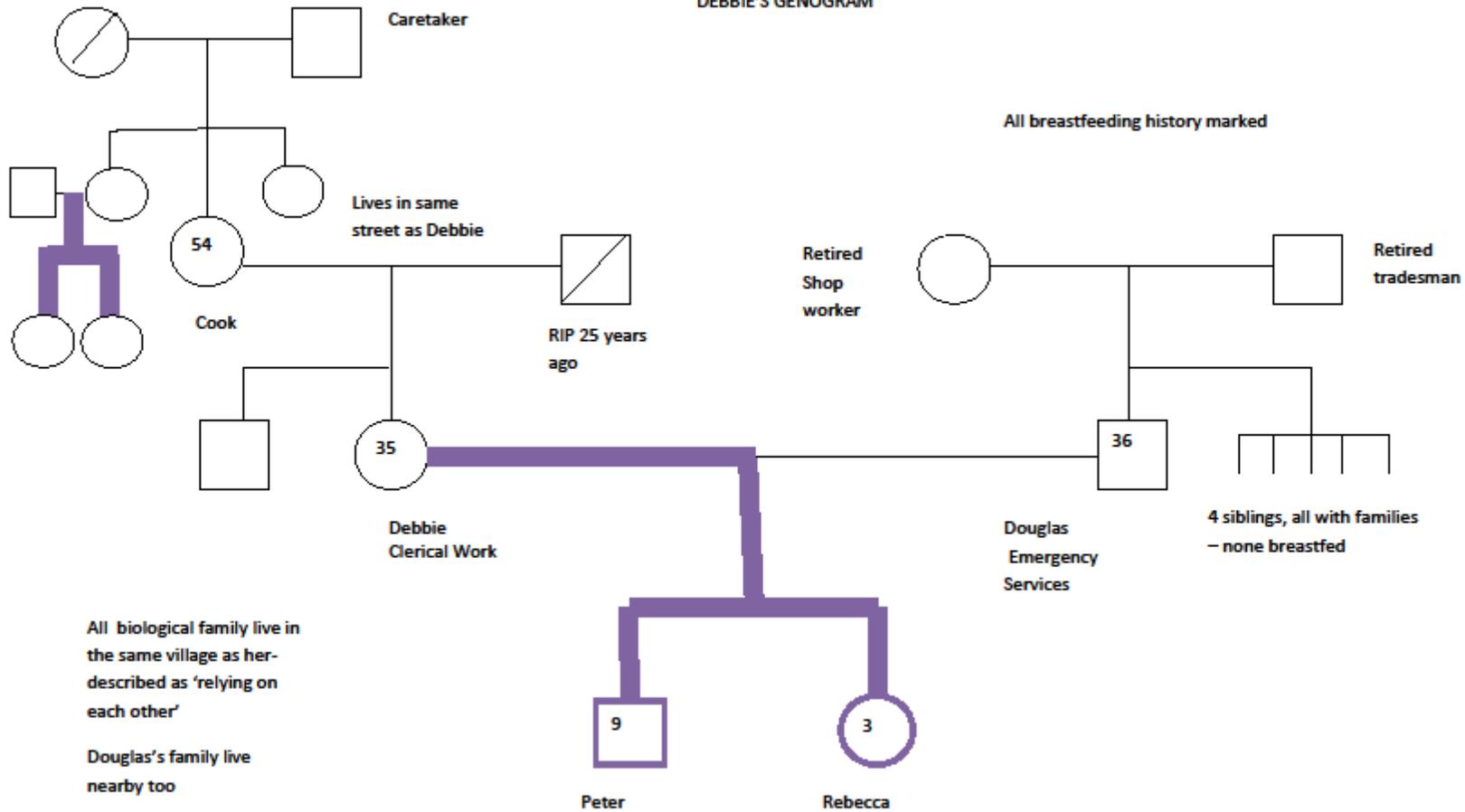
MHAIRI'S GENOGRAM





RIP 2005  
 Grandparents very involved in caring for Debbie as child, eg during holidays and after school

DEBBIE'S GENOGRAM





## **Appendix VII Interview Schedule and Prompts**

### **Their breastfeeding experience in a relational context**

1. What has breastfeeding been like so far?
2. How has breastfeeding affected the way you think/ feel about yourself?
3. How has breastfeeding affected the way others think / feel about you?
4. Can you tell me if / how you think breastfeeding has impacted on your relationships with others?

Prompts Partner, Mum, mum in law, friends, others

5. What longer term consequences might there be because of your decision to breastfeed?

### **A relational exploration of their decision**

1. Can you tell me when you first thought about how you might feed your baby?  
Prompt - Has this changed over time?
2. What do you think were the main influences on you?  
Prompt - Did anything else influence you? People?
3. What did others think about your decision to breastfeed?  
Prompts Partner, mum, friends, mum in law
4. How do you think this has affected you?
5. Knowing what you know now, what do you think about your decision?

### **General prompts**

Can you help me understand that?

Can you tell me a little more about that?

What did you mean when you said...?

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