Complex Decisions: Deconstructing Best
A Grounded Theory Study of Infant Feeding Decisions In The First Six Weeks Post-birth

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and in the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Preface

In 1994, I began a journey of research that would ultimately lead me to this thesis. I was working as a midwife, for the most part in the postnatal area of a maternity unit but also facilitating antenatal groups. At this time, it was not uncommon during the early post-birth period to hear women say 'I didn't think breastfeeding would be like this' and 'why don't they tell us about this in the antenatal groups'. I was concerned that women were not being provided with adequate or appropriate antenatal breastfeeding 'education'. My experience of breastfeeding had been very positive. I had enjoyed breastfeeding and breastfed both my daughters for a total period of 21 months. In addition to my personal experiences, I also believed that breastfeeding, if successful, could be a wonderful experience for all women. So, in an effort to provide better antenatal education and consequently improve women's experiences, I compared two methods of antenatal breastfeeding education. The experimental group was a peer led group and the control group was lead by me a midwife. I used maternal perceptions of success and duration rates as my outcome measures. I did not find any differences between the groups in relation to breastfeeding rates, which were high, or maternal perceptions of success. What I did find out though, was that I did not understand women's experiences of breastfeeding. I also discovered there was a paucity of midwifery literature exploring women's experiences of breastfeeding.

Two of my recommendations following this first study were: 1) to investigate how physical, social and emotional factors interact and effect breastfeeding initiation and duration rates and further identify the number of women who are unable to breastfeed for physical, social and emotional reasons and 2) that further substantive research was needed to identify what types or aspects of support are important to the breastfeeding woman.

Towards the end of that study, I got a job as a research midwife and during this time I was involved in a postnatal outcomes study. This larger postnatal outcomes study gave me the opportunity to assist with designing an infant feeding study, which would run concurrently to the postnatal outcomes study. The infant feeding study would give insight into some of

the questions arising from my previous work. The aim of this infant feeding study was to explore the physical, social and emotional experiences influencing women's baby feeding decisions by investigating women's' own decision making processes, and what they perceived influenced these decisions. A grounded theory methodology was chosen to collect and analyse data, which was derived from in-depth interviews with women. We chose to interview women about their infant feeding plans and experiences and purposefully sampled women form late in their pregnancy until 6 months post-birth. As the research assistant, I conducted the interviews.

Initial analysis of this data lead to a thematic analysis of the antenatal infant feeding decisions of women, the findings of which, were published in Midwifery. A copy of this article is attached to this thesis (see appendix VIII). It also confirmed the complexity and importance of exploring women's infant feeding decisions in the first six weeks post-birth. My PhD was born.

The advantages of doing this first study were that it helped prepare me for using the methodology; it extended my interviewing skills; it made me clear about the research question and confirmed the importance of studying women's infant feeding decisions in the first six weeks post-birth.

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Abstract

Breastfeeding is promoted globally as the optimum method of infant feeding. Despite this, breastfeeding initiation and duration rates differ significantly between and within countries, as well as social and cultural groups. While Australian breastfeeding initiation rates appear high, breastfeeding rates decline quite significantly in the first six weeks. In an effort to implement strategies to increase breastfeeding rates, many research efforts have aimed at identifying factors that predict breastfeeding initiation and duration and/or breastfeeding attrition. These studies have predominantly used quantitative methodologies, and although a number of factors associated with the infant feeding decision have been identified, the mechanisms by which they affect the decision remain unknown.

In contrast to quantitative studies, a much smaller amount of qualitative research has explored aspects of the infant feeding experience and has found the experience of breastfeeding to be complex. Rather than simply being an individual act, infant feeding decisions are constructed and practiced within the social milieu in which women live.

The purpose of this research was to explore and describe the experiences of women making infant feeding decisions in the first six weeks post-birth. A constructionist grounded theory methodology was used to collect and analyse data. Data were collected through in-depth interviews with thirty-seven women. The women were theoretically sampled in accordance with the principles of grounded theory. In addition to the empirical study, literature focusing on breastfeeding, aspects of the postnatal period and mothering, was used to inform, strengthen and help explain the findings emerging from the empirical data.

Four main categories emerged from the data that described what women deemed important to their infant feeding decisions. These categories were 'it's really best to breastfeed', 'it's the unknown', 'its not the only thing going on', and 'everybody's best is different'. The Basic Social Process, which was also the core category, was labelled 'deconstructing best'.

The core category 'deconstructing best' linked the categories in a process of decision-making that the women embarked on during this period. It demonstrates the individuality of the experience and provides an explanation as to why trajectories of experience cannot be explicated and predicting outcomes has been unsuccessful.

The findings demonstrate that women's infant feeding decisions in the first six weeks post-birth are multifactorial. In contrast to this, hospital policies as well as health professionals' understandings and practices, are generally embedded in the concept that breast is best.

Chapter One

Introduction

Background to the study

In 1974 the World Health Assembly formally noted a worldwide decline in breastfeeding rates and established that this was due, in part, to the inappropriate sales promotion of breastmilk substitutes (World Health Organisation, 1981). Recognising that breastfeeding provides health benefits to both mothers and infants and reduces infant mortality and morbidity, particularly in third-world countries, the World Health Organisation, in conjunction with UNICEF, responded by implementing strategies to protect and promote breastfeeding globally (World Health Organisation, 1981). To this end, breastfeeding is marketed and promoted as the optimum method of infant feeding, using a number of global and more local policies. In addition, health professionals have received increased breastfeeding education and lactation consultants as a profession have emerged to deal with, amongst other things, the perceived loss of breastfeeding skills, both from within the health-care professions and within society itself (Bocar, 1992). Despite these strategies, however, breastfeeding rates, while increasing initially, have shown little change since the 1980s. Some studies have indicated that breastfeeding initiation has increased (Binns, 2006) or can be increased with specific breastfeeding education (Rossiter, 1994; Greenwood et al., 2002), but these rates are not sustained and it is now suspected that in Australia, at least, breastfeeding duration rates may be declining (Foschia, 2004).

Given the reported importance of breast milk to the health of mothers and babies, much research over this time has set out to determine what factors influence women's infant feeding decisions. In these studies, a number of socio-demographic, biomedical and psychosocial factors have been identified as associated with the infant feeding decision.

More recently, however, the application of multivariate analysis to a number of these has shown some of these associations to be inconsistent (Scott et al., 1999a). These studies have been predominantly quantitative, and although a number of factors have been found to be associated with the breastfeeding decision the mechanisms by which these factors influence the decision have been largely unrecognised or explored. Consequently, in these studies it is predominantly believed that women cease breastfeeding due to physical problems associated with the practice and that increased breastfeeding education will address these issues. Often in these accounts the decision to breastfeed is largely considered a matter of individual choice and rational decision-making.

These findings contrast with a much smaller number of qualitative studies which have found that infant feeding choices, rather than being an individual act, are constructed and practised within the social milieu in which women live (Dettwyler, 1995). Qualitative studies have highlighted that breastfeeding decisions and practices are complex, and factors such as a woman's physical health, the health of her baby, the needs of her other children and family members, the family's living conditions and other demands on the woman's time and energy can all influence a woman's baby feeding decision (Carter, 1995; Hoddinott & Pill, 1999a; Murphy, 1999). Not surprisingly, it has also been found that health professionals' understandings of breastfeeding experiences are often incongruent with the actual experiences of women (Schmied et al., 2001a).

There has also been research that has applied traditional decision-making theories such as the Theory of Reasoned Action (TRA) and the Theory of Planned Behavior (TPB) to predict breastfeeding outcomes, but these have been limited in their utility. In addition to this, critiques of decision-making theories suggest further research into decision-making should involve studying decision-making in the field. As yet, there have been no qualitative studies that have specifically focused on exploring women's infant feeding decisions in the first six weeks. It is timely that a more grounded study of women's infant feeding decisions be undertaken.

It is expected that by undertaking a more grounded study of women's experiences, a better insight into the factors influencing women's infant feeding decisions will be gained. It is anticipated this study will lead to a better understanding of how and why women make decisions and how health professionals can better support them as they are learning to feed their babies.

Overview of methods

Therefore, the aim of this research was to explore and describe women's experiences in the first six weeks post-birth, and how these experiences impacted on and affected their infant feeding decisions.

Specifically, this research aimed to:

- determine women's perceptions of the factors that influence their infant feeding decisions in the first six weeks postpartum;
- describe the diverse personal trajectories experienced by women in relation to infant feeding experiences and practices;
- contribute towards theory development to inform clinical practice and ultimately lead to improved professional support for breastfeeding.

In this research, I have used a constructionist approach to grounded theory methodology to collect and analyse data. Data were collected from in-depth interviews with 37 women who had infants aged between one and eight weeks and were sampled from two separate research studies focusing on women's experiences of infant feeding.

To complement the interview data, a review of relevant literature on infant feeding and decision-making as well as aspects of the postnatal experiences of women was undertaken. I have chosen to present this review of the related literature in the form of a discussion at the end of each chapter of data analysis. In concordance with the principles of grounded theory, the review of literature presented in each of the results chapters did not occur until after the analysis of the data (Glaser et al., 1967; Strauss et al., 1998). In this way, the findings of the study guided the literature search. The articles used in these discussions

were collected by searching relevant databases using the search engines, Cinahl, Medline, Current Contents, the Cochrane database, and Psych INFO. Other relevant literature was drawn from the reference lists of articles obtained through the above searches. This literature was used to help expand and strengthen the findings of this study. This use of previous research findings to support the results of this analysis demonstrates the importance of understanding the meaning and experiences of infant feeding from the perspectives of women themselves. While drawing from the findings of others this work remains unique in that for the first time it focuses exclusively on the first six weeks post-birth.

This study was about infant feeding, however, most discussion centres around breastfeeding. The reason for this is twofold. Firstly, a large percentage of women in Australia initiate breastfeeding, secondly, breastfeeding is promoted as the optimum method of infant feeding and therefore, as this research has clearly demonstrated, if a woman chooses to formula–feed, she will generally need to account for her decision.

Four major categories were identified as influencing the women's infant feeding decisions. These four categories are 'it's really best to breastfeed', 'it's the unknown', 'it's not the only thing going on', and 'everybody's best is different'. The basic social process, which is also the core category in this study, was labelled 'deconstructing best' and was so named because, regardless of how the women chose to feed their babies, their decisions were measured against breastfeeding and the claim that 'breast is best.' 'Deconstructing best' was the decision-making process women used in the first six weeks as they made decisions about how to feed their babies. While I do not claim to have developed a definitive decision-making model, the findings of this study help explain the factors associated with women's infant feeding decisions, their interrelatedness and complexity and how, in turn, these affect their decisions.

Outline of the thesis

In Chapter Two of this thesis, I review the literature that addresses influences on the infant feeding decision. The chapter starts with a review of recommendations for breastfeeding,

followed by reports of breastfeeding rates. The data on breastfeeding rates demonstrates how there are variations between countries. In addition, it also discusses the differences in initiation and duration rates and highlights the steep decline in breastfeeding during the first six weeks post-birth. The chapter continues by reviewing literature aimed at identifying factors affecting breastfeeding initiation, duration and attrition rates and methods used to predict breastfeeding outcomes. The chapter closes by arguing the need for further exploratory research into women's infant feeding decisions in the first six weeks post-birth.

Chapter Three provides a discussion of the methods used in the research. It begins with a presentation of the epistemological and theoretical underpinnings of the research design and argues the rationale for using a grounded theory methodology and, in particular, a constructionist approach to grounded theory. While this study uses a constructionist approach to grounded theory, I also discuss other perspectives of grounded theory that I used to aid my understanding of grounded theory and to assist with data collection and analysis. Chapter Three closes by describing and justifying the approach I use to present the results chapters.

There are five results chapters. Each chapter begins by presenting the analysis of the women's interviews using a narrative form, and is followed by the integration of literature in the form of a discussion section, which adds depth and complexity to the women's data.

Chapter Four is the first of the five chapters presenting the results of the study. This chapter presents the category **'it's really best to breastfeed'**. This category is divided into three subcategories: 'knowing breast is best', 'feeling the pressure', and 'it's really more acceptable to breastfeed'. Findings presented in this chapter demonstrate that breastfeeding is marketed and promoted as the best method of infant feeding. Information about the benefits of breastfeeding is well known. Also hidden within the knowledge that 'breast is best' is the expectation that a 'good' mother breastfeeds. This category demonstrates how the women, health-care professionals and society act and interact with this information and the impact this has on the women's infant feeding decisions. Responses to this knowledge mean women feel breastfeeding will give their baby the best start, that there is a pressure to

breastfeed and ultimately it's really more acceptable to breastfeed. Consequently, women plan to breastfeed or, if they choose to bottle-feed they expect they will need to justify their decisions and protect themselves from sanctions. The synthesis of literature attached to this chapter expands on and strengthens the findings by providing a deeper analysis of the promotion of breastfeeding.

Chapter Five presents the category **'it's the unknown'**. The category 'it's the unknown' has three main subcategories: 'it was all new', 'it's unexpected and unpredictable', and 'needing support'. This category explains how and why women find breastfeeding unknown in the early period. At this time, the women talk about feeling uncertain, lacking confidence and feeling vulnerable. The women also describe breastfeeding as unexpected and unpredictable. This is because breastfeeding has been presented to them as easy, doable and/or fixable. When breastfeeding does not go according to the women's expectations, this can impact on the women by decreasing their confidence and leading to increased levels of distress and feelings of being out of control. These feelings can spiral, negatively affecting others and contributing to weaning. This category also demonstrates that professional support can be viewed as positive or negative and, as a positive source of support, can mitigate some of the women's negative experiences.

Chapter Six presents the category **'it's not the only thing going on'.** This category was divided into three subcategories: 'I'd just given birth', 'suddenly I was a mum', and 'establishing the maternal relationship'. The chapter identifies, how other experiences in the first six weeks act and interact with infant feeding to affect the women's infant feeding decision. These factors can be treated as separate, but this category demonstrates how they are ultimately and intimately linked to the breastfeeding experience and therefore impact on the infant feeding decision.

Chapter Seven describes the final substantive category **'everybody's best is different'**. This category articulates the women's understandings that infant feeding is an individual experience. At the very least, this can be exemplified by the overall experience of breastfeeding, which can be deemed relatively straightforward or painful and difficult. The

women's individual experiences lead to the questioning of assumptions around breastfeeding and a need to get on with feeding their baby in a way that best suits their individual needs and experiences. The consequences of this for women are that they will defend and qualify their decisions.

Chapter Eight, **'deconstructing best'**, presents a theory of decision-making. This theory articulates a process of decision-making in which women engage during the first six weeks post-birth. It describes the basic social process, 'deconstructing best', which is also the core category. The process of 'deconstructing best' begins with the planning phase and culminates with the women qualifying the breastfeeding experience. This chapter also demonstrates how the process is embedded in the substantive categories. The storyline in this chapter demonstrates the intensity of and multifactorial nature of the infant feeding decision in the first six weeks post-birth.

Chapter Nine concludes the study. It begins with a summary of the overall findings and limitations of the study. It discusses ways in which the findings contribute to and enhance professional understandings of women's infant feeding decisions. Finally, it discusses the implications of the findings for enhancing clinical practice.

Chapter Two

Background

Introduction

In this chapter, I present a review of factors reported in the literature as being associated with women's infant feeding decisions. All newborn infants need to be fed and, whilst there are alternatives to breastfeeding, including wet-nursing and a variety of manufactured formulas, the recommended method for feeding infants globally is breastfeeding. There is good reason for this, given the benefits of breastfeeding, but not all babies are breastfed. As a result of this, a number of studies have aimed to identify factors that affect the breastfeeding practices and decisions of women. The following chapter summarises what is known about the factors influencing infant feeding choice and the infant feeding decisions women make. I also present a discussion of decision-making theories and ways in which these have been used to predict breastfeeding behaviour. The chapter also highlights the disparity between professional and personal accounts of breastfeeding and facets of the breastfeeding decision-making experience that need further exploration.

Promoting Breastfeeding

Exclusive breastfeeding for the first six months has been identified as the superior method of feeding newborns and infants with cited advantages encompassing health, nutritional, immunological, developmental, psychological, social, economic, and environmental benefits (Oddy, 2001; Gartner et al., 2005). Even in developed countries, such as Australia, there is research attesting to the superiority of breastfeeding in protecting the infant against infectious diseases (Heinig, 2001). Given the stated superiority of breastmilk for the growth and development of infants and for the health of the mother, and a clear recognition that inappropriate feeding practices can lead to infant malnutrition, morbidity and mortality in all countries (World Health Organisation, 1981), the World Health Organisation (WHO) and UNICEF have jointly acted to support and promote breastfeeding.

This global support for breastfeeding grew out of concerns formally tabled by the World Health Assembly in 1974, identifying a worldwide decline in breastfeeding rates due largely to the inappropriate promotion of breastmilk substitutes. As a result of this, the WHO implemented strategies to protect and promote breastfeeding, including recommending to member countries that they review sales promotion of breastmilk substitutes and introduce legislation to remedy the decline in breastfeeding (World Health Organisation, 1981). To this end, a number of global policy statements have been developed including: The International Code of Marketing of Breastmilk Substitutes (World Health Organisation, 1981); Protecting, Promoting and Supporting Breastfeeding: the special role of maternity services (World Health Organisation, 1989); the Innocenti Declaration (World Health Organisation et al., 1991a) and, of recent importance, the Baby Friendly Hospital Initiative (World Health Organisation et al., 1991b)

The Baby Friendly Hospital Initiative (BFHI) is a global initiative aimed at promoting and supporting breastfeeding and is based on the ten steps to successful breastfeeding. The steps are:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breast-feeding within half an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in to allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

(World Health Organisation et al., 1991b)

These ten steps encapsulate the requirements a hospital needs to adopt in order to become baby friendly (World Health Organisation et al., 1991b). Guides and global criteria for implementing the BFHI have been developed by UNICEF and WHO and are controlled by

national breastfeeding authorities (United Nations Children's Fund, 2005). In Australia, the process of becoming Baby Friendly has been administered by the Australian College of Midwives with funding support from the Commonwealth Government during 2002–04. Worldwide, 15,000 facilities in 134 countries have been awarded baby-friendly status (UNICEF, 2006). To date, 53 of these BFHI-accredited hospitals are in Australia (BFHI Australia, 2006).

The Australian Government has shown a commitment to supporting breastfeeding through a number of initiatives. The Australian Government has adopted the WHO's International Code of Marketing of Breast-milk Substitutes, and in 1992 an agreement on marketing infant formula in Australia was signed with manufacturers and importers of infant formula; this is known as the MAIF agreement. The Marketing in Australia of Infant Formulas Manufacturers and Importers (MAIF) agreement is authorised under the *Trade Practices Act*, and is monitored by the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF). Breaches of the agreement are published in the annual report of APMAIF and sanctions against manufacturers are instituted where the breach is serious (Advisory Panel for the Marketing of Infant Formula, 1995).

Further Commonwealth Government support for breastfeeding has included implementing the National Breastfeeding Strategy, which commenced in 1996 and provided funding of $2 million dollars over four years to nine breastfeeding projects (Australian Government Department of Health and Ageing, 1996), as well as the National Child Nutrition program which funded 12 projects to the value of two million dollars. Until recently funding was also provided to support the Australian Breastfeeding Association to continue its work in providing breastfeeding education and support to mothers and counsellors.

In addition to the above, the National Health and Medical Research Council (NHMRC) has listed breastfeeding as a priority recommendation in dietary guidelines for Australian Adults, Children and Adolescents and in the Infant Feeding Guidelines for Health Workers, with current recommendations supporting exclusive breastfeeding for the first six months of life (NHMRC, 2003). A number of national health targets have been set including that

80% of infants be exclusively breastfed at three months and 60% exclusively breastfed at six months (Nutbeam et al., 1993). Despite these recommendations and strategies, breastfeeding rates have not significantly increased in the last twenty years and continue to fall short of targets (NHMRC, 2003). In Australia, it is estimated 87% of women with new babies initiate breastfeeding following birth (NHMRC, 2003), 81.8% of women are still breastfeeding on discharge from hospital, and 62.6% are fully or partially breastfeeding at three months (Donath et al., 2000).

Breastfeeding rates

Despite a global endorsement for and promotion of breastfeeding, breastfeeding initiation and duration rates differ significantly between countries. For example, and focusing on Western cultures, in Norway 98% of women will initiate breastfeeding and at one month and three months 97% and 88% respectively will still be breastfeeding (Statistisk sentralbyra, 1999). In contrast to this, breastfeeding rates in Britain and the United States are much lower. In Britain, 69% of women initiate breastfeeding, falling to 42% at six weeks, 28% at four months and 13% at nine months (Hamlyn et al., 2002). In the United States, 71.4% initiate breastfeeding and 51.5% and 35.1% will be breastfeeding to some extent at three months and six months respectively (Li et al., 2005).

While Australian breastfeeding initiation rates appear high, similar to the UK and US, Australian breastfeeding rates decline quite significantly over the early postpartum weeks and months, with a substantial number of women ceasing breastfeeding within the first six weeks post-birth (Donath et al., 2000; Hailes et al., 2000; Papinczak et al., 2000; Scott et al., 2001a; Cooke et al., 2003a). It has been estimated that 5%–8% of women will cease breastfeeding prior to discharge from hospital care (Fetherston, 1995; Scott et al., 2001b), with a further 9%–10% discontinuing in the first two weeks (Scott et al., 2001a; Cooke et al., 2003a) and a further 10–11% ceasing breastfeeding by six weeks post-birth (Scott et al., 2001a; Cooke et al., 2003a). These figures indicate that up to approximately 25% of Australian women who initiate breastfeeding will have weaned within the first six weeks.

In an effort to understand breastfeeding behaviours, a number of descriptive studies have been undertaken to determine characteristics and factors influencing the decision to breastfeed. It has been identified that factors associated with the initiation of breastfeeding are not necessarily the same as those that affect the duration of breastfeeding and that these should be considered separately (Scott et al., 1999a). It is also acknowledged that many factors affecting breastfeeding initiation and duration are non-modifiable, although, more recently, research has begun to focus on more modifiable factors. Dennis (2002), in her literature review of factors affecting the initiation and duration of breastfeeding, discussed factors under the headings of personal characteristics, hospital policies and intrapartum experience, sources of support and breastfeeding interventions. These factors can also be broadly categorised into three major headings: socio-demographic, biomedical and psychosocial. The following summarises some of the factors identified as influencing breastfeeding decisions, using the above three categories as sub-headings. For the purposes of this review, socio-demographic factors have been defined as those factors which pertain to social composition; biomedical factors as biological, medical and physical factors; and psychosocial factors as including factors involving aspects of both social and psychological behaviour.

Socio demographic factors

Research has identified a number of socio-demographic factors that are considered to affect infant feeding choice. In Western societies, there is a strong inverse relationship between rates of breastfeeding and socio-economic status with women of lower socio-economic status less likely to initiate and maintain breastfeeding than women from higher socio-economic groups (Scott et al., 1997; Hamlyn et al., 2002). Reflecting socio-economic status, it has also been found that women who are privately insured are more likely to breastfeed (Nicholson et al., 1995).

Differences in socio-economic status do not, however, fully explain variances in breastfeeding rates. For example, the Northern Territory in Australia is considered to have a higher proportion of socio-economically disadvantaged areas but it records some of the highest rates of breastfeeding in Australia (Donath et al., 2000). These findings suggest

factors other than socio-economic status play a major role in women's infant feeding decisions. This could explain why Papinczak and Turner (2000) found no significant association between gross household income and breastfeeding initiation and duration in an Australian population. Interestingly, and not surprisingly, when multivariate analysis is applied to socio-economic data and breastfeeding it has also been found to have a less consistent relationship (Scott et al., 1999a).

Maternal age is another socio-demographic variable that has consistently been correlated with breastfeeding initiation and duration, even when multivariate analysis is applied (Scott et al., 1999a). The older the woman, the more likely she is to initiate breastfeeding and breastfeed for longer (Nicholson et al., 1995; Hoddinott et al., 2000a; Scott et al., 2001a; Australian Bureau of Statistics, 2002). Adolescent mothers, on the other hand, have consistently been shown to have lower breastfeeding initiation and duration rates (Donath et al., 2000; Wambach et al., 2004). Specific antenatal breastfeeding programs for adolescents have demonstrated a positive effect on the initiation of breastfeeding (Volpe et al., 2000; Greenwood et al., 2002), although when duration rates are assessed these increased rates do not appear to be sustained (Greenwood et al., 2002). In Greenwood et al.'s (2002) study, for example, breastfeeding duration rates at three and six months were lower than the general population.

Another positive correlation that remains strong and consistent, even in studies where multivariate analysis is applied to data, is found between education and breastfeeding. The higher the level of education, the more likely a woman is to breastfeed (Scott et al., 1999a; Scott et al., 2001a; Homer et al., 2002; Australian Bureau of Statistics, 2003).

In Australia, differences in breastfeeding rates have also been shown to occur across cultural groups. Some research has indicated women from Culturally and Linguistically Diverse (CALD) groups are less likely to breastfeed than women born in Australia (Williams et al., 1983). In other research, a specific antenatal breastfeeding program presented to a CALD group was shown to increase breastfeeding initiation rates but again, similar to the teenage mothers group, these rates were not sustained (Rossiter, 1994).

Distinctions between different language groups have also been identified. More recently, in a study by Homer et al. (2002), differences in the early infant feeding decisions between English-, Chinese- and Arabic-speaking women birthing in one Area Health Service in Sydney, Australia were examined. Using logistic regression analysis, the authors found Arabic women were more likely to initiate breastfeeding when compared to English- or Chinese-speaking women. Chinese speaking women, although less likely to state an intention or actually initiate breastfeeding than English- or Arabic-speaking women, were more likely to be breastfeeding at eight weeks than English-speaking women (Homer et al., 2002).

Finally, in other research, women with partners (Nicholson et al., 1995; Scott et al., 1997; Shepherd et al., 2000) have been found to be more likely to breastfeed, although these findings are not always consistent after controlling for potential confounders (Scott et al., 1999a).

Biomedical factors

Parity has also been shown to influence breastfeeding. Some studies have found a primiparous woman, that is, a woman having her first baby, is more likely to initiate breastfeeding (Nicholson et al., 1995; Homer et al., 2002). Other studies have found multiparous women, that is, women having subsequent babies, more likely to have greater duration rates of breastfeeding (Ryan et al., 1990; Scott et al., 1997; Homer et al., 2002). Scott et al. (1999a) again argue, when multivariate analysis is applied, that there is a less consistent association between breastfeeding and parity.

The health of the infant has also been shown to affect breastfeeding rates. Where the mother rated her infant's health as very good or excellent, statistical analysis demonstrated significantly more successful initiation of breastfeeding (Lawson et al., 1995; Papinczak et al., 2000). Other research has shown that admission of the baby to the special-care nursery (SCN) has an inverse effect on breastfeeding duration (Scott et al., 2001a). Further to this, women who have stated the baby's breastfeeding behaviour to be positive, such that the

baby suckles well with little help from the mother, has also been shown to have a positive influence on the mother's breastfeeding experience (Hailes et al., 2000).

Breastfeeding being considered good or 'best' for the baby has been most commonly cited as the reason for choosing breastfeeding (Earle, 2000; Ertem et al., 2001; Earle, 2002). It has been noted, however, that while women in general appear to know the benefits of breastfeeding, not all women will consider breastfeeding best for them (Sheehan et al., 2003), and that breastfeeding knowledge is not always useful in dissuading women who choose to bottle-feed (Earle, 2002).

Researchers have argued that because several factors are usually involved, it is difficult to determine why mothers stop breastfeeding (Binns et al., 2002). Thus, another focus of infant feeding research has been to identify what difficulties women experience when breastfeeding. Results have found women find the first two to six weeks to be the most difficult time for breastfeeding (Hailes et al., 2000; Dewey et al., 2003). Anxiety about breastmilk supply (Cox et al., 1994; Lowe, 1994; Hailes et al., 2000; Cooke et al., 2003a), engorgement (Hailes et al., 2000; Binns et al., 2002; Cooke et al., 2003a), attachment difficulties (Lowe, 1994; Hailes et al., 2000; Cooke et al., 2003a), nipple trauma (Lowe, 1988; Hailes et al., 2000; Binns et al., 2002; Cooke et al., 2003a), mastitis (Hailes et al., 2000; Binns et al., 2002; Cooke et al., 2003a), and unsettled babies (Lowe, 1988; Hailes et al., 2000; Binns et al., 2002; Cooke et al., 2003a) have all been identified as problems experienced by women during this crucial period. The occurrence of mastitis, however, has also been associated with longer breastfeeding duration and that women with leaking breasts are also more likely to continue to breastfeed (Cooke et al., 2003a).

Nonetheless, it has been argued that many health professionals conclude women cease breastfeeding due to ineffective or poor feeding practices, such as incorrect positioning and attachment, and that by increasing maternal education, breastfeeding rates will be increased (Binns et al., 2002; McLeod et al., 2002). However, not all women who experience problems will consider these issues make breastfeeding difficult, and therefore they have been found to be an unreliable predictor of weaning (Cooke et al., 2003a). In addition, other

research has found some women will persist with breastfeeding despite the presence and/or discomfort of difficulties (Bottorff, 1990; Cooke et al., 2003a).

Hospital policies and practices have also been shown to affect breastfeeding initiation and duration rates. Some researchers have argued mothers who room-in, that is, mothers who keep their baby by their bed in hospital are less likely to have stopped breastfeeding at any time period, when compared to mothers whose infants spent time in the nursery (Scott et al., 2001a). Other researchers have proposed that bed sharing can also have a positive effect on breastfeeding (Clements et al., 1997). These findings, however, raise the argument of cause and effect. The above authors also question the relevance of these findings, suggesting mothers who plan to breastfeed and breastfeed longer may be more likely to share their beds (Clements et al., 1997). In contrast to the above findings, researchers, using logistic regression analysis, found rooming-in did not affect breastfeeding rates (DiGirolamo et al., 2001).

It has also been suggested that the use of dummies/pacifiers can lead to early weaning. The BFHI, in its 10 steps, recommends not using dummies for term infants who are breastfeeding (World Health Organisation et al., 1991b). Other research, however, has failed to substantiate these claims (Kramer et al., 2001; Benis, 2002). In a meta-analysis of pacifier use and its effect on breastfeeding, the authors concluded that there did not appear to be any effect on breastfeeding rates with the occasional use of pacifiers, and it remained unclear whether pacifier use in and of itself was a causal factor for reducing breastfeeding duration rates (Ullah et al., 2003). Kramer et al. (2001) concluded that there remains uncertainty whether pacifier use relates to breastfeeding difficulties or whether it indicates a lower motivation to breastfeed, rather than being a true cause of early weaning.

Similarly, complementary and supplementary feeds have also been negatively associated with breastfeeding rates (Hill et al., 1997). The use of a bottle, regardless of its contents, in the first month was found by Vogel (1999) to be associated with shorter breastfeeding duration (Vogel et al., 1999). Somewhat differently, Schwartz (2002) found bottle-feeding after three weeks did not appear to jeopardise breastfeeding success up to 12 weeks but,

rather, appeared to improve breastfeeding (Schwartz et al., 2002: pg7). As with pacifiers, however, the use of complementary and/or supplementary feeds may be a consequence of other experiences, rather than being the cause of negative breastfeeding outcomes (Chezem et al., 2003).

Recently, a Cochrane review, 'Support for breastfeeding', has found evidence that professional support can have a positive effect on the duration of breastfeeding (Sikorski et al., 2004). In a previous Cochrane review, 'Support for breastfeeding mothers', the authors, although cautious about what elements of support are beneficial, conceded that while overall, professional support for breastfeeding women is beneficial to breastfeeding, there was a need for fundamental qualitative research to explore the different elements of breastfeeding support strategies and the mechanisms by which support operates (Sikorski et al., 2000).

Psychosocial factors

The Cochrane reviews, as well as other research, have also identified peer support as having a positive effect on aspects of the breastfeeding experience (Kistin et al., 1994; Sikorski et al., 2000; Sikorski et al., 2004). Both emotional and practical supports have been found to be important to breastfeeding (Hailes et al., 2000; Tarkka et al., 2000; Hoddinott et al., 2000b; Ceriani Cernadas et al., 2003). Encouragement from a supportive partner, other family members and health-care professionals has also been associated with breastfeeding duration (Ingram et al., 2002; Ceriani Cernadas et al., 2003).

Fathers particularly have been identified as influencing the woman's decision to breastfeed or artificially feed, with encouragement and support for breastfeeding having a positive effect on breastfeeding rates (Giugliani et al., 1994; Scott et al., 1999a; Scott et al., 2001a; Ingram et al., 2002; Ceriani Cernadas et al., 2003).

In addition to social support, social health, described by Papinczak et al. (2000: pg 30), as relating to 'attendance at community events and socialising with friends and family' was

also significantly correlated to both initiation and duration of breastfeeding. Women with lower social health scores were less likely to initiate or breastfeed for longer durations.

An inverse relationship has been found to exist between maternal employment at three months postpartum and the initiation of breastfeeding (Papinczak et al., 2000). Mothers who intended to return to work or study within six months following birth were less likely to be breastfeeding on discharge, but no association between mothers' intention to return to work and duration of breastfeeding was identified (Scott et al., 2001a).

Smoking has also been found to have a negative effect on breastfeeding (Australian Bureau of Statistics, 1996; Clements et al., 1997; Scott et al., 1999a). In the study by Clements et al. (1997), the researchers identified a close response relationship between smoking and duration of breastfeeding: the more the mother smoked, the less likely she was to breastfeed. The authors suggest this may be related to other work, which identified that women who smoked recorded lower basal prolactin levels (Clements et al., 1997). More recently, however, a study specifically examining the link between smoking and breastfeeding has found that while women who smoke are less likely to breastfeed, it is due to a lower motivation to breastfeed rather than any physiological effects of smoking (Donath et al., 2004).

Self-confidence and self-efficacy have also been shown to be significant factors associated with more successful breastfeeding outcomes (Dennis et al., 1999; Papinczak et al., 2000; Ertem et al., 2001; Blyth et al., 2002; Blyth et al., 2004). Consistent with this finding, a literature review of parenthood experiences in the first year highlighted the importance of confidence to both the mother and father in their new parenting role (Nystrom et al., 2004). Parents of breastfed infants have also been shown to have a more positive attitude to breastfeeding (Shaker et al., 2004).

While it appears to be stating the obvious, many studies have also concluded that a woman's stated intentions regarding breastfeeding are associated with breastfeeding duration rates (Kaufman et al., 1989; Lawson et al., 1995; Tarkka et al., 1999; Vogel et al.,

1999; Scott et al., 2001a). Timing of the intention has been indicated as important, with women who made the decision to breastfeed prior to conception more likely to breastfeed (Shepherd et al., 2000). Intended duration has also been found to be associated with actual duration. In Scott et al.'s (1999b) study, mothers who intended to stop breastfeeding before four months postpartum were five times more likely to stop breastfeeding than women who intended to breastfeed for at least four months. Women who were undecided about how long they would breastfeed were more likely to stop than women who intended to breastfeed for four months or more (Scott et al., 1999b). Blyth (2004: pg 36) argues, 'given that breastfeeding intentions are consistently related to breastfeeding outcome both qualitative and quantitative research is needed to further understand maternal decision-making processes in relation to breastfeeding intentions'. Further to this, Scott et al. (1999a) argue that there have been few studies to examine the effect of intention using multivariate analysis, but they do recognise intention is consistent with the theory of reasoned action.

Predicting infant feeding outcomes using decision-making models

Given the association between intention to breastfeed and actual breastfeeding, it is not surprising that researchers have used the Theory of Reasoned Action (TRA) (Ajzen, 1988) and the Theory of Planned Behaviour (TPB) (Ajzen, 1991) to predict breastfeeding behaviours, as both these decision-making models include intention as a construct.

Intention is a fundamental factor of Ajzen and Fishbein's (1988) theory of reasoned action (TRA). The theory of reasoned action is based on the assumption that human beings generally behave in a rational manner, and it is also contingent on the behaviour in question being under volitional control. Intentions, according to the TRA, are a function of two key determinants: the individual's 'attitude toward the behaviour' and the person's perception of social norms, which are referred to as the 'subjective norm' (Ajzen, 1988). Ajzen (1988: pg 117) illustrates this concept by saying 'Generally speaking, people intend to perform a behaviour when they evaluate it positively and when they believe that important others think they should perform it'. The relative importance of attitudes and subjective norms will be dependent on the behaviour under investigation. In other words, for some intentions

attitudes will have more influence than the subjective norm, and in others the subjective norm will have more influence than the attitude. To better understand intentions, Ajzen (1988: pg 118) argues, 'it is necessary to explore why people hold certain attitudes and subjective norms.'

Attitudes and subjective norms are governed by significant underlying beliefs. Behavioural beliefs are held to determine attitudes and consist of two components: an outcome belief, and an outcome evaluation (Armitage et al., 2003). Multiplying the outcome belief with the outcome evaluation and summing the results will obtain an estimate of attitude towards behaviour (Ajzen, 1988). Similarly, normative beliefs underpin subjective norms and consist of two components: referent beliefs, and motivation to comply. Referent beliefs refer to an individual's belief that significant others will approve or disapprove of them performing the behaviour in question. The motivation to comply is underpinned by the concept that referents with which the individual is motivated to comply will apply some form of pressure to do so. Subjective norms are calculated simply by asking the respondent to estimate how likely it is that important referents would approve of their carrying out a particular behaviour (Ajzen, 1988). Generally linear regression models are used to estimate the predictive power of both attitudes and subjective norms in order to account for intention (Ajzen, 1988).

As already stated, the TRA was developed to estimate purely volitional behaviours, and while it has proven to be an effective predictor in a number of situations (Ajzen, 1988; Armitage et al., 2003), there are other situations in which its effectiveness has not been upheld. Ajzen (1988, 1991) recognises that not all behaviours are under complete volitional control, and in order to address these limitations, developed the theory of planned behaviour TPB (Ajzen, 1988; Ajzen, 1991). Ajzen (1991) cites a number of factors identified as related to influencing the degree of control an individual has over a given behaviour. These factors include information, skills and abilities; emotions and compulsions; external factors; opportunity and dependence on others. As has been recognised, breastfeeding is not under complete volitional control, as there are many factors that can interrupt breastfeeding initiation and/or duration.

The theory of planned behaviour (TPB) is an extension of the TRA (Ajzen, 1991) and, in addition to 'attitudes' and 'subjective norms', it includes 'perceived behavioral control' in the model to predict intention. The rationale for including perceived behavioural control is based on the assumption that 'holding intention constant, greater perceived control will increase the likelihood that enactment of the behaviour will be successful' (Armitage et al., 2003: pg 191). The TPB has been referred to as the most influential theory for the prediction of social and health behaviours (Armitage et al., 2003; Rivis et al., 2003).

The theory of reasoned action and its extension, the theory of planned behaviour, have been used as the basis for a number of research studies that have attempted to predict breastfeeding initiation and duration (Manstead et al., 1983; Manstead et al., 1984; Wambach, 1997; Humphreys et al., 1998; Goksen, 2002). Some researchers have argued that these decision-making models can assist in developing theory based interventions in order to increase breastfeeding initiation and duration rates (Wambach, 1997; Humphreys et al., 1998). The results of these studies have, however, been limited in their usefulness to predict breastfeeding duration (Wambach, 1997). It could be argued that some of these limitations may be related to insufficient knowledge of women's attitudes and normative beliefs about breastfeeding.

Manstead et al. (1984) used the theory of reasoned action to analyse the impact of the attitudes, perceived norms and behavioural beliefs of fifty primiparous mothers on their infant feeding intentions and actual feeding during the first six weeks post partum. Results of their study found attitudes to breastfeeding were more influential than norms in predicting infant feeding decisions. As a result, they concluded women chose to bottle-feed not because of the merits of bottle-feeding, but rather due to the perceived disadvantages of breastfeeding and because they believed breastfeeding did not make the mother feel closer to the baby. In contrast to this, women who chose to breastfeed did so because they believed it would make them closer to their baby (Manstead et al., 1984).

In an earlier study by Manstead et al. (1983), it was also identified that attitudes were more significant than intentions in assessing infant feeding behaviours. In this study, however, the authors also acknowledged that, taken at face value, the findings of their study imply behaviour is shaped in part 'by certain affective factors not tapped by measures of behavioural intentions but that are reflected in measures of behaviour' (Manstead et al., 1983: pg 668).

In a more recent study testing the assumptions behind the TRA for exclusive breastfeeding behaviour, the author found no association between intention and breastfeeding behaviour, arguing that intention alone had no predictive power on breastfeeding behaviour (Goksen, 2002). The results of Goksen's (2002) study suggested instrumental support, social embeddedness and informational support were factors that rendered intention into behaviour. The author concluded that behaviour associated with breastfeeding draws from a multifarious set of 'intentions, attitudes and social behaviours' (Goksen, 2002: pg 1752) and as such 'the TRA may not apply to relatively complex, socially determined behaviours such as breastfeeding where an individual's intentions and efforts are not enough to bring about expected behaviour' (Goksen, 2002: pg 1751).

Decision-making

Galotti (2002: pg 1) describes the term decision-making by stating 'Cognitive psychologists use the term decision-making to refer to the mental activities that take place in choosing among alternatives'. Clearly, this description classifies decision-making as a purely cognitive function, a view until recently left largely unchallenged (Loewenstein et al., 2003). Decision-making has been broken down into five stages:

1. Setting goals;
2. Gathering information
3. Decision structuring
4. Making a final choice and
5. Evaluating the decision (Galotti, 2002).

Galotti (2002) argues that the term 'stages' suggests there is a predetermined order of sequence involved in these steps, but disputes this and instead calls each stage a phase arguing that there is not sufficient evidence to suggest a sequential pattern. She contends rather that there is no pattern and that each phase can occur in different order and overlapping of another phase. Many laboratory studies of decision-making focus exclusively on the phase 'making a final choice', but Galotti (2002) argues there is reason to believe that the first three phases are at least as important, if not more important in understanding real-life decision-making.

As with the TRA and TPB, traditional decision theories have assumed the decision-maker will make a decision in a rational and dispassionate manner in order to capitalise on satisfaction (Galotti, 2002; Loewenstein et al., 2003). Traditional models of decision-making use linear models and have generally been tested under controlled conditions. Recent critiques of traditional decision theory, known as behavioural decision theory, has shown people often make judgements that appear inconsistent and have subsequently identified a number of cognitive errors and heuristics associated with the decision-making process (Tversky et al., 2000). Further to this, some commentators, while respectful of the long history of traditional decision theory, have questioned the relevance of laboratory testing arguing they do not truly reflect real-life conditions (Connolly et al., 2000; Galotti, 2002) claiming 'that in real life decisions, all the information required to make a decision isn't neatly presented (as it generally is in laboratory tests) and there isn't always one single correct answer' (Galotti, 2002: pg X). While Galotti (2002: pg X) does not go so far as to claim laboratory models of decision-making are irrelevant she does question 'when and how laboratory based phenomena apply'.

In the last few years, decision theory has also seen an increasing interest in the effect of emotions on the decision, with researchers identifying that decision-making is not purely a cognitive process (Loewenstein et al., 2003). Loewenstein and Lerner (2003) argue that while expected emotions are generally considered in most theories of decision-making, they are not all that matter and in fact have limitations. These limitations include the fact that people often mispredict their own affective reactions to possible outcomes and that

expected emotions do not account for gut reactions, which, while predominantly vague, are important inputs into the decision (Loewenstein et al., 2003).

If decision-making models are to be used to help understand breastfeeding behaviours, Wambach et al's. (2004) recommendation for a better understanding of decision-making processes should not go unheeded. Despite the long traditional history and 'major intellectual achievement' of traditional decision theory (Connolly et al., 2000: pg 755), it is argued there is still further research to be undertaken in the area of understanding decision-making in the field (Galotti, 2002). In particular, it has been argued that this field of study needs to develop research methods that allow for the study of 'actual decision-making in the field ... Investigators, it is argued, 'need to know how to elicit the thinking that people engage in 'on-line' that is while they are actually undertaking the process' (Galotti, 2002: pg 153)

Qualitative research

By far the majority of breastfeeding research has used quantitative methodologies and focused primarily on the biophysical aspects of breastfeeding. It has been argued that many studies into breastfeeding list only one-dimensional and often simplistic relationships between the social, emotional and demographic factors related to the practice. Further to this, it has been purported that research such as this fails to acknowledge the interdependence, interaction and complexity of the total breastfeeding experience (Dignam, 1995) and, in the process, ignores women's own experiences and voices (Maclean, 1990; Carter, 1995).

In response to these accusations there is an increasing body of qualitative research interested in women's experiences of breastfeeding. This more woman-centred approach has highlighted the emotional and social significance breastfeeding has for women.

Murphy (1999) demonstrated how infant feeding decisions are a highly accountable matter and 'irreducibly' moral in nature. Hoddinott et al. (1999a) found that for women from a lower socio-economic background, exposure to breastfeeding was more influential to their

decision than theoretical knowledge focusing on breastfeeding skills. Schmied and Barclay (1999) demonstrated the embodied nature of breastfeeding that for some women created a connected and harmonious experience, but that for other women was disruptive and distorting of their known self. Both Hauck et al. (2002a) and Mozingo et al. (2000) found women experienced incompatible expectations in relation to their breastfeeding experiences. Using phenomenology, Bottorff (1990) explored the reality of persistence with breastfeeding and Leff et al. (1994) explored maternal perceptions of breastfeeding success. While these studies have added important and significant insight into aspects of the breastfeeding experience, from the perspectives of women, as yet no research has focused solely on the decision-making experiences of women making infant feeding decisions in the first six weeks. More recently, researchers have highlighted the importance of undertaking research that will explore the experiences and decision-making processes of both breastfeeding and formula-feeding women (Wambach et al., 2004).

Conclusion

Given that breastfeeding has significant health advantages to both the mother and infant, it is understandable that there has been considerable research focusing on trying to understand and predict breastfeeding behaviours. These studies have predominantly focused on the biophysical and biomedical aspects of breastfeeding using quantitative methodologies, which, it can be argued, do not fully explain the complexities of the infant feeding decision. In contrast to this, recent qualitative research has highlighted the emotional and social significance breastfeeding can have for women. Notwithstanding this disparity, most professional accounts around the decision to breastfeed consider the decision largely a matter of individual choice and rational decision-making. Not surprisingly, attempts to predict breastfeeding using traditional decision-making models based on rationality have had only limited success. Recent decision-making theory has identified that decision-making is not always consistent and, further, that emotions also play a significant although poorly understood role. There has been some research exploring elements of the infant feeding experiences of women from a qualitative perspective. Findings from these studies have shown there are differences between women's and professionals understandings of the infant feeding experience. As yet no one has focused on the infant feeding decisions of

women in the first six weeks post-birth. Increasingly, the importance of exploring the decision-making processes for women who are either breastfeeding or formula-feeding is being identified and will be explored in this study from the perspectives of the women themselves.

Chapter Three

Methods

Introduction

The review of literature presented in the previous chapter suggests there is incongruity between the assumptions of professionals and the understandings and experiences of breastfeeding for women (Leff et al., 1994; Schmied et al., 1999; Hoddinott et al., 1999b; Hoddinott et al., 2000b), and that predicting breastfeeding duration using decision-making models has not been successful. Further, the predominant research methodology used in studies to identify factors related to the decision to breastfeed or formula-feed has been quantitative. Comparatively, there has been only a small amount of qualitative research exploring aspects of the infant feeding experience. In this chapter, I provide a discussion of the epistemological and theoretical underpinnings of the research, provide a rationale for using a constructionist grounded theory methodology, and describe how this approach was applied to data collection and the analysis of data in this study.

Choosing a methodology

Qualitative research has a long history, however, it was not until the 1920s and 1930s that the importance of qualitative research was truly established, largely through the 'Chicago School of Sociology' (Denzin et al., 2000). Qualitative research, while historically connected to sociology and anthropology, is according to Denzin and Lincoln (2000: pg 2) 'a field of inquiry in its own right which crosscuts disciplines, fields, and subject matters'. Particularly in recent times, qualitative methodologies have been taken up by a number of disciplines including 'education, history, business, medicine, nursing, social work and communications' (Denzin et al., 2000: pg 2) and are increasingly playing an important role in research (Dixon-Woods et al., 2001). The purpose of qualitative research is to 'study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them' (Denzin et al., 2000: pg 3).

Qualitative research has been viewed as an assault against positivist research, and throughout history there has been a refusal to accept qualitative methodologies, based on the argument that it is not 'true science' (Denzin et al., 2000). Positivists will argue that qualitative researchers have no way of verifying their 'truth statements' (Denzin et al., 2000: pg 8). Yet, much of qualitative work is historically steeped in objectivism (Crotty, 1998) and so understanding the epistemological underpinnings of methodologies is important to explain and justify the choice of methodologies (Crotty, 1998).

Exploring Epistemologies

Arguably, the most dominant epistemology throughout history has been objectivisim. Objectivism has its roots in ancient Greek philosophy and leads to a positivistic theoretical stance. Positivism informs many of the research methodologies that have been used in science and sociology and is still inextricably linked to empirical science (Crotty, 1998). Positivism lays claim to being unambiguous and accurate because it is considered as objectively proven knowledge derived in a rigorous manner through observation and experiment. (Chalmers, 1982; Crotty, 1998). The dominant biomedical model is based on the positivist approach to research and privileges quantitative research, and, in particular, the randomised controlled trial over other methods of research (Dixon-Woods et al., 2001).

It has, however, been argued that the positivistic world is not the world of the everyday and, while science has been and is very useful in many ways, the positivistic claim that only scientific knowledge is valid, certain and accurate has been shown to be largely flawed. (Kuhn, 1970; Popper, 1976; Chalmers, 1982). Philosophers such as Popper, (1976) Kuhn, (1970) and Feyerabend, (1975) have quite radically questioned some or all of the positivistic assumptions. As a consequence of their work, a more modest perspective of positivism has been proposed that argues probability not certainty, only a certain level of objectivity rather than total objectivity, and accepts that truth may not necessarily be understood in its entirety. This theoretical perspective is known as post-positivism (Crotty, 1998).

Further to this, and in contrast to objective scientific knowledge, there are other epistemologies that favour subjective understandings. These understandings encompass and privilege beliefs, opinions, feelings, assumptions and preferences (Chalmers, 1982; Crotty, 1998) and are to be found in epistemologies such as subjectivism and constructivism.

Subjectivism argues that knowledge is generated from the mind, without reference to reality, that meanings are invented and imposed on an object (Crotty, 1998). Constructionism claims that meanings, and therefore truth, cannot simply be described as either objective or subjective because meanings are constructed by human beings as they engage with the world they are interpreting (Crotty, 1998). Crotty (1998: pg 45) described this by saying 'because of the essential relationship that human experience bears to its object, no object can be adequately described in isolation from the conscious being experiencing it, nor can any experience be adequately described in isolation from its object'. Constructionism brings together objectivity and subjectivity in an indissoluble way, allowing that meanings will emerge as the subject interacts with the object. What constructionism insists, therefore, is that meaning is not discovered, but is constructed in and out of the interaction between human beings and their world, there is no 'true' or 'valid' understanding but rather useful interpretations that will presuppose interpretations that in contrast have no useful purpose (Crotty, 1998; Schwandt, 2000).

Grounded theory methodology

Barney Glaser and Anselm Strauss developed grounded theory in the 1960s as a method of generating theory for social scientists (Hutchinson, 1986). The origins of grounded theory can be traced back to two divergent analytic traditions. On the one hand Barney Glaser bought to grounded theory a background of quantitative survey methods born out of the Department of Sociology at Columbia University. Anselm Strauss, on the other hand, came from the Chicago 'tradition' of qualitative research steeped in symbolic interactionism (Glaser et al., 1967; Dey, 1999). Symbolic interactionism, a major theoretical perspective in sociology, can be described simplistically as 'the study of how the self and the social environment shape each other through communication' (Lindlof et al., 2002: pg 41).

Charmaz (2000) has stated that Glaser and Strauss wrote 'The Discovery of Grounded Theory' at a critical point in social science history, defending qualitative research against the view that quantitative research was the only way of conducting empirical research. They contended that rather than focusing simply on testing existing theories, or theories as yet still barely generated, theories could be generated from data by using a systematic approach to data collection and analysis. They developed grounded theory as a methodology, arguing its usefulness to both generate and verify theory during the conduct of any given research (Glaser et al., 1967). The point of generating theory in this manner is that it offers a new perspective on a given situation and a good and useful way of looking at a certain world.

Despite the fact grounded theory is a qualitative methodology and there is an almost accepted assumption that qualitative research stems from a more subjective epistemology, Glaser and Strauss's original work was very much steeped in positivism, emphasising a process of both induction and deduction. In more recent times, however, grounded theory has undergone a number of changes and taken a less positivist form. For example, while retaining much of the positivist ideals of grounded theory, Strauss and Corbin have emphasised the need to give voice to the participant and, as such, have taken a more post-positivistic perspective to grounded theory (Charmaz, 2000). Further, in response to criticism by postmodernists and poststructuralists to grounded theory's positivist foundations, researchers have applied a more constructionist approach (Charmaz, 2000).

Charmaz (2000) is a researcher who uses a constructionist grounded theory approach arguing that this approach 'takes a middle ground between postmodernism and positivism' (Charmaz, 2000: pg 510). In a constructionist grounded theory, there is emphasis on the emergent constructivist elements that calls for grounded theory strategies to be applied in a less rigid manner that includes a less positivistic approach and a focus on meaning that enhances interpretive understanding (Charmaz, 2000).

With all these differences in epistemologies and methods, it is not surprising that defining grounded theory and knowing how to put it into practice can be problematic (Dey, 1999;

Charmaz, 2000). Dey (1999) argued that this inconsistency is exemplified by the very differences inherent in the approaches taken by the creators of grounded theory, Glaser and Strauss, who have in more recent times had a very public disagreement about what grounded theory actually is and how to carry out the process of grounded theory analysis. Dey (1999), in fact, has been bold enough to assert that there are probably as many ways of using grounded theory, as there are grounded theorists. Charmaz (2000) has been more moderate in her assessment of these differences, arguing that it is an innate quality of grounded theory to provide a flexible set of strategies rather than fixed prescriptions. Nonetheless, others have argued there are fundamental analytic steps to grounded theory that must be undertaken and criteria that allow for judging the scientific merit of a study (Strauss et al., 1998).

Rationale for using a constructionist approach to grounded theory

It was proposed that the development of a grounded theory of infant feeding decisions would help to explain the 'characteristics' and 'dimensions' of particular concepts and categories of the infant feeding experience. Such work goes beyond simple correlations possible from survey data and will outline the conditions under which particular experiences may occur and the consequences of particular actions, interactions or experiences (Strauss et al., 1998). Using a grounded theory method allows for theorising to be undertaken from the 'ground up' by focusing on the seemingly complex interactions of the women when making decisions about infant feeding.

I chose to undertake a constructionist approach to grounded theory because of its focus on the interpretative understandings of the participant. I took this perspective because of my unease in taking a purely positivistic stance, both from a personal perspective but also given the volume of positivist research already previously undertaken that has examined aspects of infant feeding. In addition, I found the constructionist approach to grounded theory, which uses grounded theory methods as 'flexible heuristic strategies rather than as formulaic procedures' (Charmaz, 2000: pg 510), much more flexible.

While the framework used to present the process of analysis in the following sections may appear linear, this was not the case. Firstly, grounded theory is not linear and the steps are not clearly broken up or delineated but rather somehow blurred, moving in a circular fashion or in a back and forward process (Strauss et al., 1998). Secondly, I found early attempts at using grounded theory methods in a rigid fashion counterproductive. For example, my initial interpretation and application of Strauss and Corbin's method (Strauss et al., 1998) ultimately led me to a descriptive rather than theoretical analysis, a criticism levelled at this model by Glaser (Glaser, 1992). Charmaz's (2000) suggestion of a much more flexible approach to grounded theory was far more helpful. I found it more useful to examine a number of approaches and critiques offered by different proponents of grounded theory and apply their different strategies where it was deemed appropriate, to assist with uncovering the emergent concepts (Glaser et al., 1967; Glaser, 1978; Hutchinson, 1986; Strauss et al., 1998; Dey, 1999; Charmaz, 2000). To this end, I was later able to return to Strauss and Corbin's (1998) work and make use of some of their strategies, applying them in a less prescriptive manner. I ultimately found this, from my perspective, much more productive. The following outlines the process undertaken in this grounded theory study of women's experiences of infant feeding decision-making in the first six weeks post-birth. I begin with a discussion of the role of reflexivity.

Reflexivity

It is not possible to be completely objective in qualitative research and, it is argued, neither is it beneficial (Ahern, 1999). There is, however, an increasing expectation for qualitative researchers to be reflective of their own subjectivity and demonstrate attempts to control or at least acknowledge personal assumptions or biases and the effect these may have on the research (Ahern, 1999; Carolan, 2003; Finlay, 2003). Finlay (2003) has suggested that reflexivity in one form or another has occurred for at least a century and addresses a range of purposes. These purposes have included providing a sense of validity and trustworthiness to research, to accommodate a more positivist expectation or a more subjective account of unravelling how a researcher's life experiences affect her/his interpretation of the research (Finlay, 2003). As reflexivity is now considered a defining feature of qualitative research, there are a number of ways suggested to researchers for

addressing the process of reflexivity (Finlay, 2003). Finlay (2003) listed five variants of these as introspection; intersubjective reflection; mutual collaboration; social critique and ironic deconstruction. In this research, I have attempted to use introspection and intersubjective reflection through a 'confessional account' (Finlay, 2003: pg 16) of my preconceptions found in the preface and throughout my discussion on the methodology and methods. I use first person to present these.

Sampling

In grounded theory data collection and analysis occur concurrently. Theoretical sampling, crucial to grounded theory, begins early as the researcher discovers codes and tries to saturate them by looking for comparison groups (Glaser, 1978). This process allows for the analyst to elaborate on possibilities and probabilities through the deductive process of analysis, in order to determine where to sample in terms of locations and groups in the field. This means the analyst will deliberately sample the data to discover more ideas and connections (Glaser, 1978). Unlike statistical sampling, theoretical sampling cannot be predetermined prior to the outset of the study, and sampling decisions emerge as the study progresses (Strauss et al., 1998).

The grounded theory method assumes that at the outset of data collection, the analysts will not know what the important issues in the data will be, that is, what the problem will be for the participants. Data collection, therefore, will begin in a generalised way, as the researcher explores and examines the research participants' concerns. As these concerns become apparent, the researcher further develops questions around these concerns and, as the study progresses, the range of interview topics will narrow as the grounded theorist seeks specific data to establish a theoretical framework (Charmaz, 2002). Grounded theory specifies analytic strategies rather than data collection methods (Charmaz, 2000). In terms of deciding who or what the sample will be, data collection often begins using a site chosen based on the researcher's experience and/or knowledge of the subject (Dey, 1999). In this study, data were collected through in-depth interviews.

Interview data for this study were obtained from two separate research studies focusing on women's experiences of infant feeding. The first study allowed me as the researcher to become clearer about the research question and helped me identify the importance of studying the first six weeks post-birth in terms of decision-making experiences. The second study was designed to build on the findings of the first study, by focusing on the first six weeks post-birth and the emerging issues identified during data analysis. The following describes these studies.

Study One

In the first study, women were recruited as part of a larger research study that surveyed the postnatal outcomes of women. The purpose of the larger postnatal outcomes study was to examine the social, physical and psychological health outcomes of women in the first six months postpartum. The study was conducted in three public hospitals in one Area Health Service in Sydney during 1999–2000. Women were recruited to the study in the antenatal period when they were between 28–36 weeks gestation. If women gave informed written consent to the larger study, they were then asked if they would also be willing to consent to participate in a face-to-face interview with a researcher about their infant feeding experiences. If the woman was willing to participate in an interview she was then required to sign a separate consent form (see appendix I). Women who gave consent to participate in the face-to-face interview were then purposively sampled according to the answers they gave to breastfeeding questions asked in the larger study questionnaires. Questionnaires were administered antenatally and then at two weeks, six weeks, three months and six months postnatally. Purposive sampling was chosen in order to obtain a variety of infant feeding experiences and socio-demographic characteristics such as age, parity, socio-economic status, based on income, breastfeeding intention, reasons for breastfeeding and experience with breastfeeding. When a woman was selected for sampling she was contacted by telephone. During the telephone call, the woman was asked if she was still willing to participate in the face-to-face interview and, if she agreed to take part, a mutual time and place was arranged for the interview to take place. Interviews usually took place in the woman's home, although one woman chose to be interviewed at a café and another at the hospital where she birthed. The purpose of the interview study was to explore the infant

feeding experiences and decisions of women from the antenatal period through to six months post-birth.

A thematic analysis of women's infant feeding decisions during pregnancy was the first analysis to be undertaken with data from this study (see appendix VIII). Ongoing and further analysis of the data revealed the complexity of establishing feeding in the early post partum period and a 'failure' by some women to achieve their infant feeding goals established in the antenatal period. These ambiguities led me to refine the focus of the study to exploring the infant feeding decisions of women in the first six weeks post-birth, using a grounded theory methodology. Twenty-nine women participated in this first study. Interview data collected from twelve of these women, interviewed in the first eight weeks post-birth, was retained and reanalysed in the second study, which was the focus of this doctoral work.

Study Two

For the purposes of my doctoral work, a second study was designed to collect further data specifically focusing on the first six weeks post-birth to more closely explore and describe the experiences of women making infant feeding decisions in the first six weeks post-birth. In the second study, women were recruited either through the Child and Family Health Centres of two Area Health Services in Sydney or through a separate process of snowball sampling. Two different Area Health Services were used from the one sampled in the previous study. The decision to primarily sample women through the Child and Family Health Centres was based on the fact that Australian women have access to some form of universal and free child health nursing, with access predominantly occurring in the first few weeks post-birth (NSW Health, 2000). Having a large percentage of potential participants accessing this service made the process of locating participants much simpler.

The Early Childhood Health Centres in one Area Health Service in Sydney were initially used to access potential participants in this second stage of the study. This Area was chosen because I had previously worked in this Area Health Service and was confident women

from a variety of socio-demographic backgrounds and infant-feeding experiences accessed these services.

It was arranged that two approaches would be used to recruit women. Firstly, the Child and Family Health Nurses (CFHNs) would identify women who fitted the current criteria based on theoretical sampling and provide them with an information sheet (see appendix II). If a woman wished to participate in the study she would contact me via telephone to make arrangements for the interview to take place. Secondly, I would visit the clinics on the days the new mothers' parenting groups were held and personally present a brief outline of the research and a written information sheet to the women. During the presentation to the women, I was careful to ensure I explicated the types of experiences I was specifically looking for, based on theoretical sampling techniques. If a woman fitting the sampling criteria wished to participate, she could approach me at the clinic or she could contact me later by phone. If the woman was willing to participate in a face-to-face interview, a time and place for this to occur was arranged. All these women chose to be interviewed in their own home and a consent form was signed prior to the interview taking place (see appendix III). I visited three different clinics in one sector on five occasions, and ten women who fitted the sampling criteria volunteered to participate in face-to-face interviews. Continuing and concurrent analysis revealed that the women agreeing to participate in the study at this stage were older, highly educated, and middle class, and, despite having different feeding experiences, had all initiated breastfeeding.

At this stage theoretical sampling guided me as a researcher to seek women who were younger, or from a lower socio-economic background and/or women who had chosen to bottle-feed from the outset. To this end, I attended two young parent groups within this Area Health Service and a concerted effort was made by the CFHNs to provide information to women who fell within these categories. Despite these efforts, I was unable to recruit women who fitted these criteria from within this Area Health Service within a reasonable timeframe. As a consequence, arrangements were made to submit the proposal to another Area Health Service in Sydney.

The second Area Health Service was chosen to collect data based on the fact that it reports some of the lowest breastfeeding rates in Australia. In addition to this, new mothers in this Area are more likely to be socio-economically disadvantaged as well as younger, with the average age of women giving birth in the Local Government Area significantly lower than in NSW overall (Vaughan et al., 2003). It was also identified by one of the women in an earlier interview who worked in this area that there appeared to be a different mindset about breastfeeding in this area. She stated '*so I sort of got that feeling that oh it's (breastfeeding) not acceptable out here'* (P4).

A different approach to recruitment was used in this Area because Universal Health Home Visiting [1] was provided to all new mothers in the first six weeks. The recruitment process used in this area had the CFHNs identifying women at the first home visit who fitted the sampling criteria and providing them with information about the study (see appendix IV). At this time, the CFHNs also asked the women who fitted the criteria if they would be willing to consent to having their contact details forwarded to the researcher. If a woman consented to her contact information being given to me as the researcher, she signed a consent form (see appendix V) that allowed me to contact her by phone. These consents to be contacted were kept in a locked office at the Early Childhood Health Centre, and one of the CFHNs previously designated to the task contacted me and let me know they were available. Following this, I would collect the consents from the centre and contact the women.

During the initial telephone calls, while reiterating that participation was voluntary and answering any questions the woman may have had regarding the research, I invited the woman to participate in an interview. If the woman agreed to participate, a time and place to meet was arranged. At this meeting, the woman was asked to sign a further consent to participate in the study (see appendix VI). Participation involved a face-to-face interview with me that was audiotape recorded. Nine women from within the second Area Health Service were recruited to the study through this process.

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[1] Universal home visiting is the offer of a postnatal home visit to every family with a new baby Families First (unknown) Welcome to Families First. Families First a NSW Government Initiative. www.familiesfirst.nsw.gov.au.30/05/06.

In addition to the above two modes of recruitment, ethical approval was also given to snowball sample. Five women were recruited to the study through snowball sampling. Each of these women was accessed through social contacts. Friends of the researcher asked friends fitting the criteria if they would be interested in participating in the study. If a woman was happy to participate she either contacted me or gave permission for me to contact her. Again, the women chose to have these interviews at their homes and a consent form was signed prior to the interview taking place (see appendix VII).

In total, interview data were collected from thirty-seven women. Twenty-three women were first time mothers and fourteen women were mothers who had previous children. The age range of participants was between twenty and forty-seven, with the average age being thirty years. Twenty-seven women were married, eight were in de-facto relationships and two identified themselves as separated. Twelve of the women stated they had private health insurance and twenty-five women received Australian public health cover (Medicare). In all, twenty-six women received maternity care in public hospitals and eleven women received maternity care in private hospitals. In terms of the highest level of education achieved, sixteen women had university degrees with three indicating they had post-graduate degrees, three women had diplomas, seven women had completed secondary school to year 12, and eleven women had completed secondary school to less than year 12. All women spoke fluent English.

It was necessary to restrict this study to English-speaking participants because data involved language and I only speak English. In addition to this, it is recognised that breastfeeding is culturally constructed and that amongst different cultural groups there are significant differences in both breastfeeding initiation and duration rates, as well as individual experiences. (Rossiter, 1992; Rossiter, 1994; Homer et al., 2002).

At the time of the interview, fourteen women were fully breastfeeding and sixteen women were fully bottle-feeding. Of the women fully bottle-feeding, twelve had initiated breastfeeding but subsequently fully weaned. Three women were expressing and feeding

their babies fully on expressed breastmilk (EBM), three women were expressing and giving both EBM and supplementary formula and one woman was breastfeeding, expressing and giving EBM and also supplementing her baby with formula.

I found it difficult to recruit first-time mothers who had specifically planned to bottle-feed from the outset. Only one first-time mother who had planned to bottle-feed prior to birth consented, and she withdrew from the study before her interview because she went back to work at three weeks post-birth and felt she did not have the time to participate. Given that the findings of this research found that women who chose to bottle-feed at the outset often feared they would be judged or sanctioned, this may explain why these women were more reticent to be included. Any possible limitations associated with this may have been offset, however, because included in the study were second-time mothers who had planned to bottle-feed prior to birth and were able to reflect on their previous experiences as well as first-time mums who had weaned early.

Interviews

In-depth interviews were chosen to collect data, because they provide a greater depth of information than that collected through surveys and focus groups (Johnson, 2002), and lend themselves to a grounded theory methodology (Charmaz, 2002). Having said this, however, in-depth interviews differ somewhat in grounded theory, in that as the research progresses, the range of interview topics narrows (Dey, 1999; Charmaz, 2002). Dey (1999: pg 6) has described this well, by suggesting that with interview data, collection may begin with 'long conversations' but as the study progresses, they will become 'highly selected and focused on particular topics and consequently become much shorter'.

One of the most important aspects to consider when conducting an interview is rapport. Rapport is a quality of communication that allows for a level of trust between the researcher and the participant to be created so that the participant will feel comfortable to open up with her/his story (Lindlof et al., 2002). Johnson (2002) suggested that to be effective, in-depth interviewing will resemble friendship differing only in that the goal of the conversation will be to gather data. It is argued that there is a need for reciprocity and it

has been suggested that for true reciprocity to occur, the researcher must be a previous or current member of the group under study and willing to share this information by expressing 'her own views, feelings or reflections on the topic being discussed' (Johnson, 2002: pg 109). This is consistent with a feminist perspective on interviewing which would argue for a non-hierarchical relationship between the interviewer and interviewee (Oakley, 1981; Reinharz et al., 2002). As a mother myself, I can be considered a member of this group. Another suggestion for negotiating rapport is that the researcher should try to anticipate how the participant might view her/him and what sort of questions the interviewee may have of the researcher (Lindlof et al., 2002). The following outlines some of the steps taken to establish rapport with the women who were interviewed in this study, using the above suggestions. It is also an exercise in reflexivity.

At all stages in the recruitment and conduct of the research, I used a friendly and flexible approach, arranging for the interviews to occur at a time and place suitable to the women, and changing meeting times and dates at short notice if the women requested this. All the women chose to have the interviews conducted in their own homes during the day. My conversations with the women always began with 'chit chat'. I generally asked them how they were feeling, how they were enjoying being a mother or commented on how beautiful their baby was. Sometimes, the women led the conversation, particularly if they were keen to open up about some important or distressing aspect of their birthing or feeding experience. This never proved counterproductive to the research focus. Sometimes, the women asked me questions, such as whether I was a mother. At other times, I volunteered this information along with other information relevant to being a mother, as an act of disclosure. It was important to me that I convey to the women both verbally and in my actions the importance and validity of their individual experiences. I was careful about what I wore, wearing clothes that were somewhere between what a professional might wear and what a mother might wear.

I tried to anticipate some of the questions and barriers to participating in the research. I reassured the women that participation was voluntary, that they could withdraw at anytime and that the interviews would be treated with confidentiality. It was made explicit that there

were no right or wrong answers that I wanted to hear about their experiences and I held no expectations about how they should or should not feed their babies. I was aware that this was a busy period in the women's lives, and so limited the interview as much as possible to approximately one hour in order to make it less onerous on the participants and perhaps more appealing to them in an effort to recruit them to the study. I also showed appreciation that they had given me time by acknowledging this fact and thanking them both verbally and also with a thank you note posted soon after the interview. I reassured then that if any questions were asked that they felt uncomfortable about answering, they were well within their rights not to answer them.

Although interviews are the most widely used technique for conducting systematic social inquiry, they are not flawless and are contingent on an understanding that the self is a proper subject of narration (Holstein et al., 2003). This understanding is only possible in societies where there is a common awareness that any individual can be a respondent and, as such, will have something meaningful to offer (Holstein et al., 2003). Western cultures are familiar with this understanding, however, I would argue that there were some women whom I encountered during the course of data collection who found it difficult to articulate their experiences and perhaps had not been as reflective of their experiences as had other women. This meant that trying to draw out their individual experiences was challenging. As I reflected on this, I tried to understand why these interviews might have been so difficult. These women were generally poorer and less educated than the other women who participated in the study and may have been less articulate or perhaps could less afford the perceived luxury of reflection. Certainly, even to recruit younger and less educated women to this study was difficult. Reinharz (2002) highlights the subjugation of women's voices over the centuries, while also noting that interpreting any individual's woman's silence is a complex task (Reinharz et al., 2002). It was interesting that in this research it was easier to recruit older, more educated women to the study and that it was these women who were generally, although not always, far more articulate, perhaps suggesting these women felt confident to offer their stories. Interestingly, Hoddinott and Pill (2000) also highlighted how they initially recruited older women who were breastfeeding (Hoddinott et al., 2000b).

That it was difficult to recruit women from lower socio-demographic groups and to get them to be able to articulate their experiences may also have been related to the issue of power. It has been noted that interview relationships can be hierarchical in nature. Although it has been suggested that a non-hierarchical approach to interviewing women can be achieved by having women interview women (Oakley, 1981), it has also been identified that gender is not the only difference that can impact on power relationships in interviews (Tang, 2002). Imbalances in power can also occur because of social, cultural and personal differences (Tang, 2002). In this regard, although I tried my best to downplay some of these differences by dressing in a semi casual manner, using non-academic language, giving the women a choice of time and place to be interviewed this may not been achieved.

Finally, interviews are not a flawless exchange of information between an interviewer and an interviewee that explains an individual's experience. Modern thought contends that behind the interviewee and the interviewer, there are other subjects who may provide 'alternate voicings and varied subject positions' (Holstein et al., 2003: pg 20). In this study, the women made some of these subject positions explicit. For example, one of the women identified herself as a midwife and talked about this role and its affect on her decision, and by implication, the affect her decision about feeding had on her sense of self not only as a mother but also as a midwife. Another woman talked about her place in the community as an ABA counsellor and the constraints that were placed on her breastfeeding decisions and even the way she talked about and supported other women breastfeeding. However, because these respondents' subject positions were made explicit and other respondents' subject positions were not so evident, does not discount the possibility of other voices behind all the respondents as they talked about their experiences. Alternatively, this exposure by these two women of alternate subject positions may indicate that they as individuals can speak for themselves outside of these other subject roles, and in doing so recognise the subject positions these other roles create for them. Given the strong poststructuralist argument that persons are socially and discursively constructed it could also be that the process of the interview itself allowed for this closer examination of their alternate subject positions (Lye 1997). Consequently, the interview itself and, the interpretation, should be viewed as a social encounter where meaning is constructed not just

by the interviewee but also by the interviewer who imposes 'particular ways of understanding reality upon subjects responses' (Holstein et al., 2003: pg 4).

Ethical considerations

For both Studies One and Two, ethics applications were prepared and submitted to the relevant Area Health Services as well as the Human Research Ethics Committee of the University of Technology, Sydney. All applications were approved prior to the commencement of data collection.

In any research study, there will be a number of people who need to be considered in terms of addressing ethical issues. In this study, there were two main groups of people who needed ethical consideration; these were the Nurses and Managers of the Area Health Services and the women who were offered participation in the study. In the above discussion, I have addressed the process of sampling and recruitment. The following will only discuss other relevant ethical issues.

Informing nurses and managers

In both studies, discussions took place with the relevant managers and staff of each of the Area Health Services. Discussions involved describing the purpose of the study and what participant involvement would entail. Arrangements were made to meet face-to-face with the managers and staff to discuss the study and answer any questions they may have had about the research. In addition, the managers and other staff were supplied with a written copy of the study proposal.

In the first study, discussion with the managers and staff took place within the context of the larger postnatal outcomes study. Women were recruited to the study by one of three researchers, including myself, involved in the larger study.

In the second study, because of the involvement of the CFHNs in recruiting participants, it was important that, prior to the commencement of the study, the CFHNs be fully informed of the aims and objectives of the study and their anticipated role. To achieve this, I met

with the (CFHNs) in both Area Health Services during a routine team meeting at a time and date set by the mangers. At these meetings, I provided the nurses with both a verbal and written description of the research project and requested their support in recruiting participants. I also gave the nurses the opportunity to discuss any concerns or questions they may have had regarding the study, which also included providing my mobile telephone number and letting the nurses know they could contact me at any time if they had questions. The nurses contributed their ideas as to the best way of recruiting the participants to the study in their area, based on their clinic practices. This explains the differences in recruiting women between areas discussed earlier. The support and advice provided by the nurses was invaluable. I was conscious that I was a visitor in the nurses' workplace and was asking for their assistance, and that their support was crucial to the conduct and success of my study. To this end, I showed respect in my approach to the nurses and expressed my gratitude for their assistance, both verbally and in written form. At the conclusion of the study, I returned to the nurses to present a summary of the results.

Informing the women

As previously discussed, there were a number of methods used for recruiting the women to the study. All women were fully informed about the study and what was expected of participation through a written information sheet (see Appendices 1-7). In addition, I made myself available to answer any questions they might have had about the study, either in person at the clinic or via telephone. I provided the women with my contact numbers at the university as well as a mobile telephone number. I stressed to the women, both verbally and through the information sheets and consent forms, that their participation was voluntary and that they could withdraw their consent at any time throughout the research process. The fact that thirteen women from the second Area consented to my contacting them and only nine women agreed to participate in the face-to-face interview demonstrates that women were free from coercion to participate. Consent forms were signed either prior to participating in the study and/or being contacted by the researcher (see Appendices 1-7). The women were informed that consent to participate in the study involved agreeing to a face-to-face interview as well as having the interview audiotape-recorded. The women were informed that the results of the study would be published in a PhD thesis and in professional journals,

but they were also assured that they would not be individually identified. On all the consent forms, contact numbers of independent ethics officers were provided, should the women wish to complain about the conduct of the study. There were no complaints and no adverse outcomes.

Treatment and storage of data

A number of steps were implemented to ensure confidentiality and minimise the possibility of individual participants being identified. All audiotapes and transcripts were coded. When transcribing the interviews, I removed all identifying information. Transcripts were stored on a computer needing a password for access, and a hard copy of the transcripts was kept in a filing cabinet in my home office. Audiotapes were also locked in my home office, separately from the consents. The consent to be contacted forms, were initially stored in a safe place at the Community Child Health Centres and then collected by me. After contacting the women, these forms were stored in a filing cabinet in my home office, again separately from the transcripts.

Risks and benefits of participation

Finally, it was not expected that participation in this research would expose the women or the nurses to any risk. I was, however, aware that a woman experiencing difficulties as a result of her feeding experiences might be or might become distressed during the course of the interview. To allow for this, I was prepared to offer immediate comfort needs. Although I would not provide counselling, I came prepared to the interviews with contact details of support services in the area, should the need arise. No woman interviewed for this study became distressed. Alternatively, while not directly providing any benefits to the women some women expressed the view that they had enjoyed the opportunity to discuss their experiences and so, consequently, participation in this study could have been viewed as having a positive outcome for these women.

Data analysis

I have already discussed the use of grounded theory in sampling and interviews, and hope that I have stressed that grounded theory methodology includes both data collection and

analysis, and that these occur concurrently. In the following, I explain the way in which I applied grounded theory methodology to this study. I explain the process by presenting it in a linear way by talking about steps in grounded theory. Grounded theory is, however, not linear, and the steps are not clearly broken up or delineated, neither did I analyse the data by utilising a step-by-step approach. Consequently, I have found it difficult to disentangle my steps and explain in a procedural manner exactly how analysis was undertaken. Analysis occurred for me as I moved in and out of these different steps. I had plenty of false starts. Grounded theory methodology truly is a dynamic process and one I did enjoy ... eventually.

The constant comparative method, which forms the basis of grounded theory, is based on the systematic generation of conceptual categories derived from within the data. These categories are compared against each other for similarities and differences in order to generate properties and dimensions of categories that will eventually form a theory around the problem being explored (Glaser et al., 1967). A grounded theory is expected to include as much variation as possible in order to provide generalisability and explanatory power. It has been suggested that grounded theory is probably not replicable because it is about interplay between the data and the analyst, therefore another analyst may see something different. Despite this, theoretical constructs need to have 'fit and grab' and should be recognisable and meaningful to the people involved (Strauss et al., 1998).

Coding

One of the first steps in grounded theory is coding. Glaser (1978) has described coding as a process whereby the analyst fractures the data, then conceptually groups it into codes that then become the theory, which explains what is happening in the data (Glaser, 1978). Glaser has stated that there are two types of codes to generate. These are substantive codes and theoretical codes (Glaser, 1978). Strauss and Corbin (1998) have used different terminology to differentiate between codes, referring to in-vivo codes, which are words taken from the respondents themselves, and sociological constructs (Strauss et al., 1998).

Authors have described the actual process of coding variously. Strauss and Corbin (1998), for example, divided coding into three levels, which they described as open coding, axial coding and selective coding (Strauss et al., 1998). Hutchinson (1986) talked about coding as level 1 coding, level 2 coding and level 3 coding. Glaser and Strauss's original approach, still adhered to by Glaser, does not provide a specific or enclosed process that outlines grounded theory step-by-step arguing that by coding incidents in the data into as many categories as possible categories will emerge (Glaser et al., 1967).

Open coding

In all these approaches to coding, grounded theory begins with an opening up of the data known as open coding (Glaser, 1978). Strauss and Corbin (1998) have described open coding as the process by which concepts, along with their properties and dimensions, are identified in the data. Glaser (1978) described opening the data, or open coding, stating that the analyst should code for as many categories that might fit. Glaser suggested that when open coding, an analyst must ask questions such as what is this data a study of, and then what category does this incident indicate? Or, what category or property of a category, of what part of the emerging theory, does this incident indicate? And finally, what is actually happening in the data? What is the basic psychological problem faced by the participants in the action scene? What are the basic social psychological processes or social structural process that processes the problem to make life viable in the action scene? What accounts for the basic problem and process? (Glaser, 1978: pg 57)

Conceptualising is part of the open coding process – labelling an object, or incident with a conceptual label. Strauss and Corbin (1998) argued that conceptualising is the first step in 'theory-building'; they suggest labelling then grouping into a conceptual category. They argued that anything under a given classification will have one or more recognisable (actually defined) properties/characters. They also suggested that when an object is classified, there will be an implied (either explicitly or implicitly) action that is taken with regard to the classified object. This is where the analyst can display her/his creativity, because a particular object could be classified in a variety of ways (Strauss et al., 1998).

I began the process of coding by reading the first transcripts as a whole to get a general sense of what was happening in the data. I then began a detailed line-by-line analysis described by Strauss and Corbin as microanalysis (Strauss et al., 1998). I took Glaser's advice and coded for as many categories as possible (Glaser, 1978). In the beginning when I was exploring possibilities, I sometimes coded the words or phrases with two or three labels. My initial attempts at coding were awkward, often descriptive and I ended up with an unwieldy number of categories. One reason for this was that I did not want to miss any possibilities in the data and the other reason was that I wanted to be as objective as possible. In doing this, I was trying to straddle the paradoxes I perceived were intrinsic to grounded theory of both meaning making and an exact science. I was relieved to see Charmaz (2002: pg 677) discusses this inherent difficulty, arguing that the objectivist position 'assumes that data represent objective facts about a knowable world, that the data already exists in the world, and the researcher finds them'. I was so concerned about the exactness of interpreting the data that I was almost paralysed in my efforts to conceptualise data. Data collection and analysis only moved forward when I relaxed and used a more flexible approach to grounded theory.

This more flexible approach to grounded theory was led by the constructionist approach described by Charmaz (2002) and my interpretation of Dey's (1999) very helpful critique of grounded theory. Charmaz's constructionist approach 'explicitly provides an interpretive portrayal of the studied world, not an exact picture of it' (Charmaz, 2002: pg 678). As I accepted that I was also a participant in the research process and that it was impossible to extricate myself fully from this role, I felt the important issues in the interviews became clearer and the categories began to emerge. I acknowledged the final analysis would be my interpretation of the data and that this was acceptable. Having said this, however, I did give pre-eminence to the women's voices and consequently, preferred as much as possible to use the women's own words to label the data and present the findings. Strauss and Corbin (1998) called these types of labels in vivo-codes (Strauss et al., 1998).

I felt this was important, because being a midwife and a researcher who has studied breastfeeding and infant feeding previously, with a fairly comprehensive knowledge of the

literature, I wanted to avoid using any preconceived conceptual labels as much as possible. I did not want these preconceived meanings to inadvertently overshadow the meanings the women themselves bought to their experiences and what these concepts meant to them. To facilitate this, I asked questions of the women that aimed at understanding their definition of terms and situations and how these made them feel and respond. I used open-ended questions that often started with questions such as 'tell me about ..., how did that make you feel? What did you mean when you said ...? This style of questioning is an application of the constructionist approach to grounded theory and, according to Charmaz (2002), builds on the symbolic interactionist theoretical perspective.

With such an unwieldy number of codes, it became essential that I start to group them into categories. Glaser (1978) stated that the important thing with coding is sortibility and flexibility. By sortibility, he means conceptual sorting not data–sorting, in other words, sorting categories and properties by similarities, connections and conceptual orderings. This forces patterns that eventually become the outline for the theory (Glaser, 1978).

The original method of classifying codes in grounded theory uses the concept indicator model (Dey, 1999; Charmaz, 2006). Dey (1999: pg 66) described the concept indicator model as assuming 'the meaning of a concept can be conveyed through indicators that may express the meaning of the concept entirely or at least capture its essence. Meanings are treated rather like objects, which can be reduced to (or assembled from) their constituent parts'. Again, I found this objective interpretation of an unambiguous category too difficult to work with because of its demand for exactness and my fear that I was unable to achieve this. Dey's (1999) discussion of categorisation was very helpful in this regard, and ultimately I used two of his suggestions for categorisation. These were assigning category members based on the prototype approach, which assigns members to a category based on a resemblance to a prototype rather than by strict definition, and accepting the idea that categories could be fuzzy. I found it easier to categorise using these two approaches and they served as a counterbalance to the concept indicator model (Dey, 1999).

The following figure gives an example of initial coding and preliminary sorting and categorising.

Figure 3:1 Coding and categorising

Quotation	Code		Substantive category	Theoretical code
MOTHER: (pause) not very well. Umm we did all right the first day. Well I thought we did all right the first day. My big thing with it was no-one sits down and goes through fundamentals with you. I think we did all right the first day but we weren't doing it right from go because no-one had sat down and said to us … um you know …	Feeling uncertain Poor support We weren't doing it right Poor support	Lacking confidence Needing support It was all new Needing support	***Unknown***	***Realising***

Axial coding

Axial coding is the process of reassembling data that were fractured during open coding and relating categories to subcategories along the lines of their properties and dimensions. In other words, the category is a phenomenon and the subcategories answer questions about the phenomenon such as when, where, why, who, how and with what consequences. This process gives the phenomenon greater explanatory power (Strauss et al., 1998). Glaser (1992) has argued that axial coding only contributes to full conceptual description rather than explicating the processes of grounded theory. In contrast to this, Glaser (1992: pg 62) argued 'that theoretical coding families emerge as connections between their categories and their properties' and 'if one category is a condition of a property, then this will emerge as such'. Glaser's suggestion was exactly what occurred for me within my analysis. Another

important part of coding also occurred at this delimiting stage. I started to focus on the codes most relevant to the emerging theory. This is part of the process of selective coding.

Memo notes

I found it critical to be writing memo notes. Memo notes helped me answer the questions of when, where, why, who, how and with what consequences. For example, a simple memo written about the above sample would read as follows:

> When this woman started to breastfeed it was all new. She thought she knew what to do but she was unsure about it. She didn't get the help or information she needed. This meant she didn't know what to do. Why was it all new? Why did she think it was all right on the first day? Why did she need someone to sit down with her and go through fundamentals? What did it mean to her to 'sit down' ? What about antenatal classes – where do they fit in?

As data collection and analysis continued, these questions were answered and the memo writing became more of a fuller narrative of what was happening in the data. This final approach to coding and data collection corresponds to the final steps in analysis. Strauss and Corbin (1998) have described it as selective coding, wherein the researcher specifically looks to fill in and refine categories that are in need of further development. Glaser (1978) stated that theoretical coding conceptualises how the substantive codes relate to each other as a hypothesis that will be integrated into a theory.

Glaser (1978) has stated that memos are crucial to the generation of theory. Memos need to be written up as they strike the analyst and should begin as soon as the data collection and analysis begins. They are the analyst's store of ideas, and Glaser (1978) has even argued that, as the final draft is being written, the analyst will still be writing these memos (Glaser, 1978). I found the final writing-up incorporated and deepened a collection of memo notes that had emerged and been edited and added to as the categories became denser.

Selecting a core category

A grounded theory study always has a core category. The analyst should consciously look for a core variable when coding her data. Glaser (1978) stated that the core category is the main theme. The core category must also be related to all the other categories. Strauss and Corbin (1998) referred to the core category as the central category. In other words, the core category is the main concern or problem for the people in the setting. The core category has analytical power that draws all other categories together to form an explanatory whole (Strauss et al., 1998). The central category may be one of the identified categories or all the categories may need to be subsumed under another more abstract term.

A Basic Social Process (BSP) is a type of core category. A BSP is processural as it has two or more clearly emergent stages (Glaser, 1978). Basic Social Processes are always core categories but core categories are not always BSPs. In this research, it became clear that the core category was a basic social process. The BSP did not become clear until the writing-up of the substantive codes became well advanced, because the process itself involved a sequence of events that occurred within the structure of the four substantive categories.

Writing the theory

There were four main categories identified in the data that captured the factors deemed important to women's infant feeding decisions. There was also a basic social process that linked and described the dynamism present in the data. The following five chapters will present these findings. The first four chapters discuss the four substantive categories. The following chapter will present and discuss the basic social process 'deconstructing best' which is also the core category within the analysis. This chapter also demonstrates how the basic social process sits within the substantive categories. Each of the results chapters is divided into two sections. Section one presents the findings from the women's interview data and this data is presented in a narrative form. I chose to write the findings in narrative form because it is a more personalised approach (Richardson, 1994) and as such gives pre-eminence to the voices of the women. This approach is also in keeping with the constructionist approach to grounded theory (Charmaz, 2002). To further highlight the voices of the women, I have italicised all the women's quotes from this and other studies.

The use of a narrative approach to presenting the findings, means that the elements of grounded theory such as those described in the paradigm model presented by Strauss and Corbin (Strauss et al., 1998) are not emphasised but are woven through the stories.

The second section of the results chapters is a synthesis of relevant literature presented as a discussion. The literature helps illuminate the data, giving added strength to the findings. In accordance with the principles of grounded theory, the literature was sought at the completion of the empirical study and as such the findings guided the literature search.

Finally, while the focus of this study was to explore the infant feeding decisions of women in the first six weeks post-birth, the antenatal period could not, and should not be ignored. The early analysis of data collected from women who participated in the first study has identified that prior to birth, women put a lot of thought into their infant feeding decisions, and that generally a decision will have been made prior to birth about how they will feed their baby (see appendix VIII). It is these decisions that set the path for their infant feeding decisions in the first six weeks post-birth.

Conclusion

This chapter has described the methods used to conduct this research. In this chapter, I have presented the epistemological and theoretical assumptions underpinning the use of grounded theory and have described the subsequent constructionist approach to grounded theory used to collect and analyse data. A constructionist approach to grounded theory was chosen as the methodology, because of its focus on the interpretative components of grounded theory and because it allowed for a more flexible approach to analysis. Data was derived from in-depth interviews with thirty-seven women. A number of approaches were used to recruit women to the study. Four main substantive categories emerged from the data as well as a basic social process, which was also the central category.

Chapter 4

It's really best to breastfeed

Introduction

This chapter describes the category 'it's really best to breastfeed' and is divided into two sections. Section one presents the analysis of the women's interview data and section two presents a discussion of the data in relation to other relevant literature.

In the category 'it's really best to breastfeed' there were three main subcategories. These subcategories were 'knowing breast is best', 'feeling the pressure', and 'it's really more acceptable to breastfeed'. The subcategory 'knowing breast is best' describes what the women knew about breastfeeding and how this was disseminated and responded to by the women. The subcategory 'feeling the pressure' describes how the women believed health professionals responded to and used the information that breast is best to influence and affect women's decisions and how this impacted on them. Finally, the subcategory 'it's really more acceptable to breastfeed' is not so much about the benefits of breastfeeding but what happens when information about the benefits of breastfeeding is absorbed into the social realm. This subcategory describes how this knowledge is interpreted and played out in everyday society/life and consequently, the impact this has on the women's infant feeding decisions.

The discussion section draws on the findings of other research to provide support for and/or to confirm these findings, as well as providing information that can further help explain why the women responded to the concept that breast is best in the manner they did.

Knowing breast is best

This subcategory describes what the women knew about breastfeeding, why they knew this information and how they responded to this information.

It's marketed and promoted

The women in this study were well aware that breastfeeding was the recommended method of infant feeding and believed this information was widely disseminated. One of the predominant ways in which this information was circulated was through marketing and promotion. The women described this by making statements such as *'breastfeeding is the way to go. That's what's marketed to the women now as well'* (P5), *'the media, everywhere, everywhere, hospital, you see it on the TV, breastfeed'* (P18), and

> *it's so hyped up in the media it's almost like you know the anorexic model portrayed as the normal woman and breastfeeding is portrayed the same sort of way* (P26).

There did not appear to be any difficulties in accessing information about the benefits of breastfeeding. In addition to breastfeeding being marketed and promoted, the women spoke of reading about the advantages of breastfeeding in infant care books as well as being given information through hospitals:

> *I got or I've read in books. I think the most common one is breast is best. So I read books while I was pregnant, before I was pregnant umm leaflets from hospital* (P10).

The women were very cognisant that hospitals, midwives and antenatal classes also recommended breastfeeding as the preferred method of infant feeding saying *'that's presented even by experts like the midwives ... they really make you feel like breastfeeding is the far superior option'* (P4), and *'there was lots of information from hospitals as well* (P9).

You know that breast is best

The slogan 'breast is best' and the term 'best' or its derivatives were frequently used when the women talked about breastfeeding, with some women appearing to directly quote from the books and promotional material with comments such as *'You know that breast is best'* (P14). Not only did the women know breast was considered best they were also able to list

many of the health benefits of breastfeeding and the term 'best' was often couched around these: *'I knew umm from a health point of view that it was the best thing for him, umm that it was a good thing for me umm for various reasons'* (P2). While some mention was made of the health benefits to women as this previous quote indicates, what appeared to be of particular and of more pressing importance to the women were the health benefits of breastmilk for the baby. Women frequently made reference to the health benefits of breastfeeding to the baby with comments such as *'It's best for the baby, 'cause that way they get the immunity from the mother and the mother's milk is sort of tailored more to the infant'* (P4), and *'it's good for their immune system and their growth as well ... and their brain development and stuff'* (P33).

Even the women who were formula-feeding knew that breastfeeding was considered 'best'. As one of the formula-feeding-woman said:

> *oh everyone's just breastfeeding is better. Do it for the baby they get the colostrum. They get the umm, what do they call it, so they don't get any germs like* (P18).

The women talked about research attesting to the benefits of breast milk. The women made statements such as *'I guess with the research that's been done they are saying to you breastmilk is better'* (P5). It was research that appeared to underpin the knowledge that breast was best, and therefore, breast milk was the superior option for feeding babies *'well it's research, isn't it, what makes you think it's the best'* (P10). Finally, the importance and authority of this research was also made clear in the women's comments, with one woman summing it up in this manner: *'You know if it is factual and it's been proven that it's what's best then it's hard to argue with that'* (P12).

In contrast to the 'soundness' of scientific knowledge, breastfeeding was also seen as best because it was natural. The term natural had strong connotations of that is what breasts are for, and to this end, the women made statements such as *'it's the natural way for us to feed, we are designed to breastfeed our young'* (P13), and *'that's the way we're designed, the*

whole system is meant to work best that way (P4). Being natural also reinforced that breastmilk was more suitable for babies:

> *the body produces it naturally and therefore it's going to be the most compatible thing for the baby ... I think that's it, that it's human milk, it's meant for human babies* (P15).

The fact that breastfeeding was deemed natural also reinforced the notion of best *'you know the natural ways are best'* (P12), and *'I do believe that's the best for a baby and I wouldn't want my baby to be brought up on something artificial'* (P1). In the women's discussions of breastmilk and breastfeeding, it was also clear that because breastmilk was natural it had unique qualities that could not be found in formula:

> *everyone says breast is best and you know that sort of, you get that and you know umm the nutrients and everything you know are coming out [of] the breastmilk, you know formula is never going to compete with that and you know all the antibodies and everything can build up with that and that sort of thing so ...* (P6).

For many of the women in this study, sitting alongside the understanding of natural was the expectation that breastfeeding would 'be' natural: *'I thought it should just come naturally because it's, you know, the natural thing'* (P9), and *'I just assumed that it would be normal'* (P24).

That breastfeeding was considered natural was also related to the concept of bonding. Bonding was considered an important benefit of breastfeeding and another reason why breastfeeding was considered 'best'. Bonding was one of the most commonly quoted advantages of breastfeeding given by the women: *'I knew that breastfeeding was the preferred option in terms of nutritional value and bonding with the baby'* (P5). To this end, the women believed breastfeeding was important to creating and/or enhancing a connectedness between the mother and child *'you do bond with your baby better'* (P5). As a

consequence of this knowledge, a number of women cited bonding as an important reason for planning to breastfeed.

> *I wanted that you know that immediate closeness of him to feed you know straight away. Just for the nurturing and bonding, that bonding experience I suppose* (P25).

One of the aspects of breastfeeding that made it so pivotal to bonding and specifically to creating a relationship with the mother was that it was something no-one apart from the mother could do: *'that's the one thing that only you can do for the bub, everyone else can change nappies and do everything else but that's one thing that you can do'* (P15).

> *because she was a breastfed baby they had to call me if she needed a feed type of thing. So it was like I felt as though I had some sort of importance and that she needed me that she wasn't just oh she's been born ... That was my important connection with her and that continued all the way through and it has with all of them, it's nice but they've got to come back to me that nobody else can do that.* (P13).

This connection between breastfeeding and bonding was so strong that for some women, the terms breastfeeding and bonding almost appeared to be synonymous *'I sort of thought of it as a bonding thing'* (P15).

Giving them the best start

The effect of the 'breast is best' mantra meant that many women believed that by breastfeeding their baby they were giving their baby the 'best'. The women made statements such as *'you want to give your child the best, you know what I mean'* (P19) and *'I never wanted to bottle-feed her, not at least in the first few months because I know the benefits of breastfeeding as opposed to bottle-feeding'* (P20). Particularly in the antenatal period, this was very apparent in their discussions about how they were planning to feed their baby. These plans were heavily influenced by the information regarding the health benefits of breastfeeding and particularly the health benefits to the baby. Many of the

women described their plans in terms of wanting to give their baby 'the best start', saying *'I want to give her a good start'* (P4), and *'I really wanted him to have the best start in life that he could have'* (P25). There was also an inference that by giving their baby the best start they were doing the right thing *'You want to do the right, what you think is the right thing by them you know umm and give them the best possible start'* (P8). Some women talked about how knowing that breast was best created a sense of commitment to breastfeeding '*you understand that breastfeeding is the way to go and so that's part of the thing that gives you that resolve as well you sort of feel like that is the best option for your baby'* (P5).

The strength and authority given to the information relating to the health benefits of breastfeeding was so powerful that not only did women believe that breast was best, many women actually believed formula-feeding was second best. They made statements such as:

> *I've just always thought breastmilk is the best for him to give him the best start. Umm and so it probably would have been more concern that having to go for it [the bottle] would have been going for second-best, in terms of his diet* (P3).

Some women were so influenced by the 'breast is best' message that they felt by bottle-feeding they were not just going to be giving second-best but in fact they were going to be doing something that would have a life-long damaging impact on their baby. As the women said,

> *I was like oh my goodness umm, you know, what am I doing am I going to therefore make the decision that is going to affect him for the rest of his life? That's how I really felt. You know, that I was really going to do something that was so detrimental to him that he'll suffer later on and throughout his whole life because of it. It was just not just making a decision that was going to affect the next twenty-four hours, it was just I felt I was going to affect his whole life* (P8).

I think my biggest fear of stopping now is if someone said in ten years' time or discovered that if I'd have breastfed longer your son wouldn't have this if or you know if you gave your child formula we've now discovered formula is linked to this. I think that's my biggest fear (P10).

they kept on telling me at the hospital that breastfed babies are smarter, they develop better and all that type of stuff, and I didn't know what was going to happen 'cause he was having formula (P22).

Even the formula tins added to the women's concern over the dangers of formula–feeding, with one woman making the statement: *'I was a little bit worried because it says you know on the tins do not, you know, breastfeeding is, you know, best and do not commence formula before speaking to a doctor or health-care professional'* (P9).

For women who were either struggling with breastfeeding and/or having to make the decision to bottle-feed, the fact that breast was considered best and formula second-best or, even worse, dangerous, added enormous pressure to their decision-making, creating increased levels of stress. *'I was looking at him and saying oh my God, look at that precious bundle, look, he is five days old, what am I doing to him?'* (P8). These feelings of distress could be further exacerbated, because, as some of the women described it, rather than simply promoting breastfeeding, breastfeeding was pushed and particularly by health professionals.

Feeling the pressure to breastfeed

A number of women in this study talked about feeling a pressure from professionals to breastfeed, saying: *'The medical profession, I find really puts a lot of pressure on you to breastfeed'* (P26), and *'they [the midwives] pushed and pushed and pushed for me to breastfeed'* (P22). The women talked about experiencing this professional pressure to breastfeed both during the antenatal and postnatal periods. *'I sensed the pressure at the antenatal classes, umm, that it was the best thing to do'* (P3), and *'we went to antenatal classes at the hospital and they very much present breastfeeding as almost the only option*

sometimes' (P5). This professional preference for breastfeeding was further fixed in the women's minds because they were aware that bottle-feeding was not really mentioned *'They don't really talk about the bottle up there much, you sort of have to ask for it more'* (P11). In the post-birth period, this professional preference for breastfeeding continued, with women stating: *'every time I mentioned a bottle oh no, no, no, keep trying, keep trying'* (P15), and *'I think they were pushing, as I said, they didn't want me to give him the bottle. So they were pushing to breastfeed'* (P19).

Even after hospital discharge, women felt breastfeeding continued to be pushed, with some of the women stating that information about bottle-feeding was withheld, despite their requests for this information.

> *Every time I rang the Tresillian or Karitane or even the health-care nurse, the early childhood nurse, would say no, keep going, come on, you can keep going. They wouldn't really give me any information on weaning and they weren't forthcoming with it. I'd ask the question okay, can you tell me how to wean and they'd say look just try this one more thing and then you can think about weaning. So then I started to get frustrated. Well, all I want to know is how to do it, so in the back of my mind I know what to do, but no-one would give me the information either* (P32).

> *When we tried ringing the hospital for help, my husband said he got the impression that ah that they don't want to entertain any questions about bottle–feeding, he got that impression* (P28).

Some of the women felt this pressure from professionals extended to breastfeeding at all costs, regardless of what they were going through or their individual needs. *'The judgment was to continue to breastfeed regardless of all these problems'* (P23).

> *There is certainly a lot of pressure put on you to do it no matter what. And I felt that a lot with professionals as well, with L, umm that if you don't, you know, no matter how painful it is you still have to keep going. I think there was probably only one or*

> *two people who actually said to me look, you don't have to do this, I think that you know even the lactation consultants that I saw, it was very much like, you know, no matter what you've got to keep persevering* (P25).

For some women, the pressure to breastfeed at all costs impacted on them as a person. To this end, they felt any personal discomforts or needs should be set aside in preference to the baby's needs, which, given the superiority of breastmilk, always meant breastfeeding. As a result of this, some of the women felt that their individual needs were disregarded '*it was like, well, you just put up with pain* (P25), and diminished:

> *I don't think they respect you as an individual person, a person in your own right who has feelings and whatever as well. You tend to caught up in the machinery of this is what you should be doing* (P26).

The pre-eminence accorded to breastfeeding over any other needs of the woman was described in even more powerful words by one woman in the first study (see appendix VIII), who said: *'it's almost like you as a person are gone and we need your body and we need those breasts and we need those nipples out'* (Sheehan et al., 2003: pg 263).

This pressure to breastfeed and the diminishing of the woman's sense of self added to the women's distress *'they really do pressure you and it's really bad and it upset me for a really long time'* (P22).

The knowledge of the benefits of breastfeeding, along with the pressure to breastfeed impacted on those women who felt they did not want to breastfeed. This pressure that the women should do the 'best' for their baby was so powerful that for some women, despite preferring to bottle-feed, they ultimately felt coerced to breastfeed, saying: *'I gave it a go because there was so much pressure down in the NICU* (P17), and '*everyone's kind of it's good for the baby, let's do it, and I felt pressured to kind of keep going ahead to do it, so I tried* (P18).

This professional preference for and pressure to breastfeed also meant that some women who planned to bottle-feed feared they would be sanctioned. In the first study by Sheehan et al. [see appendix VIII], one of the women stated: *'when I asked the midwife at the hospital whether I will encounter any problems with the staff if I don't breastfeed, she (the midwife) said "yes"'* (Sheehan et al., 2003: pg 262).

Although women in this second study who chose to bottle-feed did not mention being sanctioned personally, two women did raise this issue when they said:

> *There is no attitude ... if you choose not to ... because there was a girl in hospital with me who didn't want to breast feed, because she was very young and it was her first baby, and she didn't want to, and that was fair enough, but she basically got ignored* (P26).

> *if I were to have said I want to bottle-feed him, they would have actually looked down on you. You could see it* (P19).

It's really more acceptable to breastfeed

Just as some women believed there was a professional pressure to breastfeed, many of the women also talked about a societal pressure to breastfeed. In this study, the majority of women believed that there was a general societal belief that *'it is really more acceptable to breastfeed'* (P23). This societal pressure that a woman breastfeed was exerted in a variety of ways that were played out in both subtle and overt behaviour.

At one level, the fact that it was really more acceptable to breastfeed was quite ethereal, something out there that you could not necessarily put your finger on: *'that's the sense I got, that it was the best thing to do'* (P3), and *'it was just like even though people don't actually say it you just know breast is, you know breast is best'* (P6.). The women made statements that confirmed the expectation that breastfeeding was the socially acceptable thing to do by saying, *'It's very much the philosophy, I think, in this day and age that*

breastfeeding is the way to go' (P5), and *'I think the large majority of people do breastfeed'* (P8).

Given the promotion of breastfeeding as 'best' for the baby the women believed that there was also a general societal expectation that they would breastfeed. They made comments such as *'I think everyone assumed I would breastfeed'* (P8), and *'everybody you spoke to assumed that you would breastfeed'* (P26). It was not always subtle either, as one woman described it: *'you find a lot of strangers in the street that you're talking to and they say "oh are you breastfeeding?" and I'd go "no" and they'd go "oh you should be, you know"'* (P26). Not surprisingly, this powerful societal expectation meant many of the women themselves also just assumed they would breastfeed after the baby was born. *'I just assumed I'd breastfeed'* (P3), and *'I never really considered using the bottle, I always just assumed I'd breastfeed'* (P7). The fact that this assumption was entrenched in societal thinking and, as such, was quite unconscious, was exemplified in the following quote when one woman said: *'I felt subconsciously it was the right thing to do'* (P5).

A 'good' mother breastfeeds

Not only was there an assumption that the women would breastfeed, it was also clear in the conversations with the women that there was a connection between breastfeeding and being a 'good' mother. *'I suppose I was just so convinced that she had to have breastmilk that it had to come from me and that I had to be the good mother* (P13), *'well, I wanted to be super mum and wanted to do everything right with my first baby, you know I read up about breastfeeding and all that sort of thing and decided yes, this is what I wanted to do'* (P21), *and 'I wanted to breastfeed and that was so important to me being a good mother'* (P25). It was believed a good mother would breastfeed because it's the 'best' and consequently, a 'good' mother would only want to do the 'best' for her baby: *'just knowing all the positives of what's in breast milk why wouldn't you give you know if you could give your baby the best'* (P1).

Not surprisingly, given the above statements, there were clear moral overtones in this study around the infant feeding decision. Some women felt the expectation to breastfeed and its relationship to being a 'good' mother was so overt that if they chose to bottle–feed, they

needed a good reason to do so: *'if you can breastfeed you're giving your child the better option and really, unless you've got a good reason for not breastfeeding, I get the impression you should'* (P23). These societal expectations were confirmed by the fact that a number of women in this research also held these views, arguing:

> *I think that as mothers we produce milk for a reason and I think it's because that's what's best for our baby and if there is no actual physical or medical reason as to why we can't feed or umm, yeah, I just I think that's what should be done* (P13).

Or, as one woman expressed it more strongly: *'if there's something wrong that's okay, but if there's not, they should have tried harder'* (P14).

To this end, the women were aware that if someone chose to bottle-feed, she risked being judged and looked down on. They talked about women who bottle-fed being viewed as 'copping out', lazy and not doing their job as a mother: *'people sort of look down on you if you bottle-feed...that you're not as good of a mother or you are a bit lazy or, you know, didn't want to put in the effort'* (P9). Some of the women themselves admitted they judged other women who did not breastfeed, saying: *'Like you see a brand new newborn in a shopping centre being bottle-fed and you think God that's lazy or oh that's awful, that baby should be breastfed, knowing how good it is for the baby'* (P14), and *'like if I saw a mother bottle-feeding her baby, I would think oh I wonder why?'* (P12).

That a woman could be judged if she did not breastfeed influenced some women's decisions and experiences, because they were concerned that they would be viewed as not being a good mother. The comments made by the women regarding this also confirmed the relationship between being a good mother and breastfeeding *'I was also worried initially about what other people would think if I chose not to breastfeed ... that people would judge me, that they would, you know, think I was not doing the right thing by the baby* (P8), and *'other people probably view you as failing at being a mother, of not being able to feed your baby'* (P25). In fact, one of the women in this study did say she felt she was made to feel

like a bad person for not breastfeeding: *'it made me feel like I was the bad person by not giving her my breastmilk. By people saying that it was always better'* (P17).

Given that the women were aware they could be judged or sanctioned, the women in this study used a number of protective strategies. These protective strategies included justifying, hiding, shielding, toughing it out and clarifying.

The majority of women who formula-fed knew they would be expected to justify their decision to formula-feed. Justifying was an almost universal response to formula-feeding.

> *well I just feel like I've got to justify. Like I was saying to, you know, like I felt like I needed to even justify to that lady at the shop and explain, like I can't just say oh no, actually I'm not breastfeeding, I'm bottle-feeding. I've even got to tell this stranger who's just stopped and talked to me like oh, I don't breastfeed because ... I feel like I just can't say no, I'm bottle-feeding, I sort of say look, I can't well, you know, I've sort of been advised that it's best not to. And I think why do I have to explain this, if that's your choice but it's just the way society is'* (P23).

The women also discussed what was deemed appropriate as justification for formula–feeding, with some women citing a bad experience as useful in defending their desire to wean or not breastfeed their baby, saying: *'I don't know, getting the mastitis probably for me was probably like good in a way, 'cause then it gave me a reason to put her on the bottle'* (P18).

Another method used by the women to avoid judgment and sanctions was hiding. The women talked about hiding their decision, making comments such as the following:

> *I was not game to tell the staff at the hospital that I wanted to bottle-feed, so I persevered that time in hospital and continued to breastfeed and express and give the bottle when they said to bottle-feed but changed in the car* (P23).

In this study, one of the women talked about hiding her decision to bottle-feed until the end of her pregnancy, by saying:

> *right at the beginning, umm at that stage I did say I wasn't sure but I was sure ... and towards the end of the pregnancy I just said I don't know whether you have to fill it in on the computer, where it was skipped at the beginning when I booked in but I'm planning on bottle-feeding* (P18).

Shielding was another protective strategy used by the women to avoid sanction. Shielding involved using others to support and defend their decision.

> *when I went in to have my second son I said to the obstetrician I was going to bottle-feed and if it is possible could he please speak to the midwives first, because I was fairly worried about their attitude and how I was going to be accepted* (P23).

> *my partner stepped in and said look, she doesn't want to breastfeed, she doesn't want to do it and that's the end of the story* (P17).

Another strategy used by women to protect themselves if they chose to bottle-feed was toughing it out, making statements such as *'I don't care what anyone says or if they don't like me at the hospital. I'm bottle-feeding'* (P18), *and 'I had already decided that I would not be swayed'* (P21).

Finally, this fear of being judged and or sanctioned was so powerful that it extended beyond just giving formula. Even if women were giving expressed breastmilk (EBM) in a bottle, they felt they needed to clarify this to avoid judgment. They said:

> *even when I'm in the mothers' room I do tend to talk if there is someone else in there. I do tend to talk to them and sort of say this is breastmilk but like as if like it's this big shameful thing that I'm giving this newborn a bottle even if it's, you know, it's not formula but I feel like I have to say that* (P6),

and

I do actually think I'd feel a bit ashamed to bottle, feed bottle-feed there and I do actually think if it was breastmilk in the bottle I'd have to tell them it was breastmilk … because I think breast is best and I don't want them looking down on me because they think I'm giving the baby formula (P10).

Chapter discussion

Knowing breast is best

Just as this study has found, there have been a number of other studies that have shown, regardless of how a woman chooses to feed her baby, that she is well aware of the health benefits of breastfeeding (Coreil et al., 1995; Blum, 1999; Murphy, 1999; Hoddinott et al., 1999a; Shakespeare et al., 2004). In addition, as this research indicates and others have found, women who plan to breastfeed will generally couch their decisions around the health benefits of breastfeeding, referring particularly to the health benefits for the baby (Coreil et al., 1995; Blum, 1999; Murphy, 1999; Hoddinott et al., 1999a; Lupton, 2000; Shakespeare et al., 2004; Dykes, 2005).

It can be argued the knowledge that breast is best and the benefits of breastfeeding were well known by the women in this study because, as they described it, breastfeeding was marketed and promoted. This corresponds with the literature review findings that a number of strategies have been deliberately employed in the last twenty to thirty years to actively support and promote breastfeeding. What the findings of this research also demonstrated was that when women discussed breastfeeding they commonly used the words 'natural' and 'best'. This corresponds with other research, which has also identified that women call on the authority of nature to support their infant feeding choices (Dykes, 2005). In Australia, it can be argued the words best and natural have formed the dominant themes in the promotion of breastfeeding with slogans such as 'breast is best', books such as *Breastfeeding Naturally*, and posters saying 'Breastfeeding Natural, Healthy, Loving' (Australian Breastfeeding Association, 2004).

These themes are also prevalent in other breastfeeding promotional material. Wall (2001) analysed state-authorised Canadian breastfeeding educational material produced or in use during the 1990s and found the most pervasive theme was the connection between understandings of breastfeeding and social constructions of nature, with nature and natural experiences viewed as sacred, wise and deserving of respect.

For a number of women in this study, the breast is best message was so powerful that they did not simply view breastfeeding as 'best', they viewed formula-feeding as second–best, or, even worse, detrimental to the health of their baby with the potential to cause life long damage. These findings build on the findings of Murphy (2000) who reported women in her study also viewed formula-feeding as dangerous with the potential to cause future health problems for their babies. That women view bottle-feeding as dangerous can also be seen in women's inverted interpretation of the health promotional messages around breastfeeding. As the following quote exemplifies, rather than viewing breastfeeding as beneficial to a child's IQ, health or immunity, some women will view bottle-feeding as detrimental to these '*you read things about their IQ being lower if they're bottle fed, about their health being poorer, about they have less immunity, you know*' (Shakespeare et al., 2004: pg 255). When women couch their discussions in this manner that is, by turning a positive attribute of breastfeeding into a negative characteristic of bottle-feeding, it helps to illuminate how some women receive these health promotional messages. Rather than simply viewing breastfeeding as providing a health advantage, it can be argued that many women consider 'not breastfeeding' as risky.

Using the discourse of risk

It can be claimed that women view the health promotional messages in this manner because health promotion messages in Western industrialised nations are generally couched in risk discourse, with an increasing focus on reducing lifestyle risks. To do this, health promotional messages 'create public awareness of the health risks posed by "lifestyle" choices made by the individual' (Lupton, 1993: pg 429). Lifestyle risk, is therefore, particularly concerned with ensuring an individual takes responsibility for and avoids

health risks not only for the sake of her/his health, but also for the greater good (Wall, 2001). As opposed to the original mathematical definition of risk, which is considered neutral and refers to probability, in public health discourse, risk is synonymous with danger and is largely weighted heavily in favour of disaster and anxiety rather than peace of mind (Lupton, 1993).

Jules Law (2000) argues infant feeding decisions are given 'epic' levels of consequences in relation to their effect on the mother, the infant and the nation. His point is perfectly exemplified in a recent article, in which it was stated: 'In addition to the health benefits, breastfeeding also provides significant social and economic benefits to both the individuals involved and the nation as a whole' (DiGirolamo et al., 2005: pg 208). Law (2000) argues that the risks of infant feeding in the Industrialised West are far less dramatic and more complex than presented. Even further, he argues that all literature on breastfeeding is highly polemic, stating: 'quite simply much (though certainly not all) of what has been written about the relative merits of breastfeeding and formula-feeding is misleading at best and false at worst' (Law, 2000: pg 412). He argues that although the breastfeeding literature tends to present the benefits of breastfeeding and the risks of formula-feeding in categorical terms, there are significant controversies in the epidemiological community, and reliable data is, in fact, difficult to achieve. Law (2000), as well as other researchers (Carter, 1995; Blum, 1999), suggests infant feeding decisions loom large for women and women are placed in greater dilemmas when they are faced with the overestimated risks of formula-feeding and the benefits of breastfeeding and other important potential effects of infant feeding decisions such as household finances and the division of labour are minimised. Murphy (2000) found the techno-scientific risk discourse was a reference point for mothers from all the occupational classes and age groups she sampled, regardless of when formula milk was introduced. Certainly this was evident in this study when some women talked about their fears that by giving formula they could cause life-long damage. I would also suggest the feelings of guilt women express when unable to breastfeed is another result of this and is exemplified in a quote from a woman in a study by Shakespeare (2004: pg 258) when she says *'I feel very, very guilty about not being able to breastfeed, very, very guilty, I still do feel very, very guilty about not being able to, you know. Every time Ruth has a patch*

of eczema I attribute it to the fact that I didn't breastfeed'. This research would indicate risk discourse goes a long way to explain why there were women who felt coerced to breastfeed and/or hid their decision to formula-feed. It would also substantiate the claim that sociocultural risk discourse is heavily laden with meaning and can be used to apportion blame (Lupton, 1993).

A good mother breastfeeds

Findings of this study and of others, have clearly identified that embedded within the understanding of the benefits of breastfeeding is the notion that breastfeeding is the 'right' thing to do (Dykes, 2005) and that being a 'good' mother and breastfeeding are linked (Murphy, 1999; Hailes et al., 2000; Murphy, 2000; Schmied et al., 2001a; Hauck et al., 2002a; Shakespeare et al., 2004). As others have identified the breast is best message is strongly related to the ideal of the good mother (Maclean, 1990; Carter, 1995; Blum, 1999; Murphy, 1999; Hoddinott et al., 1999a; Hailes et al., 2000; Lupton, 2000). A good mother, it would seem, would want to give her baby the 'best' and given that breastfeeding was promoted as 'best' meant she needed to breastfeed. The strength of this association between breastfeeding and the 'good mother' was summed up in a comment by one of the women in a study by Hailes and Wellard (2000: pg 7) when she made the statement *'I'm a bad mother if I don't breastfeed'*.

Wall (2001: pg 595) argues that breastfeeding being bound up in the moral construction of motherhood is related to 'the moralization of pregnancy that has accompanied the subjectification of the fetus and the neoliberal preoccupation with individual responsibility, individual self-enhancement, and the cost of social programs'. It has been argued that risk discourse associated with breastfeeding draws on the assumption good mothers will want to maximise their child's physical and psychological health outcomes (Murphy, 1999). Contemporary Western notions of a good mother demand she will privilege the needs of her children above her own (Blum, 1999; Murphy, 1999; Schmied et al., 2001a). This pre-eminence of the infant's needs over the mother's needs has been clearly identified in the promotional messages around breastfeeding (Wall, 2001). Wall (2001) identified that the discourse was very child-centred, with the benefits of breast milk and breastfeeding to the

baby the major focus of the literature. As such, the mother as a subject with legitimate needs and wants was invisible and was simply viewed as the provider of the perfect food for her baby (Wall, 2001). A commentary published in the *Journal of Human Lactation* and titled 'Breastfeeding and Human Rights: Is there a right to breastfeed? Is there a right to be breastfed' provides an overt example of the invisibility of the mother as a subject in her own right and the pre-eminence of the needs of the child. The article argues that the best interest of the child must be paramount and that parents will act in the best interests of the child. While it argues that mothers are not mandated to breastfeed, there is a clear assumption by the author that if they are educated about the benefits of breastfeeding they will do so because to do so will be acting in the best interests of the child (Bar-Yam, 2003). Clearly, in my research some women did feel displaced as a subject, arguing that the breast is best message and the subsequent pressure exerted on them to breastfeed diminished them as an individual leading one of the women to say *'it's almost like you as a person are gone and we need your body and we need those breasts and we need those nipples out'* (see previous section)

These understandings support the concept that risk definitions can be 'hegemonic conceptual tools that can serve to maintain the structure of society' (Lupton, 1993: pg 432). To this end, a number of commentators and researchers (Carter, 1995; Blum, 1999; Law, 2000), have argued that the literature around infant feeding is not essentially about milk at all, but rather social, domestic and technical arrangements (Law, 2000) that are associated with infant feeding. Law (2000) argues along with others (Blum, 1999; Wall, 2001) that maternalist thought pervades all literature on breastfeeding and that at the core of this are assumptions of maternally dedicated childcare and the domestic division of labour. Further to this, he claims, it is the presumption of the traditional division of domestic labour that forces the skewing of the risk/benefit calculations in infant feeding literature (Law, 2000). To illustrate this, Law (2000) uses the concept of maternal/infant attachment, arguing that the concept of 'bonding' forms part of the maternalist ideologies asserting the mother as the appropriate and ideal carer for her child. Law's argument has merit given that despite attachment theory having been convincingly challenged (Eyer, 1992), bonding remains embedded in the health promotion literature (Wall, 2001) and is commonly cited as a health

benefit of breastfeeding by researchers and breastfeeding advocates (Tarkka et al., 1996; Cantrill et al., 2004; Allen et al., 2005). It has even been argued that knowledge of attachment theory is essential to midwives' ability to correctly foster the initial breastfeed (Cantrill et al., 2004).

Yet, Law (2000: pg 417) reveals that in some instances 'studies that have been cited as evidence that breastfeeding leads to bonding are actually methodological studies in which breastfeeding was an outcome measure'. Notwithstanding this controversy, the strength of the bonding discourse to women, particularly in the antenatal period, was evident in the findings of this research. The majority of the women were convinced of the value of bonding and its relationship to breastfeeding, calling on its authority during the antenatal period when considering infant feeding choices and citing it frequently as a reason for planning to breastfeed. Given the fallaciousness of the bonding argument (Eyer, 1992), it would appear that these findings support the suggestion by Law that the breastfeeding literature can be misleading (Law, 2000).

That breastfeeding is viewed as a way in which the 'good mother' is constructed within western societies (Carter, 1995; Blum, 1999; Murphy, 2000; Schmied et al., 2001a) also means that breastfeeding is seen as a 'highly accountable matter' (Murphy, 1999). This can explain why some women feel a sense of failure when they do not breastfeed (Hailes et al., 2000) and why Murphy (1999) argued that women in her study were accepting of the fact that having failed at breastfeeding was deviant behaviour. It can also explain the societal expectation that a woman breastfeed, as found in this research as well as other studies (Maushart, 1997; Murphy, 1999). Given the advantages of breastfeeding, it was generally assumed a woman would breastfeed. It has been highlighted by other researchers and commentators such as Maushart, who describes in her book *The Mask of Motherhood* how in certain groups of women it is almost unacceptable to relate why one stopped breastfeeding (Maushart, 1997). In this study, women who were bottle-feeding were fearful they would be judged as less than acceptable mothers.

Feeling the pressure

In line with other research (Carter, 1995; Blum, 1999; Hoddinott et al., 2000b; Shakespeare et al., 2004), this study found some women felt pressured to breastfeed by professionals. In other studies these findings may be hidden in the results and not identified as such by the authors. A study by Hauck et al. (2002a: pg 902) provides an example of this when the authors quote a participant's partner as saying: *'women when at their most vulnerable are made to breastfeed by the establishment. If they can't they are made to feel like second class citizens'*, and then present this as being related to differing professional opinions.

Women in this study also talked about fearing sanctions and having information about bottle-feeding withheld by health professionals. Other researchers have identified these behaviours. One of the women in Hoddinott et al.'s (2000b: pg 229) study described the use of sanctions saying: *'I think they do prefer you breastfeeding because the lady in front of me, she was breastfeeding and she got visited about three times in the morning and no-one ever came to me'* (Natalie).

In Murphy's (2000) study, the women talked about being challenged and criticised by health professionals. These women reported how health professionals tried to block their decision to formula-feed. Also occurring in the Australian context was Hauck et al.'s study (2000b), which found women reported they received information that was strongly biased towards breastfeeding or intolerant of bottle-feeding. The strength of this perceived bias and professional preference for breastfeeding by some women was illustrated in a quote from Shakespeare's (2004: pg 257) study where one of the women felt the health professionals at the breast clinics *'would be bestowing the virtues of breastfeeding and how, you know, people who bottle feed are the devil's spawn and I just felt awful'.*

Given the perceived pressure from professionals, the results of this study would support the findings of Murphy (1999: pg 187) who argues the breast is best message underpins policy and professional practice and 'is part of the context in which women decide how to feed their babies and in turn how they display and defend their decisions'. Women in this study as well as others were clearly knowledgeable of the health professionals' preference for

breastfeeding over any other form of infant feeding, with some women feeling they were expected to breastfeed at all costs. It has been demonstrated in this study as well as others studies that professional pressure to breastfeed increases levels of distress in women during this early period (Blum, 1999; Murphy, 2000; Hoddinott et al., 2000b; Shakespeare et al., 2004).

Although Murphy (2000) suggests the power of expertise did not force the women in her study to feed their babies in ways they did not choose (Murphy, 2000), findings of this research and also a study by Hoddinott and Pill (2000b) suggest pressure to breastfeed did mean that some women initiated and or continued breastfeeding despite not wanting to. In this study as well as other studies, women have described how they felt coerced to breastfeed (Blum, 1999; Hoddinott et al., 2000b) and/or hid their decision to bottle-feed (Maushart, 1997; Sheehan et al., 2003). Despite breastfeeding being referred to as a choice, this research supports the argument put forward by Bartlett (2005) that when it comes to infant feeding there is quite obviously a right and wrong choice. Lupton (1993) argues that the discourse of risk contributes to this because seemingly the discourse of risk gives people a choice, but the rhetoric in which choice is couched leaves no room for manoeuvre. Based on the assumption that a good mother breastfeeds, it was not surprising these findings identified that women who chose to bottle-feed felt they were judged and needed to justify their decision. Murphy (2000) also reported in her study that women felt they needed to defend their decision to bottle-feed to a range of people.

These findings may explain why some of the women in this study talked about being embarrassed to feed their baby using a bottle even if it was EBM. Hailes and Wellard (2000) noted that women in their study also talked about a sense of embarrassment connected to bottle-feeding in public following weaning. In their discussion, however, they simply surmised that women experience embarrassment when feeding in public, regardless of the feeding method used (Hailes et al., 2000). This may very well be the situation, given other studies have found women are embarrassed to breastfeed in public (Morrow, 1995). I would argue, however, based on the findings of this research, that embarrassment related to bottle-feeding in public is a relatively new phenomenon that is directly linked to the use of

risk-related health promotional material and discourses around breastfeeding and the contemporary construction of a 'good' mother as being one who breastfeeds.

Contradictions and controversies

As this research bears out, there are two predominant models of breastfeeding in western culture, the maternalist, and the medical model. The maternalist model privileges the discourse of natural and the medical model the health benefits (Blum, 1999). Blum (1999) argues that within these two perspectives there are both empowering and oppressive potentials. This argument is substantiated in the findings of this research. Despite breastfeeding being purported to give women freedom over their body (Palmer, 1993), results from this study showed, as others have also reported, that through the promotion and education of breastfeeding the subject positions of women can also become restrictive (Blum, 1999; Law, 2000; Wall, 2001). Strategies that promote breastfeeding based on information about the benefits of breastfeeding assume women will choose to breastfeed on the basis that 'breast is best'. This, however, fails to take the wider socio-cultural factors into account and also undermines a woman's concern for her baby's wellbeing (Gerrard, 2001). Given this restricted subjectivity of the woman, a number of authors have highlighted the paucity of feminist critique of breastfeeding promotion (Carter, 1995; Blum, 1999; Schmied et al., 2001b). It has been argued that this lack of feminist critique of the assumptions underlying the growing medical and official concern with increasing breastfeeding rates has occurred predominantly because this has occurred at the same time as the exploitation of women in third-world countries by formula companies was being exposed (Wall, 2001). While there is an understanding that formula companies have exploited women, women can also feel restricted by rules that govern breastfeeding (Wall, 2001). Wall (2001: pg 599) further claims the reluctance to acknowledge the range of difficulties that can accompany breastfeeding is because to do so would put breastfeeding into 'a negative light and feeding into ideas that have been used to promote infant formula as the better option'.

Lupton (1993: pg 432) argues 'analysis of moral and ethical implications of risk communication tends to implicitly accept that public health communication of risk is

desirable in most circumstances; with no further need to evaluate the ethical implications other than those posed by the involvement of journalists and public relations firms'. Further, Lupton (1993) suggests there are ethical questions related to risk discourse in public health that have been questioned little. Given the findings of this study that illustrate the restrictive maternal subjectivities to which risk discourse can contribute, this demonstrates that it is time some of these ethical implications were explored.

Conclusion

This chapter has described the category 'it's really best to breastfeed'. Findings have clearly demonstrated that at a personal, professional and social level, breastfeeding was considered the best method of infant feeding and that this knowledge was very influential to the women's decisions, particularly in the antenatal period. Not only was breastfeeding considered best, bottle-feeding was viewed as second best and/or even dangerous. The findings of this study, supported by the literature, demonstrate that 'it's really best to breastfeed' is strongly related to the promotion of breastfeeding with connections to risk discourse and the social construction of a good mother as one who breastfeeds. The literature demonstrated how many of these understandings restrict women's subject positions, a suggestion evident in the findings of this study.

Chapter Five

It's the unknown

Introduction

As can be seen in the previous chapter, the women were well aware that breastfeeding was recommended as the best way to feed their baby. Subsequently, this knowledge was shown to influence their infant feeding experiences. This was particularly obvious in relation to their plans for the immediate post-birth period. This chapter describes the category 'it's the unknown'. This category describes the experiences of the women as they encounter the reality of breastfeeding and how this then impacts on their decisions. The category 'it's the unknown' has three main subcategories and these are: 'it was all new', 'it's unexpected and unpredictable', and 'needing support'. What needs to be clear is that while many of the experiences discussed in the following chapter appear to occur only in the initial first week, this was not always the case. For some women, the experiences discussed in the following chapter occurred at any time during the first six weeks. This meant that even if the breastfeeding experience in hospital was considered 'easy', that did not necessarily preclude woman from experiencing difficulties in the following weeks. A discussion of the findings as they relate to the literature concludes this chapter.

It was all new

In the first few weeks following birth, some of the women, particularly the first-time mothers, acknowledged that what they were encountering was a whole new experience. As the women explained it *'in the first couple of weeks everything's so new and so hard and it's different* (P32), and *'this is totally new to you'* (P9). And while breastfeeding was not the only thing factoring into this, particularly for the women who had chosen to breastfeed, breastfeeding was definitely one of these new experiences *'he's feeding from you and it's just totally different feeling than you would ever feel in your life'* (P32).

It was not just first-time mothers either, who talked about breastfeeding being a new experience, women having subsequent babies also identified that each experience was new and different '*you know each breastfeeding experience is different, not just each mother* (P13), and '*Very different, the second time... '* (P25).

Breastfeeding was new to the women from a number of perspectives. The first-time mothers particularly talked about the unreality around breastfeeding that questioned aspects of their known self:

> *I remember thinking it was a very strange umm very strange having some little baby that was apparently mine, umm, I'm trying to get them interested in my nipples, you know, which had never been used for that kind of purpose before, so that was very strange* (P2) and
>
> *I remember thinking how strange it was that there was somebody sitting here and sucking on my nipples and that was going to make her grow [laughing]. It was, I found it quite strange that suddenly my breasts, which had been very private and personal, were suddenly out in the open* (P13).

In addition, some of the women talked about how new and unknown some of the practical aspects of breastfeeding were, such as positioning and attachment, saying:

> *you kind of don't even know how to hold them to start with, umm, and then getting him to the right position to get your breast into the right position* (P2).
>
> and
>
> *having trouble handling my own breasts umm was becoming increasingly frustrating ... I did get to day six and that night, umm, at about two-thirty in the morning I was just really struggling and he wasn't latching ... it was beginning to hurt a lot and, umm, I felt it was me that really wasn't getting the hang of it* (P8).

Other women expressed more generalised feelings of unknowing, saying: *'I didn't know anything about it'* (P7), and *'I didn't really have a clue as to what I was doing'* (P15). These feelings of unknowing were made even clearer when women reflected back over these early weeks and recognised that despite still breastfeeding, they really had not known much initially: *'For the first four weeks I think I was just umm, you know, just mucking around, didn't know what I was doing'* (P2), and *'I don't know, it's all very confusing to start because things change from day to day. What works one day doesn't work the next day'* (P4).

Lacking confidence

Given that it was all new and unknown, it was not surprising that the women talked about lacking confidence during the first few weeks of breastfeeding, saying: *'I basically spent the first two days panicking'* (P32), *'I just didn't have the confidence* (P2), and *'I feel so inadequate, why do I feel so like lacking confidence ... that's I suppose I think that's been the hardest thing is not knowing'* (P34).

Given the women's lack of confidence during this time, many of the women expressed feelings of uncertainty about their ability to breastfeed, making comments such as:

> *I remember the first few days saying "I can't do this, you know, I don't know how to do this and I can't do it and I can't get most of it in his mouth and, you know, trying to see if his mouth is wide enough and not quite knowing if it is* (P34).

They also began questioning their ability to be able to produce enough breastmilk to meet their babies' needs, saying *'is she getting enough milk? Am I doing this right? Will I have enough to keep this up?* (P30), and *'I felt, you know, is he going to be able to get it out, you know is there going to be enough there?'* (P3).

If the baby was upset or crying, this could exacerbate the woman's uncertainty:

Yeah, yeah, well as soon as you hear her crying, you know, screaming like that, that's the first thing you think – is she getting enough milk? I mean, after you change her and bath her and everything and she's still screaming, you know, you feel that there's something wrong (P30).

During this early period, the baby's behaviour could affect a woman's confidence by either decreasing her confidence or, alternatively, acting as a buffer. To this end, if the baby was unsettled and/or not getting sufficient breastmilk, '*he was getting really restless, he obviously wasn't getting enough milk, screaming all the time'* (P15), and '*I just felt like he wasn't getting enough food and he was crying a lot'* (P5). This lowered the woman's confidence in her ability to breastfeed *'which didn't make it any easier in terms of building up my confidence with breastfeeding'* (P5), and *'You can so easy to be upset when he's getting upset at feeling useless'* (P15).

In contrast to this, a positive response from the baby could have a buffering effect on the woman's confidence. If the baby's behaviour was perceived as positive this would confirm to the women they were doing something right: *'she's just thriving on it'* (P6), and '*every time he was weighed it was like "well he's putting on weight, you're doing something right"'* (P34), consequently building the woman's confidence.

Unexpected and unpredictable

Not only did the women highlight that breastfeeding was unknown in the first few weeks post-birth, the women also highlighted how unexpected and unpredictable the experience was. The fact that women found breastfeeding unexpected occurred regardless of how difficult or seamless the breastfeeding experience was. The women made statements such as : '*the reality is that it's different to umm how you think it might be'* (P25), and *'the experience was much different than what I had in my head'* (P15). The women talked about a level of unpredictability around breastfeeding '*we knew more or less what to expect, but of course you don't really know what to expect until it actually happens to you, really'* (P35), and *'I just had no perception of how it would feel, I guess you don't anyway until it*

happens' (P32). Even women having subsequent children talked about how their experiences were unexpected and unpredictable, saying:

> *Even though I managed to feed my first without getting sore nipples at all but with my second and third I had a lot of trouble and you know they are different babies and different dynamics I suppose* (P13).

As a result, some of the women described breastfeeding as being less difficult than they had expected. They made comments such as *'I think it was easier than I thought'* (P2), and *'I just thought it would be a lot harder than it is'* (P16). In this study, however, these women proved to be exceptions. By far, the majority of women were surprised at how difficult they actually found breastfeeding to be, saying they thought it would be easier. They made statements such as*: 'you just think it's all going to be easy'* (P11) and, *'I thought it would be easier and more convenient as well'* (P10). Some of the women talked about specific aspects of breastfeeding that surprised them, saying: *'I didn't expect it to hurt'* (P9), and *'the first thing that surprised me was he wouldn't suck he actually ... he wouldn't actually suck for the first day'* (P1).

Even some of the multiparous women who had had previous difficult breastfeeding experiences believed that it would be different this time and that they would be able to do it. They made comments such as: *'and even with my second one even though I didn't overly do it successfully with my first one, I just assumed that I would be able to do it with this one'* (P14). One of the reasons for this was that they believed if you took away the problems they had experienced last time, the experience had to be different.

> *I think that I actually felt that umm, that it would be different because so much of the feeding was about, well, the problems that were identified as why it wasn't working was so much about L and how the structure of his mouth and how he physically fed that I felt well, okay, this baby will be different, it won't necessarily you know have the same sort of mouth as him. Umm, and so I actually yeah*

probably thought more this time that it was actually going to work, that I was going to be fine (P25).

While there were some women in this research who did not anticipate breastfeeding problems at all, this was not always the case. A number of women in this study were aware that there might be a possibility of experiencing some difficulties with breastfeeding, making comments such as: *'I didn't have a vision in my head that everything was going to be light and fluffy and it was going to be magical, I imagined it was going to be hard work but I don't know ...'* (P15). What was unexpected for these women was not that they could have problems but the degree of difficulty these problems could create. They made statements such as *'I expected minor, I expected some problems but not the degree of problems I've had'* (P15), and *'that was beyond anything I was expecting'* (P1).

One specific aspect of breastfeeding the women found particularly surprising and unexpected was the level of pain they experienced:

I absolutely did not expect the pain and I just I don't mean it was not just sore I mean it was excruciating, like a couple of times I would be up particularly at night and be in tears with him on the breast knowing that he was attached well ... I haven't eaten so many Panadols as I have in my life since I've been breastfeeding, even go at night, sometimes I need to have a hot compress across my nipples so I can get back to sleep (P1).

Again it was not necessarily that the women did not expect to experience pain, it was the degree of pain that was the surprise to many of them:

I think the degree of the pain was a surprise to me. I was ready to expect a little bit of soreness ... but I never realised it was going to be that painful, that I would be reduced to tears every time I fed, umm, so yeah that was a surprise, yeah (P5).

As the women began to discuss their infant feeding experiences, a number of factors emerged that helped to explain why the women had been so surprised by the reality of breastfeeding and why they had expected breastfeeding to be easier.

It's like some secret society

Amongst the women, there was a belief that no one really tells you about the reality of breastfeeding: *'it took me an hour an hour and a half to feed him every time. The sore nipples, the cracked nipples, the bleeding, nobody tells you all that'* (P14). In fact, one woman even suggested *'it's like some secret society'* (P27).

In this regard, some of the women considered that while the benefits of breastfeeding were readily extolled, the more negative aspects of breastfeeding were generally glossed over.

> *I think that's one thing they really don't tell you even in the antenatal classes, even though they keep going on about breastfeeding and how fabulous it is they don't tell you how excruciatingly painful it is. They sort of say you might have a few cracked nipples and you might have, you know, a bit of soreness* (P5)
>
> and
>
> *I suppose that came from the reading that I'd done, that you know after the first sixty seconds or so you should feel no discomfort* (P25).

Further, some women believed that potential difficulties and problems with breastfeeding were not even discussed: *'in fact people don't sort of talk about problems'* (P11), and *'nobody told me any horror stories about breastfeeding. I guess people don't really want to tell you too many bad stories'* (P27).

One of the women, who was a health professional and who had worked with pregnant women and breastfeeding mothers, was particularly disappointed that she was in the dark about the realities of breastfeeding, saying: *'I do actually feel, because of my background,*

feel a bit disappointed that either I've missed something or the books haven't told me something' (P1). Even more vehemently, another woman went so far as to say that not only did they not tell you about the difficulties around breastfeeding, but what was said about breastfeeding was full of myths. When asked whether the experience of breastfeeding had been what she expected she said *'no, no, lots and lots of myths around about that'* (P14).

The women felt that breastfeeding was presented in ways that made it look easy. The women made statements such as: *'but I think that all the images you see of women feeding, it all just looks so and everything you hear it just looks so natural and yeah unpainful'* (P25), *'well they made it look easy on the video. You just open their mouth up and stick it in'* (P24), and

> *my memories of breastfeeding went pretty much back to my mum and it always seemed like a really straightforward easy thing to do. You know I'd see her and she'd just pick up the baby and feed it* (P13).

In addition to the visual images that made breastfeeding look easy, the women also described other ways in which breastfeeding was presented as completely 'doable':

> *because bottle-feeding is discouraged and so therefore you have a vision in your head, all right, that if they're plugging this breastfeeding thing so much and Jo Bloggs can do it then I must be able to do it and you speak to other people and they say they can do it* (P15), and

'All the literature and everything else you see babies can breastfeed' (P14). There was also a belief amongst the women that difficulties would only occur if you were not doing it the 'right way' and so if you did all the 'right' things you would not experience problems *'I thought it would not hurt at all, only if the baby wasn't attached properly or if you had cracked nipples, or any kind of problems'* (P9).

Some of the women argued that the breastfeeding literature actually reinforced this perception. One woman, who had experienced very painful nipples, drew attention to this by quoting some of the breastfeeding literature,

> *when your baby is on your breast the right way the first point is, it says it does not hurt. ... well that's my biggest comment is the literature and it basically everything states no pain* (P1).

Another expectation expressed by many of the women was that they believed that everything was fixable, that even if they encountered problems they would be fixable: *'the breastfeeding girls came and saw me at the hospital and reassured me that we can, if you really want to do it then we can do this'* (P14). These women believed that if you were willing to do certain things such as reading, getting information or being prepared to seek help if necessary, they would be able to resolve any problems:

> *I am also umm well read, I think, in what to do about it and also not afraid to ask for help I think, umm, I've heard of people who have sort of given up on breastfeeding because it was too painful or whatever, umm, but I always knew that if I was to feel like I was close to giving up I would make sure that I spoke to somebody about it first, a professional who would make sure that I was doing right or wrong or whatever* (P2).

In this regard, some of the women sought help for anticipated breastfeeding difficulties during the antenatal period, expecting this would prevent or limit any future problems.

> *I knew the problems I had with H so I joined the ABA probably six months before I had him. I went to all the meetings I went and did a 'BOB' seminar, which is a basics of breastfeeding umm got into a mothers' group with the ABA. I thought I knew not knew everything but I knew enough and I had a support network to ring to say come and help me I can't do this and I was quite happy to do that this time because I was adamant I was going to breastfeed* (P14).

In the postnatal period, there was evidence again that the women believed difficulties could be solved by seeking the correct support and advice and that by doing this their problems would be resolved *'I thought going to Tresillian, that would fix the problem ... they would show me how to correct it and it would all be better'* (P14), and *'I really want to try and prevent that from happening, can someone please sit with me, spend some time with me'* (P25).

Further to this, there was a belief that time itself would resolve any breastfeeding difficulties, that it was just a matter of persevering: *'once I'd pass that first six weeks I knew it would settle down and it would be all right, so it was a matter of surviving for six weeks'* (P4), and *'I knew it was going to get better and the books always said about six weeks it will get better, so I was just holding out for that'* (P5). In these discussions with the women, some of the women drew attention to the fact that there had never been any recognition that sometimes breastfeeding just does not work: *'there's no talk of occasionally babies just can't do it'* (P14), and *'everyone that I spoke to and everything that I read said to me keep persisting because it does get better, and I figured that if everyone was telling me that then it must be true'* (P5). Consequently, many of the woman approached breastfeeding with a sense that while the first few weeks might be a little difficult, any difficulties would be resolved in time.

Given, therefore, that the women generally believed the 'breastfeeding norm' was presented as easy, doable or fixable, this would also explain why some women who were aware of difficulties felt these would not ultimately prevent them from successfully breastfeeding:

> *I'd seen my sister with her first one, she had a bit of trouble with her first one ... but it's different sort of because even though you talk about it you just assume that you're going to be able to do it* (P26),
>
> and

I just thought nature will take its course, everything should be fine (P20).

As discussed in the previous chapter, there was an expectation by many women that breastfeeding would be 'natural'. Certainly, it could be argued that because breastfeeding is constructed and promoted as 'natural', this implies that breastfeeding is 'innate', 'spontaneous', 'normal' and 'happening in the usual course' as it is defined in the *Chambers Dictionary* (Kirkpatrick, 1983). Some of the women confirmed this perception of 'natural' when they made comments such as: *'we had this misconception that it is just a natural thing, like you just put your breast to the baby and everything just goes naturally'* (P28), and

> *like it's supposed to be the natural thing to do and I just thought it would be easy, you just stick the nipple in there [laughing] it would just happen, but yeah, it doesn't* (P6), and

> *Like some people go into motherhood assuming that it's all going to be a breeze and their motherly instincts are going to kick in and they're going to automatically know what to do you know, and then it's a surprise to find out that it doesn't work that way* (P26).

Ultimately, the reality of breastfeeding for some women proved to be much more involved and difficult than they had ever expected it to be *'I didn't think it would be as big a deal as what it was'* (P22).

What's wrong with me?

When things did not go according to the women's expectations and they found breastfeeding to be much more difficult than they had expected, it impacted further on their confidence. The women began to feel there was something wrong with them, they made statements such as: *'like I think oh I know, she can just do it and there's no problems, you know, what's wrong with me?'* (P6), *and 'why can't I do this if they're telling me to do this*

why can't I do this?' (P15). This trust in the information that everybody can breastfeed led some of the women to believe if they were having difficulties then it had to be their fault: *'when it says it does not hurt it's black and white and it makes you think, well, okay, what's wrong with me or what's wrong with my baby?'* (P1). Other women talked about blaming themselves when things were not working out feeling there must be something that they were doing wrong: *'I think you naturally just, you know, blame yourself'* (P6), and *'I was kind of blaming myself'* (P28). When breastfeeding was not working, some of the women talked about feeling like a failure, saying: *'I've got so many friends that breastfeed and it's so easy and sometimes you just feel like this big failure'* (P6). These feelings of failure made the women feel vulnerable and emotional: *'when you can't do it there's a feeling of helplessness'* (P15), and *'I started getting really emotional by this stage'* (P6).

Feeling stressed

Not only did the women talk about feeling emotional and vulnerable when breastfeeding proved to be problematic, this could also lead to feelings of distress. The women made statements such as *'I was just so stressed and distressed every time I wanted to feed her'* (P25), and *'every time I'd have to feed him I was like [gasping sound] ... and I'd be thinking, relax, relax, you have to relax. I just couldn't relax'* (P26).

It was not just during the feeds that the women felt distressed. For some women, simply anticipating the next breastfeed became distressing,

> *I wasn't able to rest in between feeds, I was stressing, I was lying in bed, my heart was pumping so fast that I couldn't rest, I gave myself a headache because I built up stress between every feed anticipating it and feeling really anxious about it* (P8).

And for others, there was no let up of these emotions *'I was just feeling keyed up all the time'* (P36).

Finally, the women talked about the negative impact these feelings and emotions had on them as a person, saying: *'I'd be bawling because I had to feed him'* (P26), and *'it was*

turning me into a, I was a blubbering mess' (P9). For some women, as these feelings continued to spiral out of control, they began to feel they could not cope: *'oh my God, I can't cope like this any longer, you know, I am going to go mental'* (P26), and *'I didn't feel I could cope, I felt I couldn't cope with it'* (P8).

The domino effect

What was also clear in this research was that when the women became stressed, it did not just affect them. Firstly, many of the women believed their stress affected the baby, saying: *'me being upset that, you know, she picks up on that so and then she's upset, so we're both upset'* (P9), and *'she was getting stressed and I was getting stressed because she was getting stressed'* (P16). But it was not just the baby who was affected. The women also talked about how being stressed affected their husbands and partners, saying: *'I'm, you know, calling my husband crying, you know, and that stresses him out'* (P9), and *'I was distressed most feedings ... and it you know it affected my and P's [husband] relationship, I mean it was horrible for him to stand by and watch that every couple of hours for me to go through that'* (P25). As one woman described it, *'it was like a domino effect ... 'if the baby's not happy, I'm not happy, if I'm not happy then my husband is not happy'* (P15).

> *Everybody .... me, my husband, the baby, the baby is always crying, my husband is stressed out because he doesn't know what to do and then a bit depressed and stressed out too because everything is not turning the way we expected it, you pictured it to be* (P28).

Further, it was not just the couple and their baby who could be affected. One of the women pointed out that it was not good for her older child to see her distressed at each feed, saying: *'I was distressed most feedings and that wasn't obviously good for L [older son]'* (P25). Ultimately, the women believed that feeling distressed and unable to cope affected the whole family *'I just wasn't coping and that just affects everyone'* (P25). It was at this stage that a number of these women weaned, saying *'I had had enough'* (P15), and *'I just didn't think it was going to be worth it'* (P9).

Needing support

Given that the women felt they did not know what to do, were lacking in confidence and found breastfeeding more difficult than they had expected during this early period, it was not surprising that the women talked about the need for support. It appeared that receiving appropriate and adequate support could cushion some of the discouraging and difficult aspects of breastfeeding in the early days. The women made comments such as *'support is very important'* (P2). The women mentioned different sources of support such as friends, family and health professionals, saying: *'support from family and friends, support from professionals to give you the right advice'* (P2). How important support was to breastfeeding was demonstrated in some of the comments women made: *'my partner's helped me out a lot with night feeds, if it wasn't for that I would have probably given up'* (P10), and *'when you have someone who sits with you and persists with you, which I had at the hospital the first time and that nurse was there my whole stay, it makes it easier'* (P11). Particularly when the women experienced difficulties, they highlighted the fact that without support breastfeeding their baby would have been even more difficult or impossible. They made comments such as: *'my husband was very supportive and I probably couldn't have done it without his support and encouragement'* (P4), and *'I really felt I really understood ... how easy it would be to give up and particularly if they didn't necessarily have a supportive partner'* (P1).

While the women discussed lay support, there was also a strong emphasis placed on the expectation that the health professionals would or should support them as they learned to breastfeed *'you just expect that they [the midwives] will, you just expect that they will come in and they'll show you how to do it and that's it and you'll do it'* (P14), *'I hope someone's going to help me when I get there'* (P3), and *'I remember having to ask someone in the hospital to help me'* (P2). It was not just first-time mothers who expected they would need help. Women having subsequent babies also talked about their learning needs, saying: *'Even if you have had experience with it before you're trying to do it better this time and so you do listen to what they say'* (P4).

The women identified that information received about breastfeeding prior to birth did not prepare them totally for the actual experience, saying: *'you read stuff but you don't know how to actually do it'* (P35), *'there's only so much knowledge that you can theoretically get in your head and understand'* (P3), and *'I'm a very practical person, I like to do things'* (P11). Consequently, women recognised and acknowledged that this was a period of learning: *'I'd always thought this is going to be a big learning process for at least six weeks'* (P1), and *'I know it is a learned thing obviously, both for the baby and for the mother'* (P8).

It was not that the antenatal information was not useful it, was just that when the women got to actually breastfeed it added a whole new dimension to breastfeeding that they felt necessitated some further guidance.

> *You sort of can take it all in at antenatal classes but it when you have to lay it down practically that you just sort of need guidance and someone just to say to you, you're not doing it right* (P15),
>
> and
>
> *I suppose I had a fair bit of technical knowledge swimming around in my head but it was having a midwife there that was saying this is what you have to do, this is what you have to do to get her on that I think this is probably how we made it happen* (P13).

Importantly, what appeared to be of specific importance from the women's perspective was that the support they received, including from professionals, increased their confidence: *'I think it's not just about showing women how to do it but boosting them up as well, umm, I think that's really important .... they need that emotional sort of support that confidence-building* (P2), and *'she sort of gave me the confidence to keep going'* (P13).

The women gave examples of what they perceived as positive support and these included being available *'I mean the midwives were all fantastic, you know, they were great and I knew I could I could buzz them* (P3), staying with you *'it was a special breastfeeding midwife that was in the hospital that came in and she actually sat there* (P7), and *'but it was having a midwife there ... I think this is probably how we made it happen* (P13).

In this study, it appeared that good professional support could ameliorate some of the difficulties experienced by the woman by increasing their confidence. In contrast, lack of or inadequate support appeared to contribute to decreasing the women's confidence to breastfeed: *'I had one that made me feel really uncomfortable and felt that I couldn't do it ... My confidence was gone so I thought I can't do it'* (P16), and *'I was losing confidence in myself when she was saying all of this'* (P32). Decreasing confidence due to lack of support could then have a negative impact on breastfeeding rates. This was illustrated in the comments made by a number of women who weaned early. When discussing reasons for weaning these women talked about not receiving satisfactory professional support, saying: *'I didn't get the support I needed basically'* (P29), *'I did really want to breastfeed but it just wasn't working and they didn't explain it enough to me and they didn't spend enough time helping me, showing me'* (P22), *and 'no-one sits down and goes through fundamentals with you ... '* (P15).

Analysis of the data revealed five dimensions of inadequate support. These included *'lack of help'* (P19) which included statements such as *'Sometimes you get the help and sometimes you don't'* (P11), and *'Even if you wanted help it wasn't there sort of thing'* (P19); *'you're left to your own devices'* (P15) which included statements, such as: *'the first midwife when I was in the room still the first time I fed, she showed me very quickly what to do and then walked out so I was like ... '* (P32), and *'someone tells you something and then they walk out the door, here's your baby. That's what happened to me the first time too'* (P11); *'they were rude'* (P22), which included statements such as *'she was quite abrupt on the phone [inaudible] so that put me back a few steps as well because she was rude'* (P32), and *'she said oh suit yourself and walked out ... I just think her saying well suit yourself and walking out was off ... well she left me there not knowing what to do'* (P10).

Sometimes what some of the professionals did offer as a substitute for appropriate support was considered inappropriate and described as poor support by the women and included being <u>directive</u> *'oh no, you've got to do this and you've got to do that'* (P16), and *'they had all different opinions as if they knew better than the other midwife'* (P19). Directive support as described here contributed to the women's feelings of uncertainty because it confused them and made the women question *'what am I doing right? What am I doing wrong?'* (P32), and *'I don't know who to listen to, what to listen to, who's right, who's wrong,* (P34). Finally, some of the women described support that was <u>*inflexible*</u> in that the women felt they could not make the feeding decisions they considered were appropriate for their baby because any decision apart from breastfeeding was devalued and not tolerated:

> *the decisions I want made for my baby are being taken away from me. And then not being able to perhaps voice your opinion where you normally would say to people this isn't working why are we doing this if this is not working? Why are we keeping on going?* (P15)

and

> *I went to the clinic and the lady was nice, nice lady, but really, you know, you have to breastfeed, you can't not breastfeed and I was like, "Why can't I not breastfeed?" (P26).*

Chapter discussion

It's all new

The finding that breastfeeding is 'unknown' in this initial post-birth period has been reported by other researchers who have identified women perceive the first six weeks as a period marked by new experiences and punctuated by feelings of uncertainty (Hoddinott et al., 1999a; Hailes et al., 2000; Fredrikson et al., 2003). As with other research, the findings of this study demonstrate women express a lack of confidence about their ability to breastfeed (Dykes et al., 1998; Dennis et al., 1999; Hoddinott et al., 1999b; Papinczak et al., 2000; Ertem et al., 2001; Blyth et al., 2002; Cooke et al., 2003b; Dykes et al., 2003;

Blyth et al., 2004; Hauck, 2004) In addition, and in line with the findings of this study, it has been identified that the behaviour of the baby can affect a woman's confidence to breastfeed, with an unsettled baby decreasing the woman's confidence (Tarkka et al., 1999; Hailes et al., 2000; Dykes et al., 2003; Dykes, 2005). These findings suggest that levels of confidence are fragile and vulnerable during this period of time.

This research also identified and builds on other research that has shown breastfeeding is viewed by a large number of women as unpredictable, regardless of whether they are first-time mothers or mothers having subsequent children (Leff et al., 1994; Fredrikson et al., 2003). In Fredickson et al.'s (2003: pg 270) study, one of the women described this level of unpredictability in the early post-birth period similarly to women in this research, by saying: '*all births are different and all children are different, so you cant say that this is the way it's going to be. But it'll be the way it is ... you don't know until afterwards'.*

Findings also revealed breastfeeding was viewed by women not simply as unknown and unpredictable, but also unexpected. Again, both first-time mothers and mothers having subsequent babies viewed breastfeeding as unexpected. These findings build on previous research findings that have shown women's experiences of breastfeeding often contrast with their expectations. Similar to this research, the majority of women in these other studies reported an expectation that breastfeeding would be easier (Bottorff, 1990; Britton, 1998; Hoddinott et al., 1999b; Binns et al., 2002; Hauck et al., 2002b; Shakespeare et al., 2004).

Experiencing difficulties

The study found that, while there were some women who did not expect to encounter any breastfeeding difficulties at all (Binns et al., 2002; Shakespeare et al., 2004), a number of women found breastfeeding unexpected not because they experienced difficulties but because of the severity of the difficulties (Hauck et al., 2002b). One of the most unexpected aspects of the breastfeeding experience for the women in this study was that breastfeeding could be painful and, again, not so much that the women would experience pain, but that the levels of pain experienced exceeded the women's expectations.

Painful nipples have been shown to be a common problem in the postnatal period (Ziemer et al., 1990; Amir et al., 1997; Henderson et al., 2001; Cooke et al., 2003a). Studies report varying proportions of women experience nipple pain, with some estimates ranging from 66% of women (Cooke et al., 2003a) to 96% (Ziemer et al., 1990). Given these relatively high rates of nipple pain, Cooke et al. (2003a: pg 154) suggest painful nipples may very well 'be a "normal" experience in the first two weeks after birth'. Yet despite this, women in this study reported being surprised at the experience of painful nipples or by the level of pain experienced.

The women in this research talked about why they considered their experience was so unexpected. One of the reasons given by women in this research for breastfeeding being so unexpected was that the women believed no-one really tells you about the reality of breastfeeding. This perceived secrecy has been identified in other qualitative work, with women reporting they hear very few negative stories about breastfeeding antenatally (Hoddinott et al., 1999b; Binns et al., 2002; Harris et al., 2003). Health professionals have been charged with contributing to this secrecy, by focusing on the benefits of breastfeeding, rather than discussing the problems and practicalities involved (Hoddinott et al., 1999b; Binns et al., 2002; Harris et al., 2003).

Women in this study believed they had not been told about the reality of breastfeeding and, in addition, believed the images of breastfeeding made it look easy. Other researchers have also argued breastfeeding is presented in ways that make breastfeeding look easy by projecting images of a happy mother and a happy sleeping baby (Britton, 1998; Henderson, 1998; Blum, 1999). In a study by Britton, (1998: pg 313) one woman even stated *'I think the photographs are misleading'*. As a result of her findings, Britton concluded her study by suggesting that 'some images and descriptions may encourage unrealistic expectations of the breastfeeding experience' (Britton, 1998:pg 313).

As identified in the previous chapter, women in this research also considered breastfeeding was natural, which, given the meaning of natural described earlier, implies breastfeeding is innate and normal. Lupton (2000) also identified that because women in her study thought

mothering was natural, many women expected breastfeeding would also be intrinsic. That women are expressing these feelings is not surprising, given that Wall (2001: pg 593) argues the discourse of natural also 'lends itself to the view that all women can breastfeed successfully'.

Some of the women in this study also said that not only did they believe breastfeeding was made to look easy, they also felt they were led to believe that problems would only occur if they were doing something wrong, such as incorrectly attaching the baby to the breast. To demonstrate just how they were led to this understanding, one of the women even quoted verbatim from a breastfeeding manual saying *'when the baby was on the breast properly it does not hurt'* (P1).

The argument that correct attachment and positioning will prevent painful nipples appears to stem from the work of Woolridge (1986). Woolridge (1986) theorised correct attachment could alleviate nipple pain, based on the anatomy of infant sucking. Since then there have been a number of studies, which have set out to assess the effect of education for correct positioning and attachment. While some studies have shown reduction of breast pain and trauma by correct attachment (Duffy et al., 1997), it has yet to be proven that women will experience no pain with correct attachment (Page et al., 2003). Even Woolwich (1986) suggested that some women will have problems with gaining sufficient nipple and areola in the baby's mouth if the mother has inverted or retracted nipples, for example, or has a premature baby or a baby with a small mouth and so therefore correct attachment may not always be achievable. Despite this, correct attachment and positioning is still purported to prevent painful nipples, with researchers suggesting painful nipples or attachment difficulties are common problems that are preventable or successfully managed with appropriate education and support (Scott et al., 2001b; Binns et al., 2002). Given these understandings, it is not surprising the findings of this study found women believed painful nipples would only occur with incorrect attachment and/or if breastfeeding problems were encountered these would be fixable.

Wall's (2001: pg 597) analysis of infant feeding promotional literature can verify the expectation of women that everything is fixable because, as she found, any difficulties were 'characterized as small concerns that can be easily dealt with by seeking the advice of a professional or breastfeeding advocate, or being motivated, having patience, and maintaining a sense of humour'. In line with the findings of this research, Wall (2001: pg 597) further argued that in her analysis of promotional material, breastfeeding was presented as easy, doable and enjoyable, with any difficulties fixable, therefore creating a 'picture of a relatively easy process that any motivated mother should be able to succeed at and find rewarding'. Adding further validity to these claims are the findings of other research around breastfeeding experiences which have shown professionals often minimise some of the distressing aspects of breastfeeding (Britton, 1997; Schmied et al., 1999; Brown et al., 2005).

In Hoddinott et al.'s (2000b) study, when women experienced breastfeeding problems they were often told it was faulty positioning and felt that this was their fault, leading to guilt and loss of confidence (Hoddinott et al., 2000b). Wall (2001) argues by repressing the darker side and the real difficulties of breastfeeding means the focus is on the positive only, such as personal fulfilment and enjoyment. Consequently, this suggests anything outside the positive is unnatural and a shortcoming of the mother (Wall, 2001). The findings of this study support her analysis and the findings of Hoddinot et al.'s. (2000b), because they demonstrate that when women encountered problems with breastfeeding, their confidence decreased as they questioned their ability to breastfeed, believing something was wrong with them. This adds further weight to previous research findings that have also demonstrated women blame themselves, feel like failures and suffer a subsequent loss of confidence when they have difficulty breastfeeding (Hailes et al., 2000; Mozingo et al., 2000; Hoddinott et al., 2000b).

These findings suggest that rather than simply being the difficulties experienced, it is the incongruity between the women's expectations and early breastfeeding problems and the subsequent effect this has on the woman's confidence to breastfeed that impact on her decision. These findings concur with other qualitative research, which has demonstrated

women with unmet expectations often lose confidence (Hoddinott et al., 1999b; Mozingo et al., 2000) and cease breastfeeding (Mozingo et al., 2000). Quantitative research also supports these findings. In a study by Cooke et al. (2003a) multivariate analysis demonstrated that painful nipples did not appear to increase weaning at any time period, despite being the second most frequently cited reason by women for weaning. The authors argue the discrepancy in these findings can be explained because at least two thirds of the women who reported experiencing painful nipples did not consider they made breastfeeding difficult.

Getting support

In this study, the women highlighted the importance of support to the success of breastfeeding. This has also been shown in other research (Hendricks, 1998; Hailes et al., 2000; Cooke et al., 2003b; Cronin, 2003; Dykes et al., 2003). Also highlighted in this research and concurring with other research was the finding that women expect they will seek and or receive support for breastfeeding from professionals in the early postpartum period (Tarkka et al., 1998; Bernaix, 2000; Shakespeare et al., 2004), viewing this period as a time of learning (Hailes et al., 2000) and health care professionals as authorities on breastfeeding (Coreil et al., 1995).

These results also correspond with findings that show assistance for breastfeeding is the most common postnatal care need for women (Cooke et al., 2003b) and that midwives view breastfeeding education as a significant component of their role (Henderson et al., 2000). Despite this shared understanding between midwives and mothers, this research found, as has other research, that health-care professionals are often unable to provide the support women need (Coreil et al., 1995; Stein et al., 2000; Hoddinott et al., 2000b; Cooke et al., 2003b).

Women in this study talked about their interactions with health professionals in terms of positive support or negative support. Other research has found women rate professional support similarly (Hailes et al., 2000; Mozingo et al., 2000; Hoddinott et al., 2000b; Shakespeare et al., 2004). In this study, the women were relatively explicit about the type

of care they found unsupportive and many of these behaviours have also been identified in other studies. For the women in this study, when discussing inadequate support from professionals, they highlighted lack of help and being left to their own devices. Similar behaviours have been identified by and described by women in other studies as inadequate support (Coreil et al., 1995; Hailes et al., 2000; Mozingo et al., 2000; Cooke et al., 2003b; Dykes et al., 2003; Shakespeare et al., 2004). Other components of care that women in this study considered negative were related to communication and included health professionals being rude, directive and inflexible. Women have identified aspects of communication deemed as negative and these correspond with the findings of this study. For example, other studies have found health professionals can be rude by being abrupt, judgemental and intrusive towards the woman (Mozingo et al., 2000; Shakespeare et al., 2004), directive, which includes giving conflicting advice because everybody had different ideas and 'tells you' (Coreil et al., 1995; Dykes et al., 1998; Hoddinott et al., 2000b; Shakespeare et al., 2004), and inflexible (Stein et al., 2000; Hoddinott et al., 2000b; Shakespeare et al., 2004).

Importantly, this research indicates that inadequate professional support, rather than being neutral, can have a negative effect on breastfeeding rates. A number of women in this study who weaned early stated they did not receive the support they needed from professionals. Other researchers have also identified poor professional support contributed to weaning (Hoddinott et al., 1999b; Mozingo et al., 2000).

In contrast to poor support, women in this study also talked about positive support. In terms of positive support, the women particularly highlighted support that increased their confidence, which included receiving emotional support and being boosted up. Other research has identified that health-care providers need to support mothers in developing their own confidence (Hailes et al., 2000). It has been shown that it is the quality of the psychological environment that is most important to women learning to breastfeed (Smale, 2000). Consistently, emotional support, feeling cared for, listened to and being treated with empathy have been shown to be important to women (Stamp et al., 1994; Tarkka et al., 1996; Grindley et al., 2000; Fenwick et al., 2001; Cooke et al., 2003b; Dykes et al., 2003; Williams, 2005). While a number of support needs were identified in Grieve et al.'s

assessments of the counselling needs of breastfeeding women the most common need of women who accessed the NMAA counselling service was reassurance (Grieve et al., 1997; Grieve et al., 2000).

Dykes et al. (2003: pg 394) found the support needs of women in her study 'were striking in their alignment' to Sarafino's (1998) five-category schema for social support. Sarafino's (1998) schema includes emotional support: the expression of empathy, caring and concern toward the person; esteem support: positive regard for the person, encouragement and agreement with the individual's ideas or feelings: instrumental support: direct assistance of a practical nature; informational support: giving advice, directions, suggestions, or feedback about how the person is doing and network support; provides a feeling of membership in a group of people who share interests and social activities. While Dykes (2003: pg 398) found her analysis of the support needs of women corresponded with Sarafino's (1998) schema, she further identified the complexity of providing breastfeeding support when she said 'no single aspect of support was acceptable in isolation' and the significance of esteem support to the overall concept of support was found to be 'absolutely crucial to the acceptability of other forms of support'.

Williams (2005: pg 113), in her study of social support, elaborated on these findings by identifying that while women often 'craved information ... it was important this information was delivered in a way that increased their knowledge, while at the same time preserving their confidence and growing sense of themselves as a competent mothers'.

The importance of good communication in building women's confidence was highlighted in Fenwick et al.'s (1999) study. In their study, the researchers found that the verbal exchanges that take place between nurse and mother influence the woman's confidence, her sense of control and her feelings of connection between her and her baby, and that in order to be effective in providing good outcomes, nurses needed to engage in language that expressed care, support and interest in parents. Importantly, it is not just what is said; women are also sensitive to how it is said (Fenwick et al., 2001). In Fenwick et al.'s (2001: pg 587) study, 'the nurses' ability to engage the mother and establish a supportive

relationship was largely dependent on the use of language'. It has been found midwives underestimate women's need for control and confidence, in adjusting to the maternal role, with women particularly highlighting the importance of confidence-building in relation to baby care (Proctor, 1998).

For women in Hoddinott et al.'s (2000b) study, their confidence was increased if their own decision-making was facilitated. For some of the women in her study, 'if advice was presented as foolproof recipe for success and then despite perseverance it didn't work, women experienced a sense of failure which was isolating' (Hoddinott et al., 2000b: Pg 232).

Women in this study identified that positive support increased their confidence to breastfeed even when the women experienced difficulties. Hauck et al. (2000b: pg 9) also identified that a 'blend of acknowledgement, reassurance and not feeling alone contributed to the development of confidence'. These findings correspond with findings that show effective communication and appropriate support by health professionals has been rated highly as a way to improve the breastfeeding experience (Coreil et al., 1995; Stein et al., 2000). Midwives themselves have identified a number of important communication skills required to support women to breastfeed, including listening, comprehension consistency and the influence of non-verbal communication (Stein et al., 2000).

I would argue that inappropriate professional support actually decreases women's confidence and it is this that has a negative effect on women's breastfeeding rates. Given that maternal confidence to breastfeed has been shown to be significantly related to breastfeeding duration and level (Papinczak et al., 2000; Ertem et al., 2001; Blyth et al., 2002), and that recommendations have been made to find strategies and or interventions to enhance maternal confidence (Blyth et al., 2002), these findings are important. Further to this, I would argue that the findings of this research confirm the suggestion by Sikorski et al (2004) that professional support for breastfeeding can be effective for increasing breastfeeding rates during this early period, and has demonstrated that one of the most important mechanisms by which support operates is confidence-building. The findings of

this study are important because they highlight an area of support that is lacking, and with appropriate understandings and skills, should be modifiable.

Feeling distressed

Finally, this study as well other studies, have confirmed this early period post-birth can be a stressful and distressing time for women (Amir et al., 1997; Schmied et al., 1999; Hoddinott et al., 1999b; Hailes et al., 2000; Fisher et al., 2002; Shakespeare et al., 2004). Some researchers have identified that when women are struggling to breastfeed, they feel out of control and express a sense of failure as a mother, making them feel emotionally distressed (Hoddinott et al., 1999b; Hailes et al., 2000; Shakespeare et al., 2004).

The findings of this research demonstrated also that when women were distressed, this created a domino effect whereby significant others in the women's lives were affected by the women's stress. These findings may provide an alternative explanation as to why it has been suggested the father's preference for feeding type is associated with weaning before hospital discharge (Scott et al., 2001b). Given the findings of this research, I would suggest that the father's preference for weaning may in some cases be related to the mother's stress and reflective of the domino effect articulated in the findings of this study. Rather than fathers preferring a particular method of feeding per se, they may simply be concerned for the woman, preferring to see them happy and stress-free. As Anderson (1996) found, in their role as fathers, men considered themselves as protectors of both the infant and the mother and a conduit to the outside world.

Conclusion

This chapter has described the experiences of the women as they begin to learn and grasp the reality of breastfeeding. The main findings in this chapter have highlighted the newness and uncertainty experienced in the first six weeks post-birth and also identified the unexpectedness and unpredictability of the breastfeeding experience. What these findings have also elucidated is that the promotion of breastfeeding adds to this unexpectedness and how this and other aspects of the early postpartum period affect a woman's confidence to breastfeed. Confidence has been shown to affect breastfeeding rates, and the results of this

study agree with the suggestion proposed by other researchers that when a woman has decreased confidence she is more likely to cease breastfeeding. More importantly, the findings of this research have added to these understandings by identifying how confidence can be decreased during this early period of time. In this regard, while identifying poor professional support decreases a woman's confidence, it also highlighted positive professional support has the capacity to increase a woman's confidence.

Chapter 6

It wasn't the only thing going on

Introduction

In this chapter, I describe the category 'it wasn't the only thing going on'. This category demonstrates that in the first few weeks post-birth, a number of important experiences occurred simultaneously, but that were also intricately connected to learning to breastfeed. Just as breastfeeding was new and unknown, many of these experiences were also new and overwhelming, leaving the women to feel they were not themselves. This is not surprising, given they had just given birth and also become a mother. The category 'it wasn't the only thing going on' has three main subcategories, and these are: 'I'd just given birth', 'suddenly I was a mum', and 'establishing the maternal relationship'. Again the empirical findings are followed by a discussion of the literature.

I'd just given birth

Giving birth was a significant experience that impacted on the women: *'the actual birth itself took me a really long time to get over and deal with and process'* (P13). The women's responses to giving birth were both physical and emotional. In the first instance, the women talked about the shock of birth. The pain they experienced shocked many of the women, but there were also comments that indicated the women were shocked by the enormity of what their bodies had just done in giving birth. Describing these feelings they made statements such as: *'I was still getting over the shock of the birth and the fact that women go through so much pain and then go back for another baby'* (P13), and

> *It was hard to comprehend what had actually happened. And for days I kept saying to B [husband) I can't believe where he came from and he's here and he's you know it's just amazing* (P32).

In addition to this, there were also the physical effects of the birth the women were dealing with. The women made statements such as: *'I felt like I'd been run over by the truck with the pulling and the pushing and everything, you are using muscles you haven't used ever in your life'* (P32), and *'it was agony, you know. So yes, I'm still getting over that part of it'* (P11).

For some of the women, getting over the birth meant recuperating from caesarean sections *'I had a caesarean and you are trying to deal with that'* (P14). The women explained how they were affected by the drugs used following a caesarean section, saying: *'I was still in la la land with the drugs'* (P5). Further, some women experienced added complications such as anaemia and third-degree tears, making feeding the baby uncomfortable *'I had started to become severely anaemic I had lost lots of blood after having him ...'* (P8), and *'I had to sit down and feed the baby and I am sore all over and had third-degree (tear)* (P28).

If the baby was unwell and physically separated from the mother, things were even more complex and distressing. *'your baby is not here, my baby's over in intensive care'* (P14).

For some of the women, these experiences were more than overwhelming. Some of the women described how they could really affect their ability to cope *'I was so sick with the anaemia and I think that made me less able to cope'* (P8), and

> *she was sick and they didn't know how she was going to be and you know we weren't sure whether she was brain damaged from the birth, they sort of said we can't really tell, you just to have to wait and see and, umm, yeah, the whole experience was quite stressful* (P13).

Not surprisingly, many of the women talked about how drained and depleted they felt during this period, making statements such as: *'I was still in a daze'* (P3), *'you feel very worn out'* (P32), and *'I was exhausted'* (P1). As a result of this, it was not surprising the women also talked about feelings of not being quite with it *'So I was quite foggy in the head, I wasn't quite with it'* (P8), and *'after the operation I was very vague'* (P29).

Consequently, some of the women felt these feelings impacted on establishing breastfeeding in particular, because as they described it they were not even able to take it all in, *'they were telling me everything it's just I wasn't taking it in* (P32), *I wasn't sort of just really with it enough, I don't think* (P8), and *'I knew what I had to do but I wasn't doing it properly'* (P7).

Suddenly I was a mum

In addition to coping with the birth, the women also described the impact of becoming a mother. In the first instance, the women described how becoming a mother felt abrupt and sudden, saying: *'suddenly I was a mum'* (P16) and *'it's a strange feeling 'cause you don't whilst they grow inside you, you sort of feel that this thing's just been given to you'* (P11). In this regard, they also described the unreality that now they were a mother, *'I guess it just seems really surreal now it was just like I was holding on to her and, you know, and still coming to the realisation that she was ours'* (P6).

The women also described feelings of amazement, saying: *'I was just in awe of the whole scenario that I was in hospital and this was my baby'* (P7), and

> *you look at them in awe that you've created this beautiful, wonderful, perfect little thing that only took nine months, started off as nothing and then has grown, developed into this perfect little thing* (P15).

The strength of emotions around becoming a mother was made clear when the women tried to explicate how they felt. Some women described it with comments like: *'it was just the most amazing feeling'* (P6), but a number of women, however, found it difficult to put words to it, saying: *'I was so happy and proud that I don't know how to explain what I was feeling, it was just so unbelievable'* (P22). One woman when asked what being a mother was like found it so difficult to express her feelings she simply cried.

One aspect of becoming a mother the women spoke about frequently, was the all-consuming love they had for their baby:

I actually fell in love with him and it was just absolutely, all I wanted to do was to be with him and just everything else seemed to be a bit superfluous (P1),

and

I instantly just felt an overwhelming sense of love ... it just overcame me it was so overwhelming, you know, and I just, umm, would just stare into his crib and you know just be in tears for joy (P2).

The first-time mothers in particular described this love for their baby as unlike anything they had ever experienced before, saying: *'I've never felt anything like it, you know'* (P2). Again the women found it hard to express the depth of love they felt for their baby. Two women tried to explicate how intense this love was by comparing it to the love they had for their husbands: *'I love my husband and I love my family but I've never felt that kind of love'* (P2), and

it's like a deep love, you know, a really happy, wonderful sensation umm ... it's hard to describe I guess ... I mean you, you love your husband but with him it's a different sort of love that you have, like it's a more it's on a different level ... It's hard to explain' (P15).

Enmeshed in their love for their baby was a realisation that this baby was totally dependent on them: *'I had another life that was depending on me'* (P8), and *'they are so dependent on you, you know they are just so little and dependent on you'* (P31). To this end, the baby became their main concern: *'he is my priority'* (P5). As a consequence, there was an overwhelming sense of responsibility towards their baby: *'you just can't describe it, you know, all of a sudden this little thing's yours and your responsibility'* (P30), and *'I feel very responsible for everything she has and anything that happens to her and keeping her safe'* (P16).

With this responsibility, the women felt that they needed to meet all their babies' needs, make the right decisions for them, and give them the 'best'. *'I wanted to make sure that I was doing things right for him'* (P15), *'I just think that she deserves the best that I can give her'* (P9), and *'when you look at them and you think ooh, there's nothing you wouldn't do for them'* (P11).

You're not yourself

As can be seen, in these first few weeks the women were grappling with a number of life-changing and significant events that impacted on them physically, mentally and emotionally: *'it's like that first few weeks there's all this new stuff that's involved'* (P12), and *'there are so many other things going on at the same time, I mean there was a lot of different emotions'* (P3). Many of the women described these first few weeks as being overwhelming, saying: *'I was finding everything ... really overwhelming'* (P8).

The women described these feelings variously. Some women talked about how their lives had changed, saying: *'my life has changed'* (P20), and *'your whole life is just, I don't know, it's different'* (P18). Particularly amongst the first-time mothers, there was a sense that this experience had changed them at a deeply personal level. They made statements such as: *'I felt so changed within five days'* (P8), and *'it's changed me'* (P16). First-time mothers were also shocked at the changes to their thinking that becoming a mother had made, making statements such as: 'I *wasn't particularly maternal before but now it's, umm, it just brings it out'* (P15), and

> *You know like I was more worried just before I had her about leaving work and giving up work and money and you know and then all of a sudden this whole just click change and she's the most important thing now* (P6).

Many of these changes and emotions in the first few weeks were so powerful that some women felt they were no longer themselves: *'I think you're not yourself ... you're all up in the air, you're deciding what's right and what's wrong and what's normal and nothing's normal any more and all that sort of thing ... you just feel like a different person'* (P32),

and *'my life had suddenly been taken over by him'* (P34). Just how overwhelming and significant the impact of this period could be for the women was summed up in a comment made by one of the women when she said: *'I think you're not yourself'* (P32).

What is important about this and articulated in this category was that during this early post-birth period, breastfeeding was not the only thing going on. And yet all these experiences were in one way or another interconnected, one did not occur without the other. Two of the woman described the complexity of this with the following comments:

> *I think breastfeeding was really just one part of all the feelings that were floating around, you know, it was just having a new life and umm, having so many visitors and not having any sleep, you know, breastfeeding wasn't the biggest thing, really, that sort of had happened, I don't know, it was just part of it ...* (P2).

> *... so many things were going through my head that I don't know ... it wasn't just breastfeeding ... It was everything, so many things were going through my head that I was, I thought I was incapable of being a parent really, maybe I can't do it at all* (P16).

Listening to the women, it became obvious that separating infant feeding from any other experiences they were going through at this time was inappropriate. Firstly, this was because it meant taking the infant feeding experience totally out of context and creating an artificial environment in which to examine the infant feeding decision-making process. Secondly, it was also clear that while infant feeding and, in particular, breastfeeding was not the only thing going on for these women, a number of these experiences were intricately linked with the women's infant feeding choices. As one breastfeeding woman described: *'it's about the baby so it's all about breastfeeding really, it's all interconnected'* (P1).

Establishing the maternal relationship

One important facet of becoming a mother and meeting the baby's needs for the women during this period was establishing a relationship with their baby. When the women spoke about this relationship they used terms such as bonding, others talked about getting on with it but it was about establishing a relationship with their new baby. They said things like: *'I just felt that I had to umm, recreate, I suppose the outside umm, relationship with him'* (P2), and *'I just wanted to take my baby home with me and umm, start getting on with my life'* (P23). The women talked about what it was that made establishing a relationship with their baby important by making statements such as *'you're trying to get to know this new little human being, 'cause as much as they're your child then you've still got to get to know them and bond with them, I suppose'* (P12), and *'getting a close relationship with him even though he's only got primitive needs at the moment but to have him sort of recognise me, maybe by smell, maybe to look at sort of thing, and umm, for me to get to know him'* (P15).

When listening to how the women discussed and viewed their maternal role, it was clear that the choices women made around infant feeding were in fact inextricably linked to their perceptions of themselves as a mother but also to their sense of self as a woman. Consequently, there appeared to be a continuum of feelings that interrelated with choices around infant feeding and maternal identity. At one end of the continuum, there were women whose maternal identity was inextricably linked to breastfeeding and at the other end there were women whose sense of self was distorted by breastfeeding. The following describes these two dimensional ends and a middle point on a continuum that links infant feeding and maternal identity. These three identified positions on the continuum were: 'breastfeeding was meant to be', 'doing it for the baby', and 'breastfeeding wasn't me'.

Breastfeeding was meant to be

It was clear in this study that for some women, breastfeeding was inherent to the maternal role and to their identity as a mother. Different from the societal construct and expectation that a good mother breastfeeds identified in Chapter Four, for these women this belief came from within. They made statements such as *'that (breastfeeding) was part and parcel of being a mother'* (P13), and *'I was always going to breastfeed, it was just part of being a*

mother ... for me breastfeeding was such a big umm part of the whole mothering experience' (P25). Making the decision to breastfeed for these women was more than just simply deciding that breastfeeding was best and that is what they would do or even that it was more appropriate to breastfeed [as powerful as these may have been for them]. As the following quotes demonstrate, these women talked about another dimension to their decision to breastfeed that was quite distinct from the benefits. In fact, knowing the benefits of breastfeeding did not really influence their decision but rather confirmed their decision was right. These women made statements such as *'it just maybe reinforced that that was what I always thought I would do'* (P3), '*apart from all that it was really all about really wanting to breastfeed'* (P1), and *'I don't think that was really what influenced me'* (P20).

For these women, the decision process was affected by feelings and emotions that they found difficult to describe or even understand, saying: '*as I said it was just a feeling that I don't understand and I don't know where it came from'* (P20), and '*there's probably things wells from within me that I just want to do it naturally'* (P3). These powerful feelings impacted on their experiences and decisions in the postnatal period because '*you know (I thought) it was just a matter of just making that decision (to bottle-feed) and doing it. But I didn't expect the emotions to play into that decision as well. That was a curve ball'* (P20), or, as another woman described it: *'It was sort of like, you know, you just put them on the breast and you feed them and you know you're feeding them but no there's all this other stuff going on as well'* (P6). Breastfeeding for these women just: *'felt like the natural thing to be doing'* (P5), *'it felt natural like it was meant to be'* (P16), and 'I *absolutely love breastfeeding'* (P1).

Not only was breastfeeding viewed as integral to the maternal role, it was also viewed as essential to creating a bond with their baby. For these women, there was a sense that a relationship with their baby could only be fully developed if they breastfed. *'I don't think I would have bonded with her as well because that was a really important part for me of breastfeeding'* (P13), and '*I really felt that for me to have the best bonding experience with him ... I needed to breastfeed'* (P25). For these women, it was believed that breastfeeding not only enhanced the bonding experience, it also created a closeness and connection with

their child that was enjoyed by both mother and baby. They made statements such as *'the closeness like .... You know, when he feeds he is close, he's just really close to me and its just really enjoyable'* (P1), and *'it's so nice to be able to snuggle up close to her and you know the bonding that goes with it, I think'* (P20).

While the women talked about the physical closeness of breastfeeding: *'I just can remember when we were first in hospital and we were putting her on and everything and I can just remember looking at her and seeing her on the breast, it was just like the most amazing feeling, like I never thought I'd feel like that'* (P6), what was also seen in the comments made by the women was that this was more than just about a physical attachment. For some of the women, it was quite clear that there was also a closeness and connection to be gained because they were the ones providing the nourishment for their baby *'just watching him grow and just knowing that's just totally coming from me, it's hard to sort of express the feeling'* (P1), and *'I was the only one that could nourish him yeah, so I think that's special between him and I'* (P2). Just how important the relationship between providing nourishment and the sense of connection this gave the women to their baby was exemplified in a comment made by one of the women who was unable to attach her baby to the breast and so was expressing and giving her baby EBM via a bottle: *'even if I'm not like I don't have her on the breast all the time and I'm expressing, it's still coming out of me, I just think it's not something I'm just making up in a bottle'* (P6).

Given that these women felt breastfeeding was integral to their maternal identity and their connection with their baby, they talked about how important it was for them to achieve their goal of breastfeeding *'I really wanted it to work'* (P2), and *'on a subconscious level I was so determined to do it'* (P5). These women talked about being *'devastated if I couldn't have breastfed'* (P1), and *'I'd be really traumatised if I had to not do it'* (P5). And if they experienced difficulties, they responded by saying: *'I've got to make this work'* (P25) and *'I never doubted that I'd go through it'* (P1). When these women could not breastfeed due to insurmountable difficulties, they felt a deep sense of failure as a mother *'if I can't feed her so what does that make me as a mother?'* (P13), and *'I still felt that I'd failed as a mother, not being able to breastfeed'* (P22), and talked about letting their child down, saying: *'no*

matter what happens you still think that you are not providing for your baby' (P14). Not surprisingly, they also talked about their grief at not being able to breastfeed *'There is a lot of grief over it'* (P25), and *'I think you just cry yourself out'* (P14).

Breastfeeding wasn't me

Alternatively, and at the other end of the continuum, there were women who expressed feelings and emotions around breastfeeding that contrasted starkly with the above. These women talked about not liking breastfeeding *'I just didn't like it'* (P24), and *'It was something I really didn't feel comfortable with'* (P18). In Sheehan et al. (2003: pg 263), Alexia described the thought of breastfeeding in even more negative terms, saying: 'i*t sort of like repulses me, and the idea of having a baby sucking on them is oh ammm*' (see appendix VIII).

Breastfeeding was not something that gave these women any sense of maternal enjoyment or fulfilment. In contrast to the women who considered breastfeeding was meant to be, breastfeeding for these women was viewed as anything but enjoyable *'it just wasn't enjoyable, it was a real burden to me'* (P21), and *'I just dreaded feeding time'* (P23). Rather than feeling natural, for these women breastfeeding '*didn't feel normal* (P24). In fact, breastfeeding for these women distorted their sense of self. They made statements such as: *'I know some women feel so womanly but I feel less than a woman, less attractive'* (see appendix VIII. Melanie Pg 262), *'I didn't like feeling like a chocolate bar'* (P24), and *'I feel like a cow'* (P11). These feelings of distortion were further emphasised when these women talked about how they felt about their known self by saying: *'I'm not the type of person that likes being touched, like I mean that's me'* (P18), and *'I'm self-conscious about myself' (P17).* Similar findings were identified in Sheehan et al.'s (2003: pg 262) earlier work, where one of the women stated: *'My breasts have never been a very sensual part of my body. I don't even like them being touched with sex* (appendix VIII). Not surprisingly, these women did not feel breastfeeding created or enhanced a connectedness with their baby *'I didn't feel like connected to her'* (P24).

Breastfeeding for these women made them feel isolated *'I just I felt isolated like no-one else could help me with this baby, I had to do everything. That's how I felt'* (P18), and

> *I had the sole responsibility of feeding her, I couldn't handle that, like I was just like "god you know, she's living because I'm feeding her and what if I'm not giving her enough or it's not good or so that was playing on my mind* (P36).

These women also talked about feeling like they were out of control *'I think it is like I did feel out of control'* (P21). Formula-feeding gave these women a sense of containment over the situation *'being able to take the bottle out and not having to worry about finding somewhere to sit you can pretty much do it anywhere. You don't have to hide.'* (P17), and *'I felt like this was like I finally have control of this situation ... I'm happier within myself and also on my son. I'm not stressed out or depressed'* (P21).

For these women, giving their baby formula meant they could see and know what their baby was being fed *'just easier knowing how much he's getting. That I know he's got all the nourishment there, all the goodness there just in that kind of way easier'* (P18), and

> *I could see exactly how much she had drunk and know that that was enough and after that she went to sleep and she slept, she wasn't awake within the hour, half hour* (P24).

Consequently, these feelings about breastfeeding affected the women's infant feeding decisions. For some women these feelings meant *'I just didn't want to breastfeed'* (P21). What was also identified in the discussions was that those women who felt breastfeeding 'wasn't me' and continued to breastfeed (perhaps because they were coerced, as shown in Chapter Four), were also more likely to talk about feeling depressed, making statements such as *'doing something I really didn't want to do I think did put me down in the dumps, it really did'* (P18), and *'I think it did depress me a fair bit'* (P21).

These women did not feel breast was best for their baby because they feared the negative feelings they had around breastfeeding could affect their relationship with their child in a negative way, a feeling expressed by women in Sheehan et al.'s (2003) study of antenatal breastfeeding decisions (appendix VIII). As one woman in this earlier study described it: *'as far as I'm concerned to have a normal happy baby and if I'm sitting there hating the hour that I'm spending feeding my child then I don't think that that's particularly...' (21204).*

I do it for the baby

Between these two perspectives, there were other women who wished to and intended to breastfeed their baby because they believed it was best for their baby, saying: *'Yes, breastfeeding I do it for him, that's why I do it'* (P34), and *'I just, I don't know, it was just something I had to do'* (P7). For these women, breastfeeding did not create any great emotional rushes *'I thought when she'd connect to me that I'd have this big feeling going through my body. I don't have that'* (P7). Alternatively, neither did they experience any particularly negative emotions: *'I am not thinking, "oh my gosh, so now I have to feed again" or whatever. I am just giving it to her because she needs it"* (P35). Breastfeeding for these women, in and of itself did not appear to be integral to their maternal identity they simply did it because they considered it best for their baby *'I don't feed her I don't feed her for myself. I'm doing it totally for her benefit but it makes me feel good that I'm doing it for her, you know ... it makes you feel like you're wanted and you're depended upon and all that type of thing, yeah, definitely'* (P7).

These women talked about connecting to their baby in a way that was not so much about their feelings but achieving a role that was focused on meeting the needs of the baby, saying: *'I was excited that I was the person that could stop her crying, that umm, I was the person who could look after her and meet her needs'* (P9). These women breastfed primarily because it was considered best and they could,

> *I do it because I can, I do it because I know it's good for him, I do it because I then don't have to make a decision about what formula* (P34) and

for us it's not a bonding thing as people say, you don't bond with the baby, I don't think, so it that's not for that reason that I ... so it's only nutritional (P11).

Despite acknowledging that breast is best, if breastfeeding did not work out then they were equally satisfied with bottle-feeding, as long as the baby's needs were met. For these women, having a settled and contented baby was their measure of a good mother:

I think overall if she's happy then I'm being a good mother to her, if she's content and umm and obviously gaining weight and all that, and you know, getting bigger, ummm and she seems happy and then I'm probably being the best mother that I can be, so ... (P9),

and

just satisfying one of her needs and just by doing that you feel satisfied and she feels satisfied and because you can see she's calmed down and she's taking her feed you feel even better (P30).

These women did not necessarily feel that they would be devastated or even disappointed if they could not breastfeed, saying: *'I don't think I'd feel disappointed or anything like that if I had to feed her with the bottle'* (P7) *and*

I wasn't disappointed in myself because as soon as he had bottles he was a different baby. He was much more settled, he was much happier, I was much happier. I didn't have the stress of umm trying to get on to the breast and then have him not want it (P15).

They felt they just needed to get on with feeding their baby the best way possible saying *'you've got to let go because it can't happen'* (P19), and *'you have to make a decision that*

if you can't do it you can't do it. And it's not much point in beating yourself up about it' (P15).

Chapter discussion

This research confirms other research, which has identified that the first few weeks post-birth is a period of time that is associated with various emotions (Barclay et al., 1997; Rogan et al., 1997; Dykes et al., 1999). Importantly, this research demonstrated that breastfeeding was not the only thing going on during this period and in fact the women were negotiating a number of life-changing experiences, leaving them feeling they were not themselves. Despite being able to articulate different emotions and experiences, everything was interconnected. This adds to the work of others who have also found that many birth and post-partum experiences cannot be separated from breastfeeding, particularly infant feeding and mothering (Schmied et al., 1999; Hauck et al., 2002a). In particular, the women in this research talked about two major events that affected the infant feeding decision: these were giving birth and becoming a mother.

Getting over the birth

In this study, the women talked about the shock of birth and getting over the birth and the need to recuperate. For some women, getting over the birth was complicated by other experiences such as caesarean sections and anaemia. The women talked about feeling overwhelmed, tired and exhausted. These feelings are reported by researchers who have explored and examined different aspects of the post-birth period (Thompson et al., 2002; Hauck et al., 2002b; Dykes et al., 2003; Shakespeare et al., 2004; Gagnon et al., 2005; George, 2005). It has also been found that tiredness and exhaustion are exacerbated by caesarean sections (Thompson et al., 2002).

Tiredness in the postpartum period has been described as being both physical (Barclay et al., 1997; Hauck et al., 2002b; Shakespeare et al., 2004) and emotional (Barclay et al., 1997; Hauck et al., 2002b). A number of factors have been found to contribute to tiredness in the post-birth period. In this study, the women talked about how the rigours of birth left them feeling worn out and exhausted. Barclay et al. (1997) also identified that physical

tiredness was associated with recovery from the birth and lack of sleep and was compounded by emotional tiredness and upheaval. Other factors implicated in post-partum tiredness include pain and breastfeeding problems (Dykes et al., 2003). Other research has shown tiredness is related to the intensity and the constant learning associated with becoming a mother (Rogan et al., 1997; Lupton, 2000) (Rogan et al., 1997).

Researchers have found women describe the impact of tiredness as similar to not being able to cope (Dykes et al., 2003) and have identified fatigue as affecting cognitive and functional performance (Clements et al., 1997). This study's findings support and further elaborate on these findings by demonstrating that the women considered fatigue affected their cognitive ability as they learned to breastfeed. As the women in this study described it, they were 'not quite with it' and 'they weren't taking it in'. It could be argued that fatigue was also implicated in the women's spiralling stress when they felt they were not coping.

Exploring Maternal Identity

Another major experience described by the women and affecting their infant feeding decision was becoming a mother. Particularly the first-time mothers talked about the impact of becoming a mother, describing feelings of shock, unreality, amazement, intense love and responsibility at becoming a mother. These findings concur with other research, which has described motherhood as an all-consuming experience (Lupton, 2000), marked by a powerful love for their baby (Lupton, 2000; Nystrom et al., 2004), and charged with an overwhelming sense of responsibility (Rogan et al., 1997; Lupton, 2000; Cronin, 2003).

Contemporary notions of motherhood may help explain why this responsibility was considered overwhelming for many women. Lupton (2000: pg 54) found women placed an emphasis on the importance of developing a relationship with their child, believing that 'a good mother should be able to develop a strong bond with her children'. In addition to this, Lupton (2000) also highlighted how the women viewed a good mother as one who put the child's needs ahead of their own. This research also identified women were keen to develop a relationship with their new baby and viewed this as important. It can be argued that these feelings of responsibility and the emphasis placed on putting the child's needs before their

own needs reinforced the need to do the best for their baby. Given that breastfeeding was promoted as best this can be seen as creating further pressure for the women, particularly when faced with difficulties with their own health or with breastfeeding.

What was clear in this research was that infant feeding was, for some women, related to their maternal identity and sense of self. Other research has identified some of these findings also. Similarly, other research has identified that some women view breastfeeding as instinctive and essential to their maternal identity (Leff et al., 1994; Cooke, 1996; Schmied et al., 1999). The women in this study viewed breastfeeding as an emotional activity that is not simply about nutrition but also about bonding, nurturing and maternal infant attachment understandings also evident in other qualitative research (Leff et al., 1994; Cooke, 1996; Schmied et al., 2001b). Importantly, for these women, not being able to breastfeed created a sense of failure and feelings of grief. These findings complement the quantitative findings of a study by Cooke et al. (2006) who also identified that women with strong beliefs about the importance of breastfeeding for their maternal identity, and who stopped breastfeeding, were more likely to be categorised as distressed (Cooke et al., 2006). The strong sense of maternal identity these women associated with breastfeeding is consistent with other findings that have found some women will persist with breastfeeding regardless of difficulties (Bottorff, 1990; Schmied et al., 2001a; Hauck et al., 2002b), and that there is an association with increased breastfeeding duration where maternal identity and breastfeeding are linked (Leff et al., 1994; Riordan et al., 1994; Cooke et al., 2003a; Cooke et al., 2006).

In this study, the women whose maternal identity was connected to breastfeeding talked about how amazing breastfeeding was and how it created a connection with their baby. These findings support the work of Schmied et al. (1999) who found breastfeeding was an embodied experience that for some women provided a continued connection with their baby that was sensual, pleasurable and intimate. What this research has further identified is that this connection is not simply related to the physical relationship breastfeeding demands. Importantly, this study has shown that for women whose maternal identity was interconnected with breastfeeding, connection with their baby occurred not just through a

physical closeness, it also occurred because they knew they were providing the nourishment their baby needed. This was shown through women who were unable to breastfeed and were expressing and giving EBM via a bottle who also talked about this connection. This has also been observed in the work of Leff et al. (1994: pg 102) who also described how 'being able to produce the food to sustain the infant was deeply satisfying for women'. That many women describe breastfeeding as being the one thing only they can do may be as a response to this connection. These findings may also be important to supporting these women, because if they are unable to breastfeed but can express, this may help alleviate some of the grief and feelings of failure they communicate.

These women's feelings and experiences contrasted with other women for whom breastfeeding was not seen as an integral part of their maternal identity (Leff et al., 1994; Cooke, 1996; Schmied et al., 1999). Rather than breastfeeding being seen as instinctive or normal, these women viewed breastfeeding as distorting and destructive to their identity as a person. These findings are similar to those of Schmied et al. (1999: pg 329), who found that for some women in their study breastfeeding was considered 'demanding and disruptive of bodily routines, distorting of the known body and breasts and sometimes the demand for proximity to the infant was overwhelming and the women wanted separation'. For these women, breastfeeding did not create a connection with their baby. In Sheehan et al. (2003), it was identified that women who felt a strong sense of repulsion with breastfeeding were concerned that these negative feelings could affect their relationship with their baby in a harmful way (see appendix VIII). These understandings contrast starkly with the assumptions underlying the discourses around bonding that argues 'close contact experienced through breastfeeding will always be positive for both mother and baby' and 'that the bond that develops between mother and child is an intimate and special closeness that only a breastfeeding mother and her baby can know' (Wall, 2001: pg 602). All the women in this research considered building a relationship with their baby as important, regardless of their infant feeding choice.

In this study, and in contrast to the findings of Schmied et al. (1999), women who felt a strong sense of distortion chose not to breastfeed. What this research has also identified is

that women who continued to breastfeed despite feeling their sense of self was distorted experienced a lack of control and a sense of isolation. Further, these women expressed feelings of depression and being down in the dumps. Cooke et al. (2006) identified in their study, that women who had a low maternal identity related to breastfeeding measured using the Maternal Breastfeeding Evaluation Scale (Leff et al., 1994), who continued to breastfeed, were also more likely to be classified as distressed when compared to those whose beliefs about breastfeeding were compatible with their baby feeding decisions. Conversely, this research has found when these women bottle-fed they regained a level of control over their lives. Schmied et al.'s (1999) work also identified similarly that for these women. being able to bottle-feed gave them some control over their 'known breasted body and bodily comfort' with one woman, Jane, saying:

> *it was nice to have my body back, too ... just to go into the shower and come out and put a towel around myself without going ouch ouch ouch ... it was really painful ... and be able to let Jeff cuddle me ... without going 'Oh stay back there'* (Schmied et al., 1999: pg 331).

Between these two divergent standpoints were the women whose maternal identity appeared to be connected to the baby's contentedness. For these women, while they may have believed that breastfeeding was the best and planned to breastfeed their baby, if the baby was unsettled, appeared unhappy and discontented they rectified this to ensure they were fulfilling their role. For these women, breastfeeding was not essential to their maternal identity but the primacy of having a contented baby appeared to be. This appears to complement other research, which has identified that a woman's perception of herself as a mother is related to the baby's behaviour (Barclay et al., 1997). It may also explain why a baby's behaviour appears to be a mediating factor in the decision to breast or bottle-feed in the first six weeks post-birth (Barclay et al., 1997).

Similarly, although by no means the same, Cooke et al. (1996) identified in her study that there were some women whom she labelled as the pragmatist type. These women did not believe breastfeeding was an integral part of their maternal identity. As one of the women

in Cooke et al.'s (1996: pg 73) study summed it up *'I didn't need breastfeeding to fulfil an instinct ... '*. Unlike women in this research, however, whose decisions were based on the contentedness of the baby, these women's decisions were primarily based on convenience.

It can be argued that the findings of this research are important. Whereas previous research has demonstrated aspects or elements of these breastfeeding experiences this research has been able to bring together and present a broader and deeper account of the impact of maternal identity and sense of self as they relate to infant feeding. These findings, along with the findings of the other research discussed above, support a suggestion that there is a continuum of feelings around identity and breastfeeding. The stronger a women's sense of maternal identity is related to breastfeeding, the more likely she is to breastfeed. The further away from maternal identity and the more distorting of one's sense of self breastfeeding makes a woman feel, the more likely it will be that she will formula-feed.

Conclusion

The women described the first six weeks following birth as a period of time that involved a range of emotions that were both new and overwhelming. In particular, what made this period so new and overwhelming were two significant events. Firstly, they had just given birth and secondly, they had just become a mother. Both these experiences impacted on the women's infant feeding decisions. In the first instance, giving birth could leave the women exhausted and shocked and needing to recuperate. Consequently, this affected their ability to take in all they needed to as they learnt to breastfeed. Maternal identity was also shown to impact on women's infant feeding decisions. While a number of factors in this study have been identified elsewhere, what this work has demonstrated is the importance of these experiences to the infant feeding decision in the first six weeks post-birth. It also demonstrates that while these factors are important to the women they are largely ignored in terms of professional policies and practices.

Chapter Seven

Everybody's best is different

Introduction

In this chapter, I present the category 'everybody's best is different'. Rather than subcategories, this category has been divided into five sections and these are: 'it's so individual', 'questioning the assumptions around breastfeeding', 'getting on with it', 'defending the decision', and 'qualifying breastfeeding'. This category contrasts with the category 'it's really best to breastfeed' because it presents the reality for women as they engage in and understand infant feeding and what it means to them. The following describes some of the conclusions the women draw as they seek to make sense of what it means to do their best for their baby. The women acknowledge the individuality of the feeding experience, debunk a number of preconceived expectations and assumptions, explain their reality, and offer some suggestions for providing care to women as they learn to establish feeding during this early period.

It's so individual

What was clear in this research was that while the women did not dispute the benefits of breastfeeding per se, for many women, the reality of breastfeeding meant they could be faced with issues that could impact on their infant feeding decisions in the first six weeks post-birth. Despite having a whole set of assumptions and beliefs about breastfeeding at the outset, when these influences were taken into account many women found that feeding a baby was not what they had expected and was in fact different for everyone. The women made statements such as *'I think it's very individual'* (P10), *'I knew that it was so different for so many women'* (P1), and *'everyone is different'* (P18). Ultimately, this research has found that the reality of the breastfeeding experience is diverse for women. This reality often contrasts with the way in which breastfeeding is presented, as being relatively parallel for all women. At the most basic level, breastfeeding experiences were individual, because

for some women breastfeeding was pretty straightforward, while for others it was painful and difficult and/or even traumatic.

Breastfeeding was pretty straightforward

For those women whose breastfeeding was relatively straightforward, they seemingly had only few difficulties, if any at all. These women described their experiences in this way: *'he's been an amazing sucker from well from that first feed ... he went to the breast umm pretty easily'* (P3), and *'feeding was fine, actually, I don't remember it to be difficult or anything like that'* (P2), or, as this woman explained it, *'no problems doing it at all'* (P37). For these women, any difficulties encountered were resolved relatively easily or within their expectations: *'for some reason it just came to me and it stopped hurting'* (P7), and *'I felt a little bit of pain ... not necessarily painful, but it more wasn't until my milk actually came in and then he was hungry and sucking better that it felt right'* (P2).

Breastfeeding was painful and difficult

In contrast to this, other women talked about breastfeeding being difficult and painful. For some of these women, rather than the relatively easy and pleasant experience they may have been expecting, breastfeeding proved to be difficult and painful. In this regard, these women described difficulties with attachment and positioning, saying: *'We had problems from the start, you know, he wouldn't latch on properly'* (P26), and

> *I found that very difficult to try and sort of get comfortable, to get him latched on to get the breast into, my breast and the right part of it and the right amount of it into his mouth and then support my breasts without and like taking my hand away so it was always just shoved up in his face the whole time* (P8).

For other women, not being able to attach their baby unassisted proved to be difficult: *'as soon as the midwife would walk away she was detached and I found it hard to put her back on myself'* (P29).

In addition to difficulties with attachment and positioning, many of the women talked about how painful their experience of breastfeeding was, describing the pain with comments such as: *'it hurt the whole way through the feed'* (P13), and *'my nipples got very, very, very sore and it was she'd latch on and it would be like you'd been chewed with razor blades'* (P4). Some of the women described the pain as being so excruciating that it would reduce them to tears:

> *It was ... I was in tears for the first couple of weeks, umm, it was yeah, it was really sore every time he latched on, umm, and the pain wouldn't subside on the right side* (P5).

and

> *the pain was so excruciating that I'd just end up sobbing* (P25).

Some of the women even found their nipples continued to be painful long after their baby had finished breastfeeding, saying: *'like if I have her on, afterwards like an hour or two later, they'll just start flaring up and spasming'* (P6), and

> *once he feeds and he finishes and they're very erect they just ache and a real aching ... at night sometimes I need to have hot compress across my nipples so I can get back to sleep* (P1).

For some women, the difficulties and pain they experienced with breastfeeding could be so fraught that they viewed the experience as traumatic and dramatic, saying: *'Yeah, it wasn't a matter of just sort of lifting up my shirt, feeding the baby and that was it, it was always a big drama'* (P21), and *'it was so traumatic. I got home and had split nipples and they were just bleeding everywhere'* (P26).

Questioning the assumptions around breastfeeding

Based on the reality of the feeding experience, the women began to reflect and question their previous assumptions, as well as professional beliefs and attitudes around breastfeeding. For women who experienced difficulties with and/or were unable to breastfeed their baby, this was particularly important. As the following discussion will demonstrate, this meant some women argued that everything is not always fixable, breast is not always best; breastfeeding is not always natural and babies can actually survive and thrive on formula.

Everything isn't always fixable

Given that some women found breastfeeding very difficult and were ultimately unable to breastfeed, the women invariably questioned the idea that breastfeeding was doable and/or fixable. Despite the fact that the majority of women assumed or expected they would be able to breastfeed, some of the women decided that sometimes breastfeeding was not doable: *'I just felt that my breasts weren't doing it for him'* (P10), and *'it just wasn't working'* (P14). In addition, some of the women's experiences also convinced them that things were not, as they had been originally led to believe, always fixable: *'you know you try, as much as you manipulate things it just doesn't, it didn't happen'* (P11). As another woman described it: *'I suppose it doesn't matter how with babies, I've just realised that it doesn't matter how determined you are for things to go the way you want them to go, you know, but it doesn't happen like'* (P25).

The women supported their arguments that everything is not always fixable, by saying:

> *we're looking for a fixable thing that's not fixable. We've fixed the tongue-tie, we've fixed the lip-tie, we've seen the speech pathologist, we've seen the lactation consultant, there's nothing wrong with your nipples, umm, she's got a high palate and with all the trauma that she's been through and the high palate and her tongue was still so sore and her lip was still so sore from the operation, it just wasn't feasible. I just had to accept that* (P14).

I was like okay, well, someone's actually identified that it is a problem, that she does have a problem, and that it's not just something that is going to change overnight or that it's not just about how I'm attaching her or whatever, that it's actually about the mouth and what she's doing with her mouth while she's on there with her tongue (P25).

It's not always natural

As seen in earlier chapters, for many women in this study, there was a belief that breastfeeding was natural. What this research showed was that for some of the women, and particularly those who experienced breastfeeding difficulties, this concept was also ultimately questioned. In questioning the 'naturalness' of breastfeeding, women stated: *'I'm almost of the opinion that I, it's not necessarily as natural as it's made out to be, it's actually quite hard work or can be'* (P10), and *'I thought this is not right, like this should be something that just comes naturally and it wasn't coming naturally to me'* (P36).

In addition to questioning whether breastfeeding was natural, some of the women also challenged the concept that breastfeeding was better for bonding, saying: *'I don't think you have to breastfeed to bond with baby'* (P18), and

I really don't think the bonding is any different with the bottle, in some ways I think it can be a little more for one because when I'm feeding her she just sits there, she looks at me. When they're breastfeeding they're not looking at you, they've just got their head buried in your breast (P9).

Even for some of the women who had chosen to breastfeed, believing it to be important to the bonding experience, they appeared somewhat surprised to find that, in their opinion, there was no difference in bonding when they chose to bottle-feed,

I thought it would be different [with bottle-feeding] but it's not, it's just the same thing, you know, she's still looking up at you, you're looking at her. You're giving her a cuddle and it's the same feeling, like the feeling hasn't changed. I suppose it's

the same even whether I'm feeding her or not feeding her, you know, just sort of holding her in the position of feeding, it's just sort of that feeling's still there (P30).

Breast isn't always best

Finally, the concept of 'breast is best' was also questioned. Despite the fact that the majority of women in this research cited 'breast is best' as one of the major reasons given for wanting to breastfeed, when the baby was not settled or thriving: *'she wasn't getting enough from the breast'* (P9), *'he was getting really restless, he obviously wasn't getting enough milk, screaming all the time ... he was not settled'* (P15), and *'she was very fussy'* (P29), the women became concerned that breastfeeding may not be best for their baby. These women made statements such as: *'In one part of my mind I still wanted to do it and then in the other half I thought this is not the best thing'* (P15) and

> *I really wanted to breastfeed but it just didn't. I did for the first month and then that was it. And I thought well, it's (formula's) best for him and it's best for me* (P19).

In addition to reflecting on the responses of their own babies, some of the women also looked at other children who had not thrived on breastfeeding, citing this as evidence that not all babies do well on breastmilk,

> *One big thing was that I'd seen a couple of my nephews, two nephews actually, umm, not thrive when they'd been on the breastfeeding. Umm, and they were unsettled and they didn't put on weight and were fairly lifeless for a while and I didn't want that to happen to my son* (P15).

Babies can survive and thrive on formula

Not only did the women argue that breastfeeding was not always best, when women weaned they also looked for evidence that babies can survive and thrive on formula. They made statements such as *'I also was able to see that, umm, a little boy who had had formula, there was nothing wrong with him, his development was all exactly the same'* (P9), and *'I mean, we were both bottle-fed and we're all right'* (P29).

Some of the women particularly honed in on aspects of breastfeeding that had been presented to them as beneficial or fundamental to their babies' health, questioning these claims in relation to their children by saying:

> *in the NICU they reckon the more skin contact the baby has, the more the bigger they get and the quicker they get and the quicker they thrive and stuff ... I don't think it makes a difference. L still puts on weight. He's put on 400 grams in a week* (P17).

While it might be argued these women could have been defending their decision, there appeared to be much more than this going on. It was apparent that some of the women observed other children to reassure themselves their children were <u>not</u> being disadvantaged by their decision to formula-feed. This is not surprising, given women's concerns that formula was second best and/or even detrimental to the baby's health [see Chapter Four]. One significant example of this was one woman who was particularly concerned that her child would not be as intelligent, given that she had formula-fed him. During her interview, she made a number of references to her son's intelligence, and in the following quote demonstrates how she drew comparisons between her formula-fed child and her breastfed nephew, saying:

> *J is above average in intelligence ... he is never sick, you know ... not like, like (inaudible) just finished breast-feeding D, and he is about fourteen or fifteen months. He has always got a cold. Always got a respiratory infection. He is still not walking. He is still not walking and I think to myself, "How can you sit there telling me that you have to breastfeed, otherwise my child is going to end up as thick as a brick and behind everybody else". Her kids are alway sick, and I never have any problems with J* (P26).

For other women who were experiencing ongoing and seemingly insoluble difficulties with breastfeeding, they questioned not so much the concept of 'breast is best', but whether the

stated health benefits of breastfeeding were sufficient to outweigh the levels of tiredness and reduced enjoyment of their baby that continued breastfeeding had precipitated for them.

> *I'd love to know how much better it is than formula. I don't feel, you know, I wouldn't say I loved or I don't love breastfeeding, at the moment it's a hassle for me still. Just to see how if someone said to me it was 2% better than formula, I'd probably make an evaluation that it isn't worth the hassle that I'm having at the moment ... I don't know what percentage I'd think was better, would make me cut off though ... So it could be that someone said well, you're stupid, A, you've actually been more knackered and actually done more harm for your baby in those eight weeks than you've done good persevering with breastfeeding* (P10).

Finally, some women also argued that formulas cannot be all that bad in this day and age, saying: '*formulas now you know they've developed them. They're not like cows' milk or goats' milk'* (P15), and '*you can't tell me that in this day and age that if you can clone people and sheep that you can't get something that's pretty darn close to breastmilk*' Alexia (see Appendix VIII; pg 264). Further to this, some of the women who chose to formula-feed their baby argued in defence of formula-feeding, saying that given their diet was not particularly good, this must affect the quality of milk, arguing by inference that breast may not be best in their case, and in actual fact formula may be better *'I'm not the world's best eater, I'm not very good with vegetables and fruit and all that. So I suppose this way I know he's getting everything'* (P18).

Getting on with it

Given that breastfeeding did not always work out according to the women's plans and/or expectations, the majority of women in this study talked about getting to a point where they needed to make decisions for themselves and their own babies. The women argued they were the ones who needed to make the decision, because in the end it was they who were going to be looking after their babies: '*essentially you will be home and you have to care for the baby'* (P8), and '*it's your baby. You've got to take him home, you've got to look after him, it's your decision'* (P15). Many women argued they got to the point where they

needed to take control of the situation: *'everything was just getting on top of me and I thought I can't, something has to give somewhere'* (P11), and *'I needed to ... to get this problem sorted out'* (P9).

Ultimately, the women made decisions for themselves based on their experiences and what worked for them and this was regardless of what infant feeding method they had chosen. They stated: *'I'm learning that what people say is not necessarily going to work for me'* (P2), *'I just thought nah, I'm not going to listen to any of you because you're all wrong'* (P19), and finally *'do what you want to do. Don't listen to anyone else'* (P15).

You just do what works

Given that each woman's experience was so individual meant that in the end in terms of infant feeding, the women did what worked for them and their babies: *'I mean there is and there are a lot of things people do differently 'cause it works for them'* (P11). There was a sense that despite making plans, when it came to the reality of breastfeeding you just did what worked: *'I made the decision that I was going to do what I thought worked'* (P10). As one of the women described it: *'you just, like, you plan this, plan that and everything sort of gets thrown out the window, you just do what works'* (P30). For many of the women, there was an awareness that there was no one 'right' way: *'it's almost like in every situation with a baby there's about twenty things that someone suggests and one of them might work'* (P10), and *'I think we found out our own style and our own way of doing it'* (P34). For some women, doing what worked meant they made compromises in their original plans.

Compromising included giving their baby some breastmilk and formula: *'I'm expressing milk, that's getting fed to the baby and then I'm topping up with formula, so at the moment I feel like I'm doing double'* (P10), *'I went out and bought some formula and started her on supplementary bottles and expressed milk to give my nipples a chance to recover'* (P4), and *'I was actually breastfeeding and also giving him formula from that day on because he wasn't getting enough'* (P19). For others, compromising meant they expressed and fed their baby expressed breastmilk (EBM), saying: *'I'm sort of persisting with expressing and*

things like, you know, 'cause she's just thriving on it' (P6), and *'this time I'm expressing every six hours'* (P11).

Because of the complexities associated with compromising, including the amount of time involved, these women would generally set time limits, saying: *'I'm probably quite prepared to do that for three months, but after that I'll probably think ... '* (P10), and

> *so we just decided that if I could at least give her six weeks of breastmilk then I'd feel like I'd (inaudible) or that I had done whatever I could do to at least give her some sort of a start with breastmilk. And, umm, that's what I've been doing, just expressing every feed and bottle-feeding* (P25).

Finally, for other women, getting on with it meant they weaned" *'I couldn't manage it any more'* (P8), and

> *she needs to sleep and she's not going to sleep until she has something to eat ... I needed to get her something to eat before she spent the entire night screaming, so and I thought at this time of day the only thing I can do is go and get some formula* ... (P9).

These women talked about how despite making plans to and wanting to breastfeed and therefore by inference to do the 'best', they were simply unable to do so. *'You just hope that everything just goes for the best and it doesn't always work out that way'* (P14), and *'unfortunately it doesn't go your way and you've got to let go because it can't happen'* (P19).

Defending their decisions

Given the moral overtones around breastfeeding, many of the women who had had difficulties with breastfeeding and who weaned defended their decisions. To do this, the women used a variety of arguments. These included citing previous bad experiences, the effect of continuing to breastfeed on people, needing to be 'sane' and arguing that they had

done their best despite not breastfeeding. The following discussion focuses on these responses.

I didn't want that experience again

As described earlier, this group of women included a number of women who were having subsequent babies, and their previous experiences played a role in influencing their decisions. Some of the women, who had had previous bad breastfeeding experiences, made the decision not to even initiate breastfeeding, saying: *'I just didn't want that experience again'* (P23), and *'the fear of having such a bad experience again, umm, and being so tired again and that sort of thing, I just thought I'm not going there again, I've closed the door on that sort of thing'* (P21).

In contrast to this, however, there were some women who, despite having had a previously difficult experience were prepared to initiate breastfeeding, but, if they experienced difficulties and recognised a familiarity of circumstances, they chose to wean: *'I didn't want to torture myself again ... I'm not going to do it, I'm not going to torture myself again for another five or six weeks trying to do the right thing'* (P26). Having previous experience gave these women more confidence to make decisions based on their own experiences:

> *second time round when you're making the decision whether you want to breastfeed or bottle or what's best for you, I think you tend to be a lot more confident in saying "well that didn't work for me last time and it's not working this time and I'm not going to persevere with it and that's it, you know. I wasn't not breastfeeding because I just didn't want to, I was not breastfeeding because I didn't want to torture myself again* (P26),
>
> and
>
> *It wasn't going to work out so I just couldn't persevere this time* (P25).

Other people to consider

Women with previous difficult experiences were also aware of the potential impact on the family when they re-encountered breastfeeding problems and this impacted on their decisions. For these women, when breastfeeding proved to be stressful or not working, they realised their decision to continue breastfeeding would negatively impact not just on themselves but also on the family as a whole.

> *there are just too many other factors this time to consider. It's not just about her and what I'm able to do and not able to do for her, it's about, okay, what's going to work best for the whole family ... I feel like it's like I really just have to concentrate on, you know, the whole family's need and what's going to keep us all ticking along, so that, you know, we all just have a nice time rather than a stressful time* (P25).

First-time mothers who were experiencing substantial difficulties with breastfeeding, however, also reinforced this notion when they talked about future infant feeding decisions, saying: *'there is no way in hell I can do this when I have my second baby with a toddler running around'* (P10).

I needed to be sane

In terms of being stressed and not coping, the women talked about the importance of being mentally well to be able to care effectively for their baby, saying: *'you need to be sane to be able to look after the child'* (P11), and

> *I just thought the best mother I could be was if I was calm and relaxed and if the breastfeeding wasn't doing, if that, you know, if those two weren't sort of coinciding then I didn't feel I was being the best mother that I could be, I guess* (P9).

> *always at the back of my mind it is my depression in the past and I know what that was like. It was an awful struggle ... but I don't want to trigger something like that ... I am still a strong person, I am less able to cope with pressure and stress and I'm a little bit more anxious than I ever used to be. I wouldn't say I don't live on my*

nerves or anything like that but umm, I'm much more susceptible to those type of things where I never used to be in the past (P8).

Not only did the women reflect on their own experiences to justify that they needed to be able to cope, they also observed other women who experienced difficulties and were distressed:

my sister had had some difficulties with breastfeeding and she struggled with it for a long time and then still had to go to the bottle, and so I decided that I just wasn't going to spend six weeks of my life, you know, in agony or miserable or you know, awake all the time ... I didn't want to end up being upset and frantic like her (P9).

I did my best

Finally, given breastfeeding was promoted as 'best', many of the women wanted to challenge and defend their stance for weaning, by arguing that they had done their 'best' and yet had still been unable to breastfeed, making statements such as: *'I put a lot of effort into it and it still didn't work'* (P9), and *'I'd given it the best shot I possibly could'* (P14). To further emphasise this point and justify their position, some of the women felt it necessary to explicate just how much work had gone into trying their best, saying:

my nipples were cracked and she ended up under lights for about another ten days in hospital and they said it was breastmilk jaundice. And every time that they wanted me to put her back on the breast the levels would go back up (P23).

well I was having to comp feed as well so I had to express and bottle-feed and hook myself up to this central line thing and with him screaming 24/7 and my husband going back to work there is no way I could do all of it. I just physically couldn't do it (P14).

and

> *So after four and a half weeks, I gave it up. I gave it up. He was still crying, you know, hysterically and always angry* (P26).

Establishing that they had done their best was particularly important for women for whom breastfeeding and their maternal identity was inextricably linked. When these women were unable to breastfeed, they needed to reassure themselves and be secure in their belief that they had done their absolute best, saying: *'I physically could not do anymore than I'd already done'* (P14), and *'I feel like I, in a way like I don't know who I'm proving it to, but like I've proved that I've done my very best to be the best mother I could and you know the universe conspired against me for whatever reasons'* (P25). These feelings were made even more patent by another women who had not quite reached a place where she felt comfortable saying she had done her best. This woman was avoiding making the weaning decision, continuing to express and give EBM, saying: *'I myself have got to get to the point where I say I've tried everything you know and I've done everything I possibly can and I have to be happy with that'* (P6).

There were also some women who had originally made the decision to breastfeed based on the concept of 'breast is best', believing that to do the best for their baby meant breastfeeding. When these women felt their babies were not responding positively to breastfeeding, they reassessed their concept of best by focusing on what they perceived as best for their babies, saying:

> *I did think breastfeeding her was the best start for her, umm, in terms of her nutrition and ... but I felt as well that she wasn't, she didn't seem to be a very happy baby to me* (P9).

.

Ultimately, these women looked to their baby to guide their decisions as to what was best, saying: *'in the end I actually listened to my baby and that's what got me through it'* (P19), and *'It was him and the fact that he didn't take to breastfeeding'* (P15).

For these women, bottle-feeding appeared to be better for their babies because their baby appeared to respond to bottle-feeding in a far more positive way than breastfeeding: *'as soon as he had bottles he was a different baby. He was much more settled, he was much happier, I was much happier ... We haven't looked back'* (P15), and *'As soon as I put him on the bottle, he shut up like that. He was the most placid child'* (P26).

In the end, despite the rhetoric around 'breast is best', a number of women acknowledged that doing the 'best' for the baby or, by inference, breastfeeding, was not always even possible:

> *knowing now how hard it is, umm, that there's lots of things that would impact on whether the mother felt she could keep going even if she wanted to and knowing it's the best thing, umm, for some, I think it would be a hard decision (P1).*

As a consequence, the concept of doing the best for their baby could also be individual and, regardless of not breastfeeding, the women believed they were doing their 'best':

> *So many people make it out to be easy and wonderful and if you don't do it well you are not as close to your child and that. I wanted to say, "Hey, well that's not true. It's not easy and it's not wonderful, and yes you are as close to your child when you bottle-feed them"* (P26).

Finally, as a result of recognising the individuality of breastfeeding, a number of women argued that in reality and despite the rhetoric, *'everybody's best is different'* (P9).

Qualifying

Given that breastfeeding was so individual, that a number of expectations and beliefs were not seen to eventuate, and that everybody's best is different, the women also talked about a different approach to infant feeding that included acknowledgement, approval and honesty.

You want acknowledgement and approval

Because every woman's experience is unique and every woman's best is different, one important consequence for the women was that they wanted their own experience acknowledged and approved. This was regardless of whether they were breastfeeding or bottle-feeding. The women made statements such as '*you just want people, you just want people's support and you just want and you don't want people to say well, that's not the best option, you know*' (P23). The women who were compromising or bottle-feeding talked about needing reassurance: '*it's reassurance that it's okay to do that ... I suppose that I'm doing the right thing for him'* (P11), and approval: *'I wanted their approval'* (P23).

And it was not just women who had chosen to bottle-feed who talked about needing acknowledgment and/or approval. Particularly when breastfeeding was difficult and painful, it was important for the women that their experience was validated:

> *he [partner] did acknowledge what I was going through, said, you know, and I could hear him say and I think it was often what he said to friends, he'd say, look my goodness, it's just amazing what women go through, umm, and he would just really praise what I was going through* (P1).
>
> and
>
> *I was really happy with that information that I got because it was more in keeping with how I intuitively felt* (P13).

As evidenced in the above quotes, acknowledgment and approval were related to what appeared to be positive support. Acknowledgment or approval were either implicitly or explicitly present in most of the examples of what the women considered positive support: *'That's fine, you know, no worries, went and got me the bottle, nobody looked down at me, nobody had a problem with it so it was much better'* (P26).

Conversely, lack of acknowledgement was also implicit or explicit in descriptions of poor support. Women who were unhappy with the support they received often described support that lacked acknowledgement. In this first example of lack of acknowledgement, the professional caring for the woman did not acknowledge her question:

> *she didn't answer my question so I thought, well, maybe this instantly was wrong to even be expressing into a bottle and then, you know, it's again "what am I doing right, what am I doing wrong, you know, am I doing the wrong thing?"* (P32).

In the second example, lack of acknowledgement occurred because the health professional remained oblivious to the baby's distress and the mother's concern and instead continued persevering with trying to attach the baby to the breast:

> *the most stressful part was the nursing staff actually physically pushing him on and pushing against his head as he was pushing away and he was screeching. That was the pits* (P15).

Finally, one of the women talked about the shock of not receiving any positive acknowledgement by one professional she interacted with when she said *'there was no positive at all that came out of this woman's mouth, which absolutely appalled me'* (P1).

The effect of support that acknowledged and approved what the woman was going through appeared to increase the woman's confidence *'I just felt a lot more comfortable being able to do it at my own pace and being able to not have someone criticise me for not doing it right'* (P22), and *'it was her confidence that we'd be able to do it that I really needed at that time'* (P13).

Alternatively, lack of acknowledgement of what the woman was experiencing or feeling left the women feeling vulnerable and uncertain. Lack of acknowledgement was perceived as negative support and, as previously identified, this decreased the women's confidence (see Chapter Five):

It's the feeling of being hopeless and helpless, umm, and it shouldn't be like that. You should feel powerful enough to be able to say well, this is what I'm going to do. And you shouldn't be made to feel guilty for the decisions that you're making (P15).

There needs to be honesty

The women argued that the reality and a variety of breastfeeding experiences should be better explicated: *'I think there needs to be, even if it's not documented, that even through the hospitals and things like that, that it's not the easiest thing, breastfeeding'* (P6), and *'they also need to say occasionally, not all the time but very, very occasionally, there are some ladies and some women that just can't do it and that's never ever said ever'* (P14). Given the diversity of women's experiences, there was a belief that there was a need for honesty in discussing breastfeeding: *'I think there needs to be honesty about, well, this may be some women's reality'* (P1). The women talked about being honest about the reality of pain:

there's nothing ever that I've read anywhere to say that it's still going to hurt even a small amount, or even if it says that some women, they may still experience some sort of pain. Even if they just say slight pain, it at least gives you an indication that okay, that's very subjective so women can think okay, my slight pain might be a bit more or less but at least it's like well there could be some (P1).

Some women even talked about the benefits to them of having breastfeeding presented in a way that included an honest discussion of the realities of the experience, saying: *'I can see that if someone was struggling, a horror story can be so comforting to know that I'm not the only one suffering'* (P21).

You can't judge

Given that breastfeeding horror stories were generally not told and that everybody's experience was considered to be individual, some of the women talked about how it was impossible to understand what another woman was going through:

nobody knows what an individual personal experience is of anything. You know you can't get inside someone and know their feelings and their thoughts around a situation, and unless you can you've got no right to judge (P12),

and

I suppose no-one can really understand another person's pain, so it's hard to know how much pain someone's in (P25).

Consequently, a number of women became reflective in considering how women were often judged if they chose to bottle–feed, saying: *'I think any form of judgment on anybody in any kind of life or circumstance is unfair'* (P12). Even some of the women who had previously judged other women who chose to bottle-feed felt they now had a different perspective and were not so judgmental.

I used to be a bit judgmental before, thinking you know those that hadn't fed, you know, isn't that a bit of cop out (laughing) I've changed my mind slightly now (laughing) (P1),

and

I could never understand why people went to go for the bottle but now I do (P9).

Some of the women who were bottle-feeding also highlighted how they themselves had enough guilt without others adding to this, saying: *'I was torturing myself enough, I did not need that from anybody else'* (P8), and

it was like, oh my God, you feel like a failure anyway because you are not breastfeeding, and then to have the pressure from, not only the midwives from the clinic and that, but your friends ... (P26).

Chapter discussion

It's individual

In this research, many of the women recognised that infant feeding was very individual and that their own experiences were unique to them. Other research also reports women view breastfeeding as individual. Harris et al. (2003) identified that while women have a lot in common, all have individual experiences and no one course of action is suitable for all. That women can have individual experiences can be exemplified at the very base level, where some women will report a relatively straightforward experience, while others will describe experiences that are difficult and/or even traumatic.

The findings of this research show clearly that the individuality of the experience means that while women have a number of prior expectations about breastfeeding, these are often not supported by the reality of their experience. This resulted in the women debunking a number of canonised beliefs and assumptions around breastfeeding, as they were incongruent with their experience. They argued that breast is not always best, that difficulties are not always fixable and that breastfeeding is not necessarily natural and/or good for bonding.

Is breast best

An important finding in this study was that some women would have found it useful to undertake their own risk assessments around infant feeding. For these women, rather than debunking their original assumptions about breastfeeding, they wanted to know in a quantifiable manner just how much better breastfeeding was than formula. This information would have allowed these women to weigh up more accurately the benefits of breastfeeding against the levels of inconvenience, difficulties and exhaustion they were feeling. Because this information was unavailable to them, the women were unprepared to wean. This meant they continued to express and give their babies varying amounts of breastmilk despite significant difficulties because they feared by not providing breastmilk, they might expose their babies to risk. This is an example of what Lupton (1993) describes as the statistics of

danger being given to the public but not the safety margins. It also exemplifies the undue pressure women face to do what is perceived as the 'right' thing for their baby.

Law (2000: pg 415) claims that medical literature does not provide a good picture of how the risks stack up against other risks and practices associated with infant feeding, stating: 'For whatever reasons certain threats to infant health are weighted disproportionately compared to other priorities, values, sacrifices and trade offs'. This research confirms his claims.

Law's (2000) claims are also graphically illustrated in a recent *NSW Public Health Bulletin* (2005), which listed the health benefits of breastfeeding to infants as: a reduction in gastrointestinal illnesses, otitis media, respiratory tract infections, neonatal necrotising enterocolitis, asthma and allergies, some childhood leukaemias, urinary tract infections, inflammatory bowel disease, coeliac disease, obesity, insulin dependent diabetes mellitus, bacteraemia, meningitis, dental occlusion and ischaemic heart disease, as well as increasing the infants' cognitive ability. In addition to listing the benefits of breastfeeding for infants, it also listed advantages for mothers such as recovery from childbirth, reduced postpartum fertility, premenopausal breast cancer, postmenopausal breast cancer, rheumatoid arthritis, reduced maternal depression, increased maternal–infant bonding, a reduction in endometrial cancer and osteoporosis, as well as fostering weight loss and a return to pre-pregnancy weight. While this information appears to be readily accessible with many women in this research well aware of and citing many of these health benefits, what does not appear to be disseminated widely, is that from the above list only eight benefits are considered to have evidence that is convincing. In terms of infants' health, only four are considered to have enough evidence to substantiate their claims, and these are a reduction in gastrointestinal illness, otitis media, respiratory tract infections and neonatal necrotising enterocolitis. The other stated health benefits are only categorised as being 'probable', meaning that 'most studies have found an association but confirmation is required in more or better designed studies', and or that the findings are 'possible', with 'too few methodologically sound studies' (Allen et al., 2005: pg 42). One of the benefits cited as only possible was increased maternal–infant bonding. Notwithstanding this, the clear

message to women and society in health promotional literature is that breastfeeding will make healthier babies and that it has life-long health benefits (Wall, 2001).

While there has been work such as Law's (2000), which argues that the benefits of breastfeeding and the risk of formula-feeding are often over emphasised and exaggerated, there has been no research to assess the effect of this on the women themselves. This research perhaps lends itself to identifying the dilemma this creates for some women, who fear that weaning may damage their infant.

Despite exclusive breastfeeding being purported to be best as well as easy, doable and fixable, this research identified that many of the women acknowledged this was not the case for them and that they needed to make a decision based on their own experiences and reality. Hauck et al. (2000b) also found that when confronted with ongoing incompatible expectations with infant feeding, women reached a point where they could tolerate no more. It was at this point where women modified their expectations and recognised something had to be done (Hauck et al., 2002b). Harris et al (2003) also found women coped with their circumstances in different ways and ultimately had to find their own way.

The fact women talked about needing to make their own decisions is also in line with research on mothering. Barclay et al. (1997: pg 725) identified that becoming a mother involved working it out. As one of the women in their study said, *'I mean, you can listen to everyone else and just sort of take the bits and make your own mind up'*. This research, as well as the research of others, found women with experience worked it out and got on with it more rapidly (Barclay et al., 1997; Hauck et al., 2002b; Shakespeare et al., 2004). Given the different experiences and approaches women take, it was not surprising women in this study, as well as others, have felt breastfeeding is not always the best (Carter, 1995; Blum, 1999).

Women in this study felt it necessary to claim they had done their best despite not breastfeeding. This finding is supported by Murphy's (1999, 2000) research, which identified the strong moral overtones surrounding infant feeding choices and practices.

Murphy (1999) found when women changed to formula-feeding they constructed their discourse to situate themselves as moral beings and far from bad mothers. Hauck et al. (2002a) also found it was important for the women to be viewed by others as good mothers.

Murphy (2000) suggested that in order to establish or re-establish their sense of morality, women used a number of strategies to account for their infant feeding decisions. These strategies included blaming others such as professionals for not providing adequate care, and arguing the decision was beyond their control (Murphy, 2000). For example, the women talked about the birth, the impact of caesareans, being out of it and dazed and not being well, with complications such as infections (Murphy, 2000). Murphy (2000) felt these stories were generally incorporated into claims that the decision to formula-feed was involuntary with the women still claiming their commitment to breastfeeding and that they were disappointed not to have been able to breastfeed. Murphy (2000) argues the women claimed that their decision to formula-feed was a sacrifice made in the best interests of the baby.

Defending their decision

One of the reasons given by the women in this study for defending their decision to formula-feed was that they needed to be 'sane'. Another reason raised by women in this study for their infant feeding decision was that they had other important people to think of, including and in particular, other children who stood to be negatively affected by their infant feeding decision. These reasons are not surprising, seen in light of other work which has demonstrated how women believe an ideal mother is one 'who has patience, remains calm and is able to cope and deal attentively with the demands of infants and small children' (Lupton, 2000: pg 54).

I would suggest that, rather than being seen as excuses or justification for not breastfeeding these reasons need to be seen as part of the big picture that frames women's lives and accepted as valid and legitimate reasons for feeding their infant in the manner they chose. As such, these reasons should be respected. Accepting these reasons as valid and legitimate

responds to the women's requests identified in this research, that their experiences be acknowledged and approved.

Seeking acknowledgment and approval

An important finding of this research was that it was not just women who chose to bottle-feed who wanted acknowledgement and approval, women who were breastfeeding also talked about receiving acknowledgement and approval. Acknowledgement about the realities of breastfeeding appeared to be important to the women. Hauck et al. (2000b) also identified that women who were breastfeeding wanted acknowledgement of the difficulties and effort required.

In line with women wanting their experiences acknowledged and accepted, the women also talked about the importance of being honest about the realities of breastfeeding. Some women in this study, who were experiencing difficulties with breastfeeding, found it comforting to hear from other women who were also having difficulties. That they were also having difficulties was perceived as comforting. Hauck et al. (2000b) also found that women in their study felt it was comforting that they were not alone in their experience and that they were not the only person having problems. Women found it easier to persist when they knew others were in the same boat. Not being alone, according to Hauck et al., (2002b) contributed to increasing women's confidence. Given that breastfeeding is purported to be easy, doable and fixable, it could be hypothesised that women who have difficulties do not readily discuss their problems because this will be viewed as their fault. Thus, contributing to the silence about the realities of breastfeeding.

Women who wean also gain important emotional support from 'being able to talk about their weaning experiences within the parenting group and with friends who had a similar weaning experience' (Hailes et al., 2000: pg 7). Supporting the findings of this study that showed women want acknowledgement and approval, it is not surprising Hailes et al. (2000) also demonstrated women generally regarded the support provided by the Early Childhood Nurse in the community as more positive, because, regardless of whether they chose to breastfeed or wean, they felt their decision was respected (Hailes et al., 2000).

Conclusion

This chapter has discussed some of the experiences in the first six weeks that influence the women's infant feeding decisions. It illustrates the individuality of the experience and how the women apply this knowledge to their decisions. To this end, the women reach a point where they identify that they have to make a decision and ultimately do what works for them. Not surprisingly, given that breastfeeding has been pushed as best for their baby, and that a good mother will breastfeed, women will defend their decisions. The findings in this category also demonstrated how, despite being led to believe otherwise, breastfeeding is not always easy, doable and or fixable and neither is it always harmonious. Women contend that given the individuality of infant feeding experiences, there should be honesty around the reality of breastfeeding for all women. Honesty around breastfeeding experiences, rather than having a negative impact on the women's infant feeding decisions was seen as helpful. Finally, the women argue that because breastfeeding is so individual their experiences should be acknowledged and approved and women who do not choose to breastfeed should not be judged because ultimately everybody's best is different.

Chapter Eight

'Deconstructing best': the basic social process

Introduction

The previous four chapters have presented four substantive categories that describe factors influencing the women's infant feeding decisions in the first six weeks post-birth. These categories form the context within which women make their decisions. This chapter describes the basic social process 'deconstructing best'. 'Deconstructing best' is the process of decision-making in which the women engaged during these first few weeks post-birth. 'Best' has been a dominant theme in this study. The women talked about doing their best, breast being best, defending their decisions against the concept of breast is best, arguing they had done their best and that everybody's best is different. Further to this, there were both subtle and overt assumptions that a good mother would want to give her baby 'the best', which translated into 'a good mother breastfeeds'. 'Best' was at the forefront of the women's decision-making whichever way they chose to feed their babies. As the women progressed through the decision-making process they 'deconstructed best'. During the process, the concept of best shifted from being a largely objective construct to a much more subjective construct that was shaped and moulded by the women's own individual experiences. What this process also demonstrates is that while the women's concept of 'best' evolved to encompass a much broader context, professional understandings of 'best' largely remained embedded in breastfeeding itself.

This chapter is divided into three sections. The first section presents a summary of each of the phases of 'deconstructing best'. The second section tells the story of 'deconstructing best' from the perspective of the women by blending the women's stories into a composite narrative. The final section presents a diagrammatic model of the process of 'deconstructing best' as it sits within the context of the four substantive codes.

Summarising the phases of deconstructing best

There are seven phases in the process of 'deconstructing best'. These phases are planning, expecting, realising, questioning, getting on with it, defending and qualifying. Some of these categories were explicit in the data while others were implicit. The following briefly describes each of the phases.

Planning: In this study, the concept of planning was explicit. The women talked about planning to either breastfeed or bottle-feed. Planning occurred prior to birth. Although the focus of this study was to explore the infant feeding decisions of women in the first six weeks post-birth, the antenatal period could not, and should not be ignored. Earlier research identifies that, prior to birth, women put a lot of consideration into their infant feeding decisions and generally a decision will have been made prior to birth about how they will feed their baby (see Appendix VIII). Given that babies will generally feed soon after birth, these initial plans, although made prior to birth, intersected with the decisions women made during the post-birth period. Planning begins in the category 'it's really best to breastfeed'. It begins here because whether the women choose to breastfeed or bottle-feed, their plans will be rationalised against the concept that breast is best.

Expecting: Expecting was also explicitly expressed in the data. There were expectations that came with the women's infant feeding plans. Expecting straddled the categories 'it's really best to breastfeed', and 'it's unknown' This is because many of the women's expectations arose out of the factors found in the category 'it's really best to breastfeed' but then clashed with the realities of 'it's the unknown'. That the circles intersect in the middle indicates that factors derived from the other categories intersect at some level and can therefore also impact on expecting.

***Realising*:** Realising was mostly implicit in the data. There were a range of aspects to realising, and it was only in the post-birth period, when the women embarked on their feeding journey, that the reality of the experience could be known. All the women talked about breastfeeding being unknown and unexpected. For some women, rather than the easy and /or doable experience they were expecting, breastfeeding turned out to be difficult, and

sometimes, even despite their best efforts, impossible to achieve. For some women breastfeeding turned out to be easier than they imagined. For women who chose to bottle-feed, sometimes they were surprised because they were not judged as they had expected. More than this, realising took into account that breastfeeding was not the only thing going on. Giving birth, getting over the birth, becoming a mother, the woman's sense of self, the behaviour of the baby, her maternal identity, and the type of support she received were also inextricably linked to the women's infant feeding experiences and decisions. Realising was a process marked by uncertainty, vulnerability, and a lack of confidence. Realising straddled the categories 'it's the unknown', and 'it's not the only thing going on'.

Questioning: Questioning was explicit in the data and was precipitated as the reality of breastfeeding and what it encompassed emerged. The women questioned themselves and whether breastfeeding was possible for them, and they also questioned many of the assumptions about breastfeeding such as whether it is always natural, doable, fixable or even best. Questioning occurred in the categories 'it's the unknown', and 'it's not the only thing going on'.

Getting on with it: While questioning a number of assumptions about breastfeeding, the women realised they had to get on with feeding because one way or another their babies had to be fed. They were responsible for their babies and a decision had to be made. There were various ways the women chose to feed their babies in these early weeks. This could mean women compromised with their original plans and/or set limits to their original plans. Sometimes, getting on with it meant completely changing their plans. Getting on with it occurred in the category 'it's not the only thing going on'.

Defending: The women defended their infant feeding decisions based on their own individual experiences. Defending occurred in the category 'everybody's best is different'. They defended their decision against the concept that 'breast is best', and it's associated claim that a 'good' mother breastfeeds.

Qualifying: Qualifying was an interesting and explicit component of the process. At this point, the women had realised the diversity of experience but felt constrained within the concept of 'it's really best to breastfeed'. Qualifying included being able to express what they wanted and needed, such as acknowledgement and approval, and what they did not want, to be 'judged'. It also articulated how, despite the professional adherence to the concept 'breast is best', the reality of the experience was far from singular. When multifarious factors associated with infant feeding were taken into account, the reality for all women was that 'everybody's best is different'. This phase overlapped with 'it's really best to breastfeed', because for some women and, in particular, mothers having their second or subsequent babies, their planning was also influenced from this perspective.

The storyline

The purpose of the storyline is to explicate the central category (Strauss et al., 1998). In a constructionist style grounded theory, the storyline uses narrative to make theory readable by bringing experience to life (Charmaz, 2000). In this case, the storyline demonstrates the intensity and complexity of the first six weeks post-birth, as the women make decisions about infant feeding choice. The following narrative, 'deconstructing best', is a composite story. It draws together data from the individual women's stories to explicate the context and the process of 'deconstructing best'.

The story ...

You're **planning** how you're going to feed your baby before it's born. You either plan to breastfeed or bottle-feed. Of course, whether you choose to breastfeed or bottle-feed, everyone knows that *breast is best.* There's no avoiding it: *it's marketed and promoted* everywhere; everyone tells you *breast is best.* This information is powerful because *you want to do your best,* you know, and give your baby *the best possible start,* and because everybody knows breast is best means that *it's really more acceptable to breastfeed* too. So it's pretty much assumed by everyone around you that you'll breastfeed. Sometimes you just *assume* yourself that you'll breastfeed, you don't question it. Well, why wouldn't you give the best if you could? Funny though, sometimes you're planning to breastfeed not simply because of the benefits, but because there is something that really wells within you

that makes you just want to. Of course, if you're planning to bottle-feed, you'll need a good reason because *you'll be judged*, and you'll need to *justify your decision* to formula-feed. Some women use a previous bad breastfeeding experience to *justify their decision,* saying *I just didn't want that experience again*. Other women will plan to breastfeed despite preferring to bottle-feed to avoid being *judged* particularly by the health professionals in hospital. Some women really worry about what the health professionals are going to say when they tell them they are **planning** to bottle-feed. You know some women will protect themselves from being judged by *hiding* their decisions; they just won't tell anyone they are going to formula-feed.

With all the information out there about breastfeeding, you have a lot of expectations about what it will be like. Apart from **expecting** breastfeeding is *best for the baby,* you're **expecting** it's going to be *natural*, *good for bonding*, *easy, and doable*. *They make it look easy* in the pictures and on the video. Some women are **expecting** that breastfeeding might be difficult, but generally it's accepted that if you really want to breastfeed you will be able to do it. You know there is *a right way of doing it* so you plan to do that, and even if you don't quite get it right, *everything is fixable,* so you just need to seek the right advice. Even when you've had a previous baby and had problems with breastfeeding, you sort of expect that it will be different this time. Sometimes this means getting help and advice before birth, so you can avoid the difficulties you had last time.

So when you start to breastfeed it's about **realising** what it's like. The reality is breastfeeding is *unknown*, *unpredictable* and *unexpected,* and they really don't tell you *it's like some secret society*. Breastfeeding is all so new and unknown. You don't know what to do and you feel uncertain and unsure about your ability to breastfeed. And you really have no idea what to expect, so it ends up being totally unexpected. Some women will say oh, it's easier than I expected, but for the majority of us it's so much harder. I mean, I didn't have a vision in my head that everything was going to be light and fluffy, I expected some problems but not the degree of problems I've had. Particularly the pain: *it was excruciating*. When you're **expecting** breastfeeding to be *easy, doable* and *natural* and it doesn't work that way, you start **questioning** yourself, you wonder *what's wrong with me* if everyone is

telling me *it's natural* and everyone can breastfeed and other women can breastfeed, then why can't I? It's not good for your confidence. Then, if the baby isn't settled or doesn't seem happy you start to doubt yourself even more, and that knocks your confidence around even further. You can feel fragile and vulnerable. You're really *needing support.* Even if you have had experience with it before, you're trying to do it better this time. The antenatal classes are good but it's different when you've actually got to do it. You expect the midwives will help you in hospital. Sometimes you get the support you need, sometimes you don't. Professional support makes a difference to your confidence. Good support increases your confidence. I know people who *didn't get the support they needed* and you can see they just lost confidence in themselves. Good support is very powerful; it can buffer some of the harder aspects of breastfeeding.

When you're going through all this y*ou can get really emotional* and *start to feel really stressed,* and then *it's like a domino effect.* If the baby's not happy, I'm not happy; if I'm not happy then my husband's not happy. You can feel like you are not coping. But realising is more than this because *breastfeeding isn't the only thing going on,* it's just one part of all the emotions that are floating around. You are trying to grapple with the fact that y*ou're not yourself* any more, your life has changed. It is all so overwhelming. I mean, *you have just given birth.* You feel like you've been run over by a truck. *You're dazed and tired* and even when they are telling you things, *you're not taking it all in* and that's without having anything extra happening to you or the baby. Having a caesarean section, being anaemic or having your baby in the Special Care Nursery because they're sick can make it even more overwhelming.

And then *suddenly you're a mum* and that's the most amazing thing. Everything else can seem so superfluous, *the baby is your priority.* You can't explain it. You fall in love like you've never done before and you just want to protect your baby and *do the best for them.* You *feel so responsible*; *they are totally dependent on you.* It really is overwhelming. It can be even more overwhelming when breastfeeding is difficult and things aren't working out. If you can't breastfeed you start to worry, because you know that breast is best and formula is second-best and then you can start to fear that if you have to give your baby formula it's

going to do *life-long damage*. On top of all that, you fear that people will *judge you* for giving up breastfeeding, thinking you've copped out, that *you're not being a good mother*. And its not helped when the professionals make you feel you should continue *breastfeeding at all costs*. You can tell they don't want you to bottle-feed. They never even mention bottles, you have to kind of ask, and sometimes even when you do ask about bottles they keep saying oh no you can do it. Your emotions can really start to spiral and then you start to feel out of control and not coping.

But to be fair, it's not always the professionals who put the pressure on you to breastfeed. Sometimes that pressure comes from within. You see, there are all these feelings and emotions interconnected with breastfeeding and being a mother. Sometimes breastfeeding is completely integral to how you view yourself as a mother, and you can't explain it. It's just something that wells within you, it feels like the natural thing to do and it's so important for bonding with your baby. Being the only one who can nourish her or him, I think that's special. When they feed they feel so close to you. It's the best bonding experience. I know I'd be devastated if I couldn't breastfeed. I'd feel like a failure because breastfeeding *it's meant to be*. It really makes you so determined to breastfeed, and if you can't, there is a lot of grief.

I know it's not like that for everyone. Some women don't like breastfeeding; they don't feel comfortable with it. Some women will even feel repulsed by the whole idea. Their whole sense of self feels distorted when they breastfeed. Breastfeeding doesn't feel normal to them, it can make them feel like a cow and it certainly doesn't create or enhance a bond with their baby. I can't understand it, but they dread feeding time. Breastfeeding makes them feel isolated and out of control and they feel stressed and depressed when they continue to breastfeed. They say *breastfeeding isn't me*. Bottle-feeding makes them feel much happier in themselves and more in control; they know how much the baby is getting. And they don't have to be concerned that their feelings about breastfeeding are going to have a negative impact on their relationship with their babies.

Of course, there are also mothers somewhere in between these two experiences. For these women, their maternal identity is related to the contentedness of their baby. They plan to breastfeed because it's considered the best, but breastfeeding for these women isn't connected to any embodied feelings as such, so if they can breastfeed they do and if they can't, then they wean. For them, feeding is about doing it totally for the baby and if the baby is unsettled or appears unhappy, they will wean. They feel equally satisfied with bottle-feeding as long as the baby's needs are being met.

There is a lot to **realising** what breastfeeding is like. **Realising** what it's like to breastfeed means that not only do you feel uncertain, you sometimes start to question your ability to breastfeed. You can also start **questioning** some of your original beliefs and assumptions as well as those of professionals. For example, when breastfeeding is difficult you start **questioning** whether it's always natural. And when your baby is so unsettled and unhappy breastfeeding, you start to question whether it's always good for bonding and whether it's actually even best.

Sometimes you start **questioning** how much better breastmilk is than formula. When you're stressing out over having to make decisions about whether to wean or not, you would really like to know this. So you start to observe other children and babies and draw on these observations to reassure yourself that babies can survive and thrive on formula. You look at your baby to confirm that, despite not breastfeeding the baby is settled and seems happy. You must be doing something right. You start questioning whether you really need to breastfeed to bond with your baby. You can start thinking, well, *breast isn't always best* and **realising** can mean that breastfeeding is *not always doable* and *everything isn't always fixable*. And sometimes in the end, despite doing your best you just can't breastfeed.

Through all this you begin to realise that infant feeding is an individual experience. *Everyone is different.* Even at the most basic level it's different, because some people find it fairly straightforward whereas others will find it painful and difficult. You get lots of different advice about how and why to breastfeed, but in the end you begin to understand that you have to do what works for you. You need to be **getting on with it**. You realise that

how you feed your baby is your decision, your responsibility. You're the one who will be taking this baby home; you are the one who will have to feed it. If you're having a really difficult experience, **getting on with it** might mean you *compromise* your original beliefs. Still being convinced that breast is best, you might start expressing breast milk and giving the baby EBM or giving both EBM and formula. Because all of this can be so demanding of you, you might start *setting time limits*. You know you can't go on forever like this, so you think, I can do this for six weeks or maybe even three months. Sometimes **getting on with it** means you have to wean.

Whatever way you go, you're left **defending** your decision. Sometimes this doesn't change much from your original **planning**. You'll continue to feel that it's the best for the baby and that you wouldn't want your baby to be bought up on something artificial. Sometimes you'll be **defending** your decision by saying how much you enjoy the bonding and being able to cuddle your baby. Some women will simply defend their decision by saying I do it because I can, I do it because I know it's good for him, I do it because then I don't have to make a decision about what formula. Particularly when breastfeeding has been difficult though, and you've weaned, you'll really need to defend your decision. You want people to know you did your best. You might say *I did my best,* I gave it my best shot and physically I couldn't do anymore. Sometimes **defending** your decision will mean arguing that you acted in the best interest of your baby, sometimes even highlighting that it was the baby's behaviour that guided your decision. At other times you'll be defending your decision by arguing that to be a good mother you needed to be sane. Sometimes, knowing the effect continuing to breastfeed will have on yourself and your family, you'll end up **defending** your decision by saying *I didn't want that experience again.*

After a while you start to look seriously at the whole experience. You realise some understandings about the infant feeding experience need **qualifying.** In the first instance, because everybody's infant feeding experience is different, rather than saying breast is best you want it understood that *everybody's best is different.* In addition to this, because each experience is so individual and at present there appears to be *some secret society* about the realities of breastfeeding, you want any discussion about breastfeeding to be *honest and*

realistic about the realities involved for women. And because breastfeeding can be so individual and *everybody's best is different*, regardless of how you are feeding your baby you want your individual experiences and decisions *acknowledged and approved.* You definitely don't want people judging you, because no one can really understand what another person's experience is like. And that includes professionals. You want to be cared for in a way that is based on your individual needs. You want it known that good support isn't just about telling you, it's about *boosting you up*, it's about *acknowledging* what you're going through. You want it known that good professional support increases your confidence not only to breastfeed, but also to mother.

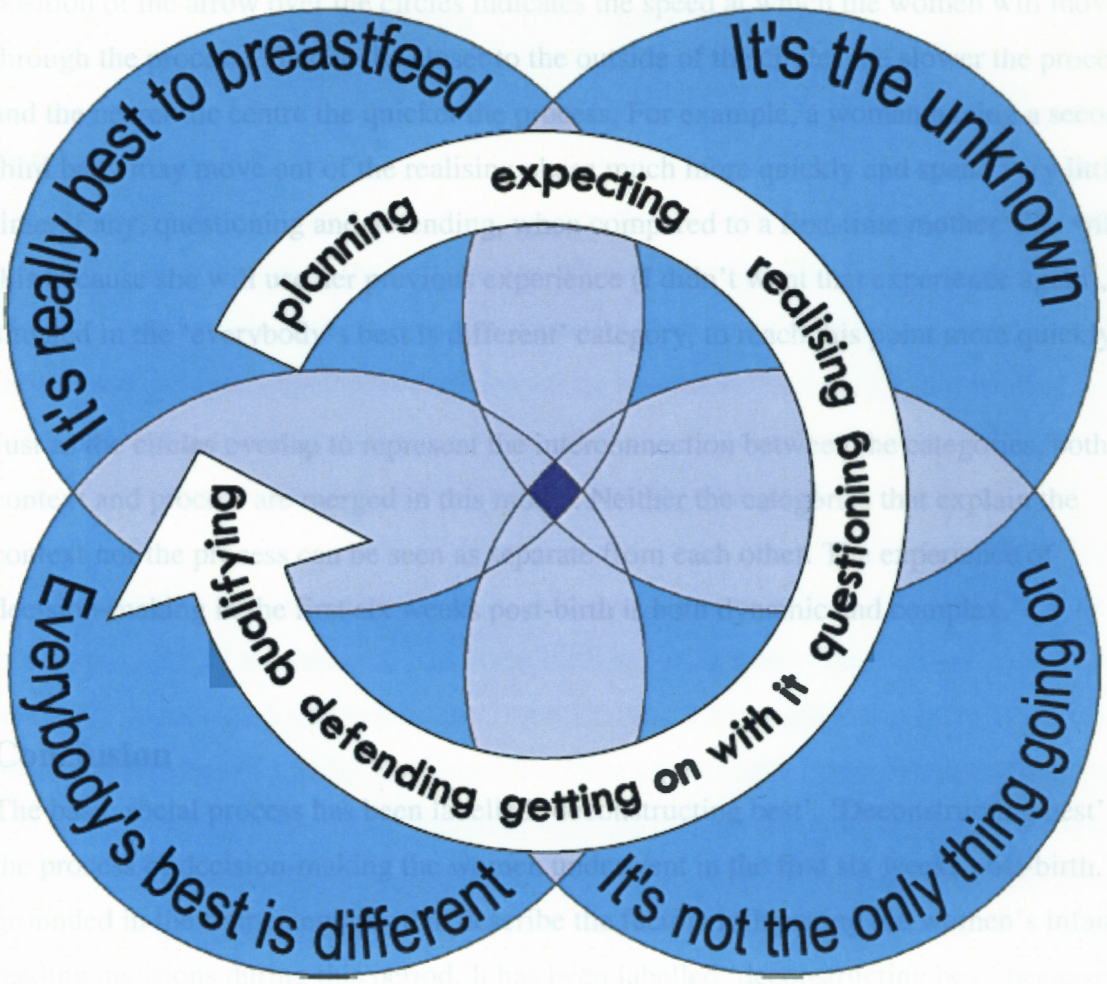

Figure 8:1: Model of the theory: Complex decisions: deconstructing best

The above model represents the basic social process 'deconstructing best' and its relationship to the substantive codes. The arrow represents the process and the circles represent the substantive codes. The process of deconstructing best starts in the category 'it's really best to breastfeed' and ends in the category 'everybody's best is different'. Each phase of the process is strategically placed inside each of the circles. The positioning indicates where most of the actions and interactions relating to this phase will occur, however, the circles overlap. The overlapping of the circles represents the interconnectedness between the categories and consequently, allows for factors from any of

the categories to impact on the process at any given time. Thus, the process is not linear. This model also allows for variances in time taken to proceed through the process. The position of the arrow over the circles indicates the speed at which the women will move through the process. That is, the closer to the outside of the circles the slower the process, and the nearer the centre the quicker the process. For example, a woman having a second or third baby may move out of the realising phase much more quickly and spend very little time, if any, questioning and defending, when compared to a first-time mother. She will do this because she will use her previous experience (I didn't want that experience again), situated in the 'everybody's best is different' category, to reach this point more quickly.

Just as the circles overlap to represent the interconnection between the categories, both context and process are merged in this model. Neither the categories that explain the context nor the process can be seen as separate from each other. The experience of decision-making in the first six weeks post-birth is both dynamic and complex.

Conclusion

The basic social process has been labelled 'deconstructing best'. 'Deconstructing best' is the process of decision-making the women underwent in the first six weeks post-birth. It is grounded in the four categories that describe the factors influencing the women's infant feeding decisions during this period. It has been labelled 'deconstructing best' because the concept of 'best', while initially embedded in the concept of breastfeeding, moves for the women often to a much broader focus as they experience the reality of breastfeeding.

Chapter Nine

Making Complex Decisions

Introduction

The purpose of this research was to explore and describe the experiences of women making infant feeding decisions in the first six weeks post-birth. Specifically, it aimed to determine women's perceptions of the factors that influence their infant feeding decisions; describe the diverse personal trajectories experienced by women in relation to infant feeding experiences and practices; contribute towards theory development in order to inform clinical practice and improve professional support for breastfeeding.

Two approaches were taken in this study. Firstly, data were collected through in-depth interviews with 37 women who had given birth to first or subsequent babies in the previous one to seven weeks. A constructionist grounded theory approach was used to collect and analyse these data. Secondly, published literature on women's infant feeding experiences and decision-making, as well as literature focusing on aspects of the postnatal period and mothering, was used to inform, strengthen and help explain the findings emerging from the empirical data. Combining this data created a rich picture of the experiences of women's infant feeding decision-making in the first six weeks post-birth.

In this chapter, I begin with a summary and discussion of the main findings of this thesis. I consider ways in which this thesis adds to professional understandings about women's infant feeding experiences and decisions and put forward the limitations and implications of these findings in relation to clinical practice.

Summary of the findings

The results of the constructionist grounded theory identified a number of factors that influenced the women's infant feeding decisions in the first six weeks post-birth. These factors were categorised into four main categories: 'it's really best to breastfeed', 'it's the

unknown', 'it's not the only thing going on', and 'everybody's best is different'. Within and between each of these categories interconnections, interactions and consequences were demonstrated. These categories were connected through the BSP 'deconstructing best', which was also the core category within the analysis. There were seven phases in the BSP and these included planning, expecting, realising, questioning, getting on with it, defending and qualifying. The BSP connected the four substantive codes through the process of decision-making in which the women engaged during the first six weeks post-birth. The intensity and complexity of this process were illustrated in the storyline presented in Chapter Eight.

A synthesis of the literature drawn from a range of contexts and countries complements and gives weight and density to the findings of the empirical study. What makes this research unique is that many factors, which have been largely disparate and diffuse throughout the literature on breastfeeding, postnatal experiences and/or the support needs of women, became integrated in a focus on the first six weeks after birth. Drawing the literature together in this way complemented and strengthened the empirical findings. Demonstrating the complexity and multiplicity of factors affecting the infant feeding decision in the first six weeks post-birth gives potency to the need for understanding the meaning and experiences of breastfeeding from the perspective of women.

Its really best to breastfeed

The category 'it's really best to breastfeed' has demonstrated that women believed breastfeeding was the best form of infant feeding, both from a scientific perspective by providing health benefits to the baby, but also from the natural perspective in that it provided emotional attachment through bonding. According to the women in this study and supported by published literature, knowledge about the benefits of breastfeeding was widely disseminated through the marketing and promotion of breastfeeding. The results of this study have shown how this information was well known across the social milieu. This meant the benefits of breastfeeding were well known by the women themselves as well as society in general. The women responded to this knowledge by believing that breastmilk gave their baby the best start, that infant formula was second-best and or even detrimental

to the baby's health. Health professionals responded by further promoting breastfeeding, which was translated by some women as applying pressure. Finally, the effect of this understanding of breast as best created a powerful societal expectation that women would breastfeed and an underlying belief that a good mother breastfeeds. Consequently, it was really more acceptable to breastfeed. The impact of this information was that the majority of women planned to breastfeed, some because they wanted to give their baby the best start, for others because they felt coerced to breastfeed. For women who planned to formula–feed, the impact of this knowledge meant they needed to protect themselves from sanctions and judgement by applying protective strategies such as justifying, shielding and hiding their decisions. For others, expecting they would be judged, they toughed it out.

In the postnatal period, the women felt there was continued pressure to breastfeed by the health professionals. Pressure at this time meant the health professionals did not mention bottles and even withheld information about formula-feeding when requested. As a result, the women believed that no matter how difficult their experiences, there was an expectation they should breastfeed and at all costs. Some women responded to this expectation by feeling they had become invisible as a person and that they were not respected as individuals. Some women continued to breastfeed or give breastmilk despite experiencing problems, because they feared that by giving their baby formula they would be doing life-long damage to their baby. This pressure to breastfeed exerted externally by the health professionals and society in general and internally by the women themselves created added stress for the women when they were having difficulties and needed to consider weaning. Finally, the women feared disapproval and subsequent judgement if they were seen to feed their baby from a bottle, even if the bottle contained breastmilk. This meant that if a woman were giving EBM via a bottle, she would clarify this to avoid sanction. These findings show the power of the promotion of breastfeeding and the underlying subtext that a good mother breastfeeds and its consequent effects on the women's decisions to breastfeed.

The literature further disclosed the power of the promotion of breastfeeding and helped to illuminate further how some of the women's experiences were shaped and moulded. It highlighted that breastfeeding promotional materials use risk discourse as well the call to

nature. It demonstrated that breastfeeding promotion is child centred and underlying the messages around breastfeeding is the concept that a good mother breastfeeds and privileges the baby's needs over her own. Finally, although breastfeeding purports to give women freedom over her body the literature demonstrated how breastfeeding promotion can make the subject positions of women restrictive.

It's the unknown

The category 'it's the unknown' has demonstrated that breastfeeding was a new and unknown experience. This was regardless of whether this was the woman's first or subsequent baby, because each new baby was different. The women expressed feelings of uncertainty and spoke of lacking confidence. During this time, their confidence levels were vulnerable and could either increase or decrease according to what was happening for the women. For example, the baby's behaviour could positively or negatively affect the woman's confidence. If the baby appeared settled and contented, the woman was more likely to increase her confidence. If the baby appeared unsettled or unhappy, the woman's confidence generally dropped.

Another aspect of the unknown was that the experience was unexpected. All the women talked about how the experience of breastfeeding was unexpected, and although some women stated it was easier than they had expected, the majority of the women found breastfeeding to be harder than they had anticipated. For many women, the experience of breastfeeding proved to be more difficult than they had expected. The women discussed how they had misconceptions about breastfeeding and that this was due in part to the way breastfeeding was promoted and presented. The women talked about how they had been led to believe breastfeeding would be easy, doable and or fixable, which meant that when breastfeeding proved to be otherwise they doubted themselves, thinking what's wrong with me? Again the effect of this was that it lowered the women's confidence to breastfeed. Lowered confidence contributed to making the experience of breastfeeding stressful and if stress levels continued to spiral, the women began to feel out of control. This led to what the women described as having a domino effect, whereby if they were unhappy the baby

would be unhappy and so would the partner/husband. Increasing levels of stress could make the women feel they were not coping and this generally led the women to wean.

Another finding in this category, is that support was important to successful breastfeeding. The women talked about a number of supports that included lay and health professional support. There was a clear indication that the women expected to have health professionals' support for breastfeeding in the early days and that they viewed this support as either positive or negative. Positive support was shown to ameliorate some of the negative aspects of breastfeeding and was demonstrated to increase the women's confidence. This was in contrast to poor professional support, which lowered a woman's confidence levels and contributed to weaning.

The literature in this chapter, supported the findings of this study that demonstrated this is a new and uncertain time for women regardless of whether this was their first or subsequent baby. While the literature acknowledged many of the factors emerging from this category, it also demonstrated how these findings added new knowledge to these experiences by demonstrating some of the mechanisms by which these factors impact on women's decisions. For example, while confirming professional support impacts on the infant feeding decision it also demonstrated that this occurs because professional practices can either increase or decrease a woman's confidence to breastfeed. It also expanded the understanding that fathers can influence the infant feeding decision. The findings of the study suggested, fathers may encourage formula-feeding not out of a preference for formula, but out of concern for their partner's wellbeing if they are seen as distressed.

It's not the only thing going on

In addition to breastfeeding, the women talked of other important experiences that impacted on or were intricately interconnected with breastfeeding during this time. For example, the women talked about having a range of emotions and feelings that left them feeling they were not themselves. In particular, the women talked about how they were coming to grips with their experience of birth, which often left them feeling drained and depleted and subsequently unable to take everything in. They also talked about the impact of becoming a

mother and their overwhelming feelings of love and responsibility towards their baby. This sense of responsibility towards their baby reinforced the need to do the best for their baby. For many women, this reinforced the breast is best message and could add extra pressure and stress when they were experiencing difficulties with breastfeeding and needed to consider weaning. There were also embodied feelings about breastfeeding and associations between a woman's choice of infant feeding, maternal identity and sense of self. This meant that for some women, breastfeeding was meant to be. For these women, breastfeeding was integral to their sense of self as a mother, they were determined to breastfeed and knew they would be devastated if they were unable to. For these women, when difficulties occurred there was an internal pressure to succeed. They talked about how they had to make breastfeeding work and when it did not they talked about feelings of grief and loss. These feelings of grief and loss are supported by the literature, which has also demonstrated women with a high maternal identity attached to breastfeeding are more likely to be categorised as distressed when they are unable to breastfeed. There were also women whose sense of self was distorted by breastfeeding to the point where they felt out of control. These women talked about how breastfeeding did not feel normal and consequently did not create a connectedness between them and their baby. For these women, continuing to breastfeed caused them to feel down in the dumps and depressed. Finally, there were also women whose maternal identity was connected to the contentedness of their baby; seeing their baby happy and contented was their measure of a good mother. These women chose to breastfeed because they considered it best for their baby, but if their baby appeared unsettled and or unhappy while breastfeeding, these women were just as happy to formula-feed.

The literature in this chapter again supported the findings of this study. It has shown that while some of the factors illustrated in this category have been found in previous research their impact on the infant feeding decision in the first six weeks post-birth has gone largely unnoticed. The findings relating to maternal identity where also shown to expand on previous understandings.

Everybody's best is different

The category 'everybody's best is different' argued the individuality of the infant feeding experience. At the very basic level, breastfeeding could be either straightforward or it could be painful and difficult or even traumatic. The individuality of the infant feeding experience meant that many women questioned some of the canonised beliefs and assumptions about breastfeeding, arguing that everything is not always fixable, breastfeeding is not always natural, breast is not always best, and that babies can survive and thrive on formula. The category also demonstrated how the women reached a point where they recognised they were the ones who needed to feed their baby and so needed to make the decision about how their baby would be fed. In this regard, they ended up just doing what works, and in doing so demonstrated a variety of methods. Different methods included breastfeeding and supplementing with formula, expressing and giving EBM or giving EBM and supplementing with formula. This meant that some of the women compromised in their original plans and, given the amount of time and effort these methods of feeding took, some of the women set time limits to how long they would persevere. Regardless of how a woman chose to feed her baby she defended her decision. Sometimes their arguments were similar to their original plans and they continued to argue that they wanted them to have the best start. Sometimes, when their plans had changed, they defended their decisions with reasons such as I did not want that experience again, I had other people to consider, I needed to be sane, and I did my best. There was a strong emphasis that they wanted it known they had had done their best and that everybody's best is different. This category also demonstrated how the women wanted to be prepared for and treated in relation to infant feeding in these first few weeks. They wanted approval and acknowledgement for what they were experiencing, they wanted honesty in the way breastfeeding was presented and finally, because infant feeding experiences were so individual, they did not want to be judged negatively for their decisions, highlighting that they already judged themselves.

While previous literature has suggested that infant feeding is individual, this category has demonstrated some of the aspects of these differences and the impact these have on the women's decisions. The smaller amount of literature in this category, also supports the notion that while women's infant feeding decisions are multifaceted health professional's

policies and practices remain embedded in the singular breast is best message. The findings presented in this chapter demonstrate the need to reconsider ways in which breastfeeding is presented to women and the importance of individualised support.

Deconstructing best

Women made plans during the antenatal period and their plans were heavily influenced by the 'breast is best' philosophy, which included the assumption that a good mother breastfeeds. Plans were also based on previous experiences and/or the women's embodied feelings about breastfeeding. Women also held expectations about how the infant feeding experience would go. Women who were planning to breastfeed generally expected that breastfeeding would be easy and/or doable or, if problems were encountered, that these would be fixable. Women who were planning to formula-feed were expecting they would be judged and so incorporated into their plans ways of shielding themselves from the accusation of being a bad mother.

When women actually came to the immediate post-birth period they began to realise what infant feeding was like for them. Women who were breastfeeding realised that breastfeeding was unexpected and unpredictable. This meant, for a minority of the women, that breastfeeding was easier than they had expected, but for the majority of women, breastfeeding proved to be far more difficult and/or painful than they had ever expected. For some of these women, what was unexpected was that they encountered any problems at all, while for others what was unexpected was not that they had problems but the degree of problems and/or pain they experienced. It was also realised during this period that breastfeeding was not the only thing going on.

In addition to breastfeeding, women were encountering a number of new experiences and emotions that left them feeling like they were not themselves and while these experiences could be viewed as separate from feeding, they were also inextricably linked to the infant feeding decision. In the first place, the women had just given birth. Apart from the shock of birth, many of the women talked about how birth left them feeling drained and depleted and, depending on the circumstances of the birth, concomitant feelings of tiredness and

exhaustion could be exacerbated. Another important experience at this time that impacted on infant feeding was becoming a mother. Becoming a mother was an overwhelming experience, with the women talking about a love they had never known and an overwhelming sense of responsibility in knowing their baby was totally dependent on them. They also talked about how breastfeeding could be connected to their sense of self as a mother, and/or how it could impact on their known sense of self. For many of the women, there were feelings they could not explain connected to their experience of infant feeding. For example, some women felt breastfeeding created a closeness and connection with their baby they found difficult to explain. For these women, breastfeeding was strongly linked to their maternal identity; they talked about a determination to breastfeed and were left feeling devastated when they could not. In contrast to this, some women felt breastfeeding did not feel normal and did not create a connection to their babies. For these women, breastfeeding could feel repulsive and distorting of their known sense of self and, as a result, could leave them feeling out of control and depressed. Finally, there were other women who simply breastfed because it was considered best. For these women, breastfeeding was not connected to their sense of self as a mother and neither did it distort their known sense of self. It was simply a means to an end and the end was a satisfied baby. A contented baby was how these women measured their success as a mother.

During this new and unexpected period of realising, the women expressed feelings of uncertainty and a lack of confidence about their ability to breastfeed. These feelings of uncertainty and lack of confidence could be exacerbated by a number of negative experiences, including the behaviour of the baby. What this research demonstrated, was that support provided through a number of sources could alleviate or buffer some of these more negative feelings. Of particular importance in these early weeks was the support of health professionals. The women rated professional support, and particularly midwifery support, as either negative or positive, with positive support shown to increase confidence levels while poor support increased the women's uncertainty, decreased their confidence and contributed to weaning.

Given breastfeeding was not what they had expected, this left the women questioning many of their previous assumptions about breastfeeding. They began to question whether breastfeeding was always natural, doable and/or best, even arguing that babies can actually survive and thrive on formula. The women recognised they were the ones who were feeding their babies and they needed to get on with it, and in some instances decisions alternate to their original plans had to be made. These decisions were based on the women's actual experiences and often included making compromises in their original plans, setting time limits and even completely changing their original feeding plans. Finally, the women defended their decisions and qualified the concept of breastfeeding, arguing that there needed to be honesty about the realities of infant feeding, and in doing so, that a woman's individual experiences should be acknowledged and approved without judgement because they had done their best.

Making the infant feeding decision

The study demonstrates that women made plans about how they would feed their baby during the antenatal period about how they would feed their baby after birth. In this study, the women came to the birth planning to either breastfeed or formula-feed their baby. The majority of women 32 (86%) in this study planned to breastfeed and, following birth, 33 (89%) women actually initiated breastfeeding. Even though these are only small numbers, these data are reflective of current Australian data on breastfeeding initiation rates, which show that approximately 87% of Australian women will initiate breastfeeding (Australian Bureau of Statistics, 2002).

The majority of women in this research planned to breastfeed believing breastfeeding gave their baby the best start. These findings are similar to other work which demonstrates the decision to breastfeed is influenced by the knowledge that breast is best (Earle, 2000; Ertem et al., 2001; McIntyre et al., 2001; Earle, 2002; Sheehan et al., 2003). The findings of this study show the influence of the 'breast is best' message on women's decisions, which is also reflected in Australia's relatively high breastfeeding initiation rates (Australian Bureau of Statistics, 2003).

In this study, women who planned to formula-feed generally chose to do so based on a previous bad breastfeeding experience. Other research has also identified that previous bad breastfeeding experiences can affect the decision to breastfeed in subsequent births (Scott et al., 2001b). What is new is that embedded in these experiences were embodied feelings. Embodiment is a term that describes both the conscious and unconscious physical and emotional sensations and perceptions of the body. The term embodiment acknowledges that the body is not just a physiological entity but also a sensual, emotional and social entity that has conscious and unconscious needs, desires and boundaries (Merleau-Ponty 1962). These embodied reasons for choosing to breastfeed and/or bottle-feed are supported by my earlier work [see Appendix VIII].

Despite a relatively high breastfeeding initiation rate, Australian breastfeeding data also show that approximately 25% of women will cease breastfeeding during the first six weeks (Scott et al., 2001a; Cooke et al., 2003a). Although previous research has identified that the first six weeks are the most difficult for women (Dykes et al., 1998; Hailes et al., 2000), and that these initial experiences may impact on breastfeeding duration, what has not been explored is the mechanisms by which these decisions occur (DiGirolamo et al., 2005: pg 221). This research has explicated a number of the factors and mechanisms that contribute to weaning in the first six weeks and, in doing so, has illustrated the multiple factors and complexity affecting the infant feeding decision at this time. This is in contrast to the decision to initiate breastfeeding, which in this study and others has been shown to be largely influenced by the singular, and often idealised concept that 'breast is best' (Earle, 2000; Ertem et al., 2001; McIntyre et al., 2001; Earle, 2002; Sheehan et al., 2003). This helps explain why the decision to initiate breastfeeding and the decision to continue breastfeeding need to be viewed as separate, and why initiation as a predictor of breastfeeding outcomes is problematic. The findings also identify why intentions cannot always be followed through, despite the women's best efforts, and confirm Bottorff's (1990: pg 203) suggestion that 'it is only in the execution of the action that a woman's intentions are able to be tested'.

These findings also demonstrate that while the decision to continue breastfeeding in the postnatal period is based on multiple factors for the women, the emphasis for the health professionals and society (in general) appears to remain embedded in the singular 'breast is best' message. This lack of recognition of the complexity and individuality of the infant feeding experience contributes to the women's need to defend their decisions and explains why the women argue for acknowledgment and approval, and express feelings of failure when they are unable to breastfeed. They also explain why there is a disparity between professional and personal accounts of breastfeeding (Schmied et al., 1999).

This lack of acknowledgement of the multiple factors influencing the infant feeding decisions of women at this time appears to account for why some women's support needs are not met. Given the importance of breastfeeding support to the overall postnatal needs of women (Cooke et al., 2003b), it can be also be hypothesised that the lack of understanding of the full complexity of factors influencing the infant feeding decision contributes, at least in part, to women's levels of dissatisfaction with postnatal care reported in other research (Brown et al., 1997; Cooke et al., 2003b; Brown et al., 2005).

Importantly, the multifactorial and complex nature of the infant feeding decision in the first six weeks post-birth means that the women's infant feeding decisions were individual and unique. This also means that although some factors relating to the infant feeding decision were suggestive of outcomes, it was not possible to develop definitive trajectories of experience as proposed in the original objectives for the study. Despite making plans prior to birth, women could encounter any number of experiences during the first few weeks post-birth, which impact on the women's infant feeding decision and most particularly breastfeeding. For example, this research identified that a woman whose maternal identity was closely linked to breastfeeding was in fact more likely to continue to breastfeed. The results also indicated, however, that despite this strong connection, some of these women were ultimately unable to breastfeed. While all these women expressed feelings of grief at not being able to breastfeed, their feeding outcomes varied. Some of the women weaned, others expressed and gave EBM exclusively and still others expressed and gave both EBM and formula. Each of these outcomes was also related to other factors that included getting

the support they needed, being able to produce sufficient milk and having the time to express.

These findings help explain why decision-making theories are limited in their ability to predict outcomes. The findings appear to substantiate Goksen's (2002: pg 1751) claim that the 'TRA may not apply to relatively complex, socially determined behaviours such as breastfeeding where an individual's intentions and efforts are not enough to bring about expected behaviour'. Understanding the unique mix of factors that can impact on a woman's infant feeding decision also helps explain why women seek and want individualised care (Tarkka et al., 1996; Hauck et al., 2002b; Dykes et al., 2003; Fredrikson et al., 2003).

Decision-making theory

As identified in the background to this study, there are five phases to decision-making. These phases are setting goals, gathering information, decision-structuring, making a final choice and evaluating. It has been argued that the earlier phases of decision–making, such as setting goals, gathering information and structuring information are probably as important, if not more important, to decision-making than the 'making a final choice' phase (Galotti, 2002). Examining the phases of decision-making in light of the findings of this study helps to explain some of the possibilities that may have had bearing on the women's decisions. It also confirms the importance of these earlier phases in shaping women's infant feeding decisions in these first few weeks. I now provide a brief discussion of the phases of decision-making and provide explanations for some of the decisions made by the women in this study.

Setting Goals

As the choice of infant feeding can be considered a goal, it is relevant to understand that goals have a number of characteristics. Goals contain dimensions and, as such, can be large or small as well as short term or long term. Some goals can be complex and difficult and include subgoals, while others will be simpler and can be rated in terms of importance (Galotti, 2002). Goals can also be categorised by their specificity, with some goals

described in broad abstract terms and others as more concrete and specific. In addition to this, it has been recognised that there are goals that the individual has more control over and other goals that are less under the control of the individual. Finally, some goals define who a person is because they are connected to the values and principles of the individual, whereas other goals are more simply tasks that need to be completed (Galotti, 2002).

It can also be argued, however, that setting and revising goals can only be considered tentative at best, and this can be explained in part because not all goals have been originated by the individual; sometimes external forces and pressure control goals (Galotti, 2002). Given this understanding, it is not surprising that autonomous goals undertaken willingly are more likely to be attained than goals that are driven by internal or external forces and pressures (Sheldon et al., 1998).

In this study, some women stated that they felt pressured to breastfeed. This appears to be based on the understanding that breast is considered best and the underlying assumption that a good mother breastfeeds. It can be argued that this information and belief created the context within which women felt pressured to initiate breastfeeding, but there was no vested interest in attaining the goal. Given that these mothers felt pressured to breastfeed, and, therefore, the act of breastfeeding was not volitional, may explain in part some of the early decline in breastfeeding rates. Experiencing a pressure to breastfeed may also help explain why some research has shown that providing specific antenatal breastfeeding education, particularly to groups who are least likely to breastfeed such as teenage mothers or women from CALD groups can increase initiation rates but not duration rates (Rossiter, 1994; Greenwood et al., 2002).

Another important point about goal-setting that may have implications for the findings of this study is that individuals generally have multiple goals, and that some goals are more important than others. The more important the goal is, the less likely the individual is to give up on it (Galotti, 2002). This research identified that for some women their role as a mother was interconnected with the infant feeding choice. For some mothers, breastfeeding was integral to the maternal role, while for other women it was seen as distorting. In

between these two experiences, there were also women whose maternal identity related to the contentedness of the baby. It could be argued that maternal identity or maintaining a sense of self were higher level goals and infant feeding was a lower level goal. Women juggled their infant feeding goal in order to meet their higher level goals. That is, women whose maternal identity was closely connected to breastfeeding persevered to try and attain their goal, women who found breastfeeding to be distorting of their known self chose formula-feeding and women whose identity was connected to the contentedness of the baby continued to breastfeed if the baby was settled but switched to formula-feeding if the baby was unsettled.

In addition, a more important goal will mean that the decision-maker is less likely to give up, whereas a less important goal can be more easily changed or abandoned. When observing the impact of maternal identity on the infant feeding decision, it can be postulated that infant feeding goals may be subgoals or lesser goals to maternal identity. This would help explain why women whose maternal identity was rooted in the contentedness of the baby were generally happy to wean if this was not achieved. In addition to having higher and lower priority goals, it is also understood that when one or more goals are evident, the decision-maker will need to prioritise their goals. This process helps the decision-maker to decide which goals to focus energy on and which goals to defer or drop (Galotti, 2002). In the case of the women who felt they were not coping or those women who felt their difficult experiences breastfeeding were having a negative impact on others, their choice to wean could be viewed as a prioritising of their goals.

Gathering Information

In addition to goal-setting, important decisions require that decision-makers also gather information about options and likelihood of outcomes, perhaps even criteria to be used (Galotti, 2002). While most information tends to be drawn from external sources, the sources can also be internal. Internal sources of information usually derive from the decision-maker's values and priorities. Gathering information, however, is not necessarily problem–free, as a number of heuristics and biases have been identified that can impact

positively or negatively on the decision. In this study, it could be argued the women used both internal and external information in making their decisions.

In terms of internal information, it could be argued that a woman's embodied feelings and her maternal identity impacted on the decision. Results from this study would suggest that internal information was more powerful than the external information. This may help to explain why Manstead et al. (1983, 1984) found that attitudes were more significant than intentions when assessing outcomes. Another important point is that in terms of information gathering, while the women planned to breastfeed it was not until after the birth that all the necessary information became available. This would indicate that the information gathering continued to occur after birth. It was also evident that the women were not always given the information they required and/or requested.

External information, and, in particular, information provided by health professionals, was primarily based on the benefits of breastfeeding to the infant. Any difficulties experienced by the women were either downplayed or ignored. Because of the health professionals' focus being on the benefits of breastfeeding to the infant, it was identified that at times, information given to women was incomplete and/or even withheld. It is possible that because all benefits of breastfeeding are categorised equally, the women were not aware that some benefits were only considered probable or possible; this could be considered incomplete information. In this study, many of the women believed that nobody really tells them about the reality of breastfeeding. The women talked about how they were led to believe breastfeeding would be easy, doable and/or fixable, which left them feeling surprised and shocked at the reality. Finally, this research identified that information about bottle-feeding was not readily disclosed and was even, at times, actually withheld, indicating women were not provided with adequate information about alternatives.

Decision structuring

Good decision-making requires that the decision-maker gather data while at the same time relating it to her/his values and goals (Galotti, 2002: pg 47). Problems can occur at this stage, because people can only retain so much information and they therefore need to find

ways of managing the information load. A pros and cons list or a mind map can be useful for this, and while this can work well in the laboratory, in real life people are not always as systematic (Galotti, 2002). Notwithstanding this, without all the required information the women may not be in a position to structure their information to make a satisfactory decision.

Making a final choice

After all the thinking and considering that has already been done, the final decision may come down to one option. Alternatively, it may mean a choice has to be made amongst a number of options. There are a number of ways that have been identified to do this. Two simple methods are 'satisficing' and 'elimination of aspects' (Galotti, 2002). Satisficing is a fusion of two words, satisfy and suffice. The term is used to describe a process whereby the decision-maker does not look to maximise the outcomes of her/his decision in a rational way but instead uses an approximate rationality. This means that the final decision is not about getting the best option, it is simply about choosing an option that suffices to meets the decision-maker's needs while at the same time satisfying her/his criteria (Galotti, 2002). Interestingly, one of the benefits of satisficing to the decision maker can be the reduction of stress (Galotti, 2002). Elimination by aspects means any options that do not fulfil a specific requirement are deleted from the decision-maker's choices (Galotti, 2002). I suggest that both satisficing and elimination of aspects were seen in the decisions women made in this study. For example, satisficing occurred when women who believed breastfeeding was critical to their babies' health or to their maternal identity, but were unable to breastfeed, decided to express and feed their baby EBM. Satisficing was also seen when women set time limits to how long they would feed their babies if they were experiencing difficulties. An example of possible elimination of aspects was seen when some women ceased breastfeeding because it did not meet their requirements for maternal identity.

Other ways of making final decisions are by using normative models, which aim for the best decision to be made under the best conditions. These models, however, are criticised for being linear and not reflective of real life situations (Connolly et al., 2000). Other more recent alternatives to the normative models are the descriptive models, which simply

describe what people do when they make decisions (Galotti, 2002). The model identified in this study was not linear. Given that linear models such as the TRA and TPB previously applied to infant feeding decisions have been largely inadequate in predicting infant feeding outcomes, it may be more suitable to apply one of the descriptive models available, such as image theory (Connolly et al., 2000). Image theory takes into account three mental representations. These are the value image, which considers a decision–maker's values, morals and principles; the trajectory image, which includes the decision–maker's goals; and the strategic image, which encapsulates the decision–maker's plans to attain her/his goals (Beach, 1990). These three images appear to be reflected in the decision making of women in this study.

Decision-making is, of course, affected by a number of other different factors that can include the age of the decision-maker, expertise, different cognitive styles, such as impulsive or reflective, and different decision-making styles, such as rational and/or intuitive styles (Galotti, 2002). Recently, emotions have also been shown to play a significant role in decision-making (Loewenstein et al., 2003). This list is not exhaustive. Although it can be argued that some of these differences in styles were inherent in the findings, they were not explored. Importantly, it has also been suggested that most of the decision-making occurs not in the final phase, but during the earlier phases. I would argue that this was evident in the findings of this study, which demonstrated most of the decision-making occurred during the realising and questioning stages.

Evaluating

Finally, and importantly, the findings of this research identified that the women evaluated their decisions. Galotti (2002: pg 6) states that the purpose of evaluating is to 'reflect and identify the areas of the process that can stand improvement as well as those that ought to be used again in future, similar decisions' (Galotti, 2002: p 6). Given that some women planned to bottle-feed based on their previous experiences and/or weaned when breastfeeding became difficult, indicates this evaluation occurred. It was evident that some of the women in this study were already evaluating some of the aspects of the process to be

used in their future decisions, realising they would not be able to do what they were doing this time (for example, persevering with expressing) in the future with a toddler.

It is revealing in this study that the women not only evaluated the process in terms of themselves, they also evaluated the process in terms of the information and support they received regarding breastfeeding. In this regard, they identified areas they felt should be improved. These included acknowledgement of their individual experiences, approval for their infant feeding choices and honesty about the realities of breastfeeding.

It has been argued that evaluation does not always occur (Galotti, 2002). The findings of this study suggest that evaluation was very important to the women. This research indicates that this may be because it was important and/or even necessary for the women to rationalise their decision against the concept that 'breast is best' and that a good mother breastfeeds. This was evident in that a number of women evaluated they had done their best despite not breastfeeding, and that they felt the need to justify their decision to bottle-feed.

Implications

Promoting breastfeeding

It can be argued the message that 'breast is best' and the promotion of breastfeeding using risk discourse with its underlying message that a good mother breastfeeds, while increasing breastfeeding initiation rates, has shown little effect, if any, on women's decisions to continue breastfeeding. The increased initiation of breastfeeding can be seen as a positive consequence of these messages, however, these findings also demonstrate that this approach to the promotion of breastfeeding can impact negatively on women's infant feeding decisions post-birth. It can be argued that this is reflected in the decrease in breastfeeding rates in the early post-birth period.

The promotional messages and information provided to women appear to have resulted in women having unrealistic expectations of the experience of breastfeeding, particularly an expectation that breastfeeding would be easy, doable and fixable. Some of these unrealistic expectations were also based on information that lacked a strong evidence base. For

example, in this study bonding was a very important reason for the women choosing to breastfeed, and yet the relationship between breastfeeding and bonding has largely been discredited. Another example was that some women were led to believe that breastfeeding would not be painful if their baby was attached correctly to the breast. Although there is theory to suggest correct attachment will prevent painful nipples, as yet this has not been verified by research and it remains that a substantial number of women will experience pain with breastfeeding. The effect of unrealistic expectations was that when the women faced the reality of breastfeeding, their confidence was undermined because they felt something must be wrong with them.

Further, the use of risk discourse in the promotional messages meant some women feared their babies would suffer life-long damage if they were given formula. This added extra stress for the women who already feared they would be considered lacking as mothers if they chose to wean. The impact of this may have been lessened if the women had access to information showing the levels of available evidence for the cited benefits of breastfeeding. This would have provided additional information that may have proved useful to the women in weighing up the benefits of breastfeeding against the difficulties, pain and/or levels of inconvenience they were experiencing.

Finally, there was evidence that the promotion of breastfeeding contributed to women feeling they were coerced to breastfeed and that health professionals were complicit in this. Other women expressed the view that when they requested it, information about bottle-feeding was withheld. These findings suggest that these women were not given the opportunity to make an informed choice. Informed choice is linked to the principle of informed consent (Hewson, 2004; Johnstone, 2004).

Informed consent is both a legal and ethical concept and is considered a fundamental right for people receiving health care that they be able make informed decisions regarding their care (Hewson, 2004; Johnstone, 2004). From an ethical perspective, informed consent stems from the principle of respect for autonomy, which centres on the person as a subject with a right to make autonomous choices (Johnstone, 2004). There are four main principles

to informed consent: that appropriate information including alternatives, side effects/consequences be provided; that information be intelligible; that a person is competent to consent and that a person is free from coercion and/or significant duress (Johnstone, 2004). While it is acknowledged that the concept of informed consent is complex, the findings of this research suggest that the principles of informed consent were breeched.

That women felt coerced to make a choice to breastfeed and/or had information about formula-feeding withheld can also be seen as one of the challenges facing health professionals. Health professionals, and in particular midwives, are expected to promote breastfeeding, while at the same time support the various needs of women. This has been shown to create conflict for some midwives who also feel the promotion of breastfeeding creates pressure for women (Battersby, 2000). It can be argued the BFHI lends itself to this conflict because it can and often is applied rigidly and without an understanding of its potentially coercive nature (Schmied et al., 2001a). The findings of this study suggest the effect of the application of the BFHI on women, including the ethical ramifications, needs to be explored.

Supporting women

One of the important factors to emerge from this study was that infant feeding is an individual experience. It also emerged that women need and want care and support that is individualised to meet their needs. Women have identified time and again the need for and value of individualised care that is based on their particular needs and circumstances (Tarkka et al., 1996; Hauck et al., 2002b; Dykes et al., 2003; Fredrikson et al., 2003). It has also been found, however, that this type of individual care is the least likely type of care to be provided to women (Tarkka et al., 1996). It can be argued that this type of support is least likely to be given to women because the factors deemed important to the women have largely gone unnoticed.

One of the criticisms of infant feeding research has been that it predominantly focuses on the biophysical factors, is often one-dimensional and simplistic, ignores women's own

experiences and fails to expose or explain the complexity of the infant feeding experience (Maclean, 1990; Carter, 1995; Dignam, 1995). Consequently, the emphasis for the health professionals remains embedded in the singular 'breast is best' message. Consistently, when discussing ways to improve breastfeeding duration rates, emphasis is placed on education and modifying biomedical factors related to breastfeeding. Some of these factors, such as the use of pacifiers and the use of formula are not even supported by clear evidence. Appropriate support, can only be achieved when professionals listen to women and gain an insight into their individual needs (Holmes et al., 1997; Proctor, 1998).

What this research has been able to identify from the perspective of the women themselves, are the multiplicity of factors that affect women's infant feeding decisions. This means that supporting women to breastfeed cannot be seen as separate from other postnatal needs. For example, it might be more beneficial, in helping a woman to breastfeed, to support her need for rest and sleep

Further, breastfeeding may not even be a high order goal so helping a woman meet her goal for maternal identity may be more important. Reva Rubin (1984) talks about feeding being a reciprocal role, and where there is no positive feedback, the mother will feel uncertain and there will be a 'dissolution of relatedness'. Rubin (1984: pg 7) states that the 'firmer the bond of relatedness, the more resistance there is to dissolution'. If this connectedness with her infant is at all compromised, Rubin (1984: pg 7) highlights the importance of a third party in giving 'evaluative feedback, and alternative behavioural initiatives to maintain an open and viable relationship'. This research suggests midwives may assist with this, and that flexibility and acknowledgement may be two ways of supporting the mother to continue breastfeeding or deal with her inability to breastfeed at the same time as maintaining her connectedness to her infant.

This research also identified that professional support can affect the woman's infant feeding decision because it can increase or decrease a woman's confidence to breastfeed. In this regard, a number of behaviours were identified as being positive or negative. Positive behaviours identified in this research included being available, staying with the women,

boosting up, giving emotional support, acknowledging what the women were experiencing and providing approval for their decisions, as well as being honest about the realities of breastfeeding for all women. Negative support was described as lack of help, being left to your own devices, being rude, directive and inflexible. Inverting the negative behaviours and adding these to the positive behaviours provides a powerful list of behaviours that can be seen as positive, including giving emotional support, acknowledging, approving, being available, staying with you, being sensitive and being flexible. What is important about this list of behaviours is that they are far more diverse than simply increasing women's knowledge about the benefits of breastfeeding and/or even knowledge about breastfeeding difficulties, which are repeatedly suggested as ways of increasing breastfeeding rates.

Displaying these positive behaviours was shown to increase women's confidence. Alternatively, poor support was shown to decrease a woman's confidence to breastfeed and arguably also to mother. These are important findings, given that confidence has been associated with breastfeeding success (Dennis et al., 1999; Papinczak et al., 2000; Ertem et al., 2001; Blyth et al., 2002; Blyth et al., 2004). Confidence it would seem is a modifiable factor. This research suggests that support, such as that described above, if applied to the multifactorial needs of the women, will increase a woman's confidence to breastfeed. These could form the basis of an intervention aimed at improving support for women and ultimately increasing breastfeeding duration rates.

This research has, however, also identified barriers to this type of care. Firstly, policies need to acknowledge that women need individualised care. Currently, policies and practices are entrenched in the concept that 'breast is best' and focus on the needs of the infant, regardless of the needs of the women. Further to this, it is suggested that these policies and practices are being applied rigidly (Stein et al., 2000; Schmied et al., 2001a). The BFHI is an example of this. Chalmers (2004) points out that the BFHI does not encompass the need for sensitive care nor the need for addressing the emotional needs of women. This research would suggest these are crucial elements in supporting women to continue breastfeeding.

It has been recognised that a standardised approach to care based on policies is likely to dominate because of the time constraints of midwives (Hauck et al., 2002b). It has been identified by both women and midwives that midwives are rushed and busy (Henderson et al., 2000; Hauck et al., 2002b; Brown et al., 2005). Given these time constraints, it is not surprising that midwives have been found to 'focus on the 'rules', and the 'stuff I'll get the rap for' rather than on women's needs (Kirkham et al., 2002). In such a climate, 'truly individualised care, while central to the rhetoric, can be seen as deviance' (Kirkham et al., 2002: pg 449). Recently, it has been identified that in Australia, workloads and ways of measuring workloads for nurses is problematic (Duffield et al., 2006). The implication here is that proper assessment of the time needed to deliver appropriate support needs to women needs to be undertaken and the workloads of midwives may need to be adjusted accordingly.

Limitations

Although I strengthened the empirical findings of this study with other literature, the findings of this study need to be considered as predominantly reflective of the views of the 37 women who were interviewed for this study and cannot therefore be extrapolated. Having said this, however, these findings have provided insight, and with support from other data, suggest new ways in which women's infant feeding decisions and care in the first six weeks post-birth need to be viewed.

At the outset of the study it was considered essential that different cultural groups should be examined separately to sufficiently capture their experiences. I would, however, suggest at the conclusion of this study, some of the findings of this research may be of value to women from Culturally and Linguistically Diverse (CALD) groups. For example, it would be useful for women from CALD groups to be treated individually. In addition, care that gives emotional support, acknowledges what a woman is experiencing, is approving, is available, is sensitive and flexible will probably be effective in covering many of the needs of women from CALD groups.

Conclusion

For the first time this study has brought together the results of an empirical study and an extensive synthesis of the literature to help explain the infant feeding decisions of women in the first six weeks post-birth. It has demonstrated that the decision is complex and that factors affecting the duration of breastfeeding are different from the factors that influence the decision to initiate breastfeeding. Infant feeding decisions in the first six weeks post-birth are multifaceted. A woman's infant feeding decision cannot be viewed in isolation and will only be understood when it is seen within the context of her life and individual experiences.

This thesis demonstrated that promotion of breastfeeding as 'best' impacts on the women's infant feeding decisions because it emphasises the health benefits to the baby and implies that a good mother would want to give her baby the best. This knowledge was shown to have both positive and negative impacts on the women and their infant feeding decisions. The concept that 'breast is best' also created a number of expectations for women, which included believing breastfeeding would be easy, doable and / or fixable. These expectations were often not congruent with the reality of breastfeeding for women in these early weeks.

Despite making plans and having expectations, breastfeeding was an unknown and unpredictable experience. The early weeks post-birth was a time punctuated by new experiences and feelings of uncertainty. The women lacked confidence in their ability to breastfeed and these feelings were exacerbated by a number of experiences in these early weeks. Health care professionals and particularly midwives were shown to have an impact on the women's confidence. Entwined in these breastfeeding experiences were other factors that were also shown to impact on women's infant feeding decisions at this time.

These multiple factors make the experience of breastfeeding different for all women. Woman may also have different goals and breastfeeding may be a lower level goal that is abandoned in order to achieve a higher-level goal. The dichotomy between what the women assumed or were led to believe about breastfeeding, and the reality for them, left them questioning some of the canonised assumptions about breastfeeding including that it was

'best'. This lead many women to arrive at a new understanding of 'best' arguing that ultimately everybody's best is different. These new understandings also mean the women want honesty about the reality of breastfeeding and for their individual experiences to be acknowledged and /or approved.

The multiplicity of factors that can impact on women's infant feeding experiences and decisions suggests that each woman's experience is individual and therefore requires support that is individualised to meet these needs. The type of support given to women by health professionals and in particular midwives was shown to negatively or positively affect the woman's confidence. Decreased confidence contributed to weaning. This demonstrates confidence is a modifiable concept and is important, given that confidence has been shown to positively affect breastfeeding. In addition to identifying the role professionals play in this, the findings provide a number of positive behaviours that can be used to develop interventions. These interventions could be tested to see the affect on breastfeeding duration.

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Appendix I

INFORMATION FORM: POSTNATAL OUTCOMES STUDY

Why have I been invited to participate?
You have been invited to participate in a study which is examining the association between infant feeding and the physical, psychological, and social effects of birth during the first 6 months after birth.

You have been invited to participate because you are between 28 and 36 weeks pregnant, you are able to read English and you live in the South Sydney Area Health Service (SESAHS) and have chosen to give birth in one of the SESAHS hospitals.

What is the purpose of this study?
We currently do not have a good understanding of the advantages and disadvantages of the different types of care or whether one type of care suits some women better than others. We hope to learn what support women require during the initial postnatal period and during the subsequent early months of being a mother. This information will help the SESAHS and other health services in Australia to plan and provide services which are helpful to mothers who are adjusting to parenthood.

The research has three aims. These are:

- To examine the postnatal health and well being of women and the use of community services in the first 6 months after childbirth.
- To describe the postnatal midwifery care provided to women in the initial postnatal period.
- To examine the relationship between, midwifery support, maternal health and well being and decisions about infant feeding.

What does the study involve?
If you agree to be part of this study you will be asked to complete five surveys over a seven-month period. You will be asked to complete a survey between 28-36 weeks pregnancy, 2 weeks after birth, 6 weeks after birth, 3 months after birth and 6 months after birth. The surveys will be mailed to you with a stamped addressed return envelope. The surveys will ask questions about: your pregnancy and birth, postnatal care, infant feeding, physical and mental wellbeing, parenting experience, life events, and family and community support. The questions ask about your experiences and there are no right or wrong answers to these questions. The surveys will take between 15-35 minutes to complete. We would also like your permission to collect information about your birth and postnatal care from your hospital patient notes.

Two models of postnatal care are offered in this hospital. These are:
Routine inpatient care: allows women to have 24-hour access to midwifery and medical staff for between 3-4 days after a vaginal birth and for 5-6 days after a caesarian birth, unless there are complications requiring a longer stay in hospital.
The early postnatal discharge program: requires women to be discharged from hospital within 48 hours of birth (for vaginal births) or within 96 hours (4 days) for caesarian births. Women, who are discharged early, are offered daily visits from midwives for 5-7 days after birth and have 24 hour phone access to midwifery advice. If required, mothers and babies can be readmitted to the postnatal ward without going to the Emergency Department.

In order to examine the effect of these two models of care we are asking women who participate in this study to be agree to be randomly allocated to the two types of postnatal care. This means that women, who agree to be randomised, will have an equal chance of being offered either routine inpatient care or the early discharge program as they are described above. The type of care offered to women who agree to randomisation will be selected by a lottery process (i.e. the selection of an envelope from a group of irregularly organised envelopes).

Finally, a small selection of women who agree to contribute to the study will also be asked to participate in face to face in-depth interviews about their experience of infant feeding. If you agree to participate in these interviews you will be asked to select a date, time and place suitable to you for the interview. The interviews will take 30-60 minutes and you will be prompted to describe you infant feeding experience and the factors which influenced your decisions about feeding. With your permission the interviews will be taped.

Are there any risks
All women and infants will receive all necessary care. This means if complications arise at any time during pregnancy or the postnatal period you **will not** be asked to leave hospital regardless of what group you have been allocated to. If complications arise (either physical or social) for you or your infant you will be provided with the treatment or intensive support you require.

All surveys and interview will not contain your name. This is to protect your identity and allow you to answer the questions confidentially. You will be asked to provide your name address and phone number to the researchers in order to send the surveys and contact you for interview. The list of participants contact details will be kept separate from the surveys and interview tapes .The list of participant contact details, completed surveys and interviews will be kept in a secure place. Only researchers will have access to this information. At the completion of the research all identifying names and addresses will be destroyed.

How will the information be used?
It is anticipated that the final results of this study will be published, but again confidentiality will be preserved and no document will identify you individually. The final results will reflect the experiences of women who give birth in the South Eastern Sydney Area and will not reflect individual experience. The results of the study will be available to you on request at the completion of the study. The results of this study will also be used to plan a larger similar study and to plan and develop future services in the SESAHS. The study data will be kept in a locked cabinet either, on disc, in a file or on cassette tape for 5 years after the completion of the research. The disc and cassette tapes will be erased and the files shredded at the end of this period.

What happens if I don't wish to participate or I withdraw my consent?
Your decision whether or not to participate will not affect your relationship with the South Sydney Eastern Area Health Service either now or in the furure. If you decide to participate you are free to withdraw your consent and discontinue participation at any time. Any such withdrawal will not affect any future treatment or your relationship with the SESAHS or any persons treating you. The SESAHS has produced a 'Customer Charter' which is available form PO Box 430, Kogarah 2217.

Who can I contact if I have any concerns or questions or complaints about the study
Prof. Lesley Barclay or Margaret Cooke, of the Family Health Research Unit, are the Chief Investigators on this study. They can be contacted on 9350 2789 if you have any questions about the research.

Roselyn Drake (Secretary SESAHS Ethics committee: Southern section) can be contacted on 9350 2986 should th be required.

You will be given a copy of this form to keep.

UTH EASTERN SYDNEY
EA HEALTH SERVICE

UNIVERSITY OF TECHNOLOGY SYDNEY

Professor Lesley Barclay
(Faculty of Nursing)
Tel: (61 2) 9350 2789
Fax: (61 2) 9350 3976

Postal Address
Family Health Research Unit
St George Hospital
Gray Street
Kogarah NSW 2217
email: L.Barclay@UNSW.edu

Consent form: Postnatal outcomes study (Pilot study)

I, _____ have read the information form for the postnatal outcome study and understand the purpose and risks of the study. I agree to complete five surveys over a period of seven months.

_____ _____
Signature of Participant Signature of Witness

Date_____ Date_____

I, _____ agree to be randomised to either routine inpatient care or the early discharge program with midwifery support at home. I understand there is an equal chance I will be allocated to either one of these types of postnatal care.

_____ _____
Signature of Participant Signature of Witness

Date_____ Date _____

I, _____ agree to participate in face to face interviews about my infant feeding experience if selected.

_____ _____
Signature of Participant Signature of Witness

Date_____ Date _____

My contact details are:
Address:

_____

_____

_____

Phone: _____

If I am unable to be contacted by mail or phone over a two-week period please contact _____on _____ and leave a message for me.
Name of secondary contact Telephone Number

ffice: Primrose House 190 Russell Ave Dolls Point NSW 2219 PO Box 430 Kogarah NSW 2217 Tel: 61 2 9583 1077 Fax: 61 2 9583 1120

Northern Sydney **Health**
better health: from the Harbour to the Hawkesbury

Hornsby Ku-ring-gai Hospital & Community Health Services

Palmerston Road
Hornsby NSW 2077

Telephone: (02) 9477 9123
Facsimile: (02) 9477 2005

Appendix II

Information Sheet

Re: **Infant Feeding Decisions: A study of Women's Experiences**

My name is Athena Sheehan and I am a Senior Research Midwife at the Centre for Family Health and Midwifery at the University of Technology, Sydney. The study you are being invited to participate in, is being undertaken as part of my PhD. The purpose of the study is to find out more about the infant feeding experiences and decisions of women in the first six weeks following birth. This study is concerned with understanding women's own experiences through interview. There have been few studies that use this style of research to explore women's own experiences at this crucial time. This study has been approved by the Human Research Ethics Committee (NSH HREC) of Northern Sydney Health and the Human Research Ethics Committee of the University of Technology Sydney (UTS HREC)

If you agree to participate I will ask you to sign a consent form. The research will involve a face to face interview with me, Athena Sheehan. In order to minimize any possible inconvenience, I will arrange for the interview to take place at a time and location that suits you. The interview will take approximately one hour to complete and will be tape-recorded and I will later transcribe it word for word. All data will be treated confidentially. All audio-tapes and transcripts will be coded and any identifying information such as names will be removed from the transcripts so that they will not be identifiable. Only I will be able to link your name to the coded data. Data will be stored securely and will only be accessed on a computer using a password and only by myself. It is my intention that the findings of this study will be published in my PhD thesis and professional journals, as well as being presented at conferences. The results may also be published as a component of a book. With your separate approval, de-identified data may also be used in other similar studies that are exploring ways in which to improve professional support for pregnant women. At no time however, will your individual identity be exposed.

There may be no direct benefits to you yourself if you agree to participate in this study, but neither do I expect there to be any adverse outcomes. I do hope however, that the results of this study will inform clinical practice that can ultimately lead to improved professional support for women. I have found in other similar work I have conducted women actually enjoyed talking about their experiences and therefore found participation positive.

You do not have to participate in this study if you do not wish to and you can withdraw from it at any time without affecting any care you are receiving from the Early Childhood Health Service.

If you have any questions you may contact me at UTS on 9514 2977 or on my mobile or my supervisors Professor Lesley Barclay or Associate Professor Virginia Schmied at UTS on 9514 2977.

THE HORNSBY KU-RING-GAI HOSPITAL & COMMUNITY HEALTH SERVICES

Northern Sydney **Health**
better health: from the Harbour to the Hawkesbury

Hornsby Ku-ring-gai Hospital & Community Health Services

Palmerston Road
Hornsby NSW 2077

Telephone: (02) 9477 9123
Facsimile: (02) 9477 2005

Appendix III

Consent Form: **Infant Feeding Decisions: A Study of Women's Experiences**

I, _____
(name of participant)
of _____
(street) (suburb) (state & postcode)

have been invited to participate in a research project entitled 'Infant feeding decisions: a study of women's experiences'.

In relation to this project I have read the Participant Information Sheet and have been informed of the following points:

1. Approval has been given by the Human Research Ethics Committee (HREC) of Northern Sydney Health and the Human Research Ethics Committee of the University of Technology Sydney.
2. The aim of the study is to find out more about the infant feeding experiences and decisions of women in the first six weeks following birth.
3. The results of this study may not be of direct benefit to me but will assist with informing clinical practice that may improve the way in which professional support is given to women.
4. The procedure will involve participating in a face to face interview with the researcher, Ms Athena Sheehan
5. Should I have any problems or queries about the way in which the study is conducted, and I do not feel comfortable contacting the researcher, I am aware that I may contact the Patient Representative who is an independent person within Hornsby hospital on 99279296 and /or Susanna Davis Research Ethics officer at the University of Technology, Sydney on 9514 1279.
6. I can refuse to take part in this project or withdraw from it at any time without affecting my medical care.
7. I understand my research data will be coded and stored in a secure office and on a computer with password access and that Ms Athena Sheehan will take all precautions to protect my identity.
8. I understand that the results of this study will be published but that my identity will not be revealed.
9. I declare that I am over the age of 18 years.

THE HORNSBY KU-RING-GAI HOSPITAL & COMMUNITY HEALTH SERVICES

Consent Form: **Infant Feeding Decisions: A Study of Women's Experiences**

After considering all these points, I accept the invitation to participate in this project.

_____ (please print name)

Signature: _____ Signature: _____
(of participant) (of witness)

I agree / disagree (please indicate) that de-identified data may be used in other studies being undertaken that are exploring aspects of professional support for pregnant women. An Ethics Committee will approve access to the de-identified information.

Signature: _____

Investigators' confirming statement:

I have given this research subject information on the study, which in my opinion is accurate and sufficient for the subject to understand fully the nature, risks and benefits of the study, and the rights of a research subject. There has been no coercion or undue influence. I have witnessed the signing of this document by the subject.

Date:._____

Investigators Name: _____

Investigators signature: _____

Appendix IV

Wentworth Area Health Service

Community Child & Family Health Services

St. Marys Community Health Centre
Cnr East Lane & Phillip Street
ST. MARYS NSW 2760
Ph: (02) 9833 6800
Fax: (02) 9833 6801

Information Sheet

Re: **Infant Feeding Decisions: A study of Women's Experiences**

My name is Athena Sheehan and I am a Senior Research Midwife at the Centre for Family Health and Midwifery at the University of Technology, Sydney. The study you may be invited to participate in, is being undertaken as part of my PhD. The purpose of the study is to find out more about the infant feeding experiences and decisions of women in the first six weeks following birth. This study is concerned with understanding women's own experiences through interview. There have been few studies that use this style of research to explore women's own experiences at this crucial time. This study has been approved by the Wentworth Area Health Service Human Research Ethics Committee and the Human Research Ethics Committee of the University of Technology Sydney (UTS HREC)

If you agree to participate in the study, I will ask you to sign a consent form. The research will involve a face to face interview with me, Athena Sheehan. In order to minimize any possible inconvenience, I will arrange for the interview to take place at a time and location that suits you. The interview will take approximately one hour to complete and will be tape-recorded and I will later transcribe it word for word. All data will be treated confidentially. All audio-tapes and transcripts will be coded and any identifying information such as names will be removed from the transcripts so that they will not be identifiable. Only I will be able to link your name to the coded data. Data will be stored securely and will only be accessed on a computer using a password and only by myself. It is my intention that the findings of this study will be published in my PhD thesis and professional journals, as well as being presented at conferences. The results may also be published as a component of a book. With your separate approval, de-identified data may also be used in other similar studies that are exploring ways in which to improve professional support for pregnant women. At no time however, will your individual identity be exposed.

There may be no direct benefits to you yourself if you agree to participate in this study, but neither do I expect there to be any adverse outcomes. I do hope however, that the results of this study will inform clinical practice that can ultimately lead to improved professional support for women. I have found in other similar work I have conducted, women actually enjoyed talking about their experiences and therefore found participation positive.

You do not have to participate in this study if you do not wish to and you can withdraw from it at any time without affecting any care you are receiving from the Community Child and Family Health Service.

If you have any questions you may contact me at UTS on 9514 2977 or on my mobile or my supervisors Professor Lesley Barclay or Associate Professor Virginia Schmied at UTS on 9514 2977.

I understand that if I have any complaints or concerns about the conduct of this project, I may contact the Area Ethics Officer, Marietta Coutinho, Court Building, PO Box 63, Penrith NSW 2751. Phone (02) 4734 3441, Fax (02) 47341365 or email Ethics@wahs.nsw.gov.au

Athena Sheehan

Appendix V

Wentworth Area Health Service

Community Child & Family Health Services

St. Marys Community Health Centre
Cnr East Lane & Phillip Street
ST. MARYS NSW 2760
Ph: (02) 9833 6800
Fax: (02) 9833 6801

Consent to be contacted by the researcher, Athena Sheehan re Infant Feeding Decisions: A Study of Women's Experiences.

I.....

give permission for my name and telephone number as well as feeding method and age of baby to be forwarded to Athena Sheehan, Senior Research Midwife, Centre for Family Health and Midwifery, University of Technology, Sydney (UTS).

I acknowledge I have received an information sheet outlining details of the study: Infant Feeding Decisions: A Study of Women's Experiences.

I understand that the researcher will only use the details provided by me today to contact me. If contacted, the researcher will explain the research and answer any questions I may have regarding the study. The researcher may also invite me to participate in the study.

I am aware that participation in the study is voluntary and that by agreeing to be contacted in no way obligates me to participate in this study.

I am aware that the Wentworth Area Health Services Human Research Ethics Committee and the UTS Human Research Ethics Committee have approved this study.

I understand that if I have any complaints or concerns about the conduct of this project, I may contact the Area Ethics Officer, Marietta Coutinho, Court Building, PO Box 63, Penrith NSW 2751. Phone (02) 4734 3441, Fax (02) 47341365 or email Ethics@wahs.nsw.gov.au or Susanna Davis Research Ethics Officer at the University of Technology Sydney on 9514 1279.

Signed.....Date.....

Witness:.....Date.....

Printed Name:.....

Telephone number:_____

Age of baby:_____

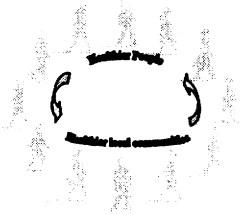
I am feeding my baby by: _____

Appendix VI

Wentworth Area Health Service

Community Child & Family Health Services

St. Marys Community Health Centre
Cnr East Lane & Phillip Street
ST. MARYS NSW 2760
Ph: (02) 9833 6800
Fax: (02) 9833 6801



Consent Form: Infant Feeding Decisions: A Study of Women's Experiences
Researcher: Athena Sheehan

I.....
Name (please print)

of.....
Address (please print)

Give consent to my participation in the above Research Project.

In giving my consent I acknowledge that:

1. I may withdraw from the project at any time and that my refusal to take part in the Project will not affect my usual medical care;
2. I understand that the Project will be conducted in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia;
3. The Project will be carried out as described in the attached Information Sheet and I acknowledge that I have read and understood the Information Sheet about the Project which was provided to me before I signed this consent form and that I have received a copy of this consent form and information sheet;
4. I understand the purpose of this study is find out more about the infant feeding experiences and decisions of women in the first six weeks following birth. The general purpose, method and demands and any possible risks, inconveniences and discomforts, which may occur to me during the Project, have been explained to me by.....
5. I understand that I will not be identified in any way and my personal results will remain strictly confidential to the extent permitted by the relevant privacy laws.
6. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
7. I have been advised that the Wentworth Area Health Services Human Research Ethics Committee has approved the Project.
8. I understand that if I have any complaints or concerns about the conduct of this project, I may contact the Area Ethics Officer, Marietta Coutinho, Court Building, PO Box 63, Penrith NSW 2751. Phone (02) 4734 3441, Fax (02) 47341365 or email Ethics@wahs.nsw.gov.au

Signed.....Date.....

Witness:.....Date.....

Printed Name:.....

Centre for Family Health and Midwifery
PO Box 123
Broadway NSW 2007
Australia

Tel. +61 2 9514 2977
Fax +61 2 9514 1678

University of Technology, Sydney

Appendix VII

Information Sheet

Re: **Infant Feeding Decisions: A study of Women's Experiences**

My name is Athena Sheehan and I am a Senior Research Midwife at the Centre for Family Health and Midwifery at the University of Technology, Sydney. The study you are being invited to participate in, is being undertaken as part of my PhD. The purpose of the study is to find out more about the infant feeding experiences and decisions of women in the first six weeks following birth. This study is concerned with understanding women's own experiences through interview. There have been few studies that use this style of research to explore women's own experiences at this crucial time. This study has been approved by the Human Research Ethics Committee of the University of Technology Sydney (UTS HREC)

If you agree to participate I will ask you to sign a consent form. The research will involve a face to face interview with me, Athena Sheehan. In order to minimize any possible inconvenience, I will arrange for the interview to take place at a time and location that suits you. The interview will take approximately one hour to complete and will be tape-recorded and I will later transcribe it word for word. All data will be treated confidentially. All audio-tapes and transcripts will be coded and any identifying information such as names will be removed from the transcripts so that they will not be identifiable. Only I will be able to link your name to the coded data. Data will be stored securely and will only be accessed on a computer using a password and only by myself. It is my intention that the findings of this study will be published in my PhD thesis and professional journals, as well being presented at conferences. The results may also be published as a component of a book. With your separate approval, de-identified data may also be used in other similar studies that are exploring ways in which to improve professional support for pregnant women. At no time however, will your individual identity be exposed.

There may be no direct benefits to you yourself if you agree to participate in this study, but neither do I expect there to be any adverse outcomes. I do hope however, that the results of this study will inform clinical practice that can ultimately lead to improved professional support for women. I have found in other similar work I have conducted women have enjoyed talking about their experiences and therefore found participation positive.

You do not have to participate in this study if you do not wish to and you can withdraw from it at any time.

If you have any questions you may contact me at 95142977 or on my mobile or my supervisors Professor Lesley Barclay or Associate Professor Virginia Schmied at UTS on 9514 2977.

Centre for Family Health and Midwifery
PO Box 123
Broadway NSW 2007
Australia

Tel. +61 2 9514 2977
Fax +61 2 9514 1678

University of Technology, Sydney

I _____agree to participate in the research project 'Infant Feeding Decisions: A study of Women's Experiences' being conducted by Athena Sheehan, Senior Research Midwife, Centre for Family Health and Midwifery at the University of Technology, Sydney as a component of her PhD.

I understand that the purpose of this study is to find out more about the infant feeding experiences and decisions of women in the first six weeks following birth. This study is concerned with understanding women's own experiences through interview.

I understand that my participation in this research will involve a face-to-face interview with Athena Sheehan. The interview will take approximately one hour to complete and will be tape-recorded and later transcribed word for word. All data will be treated confidentially. All identifying information such as names will be removed from the transcripts so that they will not be identifiable. Data will be coded and stored in a secure office, on a computer needing a password to access.

I am aware that I can contact Athena Sheehan or her supervisor Associate Professor Virginia Schmied on 9514 2977 if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish and without giving a reason.

I agree that Athena Sheehan has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I agree

_____ ___/___/___
Signed by

_____ ___/___/___
Witnessed by

I agree / disagree (please indicate) that de-identified data may be used in other studies being undertaken that are exploring aspects of professional support for pregnant women. An Ethics Committee will approve access to the de-identified information.

Signature: _____

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer, Ms Susanna Davis (ph: 02 9514 1279). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix VIII

Australian women's stories of their baby-feeding decisions in pregnancy

Athena Sheehan, Virginia Schmied and Margaret Cooke

***Objective*: to describe the baby-feeding decisions of a group of Australian women prior to birth.**

***Design, setting and participants*: a qualitative study using face-to-face in depth interviews was undertaken with 29 women. All interviews were audio-tape recorded and transcribed verbatim. Data were analysed using thematic analysis.**

***Findings*: the women observed and sought information from a variety of sources as well as exploring their own understandings of themselves and their breasts. Based on this knowledge the women made their antenatal baby-feeding decisions. These baby-feeding decisions grouped into four thematic groups, 'assuming I'll breast feed'; 'definitely going to breast feed'; 'playing it by ear' and 'definitely going to bottle feed'. Each of these standpoints was associated with, and precipitated a number of behaviours and strategies.**

***Implications*: the findings of this research highlight the need for antenatal educators and midwives who provide care in pregnancy to acknowledge a range of experiences and expectations of women and to provide diverse educational opportunities to meet a range of needs. There is a need for further research to identify how midwives can encourage and assist women to explore and challenge their assumptions about breast feeding as they relate to other aspects of their lives.**

[Production Note: the papers for Appendix VIII are not included in this digital copy due to copyright restrictions. The print copy includes the full text of the papers and can be viewed at UTS Library]

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