

A Qualitative Exploratory Study of Breastfeeding Experience

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Abstract

Background

Previous research has found that a third of women attributed their postnatal distress to breastfeeding difficulties. Further to this, other studies have found that women experience feelings of failure, guilt and shame when they have difficulties feeding their infants. This research aims to add to the understanding of how women view the impact of breastfeeding on their emotional wellbeing by exploring their lived experiences.

Method

A qualitative methodology was utilised to conduct this research. An Interpretative Phenomenological Analysis approach was used to analyse data from six participant interviews with first time mothers with experiences of breastfeeding their infant.

Results

Three overall superordinate themes were identified from the data that were shared across the participants. These included “nature’s way: the maternal self”, “expectations versus realities of breastfeeding” and “overcoming difficulties.” Within these, nine subordinate themes were also outlined and discussed.

Conclusions

The overall conclusions drawn from the interpreted experiences of the participants who took part in this study are comparable with existing research in the field of breastfeeding experience. This includes the experience that women feel a desire to breastfeed their babies so as to fulfil their perceptions of what it is to be a good mother. This can be source of significant emotional distress if breastfeeding is not possible or is difficult. There is also a perception that information provided by

health professionals around infant feeding is inadequate and mis-timed. Future research into other factors such as healthcare policy and implementation of information given is needed to help guide support for breastfeeding and non-breastfeeding mothers.

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Chapter 1: Introduction

1.1 Overview of Chapter

The aim of this thesis is to explore the lived experiences of breastfeeding in first time mothers. This chapter will provide a definition of what is meant by “breastfeeding” as well as a brief history of breastfeeding through the ages. The chapter will then go on to explore how current literature has explained women’s experiences and behaviours around breastfeeding and will present and critique some psychological theoretical perspectives that have been used to understand this.

Consideration will also be given to how the literature and healthcare policy have potentially impacted women’s lived experience of breastfeeding. The chapter will then go on to give a rationale for the current research and provide the aims and the research questions that have been explored.

Finally, the researcher will provide a reflective summary of their own initial thoughts relating to the research in order to introduce a reflexive narrative that will continue throughout the thesis, which will keep in line with the qualitative methodology adopted to conduct the study.

1.2. Definition and History of Breastfeeding

According to UNICEF (2012a) “Breastfeeding” is defined as a child receiving breastmilk either directly from the breast or expressed. “Exclusive breastfeeding” is often used to define infants who receive breastmilk, again, either from the breast or the bottle with no other additional liquids or solids.

The history of infant feeding includes wet nursing, feeding from a bottle and formula use, as well as feeding exclusively from the breast. As early as 2000BC, breastfeeding was considered as a religious obligation for women. However, this was not always possible; women experienced “lactation failure” or they died through

childbirth. During Ancient Egyptian times, wet nursing was the primary alternative feeding method where breastfeeding was not possible. Other feeding vessels such as bottles and teats made from wood, ceramics or cow horns were written about since the Roman era (Stevens, Patrick and Pickler, 2009). It was thought that a third of infants died in their first year of life due to a lack of proper milk storage and bacteria in feeding vessels. Other animal milk was frequently used such as goat, sheep, camel, pig or horse milk, although cow's milk was later considered nutritionally similar to human milk. Trends in infant feeding behaviours have since fluctuated through the centuries, for example, becoming unpopular in the Renaissance period. The Industrial revolution saw the advent of artificial feeding of other animal milk through safer, more hygienic bottles (Stevens et al., 2009).

Commercialisation of infant milk led to a global decline in breastfeeding through aggressive marketing direct to the public in the late 1980's. Research conducted in the mid 1970's revealed an increase in mortality rates in bottle fed infants in the third world, where babies were found to be three times more likely to die within the first three months of life. Infant formula manufacturers' marketing activities were held responsible for the increase in mortality as women were discouraged from breastfeeding whilst formula feeding was promoted in an environment in which it could not safely be practised. (Dobbing, 1984).

This research led to the World Health Organisation developing sets of guidelines around breastfeeding in order to address the alarming mortality rates in the third world. The following section will present how these developments shaped current healthcare policy and guidance, where the focus of research has been on the benefits of breastfeeding in order to promote this method of feeding and therefore improving breastfeeding rates globally.

1.3. Current Breastfeeding Guidelines

The current guidelines for breastfeeding as outlined by the World Health Organisation (WHO, 2003) recommend that women breastfeed their infants exclusively (i.e. without supplementing with formula or other food) until six months of age. Infants should then receive “nutritionally adequate” and safe complementary foods whilst breastfeeding continues up to the age of two years and beyond.

The current WHO guidelines were developed due to their findings that malnutrition was responsible for 60% of the 10.9 million deaths annually for the under-fives, where two thirds of these deaths were associated with inappropriate feeding practices mainly in the developing world. This included factors such as unhygienic methods of infant milk preparation and unsafe storage, or other foods being introduced too early or too late. Breastfeeding, therefore was promoted as it is safe in terms of reducing the risk of infection through contaminated feeds and nutritionally superior, given the quality of formula milk preparation or milk being watered down in order to go further.

The WHO breastfeeding strategy was based on consultations with countries such as Brazil, China, Philippines, Sri Lanka and Thailand where the aim of the guidance was to “improve nutritional status, growth, development and health, and thus survival of infants and young children, and increase the commitment of governments and international organisations for optimal feeding practices” (WHO, 2003. p.7).

The guidelines also suggest that the consequences of inappropriate feeding practices act as obstacles to sustainable socioeconomic development and poverty reduction in the third world, and so the focus is to improve optimal child growth and development for children in these areas. WHO also cite the benefits of breastfeeding

until infants are two years of age in terms of holding reproductive advantages, where women are less likely to conceive another baby whilst breastfeeding due to amenorrhea (absence of menstruation) in this period. Again, this is particularly pertinent for poorer families who are struggling to find adequate food for their children.

When considering that current breastfeeding guidance is based on ensuring survival in poor and deprived areas where supplementary feeding is unsafe, it is important to consider the applicability of such guidance to the western world where feeding practices perhaps do not hold similar potential risks in terms of malnutrition or risk of infection, nor is it a priority to prevent women conceiving within the first two years of giving birth. However, these guidelines are recommended globally, and although the UK has its own policies and practices in the form of the UK Baby Friendly Initiative (BFI, 1991; 2012) the general recommendation of exclusive breastfeeding for six months and complementary breastfeeding until two years remains. It is therefore helpful to explore in more detail the information that has been provided to women in recent decades in terms of the benefits to breastfeeding and to consider the impact of this on their experience.

Literature around breastfeeding has focused on the physical benefits to the child as well as the impact on their cognitive development and even IQ. This appears to be utilised as a way to encourage women to return to breastfeeding and to try and counter the popularity of formula use in modern day culture. Research therefore has been focused on the scientific study of breastfeeding and around the physical benefits of breastmilk.

1.4. Breastfeeding Benefits

In order to understand the nature of the information that is provided to women around infant feeding, it is helpful to outline how “benefits” are discussed and disseminated through research literature and healthcare policy. This section will present these in terms of the following areas: benefits to health, cognitive ability, mother-infant attachment and financial savings for the NHS.

1.4.1. Health benefits. In a recent systematic review of 60 studies investigating the long term effects of breastfeeding, it was concluded that breastfeeding provides some protection against obesity, and is associated with improved intelligence, with apparent strong evidence of the causal effect of breastfeeding (WHO 2013a). Further to this, a systematic review of short term effects of breastfeeding found that there was a reduced risk of diarrhoea and respiratory infections, resulting in decreased risk of associated hospital admissions and reduced morbidity in breastfeed children under the age of 5 years (WHO, 2013b).

These reviews provide further support to previous findings outlining health benefits of breastfeeding. For example, Quigley, Kelly and Sacker (2007) suggested that optimal feeding practices could prevent hospital admissions due to diarrhoea and lower tract infections. Kramer (2001) also suggested that breastfeeding exclusively until six months could prevent allergic and gastrointestinal diseases and therefore reducing morbidity in children. Many other health benefits for are cited by UNICEF, for example reduced risk of type 1 and 2 diabetes and allergies such as asthma and lactose intolerance.

In terms of mother’s health benefits, it is suggested that there is a reduced risk of ovarian and breast cancers as well as cardiovascular disease.

1.4.2. Cognitive benefits. There has been significant research into the effects of breastfeeding on cognitive ability over the last few decades. The research seems to suggest that breastfeeding is associated with consistent and statistically significant increase in IQ, reading and maths and general scholastic ability (Horwood and Fergusson, 1999). This research found that children who were breastfed for at least eight months had mean scores on cognitive tests that were between 0.35 and 0.59 standard deviations higher than children who were bottle fed. However, the study was conducted with children from high socioeconomic backgrounds, which could account for better outcomes in terms of cognitive ability. Research has since attempted to address and control for confounding factors that could relate to cognitive ability.

A meta-analysis of breastfeeding and cognitive development conducted by Anderson, Johnstone and Remley (1999) addressed the suggestion that higher scores on cognitive tests were due to co-variables such as economic status or maternal education. They adjusted scores for these key factors and still found that breastfeeding was associated with significantly higher scores on cognitive tests. They also suggested that the cognitive benefits of breastfeeding increased with duration, again independently from a range of parental and infant characteristics.

More recently, Borra (2012) examined the effects of breastfeeding on cognitive ability by using a “propensity score matching” (PSM) technique to help control for mother’s characteristics that favour positive outcomes for the child; higher social class, higher IQ, level of education and motivation. She also used rich longitudinal data that also took into account differing methods of infant feeding, for example; exclusive breastfeeding or mixed feeding (using formula or solids as well as breastmilk) and for different durations.

The findings were that breastfeeding for four weeks was positively and statistically significantly associated with increased cognitive test scores (increased of around one tenth of a standard deviation). The magnitude of the relationship was also found to increase with age and duration the child was breastfed which has been supported by recent research (Leventakou et al. 2015). However, it was found that there was no substantial difference between exclusively breastfeeding and ‘any’ breastfeeding at all in terms of cognitive outcomes (Borra 2012).

Currently, researchers are still debating the positive associations between breastfeeding and cognitive ability. Sajjad et al. (2015) conducted research with a sample of 3761 six year olds and also found an association between breastfeeding and child IQ but claimed that socio-demographic factors, parental lifestyle and maternal IQ can explain this. They suggested that such results cannot confirm the beneficial effects of breastfeeding and child intelligence.

1.4.3. Mother-infant attachment. The mother’s relationship or “bond” with their child has seemed to be long assumed to be positively associated with breastfeeding. However, there appears to be little empirical research that supports the idea that breastfeeding directly and positively improved the attachment relationship between mother and baby (Jansen, de Weerth and Riksen-Walraven, 2008).

In their study of breastfeeding, sensitivity and attachment, Britton, Britton and Gronwaldt (2006) found that the quality of the mother-infant interaction rather than type of feeding used predicted the security of the attachment relationship. However, they did find that mothers who chose to breastfeed showed enhanced sensitivity (promptness, consistency and appropriateness of responses) to their child during early infancy that could foster a secure attachment. This research suggests then some links between attachment security and breastfeeding but causality cannot be claimed.

Rather, it appears that there is a link between breastfeeding and increased sensitivity to the infant. This research supports earlier ideas that come from previous studies that explored how maternal sensitivity helped the development of a bond between mother and infant in the early days of infancy (e.g. Zetterstrom, 1999).

1.4.4. Financial benefits. Research by UNICEF (2012) has suggested that the NHS could save millions of pounds if infants were breastfed for longer periods, citing improvements in health outcomes for children, and therefore less need for medical intervention through NHS services. It is suggested that a moderate increase in breastfeeding rates could save the NHS in excess of £40 million a year when looking at five illnesses that were evidenced to be impacted positively by breastfeeding. These included; middle ear infections, breast cancer, necrotising enterocolitis (tissue death in the bowel), gastroenteritis and respiratory infections. The study also predicted, as discussed above, that other savings could be made by preventing childhood obesity and sudden infant death syndrome (SIDS) and could improve cognitive outcomes.

More recent research supported these findings and suggested that supporting women to breastfeed up to 4 months post-partum could reduce three infant infectious diseases and save around £11 million annually (Pokhrel et al, 2014).

When considering how the “benefits” of breastfeeding are addressed and presented to women by healthcare professionals and the media, questions are raised about how women might experience the messages that in order for her infant to thrive cognitively, emotionally and physically, she must ensure that she is able to supply her infant with sufficient breastmilk for a stipulated period of time. There is also a current emphasis on financial benefits to society through savings to the NHS should breastfeeding rates improve in the UK. Again, this raises further questions about how women might experience these messages in the current context, and whether they

might perceive some pressure externally, as well as internally, to “succeed” at breastfeeding.

1.5. Current Breastfeeding Statistics

In order to give some context in which current research around breastfeeding rates sits, it is important to think about current statistics for UK breastfeeding rates. These are provided by the 2010 Infant Feeding Survey (Renfrew, 2011). These suggest that there have been significant improvements in breastfeeding rates in the previous five years. Breastfeeding at birth currently stands at 81%, an improvement of 5% since 2005. At three months after birth, 17% of mothers exclusively breastfeed, (up from 13%) and 12% at four months (up from 7%). However, babies being exclusively breastfed until six months remains at 1%. Rates that include “any breastfeeding” (where breast milk is being supplemented by formula) have increased to 55% at six weeks (from 48%) and 34% at six months (from 25%) since 2005.

Breastfeeding was found to be most common among mothers who were aged over thirty years, who belonged to ethnic minority groups, had left education over the age of eighteen, were in managerial or professional occupations, and who were living in the least deprived areas.

In view of the identified health benefits, The UNICEF Baby Friendly Initiative (2012) has aimed to increase breastfeeding rates and this has been supported by the National Institute for Health and Care Excellence (NICE, 2008). The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care. It “provides a framework for the implementation of best practice by NHS Trusts, other health care facilities and higher education institutions, with the aim of ensuring that

all parents make informed decisions about feeding their babies and are supported in their chosen feeding method” (BFI, 2012).

Facilities and institutions that meet the required standards can be assessed and accredited as Baby Friendly. Currently, 90% of maternity services and 84% of health visiting services are working towards Baby Friendly accreditation. University programmes are also working towards accreditation, with 75% of midwifery and 25% of Health Visiting courses engaging in the process (BFI, 2012).

1.6. Factors impacting breastfeeding duration

In attempting to understand the reasons why women do not exclusively breastfeed until the age of six months, research has focused on breastfeeding duration and the factors that impact upon this. The research has tended to be positivistic in nature, in attempt to scientifically explain and understand the difficulty in raising breastfeeding rates.

In a study of 556 breastfeeding mothers, Scott and Colin (2002) interviewed women in hospital about their infant feeding practices and repeated the interview every four weeks up to twenty four weeks postpartum. They found that most mothers were not prepared before birth to experience any difficulties with breastfeeding. The most common problem cited by mothers postnatally for stopping breastfeeding before 2 weeks was that their baby was unsettled, which mothers interpreted as being due to insufficient milk supply. It was found that anxiety over milk sufficiency continued through to six months and often resulted in breastfeeding cessation.

Current research suggests that the two most common breastfeeding problems are to do with breast and/or nipple pain, and with low or perceived low milk supply (Amir, 2014). It is suggested that at least 30% of women experience at least one

breastfeeding problem at two weeks post-partum (Binns & Scott, 2002). The following sections will explore common breastfeeding difficulties in more detail.

1.6.1 Breast and nipple pain. One of the most common causes of breast pain is related to the presence of mastitis, which is an inflammation of the breast. Mastitis can include problems on a continuum from blocked milk ducts or engorgement of the breast, to breast abscesses where infections occur. Mastitis can be caused by the baby not attaching properly to the breast during feeding and so not draining the milk fully, infrequent feeding and pressure on the breast, for example by tight clothing. Symptoms of mastitis can include fever, lethargy, muscle aches, depression, nausea and headache, and often requires treatment with antibiotics.

The cause of nipple pain is mainly due to poor infant attachment, or ‘latch’ onto the breast. Factors which can affect latch are associated with maternal or infant anatomy for example, nipple shape, receding jaw or restricted tongue movement in baby (tongue tie). Nipple damage is also a cause of pain, where skin can be broken and inflamed due to the infant suckling in a position that is not conducive to a good latch, and can also result in the need for antibiotic treatment. Other problems associated with nipple pain are the presence of herpes, dermatitis and fungal infections such as thrush. Women can also experience nipple “vasospasm” which is a condition where the blood flow to the nipples is reduced, resulting in acute pain to the nipple and breast (Amir, 2014).

1.6.2 Low milk supply. According to Livingstone (1990), an adequate milk supply requires sufficient mammary tissue, normal hormone levels and regular removal of milk. Women with problems associated with the thyroid, those having had a post-partum haemorrhage and those with a lack of glandular tissue can experience a reduced milk supply. However, often women perceive that their milk supply is low

regardless of whether or not it is based on baby unsettledness. This means that women can therefore lack confidence in their ability to produce an adequate amount of milk for their baby, and consequently discontinue breastfeeding due to fears of lack of nutrition (Amir, 2014). This supports the idea of physiological and affective states impacting the breastfeeding process, where a failure to breastfeed is attributed to emotional and physiological interference with the “let down” reflex where the hormone oxytocin is inhibited and therefore potentially leads to “insufficient milk supply syndrome” (Hillervik-Lindquist, Hofvander and Sojolin, 1991). The idea of “milk insufficiency” will be explored further, later in the chapter.

1.6.3 Psychological factors. As well as physical problems associated with breastfeeding difficulties, research has also explored the impact of psychological factors in the duration and cessation of breastfeeding. A review by Dennis (2002) supports the idea that women often wean their babies before the age of 6 months due to perceived difficulties with breastfeeding rather than by choice (for example, perceived lack of breast milk). In her study, Dennis (2003) suggested that maternal confidence about their ability to breastfeed tended to be low in mothers who ceased to breastfeed early. A review of the relationship between infant feeding outcomes and post-partum depression supported the findings of low maternal confidence in breastfeeding and also found links between breastfeeding duration, breast feeding difficulties and increased post-natal distress.

Breastfeeding “failure” was claimed to be 4-5 times more likely in less confident women (Dennis and McQueen, 2009). This finding supports previous research that found that maternal confidence was the most significant of eleven psychosocial and demographic factors which influence breastfeeding duration (O’Campo, Faden, Gielen and Wang, 1992).

Through her work on breastfeeding confidence and self- efficacy, Dennis (1999, 2002, 2003) developed an instrument to measure breastfeeding confidence in new breastfeeding mothers and used Self Efficacy theory (Bandura, 1977) as a conceptual framework. The Breastfeeding Self Efficacy Scale (BFSES; Dennis & Faux, 1999) is a 33 item self-report instrument which measures self-efficacy expectants in new mothers. The instrument has predicted which women would be continuing to breastfeed at 6 weeks postpartum (Dennis, 1999).

Blyth, Creedy and Dennis (2002) interviewed 300 women in their third trimester of pregnancy via telephone and again at 1 week and 4 months post-partum to assess feeding methods and breastfeeding confidence using the BFSES. They found that whilst 92% of women had initiated breastfeeding, only 28.6% were still breastfeeding exclusively at 4 months post-partum, and that the most common reason for ceasing breastfeeding was cited as being a perceived low milk supply.

Scores on the BFSES were significantly related to breastfeeding outcomes at 1 week and 4 months where mothers with high breastfeeding self- efficacy were significantly more likely to be breastfeeding exclusively at 1 week and 4 months than mothers with low breast feeding self- efficacy.

The study suggested that maternal breast feeding self-efficacy is a significant predictor of breastfeeding duration. Recommendation from the research was for health professionals to use “breastfeeding self -efficacy enhancing strategies” to increase maternal confidence in their ability to breastfeed where self-efficacy expectations can influence women’s judgement regarding their ability to initiate and continue to breast feed. Self-efficacy will be discussed further later on in this chapter.

In an investigation into maternal confidence, Wojnar (2004) used the Mother and Baby Scale (MABS) and breastfeeding rates at six weeks. The scales measured

maternal perceptions and included five neonatal and three maternal subscales. The neonatal scales measured mothers' perceptions of infant behaviour (unsettledness, irregular feeding, irritability during feeds, overall alertness, alertness during feeds and infant "easiness"). The maternal subscales measured lack of confidence in care taking and lack of confidence in feeding, as well as overall levels of confidence. Here, a lack of confidence in feeding was significantly correlated with breastfeeding rates, supporting the hypothesis that the higher the mother's confidence in her ability to breastfeed during postpartum hospitalisation, the more likely that she would still be breastfeeding at six weeks.

Negative experiences of breastfeeding were found to be related to perceived insufficient milk supply, illness and incompatibility of lactation with personal needs and lifestyle. The authors emphasised the importance of mothers' perceptions of their infant's behaviour as well as of themselves as a mother in sustaining breastfeeding.

In their exploration of the influence of psychological factors on breastfeeding duration, O'Brien, Buikstra and Hegney (2008) found that 44% of women experienced post-natal distress in the 14 days following birth. The authors used a mixed methods designed and used questionnaires to measure several psychological factors such as depression, anxiety, self-esteem and stress. The results suggested that breastfeeding duration was significantly associated with psychological factors such as optimism, breastfeeding self-efficacy, faith in their breast milk, breastfeeding expectation, and anxiety and planned duration of breastfeeding at the time of making decisions about feeding. Some limitations of this study however, were that the sample used was relatively homogenous, in that it was made up of women who were married or co-habiting and (92%) and mainly white and English speaking.

The research outlined above is scientific and positivistic in its stance in that it lacks focus on meaning and experience for women. This approach might be helpful when considering ways to improve mortality rates in the third world, by adopting a more medicalised way of exploring breastfeeding rates. However, this may overlook the meaning of the challenges that breastfeeding can pose when considering reasons for the decline in rates in the western world. To counteract this, the following section will attempt to explore how some literature has made sense of women's experiences of breastfeeding and how this might be impacted by the information and ideas that they have been exposed to over time.

1.7. Women's experiences of breastfeeding

To explore women's lived experience of breastfeeding, and to consider meaning from a critical realist stance, which in keeping with the researcher's position (discussed in Chapter Two) it is helpful to explore other literature that has moved away from a positivistic or scientific investigation of breastfeeding. The following section will therefore briefly present some of the theoretical ideas that are used to understand women's breastfeeding experience. Firstly, "Maternal identity" attempts to capture the view of the self as mother and the "moral constructions of motherhood" addresses motherhood as a social construction. Some researchers have harnessed feminist ideas in considering the way in which breastfeeding might empower or oppress women in their choices in infant feeding and offer exploration of meaning of breastfeeding in public and the idea of "milk insufficiency". Other researchers focus on psychological constructs such as self-efficacy as an attempt to explore the perceived impact of successful or more challenging feeding experiences, which will be discussed below.

1.7.1. Maternal Identity and Infant Feeding. There are a number of definitions of “Maternal Identity” and ways to conceptualise this. Mercer (2005) defines maternal identity as one having an “internalised view of the self as a mother”. Rubin (1967) described maternal identity as an “ideal image of the self as a mother” which is constructed through extensive “psychological work” during pregnancy and the postpartum period. Here the maternal identity becomes incorporated into the existing “self- system”. This ideal image or self-system includes qualities, traits and attitudes that the woman feels are desirable. The theory of maternal identity describes this identity for a woman as the “end point” in maternal role taking where a woman has a sense of being within her role and has a sense of comfort about the past and future.

Rubin (1984) described maternal identity as being made up of two progressive stages. The first stage, “Replication” suggests that mothers mimic the role of mother in looking to their strongest female model. The second stage, “dedifferentiation” describes the shift from looking to models of expert mothering to the woman herself in relation to her child. This stage precedes maternal identity and involves a stabilization of the mother’s image of her child and her ability to anticipate her child’s behaviour. Conversely, in developing her model of Maternal Role attainment/Becoming a mother, Mercer (1980) used Thornton and Nardi’s (1975) work to help describe the process of maternal role attainment through their four stage model of role acquisition. This included anticipatory, formal, informal and personal identity stages which resulted in a mother’s sense of harmony, confidence and satisfaction in the maternal role and the attachment to her infant.

There has been research more recently into the constructions of motherhood specifically in terms of feeding and breastfeeding. Wall (2001) explored “moral

constructions” of motherhood in breastfeeding discourses and how these are part of a broader context of “medicalisation” and of the control of mothering. Her research found that there is a conflict in the discourse around infant feeding which, on one hand, lends itself to the view that breastfeeding is natural and that all women have the capacity to breastfeed successfully without much resource and support; but also that there are “facts” and information about breastfeeding that women need to be “taught through scientific and professional intervention”. These two differing constructions were described as a “maternalist model” where motherhood is “celebrated as an embodied connection between the mother and child that breastfeeding provides”; and a “medical model” which focuses on the benefits of the milk itself, and that mothers are “disembodied providers of milk” who must be educated and scrutinised. Wall (2001) also posited that both models could be both empowering and oppressive and that therefore health education could be perceived as controlling and/or helpful. Wall also found that the construction that all women can breastfeed successfully because it is “natural” undermines and trivialises real difficulties that many women face when attempting to breastfeed their infant. Here, difficulties appear to be thought of as small concerns that should be easily overcome by seeking professional advice or support, or by being patient, motivated or having a sense of humour. However, first time mothers reported feeling overwhelmed by major difficulties with breastfeeding and felt unprepared for the exhaustion and fatigue that came with breastfeeding (Wall, 2001).

Additional support for these perspectives comes from Blum (1999) who found that women who gave up breastfeeding after encountering difficulties reported feeling isolated and unique, that their body had failed and that they had failed as mothers. She also found that women felt that breastfeeding had become “the measure of the

mother” and that failure to breastfeed was seen as “deviant” in some way. The minimisation of difficulties by health care providers and its exclusion from educational literature as per WHO (1981) and UNICEF (2014) guidance was thought to protect the ideology of natural motherhood, and therefore avoid feeding into the ideas used to promote formula feeding. This could potentially maintain the feelings of failure described by Blum (1999) if difficulties are minimised and therefore resulting in the woman taking on responsibility for failing to breastfeed successfully.

Ellie Lee (2008) looked at how maternal identity can be impacted upon by constructions of motherhood in relation to “risk and infant feeding”. She found that mothering in general was constructed as something which involved public scrutiny and intervention and which could be defined as ‘good’ and ‘bad’ in its practice. Here mothers felt that they had to justify or account for decisions they made in terms of feeding, with giving babies formula rather than breast milk constructed as “risky” for the physical health of the baby, and for the mother-infant relationship. Lee also found that in the current cultural context, mothers who formula fed often struggled to maintain a positive sense of themselves as mothers. Deciding to formula feed, therefore, also had to be justified and defended. This finding is in keeping with the idea that women who choose to formula feed have to do ‘identity work’ in order to keep their identity as a ‘good mother’ secure (Murphy, 1999).

The idea of information about breastfeeding potentially minimising women’s experiences of difficulties appears to add to the perceived pressure to breastfeed. Knaak, (2010) suggested that the risks of not breastfeeding are emphasised in information provided to women and that “choice in infant feeding has become constrained discursively to the point where it has become more a directive than a choice”. For example, many women are encouraged to buy into what Lee (2008)

describes as the “bonding myth”; that breastfeeding is central to the bonding process and that not breastfeeding will impact the bond negatively (as suggested in section 1.4.3.). She also described how mothers faced “moral collapse” when giving their infant formula.

In her study leading to these findings, Lee (2008) found that women who had planned to breastfeed their babies and “assumed” that this would be successful talked very negatively about feeding their child formula. Forty eight percent of women in her study reported that they felt uncertain they were making the right decision when formula feeding, with 32% having a sense of failure and guilt about not breastfeeding. It appeared that women seemed to have internalised the notion that formula feeding was practised by mothers who ‘do the wrong thing’ which was strongly reflected in feelings of failure, guilt and uncertainty if experience did not match expectations.

In their research around the expression of breast milk, Johnson, Leeming, Williamson and Lyttle, (2012) found through interviews and audio diaries with 22 women, that the practice of expressing breast milk was employed as a solution to manage “the competing demands and dilemmas of early breastfeeding” where the aim for women was to ensure that they could continue to provide their baby with breast milk and so avoid any “potential accusations of poor mothering”. Johnson et al. (2012) highlighted that although expression of milk is promoted as a solution to breastfeeding difficulties (where mothers are able to still provide breast milk) there is a need for education of health professionals which emphasises the complexities of mothering, where “prescriptive notions” of good mothering can be challenged in order to provide new mothers with better support in making feeding decisions.

Williamson, Leeming, Lyttle and Johnson (2011) supported the idea that difficulties with breastfeeding threaten maternal identity. Using an interpretative

approach to analyse data from eight women who expressed difficulties with breastfeeding, the researchers found two themes through analysis of the data. Within the first theme; “difficulties with breastfeeding as a threat to maternal identity”, women talked about their ability to feed their babies with their own bodies as an “essential” part of motherhood, and that this defined them as mothers. The second theme was “interpreting and responding to pain”. Here, women appeared to be in a position where they were managing conflicting notions that breastfeeding was initially painful but also that if performed correctly, should be painless. These themes were brought together into one overarching theme that described “a tension between the women’s lived embodied experience of their struggle to breastfeed and a prior expectation that breastfeeding would be relatively straightforward by virtue of being ‘natural’” (Williamson et al., 2011, p.438).

The literature described suggests that challenges with breastfeeding not only have an emotional impact on women, but also affects their sense of themselves as mothers, in threatening their maternal identity, something which is perhaps not considered currently by healthcare providers supporting women. The following section briefly presents how some experiences of breastfeeding can be explained with a feminist slant, which allows consideration of another perspective to the lived experience.

1.7.2. Breastfeeding and Feminism. Feminist literature that discusses breastfeeding takes the position that the act of breastfeeding empowers women and contributes to gender equality. They posit that those who cannot breastfeed due to misinformation, lack of support or workplace constraints are subject to oppression or exploitation (Van Esterik, 1994).

With this in mind, feminist arguments talk about “locating guilt” and object to any kind of breastfeeding promotion, due to this potentially leading women to experience guilt for any difficulty or inability to breastfeed their child. They suggest that information about infant feeding should be presented to women as part of informed consent, likening it to decision making about other health care issues, for example, in choosing treatments for cancer, where blame or guilt is not located in the patient for their difficulties. They maintain that personal choice only exists when information about all options are available. This idea connects to the notion of “politically correct breastfeeding” where there is a cultural perspective currently that there is one “correct” way to breastfeed, again linked to the ideas that breastfeeding has become ‘medicalised’ in western society, which is reflected in the way it is approached in current healthcare policy and guidance. This will be explored further later on in this chapter. The feminist stance is that there is a danger that breastfeeding will be interpreted as part of women’s oppression instead of women’s “liberation”, (Gaskin, 1987) and potentially cause distress for women faced with challenges in their breastfeeding experience. These ideas reflect some of the discussion above around maternal identity, in terms of there being a mismatch between what is considered a ‘natural’ part of womanhood (suggested in the feminist literature) and what messages women receive in terms of there being a ‘correct’ or successful way of breastfeeding that fits into a medical or scientific view (i.e. WHO and BFI guidance).

Feeding in public. Another aspect of breastfeeding that is often represented in the media is the taboo about breastfeeding in public. Here, there is a feminist argument about breasts and sexuality, meaning it is difficult for breasts to be viewed as anything other than objects of sexual desire, thus making their exposure in public inappropriate and offensive. Marxists feminists have historically questioned and

challenged the idea of public and private breastfeeding, asking why breastfeeding should be a private act at all:

It is strange indeed that countries which so pride themselves on their fastidiousness should make social rules which often force the most vulnerable members of society to eat in places designed for the excretory needs of other members of society. (Gaskin, 1987 as cited in Van Esterik, 1994, p.S46)

There are currently regular news items that talk about the “backlash” to the cultural norm of keeping infant feeding a private practice where mothers have protested about being asked to leave public areas when breastfeeding. This has often attracted media attention where mothers have ‘named and shamed’ retail or food establishments (BBC News article, 2014; Mirror article, 2015). There have also been social media campaigns over the last year to challenge the taboo of having to ‘cover up’ when breastfeeding where women have posted pictures of themselves feeding their babies on social media platforms such as Facebook and Twitter to lend their support to this cause (Daily Mail article 2015). Recent research on “socially sensitive lactation” (Leeming, Williamson, Lyttle and Johnson, 2013a) found that women often felt tension between their need to breastfeed their babies and the perceived need to manage the expectations and comfort of others. They suggest that breastfeeding in public is still a taboo and that it remains a “problematic social act”.

Milk Insufficiency. Fiona Dyke’s (2010) work on the construction of “inadequate milk syndrome” in lactating women suggested that breastfeeding has been reduced to a mechanistic process where an emphasis is placed on the “output” of breastmilk and has contributed to healthcare professionals making “mechanistic assumptions” (i.e. focusing on the physical act of breastfeeding) related to supporting

women in feeding. She also posits that western ideologies such as biomedical science and capitalism have impacted women's perception (i.e. something to be quantified or measured) of their breastmilk, which in turn can lead to problems associated with their perceived ability to feed and the meaning that this has for them (Dykes, 2002). This idea was taken further by Boyer (2014) who researched the social and cultural contexts of milk expression and suggested that increased use of breast pumps in breastfeeding as a way of increasing the likelihood of women continuing to breastfeed contribute to the "medicalisation of motherhood". These ideas are interesting to consider when thinking about literature that has discussed the tension between women's experience of support from healthcare professionals and what impact a focus of milk insufficiency and perceived ability to breastfeed might have for women.

1.7.3. Breastfeeding Self-Efficacy. More recently there has been a wealth of literature that examines the challenges of breastfeeding and the relationship between these and duration of breastfeeding in Western society. This focus on these challenges would appear to be to aid better understanding of the reasons women might not breastfeed according to recommendations and guidelines, and so as a way to think about improving breastfeeding rates in the UK as well as globally.

As described in section 1.6.3, Dennis (1999) developed a theory of Breastfeeding Self Efficacy based on Bandura's model of Self-Efficacy (1977). Dennis' research attempted to make sense of women's breastfeeding experience by exploring mothers' perceived confidence in her ability to breastfeed. She developed behaviour specific self-efficacy scales to identify mothers with high or low confidence. The theory follows Bandura's four sources of information to inform their breastfeeding 'behaviour'. In terms of "performance accomplishment", Dennis (1999) gave an example of a breastfeeding woman having a low sense of breastfeeding self-

efficacy when she was unsuccessful at a perceived simple act of latching the baby to the breast, compared to a woman who managed to succeed and perceived the act as intricate and difficult. The latter woman would be predicted to have a higher sense of self efficacy. An example of “vicarious experience” in breastfeeding, women who have observed family members or friends successfully breastfeeding are more likely to choose and succeed at breastfeeding themselves. It is suggested that the most effective role models are psychosocially and demographically similar to the ‘target audience’ but are more competent at the behaviour being modelled. An example of this is in the use of breastfeeding counsellors or peer supporters in assisting women with initiating breastfeeding.

“Verbal persuasion” in the appraisals of a woman’s perceived breastfeeding ability by friends, family, breastfeeding support workers and so forth, was suggested to be beneficial in drawing attention to and praising the positive aspects and skills learned around breastfeeding. It was posited that this can aid in boosting the woman’s sense of self-efficacy. Here, the more credible the person who is providing the feedback, the more impact it has on changing perceptions of self-efficacy.

Overall therefore, in developing the theory, Dennis suggested that mothers with high breastfeeding self-efficacy will choose to initiate breastfeeding and establish goals to which they are committed. They will also exert effort and persevere with breastfeeding even when confronted with difficulties and envision success, think analytically, and manage self-defeating thoughts even when confronted with difficulties. It is posited that mothers with high breastfeeding self-efficacy are more likely to interpret breastfeeding difficulties as a positive challenge and not be overwhelmed. These behaviours and beliefs were consistently shown in diverse samples to predict breastfeeding outcomes.

1.8. The focus on ‘difficulties’: A review of the literature

If, as some researchers suggest, breastfeeding duration and cessation is associated with psychological difficulties such as decreased sense of self-efficacy and confidence, and an increased threat to maternal identity, as well as feelings of guilt and failure; it is important to explore how “breastfeeding difficulties” have been explored in the literature in more detail and what the findings have been about how difficulties are experienced. This section will present and summarise some of the common themes found in the literature that includes qualitative methods of research.

1.8.1 Findings of the literature review. In Nelson’s (2006) meta-synthesis of qualitative breastfeeding studies, it was found that breastfeeding was an “engrossing, personal journey” for women and that overall; the synthesis results suggested that individualised breastfeeding plans were required in supporting women. In exploring breastfeeding “difficulties”, some studies in the meta-synthesis showed how women facing these would require “persistence” (Johnsen, 2002) and “maternal perseverance” to overcome challenges (Gill, 1997). The meta-synthesis also found that support was important but that crucially, support was not always experienced by mothers as consistent with their breastfeeding goals (Hauck & Irurita, 2003). These “incompatible expectations” were recognised between the mother and her family, friends and health care professionals. The impact of difficulties on maternal self-esteem was also evidenced where mothers talked about feeling “rejected” by their infants when breastfeeding had not gone well (Schmeid and Barclay, 2001).

In a more recent synthesis of seventeen qualitative studies of breastfeeding experiences, Burns, Schmied, Sheehan and Fenwick (2010) found two overarching themes. They found that breastfeeding was described in terms of “expectation” and “reality” where women had an expectation that breastfeeding was a natural process

which was best for baby and was aligned with being a good mother. Subsequently, women felt the need to get breastfeeding “right”. The reality of breastfeeding was experienced as “demanding” and a process which required perseverance. The cessation of breastfeeding was often associated with guilt and a sense of failure. The second theme; “discourses of connection and disconnected activity” represented the ideas from women who enjoyed breastfeeding, experiencing it as allowing a special relationship with their baby.

A theme in the literature that was common across several studies was the need to seek professional support when breastfeeding and the experience of the support received. For example, Shakespeare et al. (2004) suggested that the Baby Friendly Initiative (2012) seemed to contribute to unhelpful interactions between mothers and professionals, and that the help and literature given to mothers had no mention of potential difficulties, whereas information on other methods of feeding was censored. The authors suggested that there was a need for a more “mother friendly” approach to breastfeeding support, but acknowledged that their study was focused on post-natal depression rather than difficulties and highlighted the need for more research in this area.

Hall and Hauck (2007) found that there was a need to ‘get it right’ and that women experienced pressure to breastfeed from professionals. They outlined several factors that decreased maternal confidence in breastfeeding: physical problems such as breast pain or infections, lack of milk supply and factors such as pressure from health care providers to ‘force’ feed their infants, breastfeeding in public and feeling neglected by healthcare professionals. Other research picked up on the idea of breastfeeding being “medicalised” (Mahon-Daley & Andrews, 2002) and therefore impacting a woman’s sense of being a good mother, suggesting that there is a need for

a shift from “medical discourse” around breastfeeding to a more “mother-centred” approach (Marshall, Renfrew & Godfrey, 2007).

As previously discussed (section 1.7) the idea of a woman’s self-concept about the kind of mother she is based on her breastfeeding ability was presented in researchers’ findings that maternal identity is a factor in determining the experience of infant feeding. As presented earlier in the chapter, Williamson, et al (2011) Used an interpretative approach to analyse data from eight women who expressed difficulties with breastfeeding. They described that these “difficulties” posed a “threat” to maternal identity. These findings build upon previous research by Schmied and Barclay (1999) who conducted semi structured interviews and found, as described in the earlier section, that maternal identity was impacted by breastfeeding experiences. Breastfeeding was found to be central to women’s sense of identity as a mother. They found that 25% of women interviewed found breastfeeding to be a disappointing, distressing experience and described it as disruptive (routines), distorted (perception of breasts and body) and a disconnected experience (feeling overwhelmed by proximity to infant and need for separation). The authors used discourse analysis to interpret the data and examine the way in which women “constructed” their experience of breastfeeding through language and visual imagery.

Another theme found in the literature was around maternal confidence and satisfaction with breastfeeding. Hoddinott and Pill (1999) found that women’s confidence about breastfeeding post-natally effects feeding negatively. Women were found to be unlikely to seek help for their difficulties with breastfeeding and that they had an expectation that breastfeeding should be easy, again, as previous research found, making any difficulties experienced likely to make them feel a failure. This was also reflected in interviews conducted by Labarere et al (2012) who explored

maternal satisfaction. In this study the researchers identified and defined physical difficulties experienced by mothers as well as psychological, social and peer/professional factors that impacted upon maternal satisfaction, and found that breastfeeding difficulties were associated with decreased maternal satisfaction. They also suggested that information about women's' expectations regarding breastfeeding duration may help healthcare providers give more appropriate guidance to women. Other studies also highlighted that mothers who "came off the path" in terms of attempting to overcome difficulties reported experiencing feelings of isolation, despair and frustration (Hauck et al., 2002). This was also highlighted in Palmer, Carlsson, Mollberg, and Nystrom's (2012) findings that mothers difficulties around feeling alone and exposed when trying to feed their infants. The authors described mother's "existential lostness" to encapsulate how some women find their experience of breastfeeding one which adversely impacts connection to their infant, causing alienation and ambivalence to breastfeeding.

Once mothers had discontinued breastfeeding due to difficulties, it was found that they felt grateful for some "resolution" (Hauck & Irurita, 2002) although this was often experienced as mixed feelings, i.e. resolution vs. guilt, shame and feelings of failure (Mozingo, Davis, Droppleman, and Merideth, 2000).

1.8.2. Summary of breastfeeding literature. The overall themes explored through breastfeeding literature suggest that breastfeeding mothers can describe experiencing many psychological and emotional difficulties related to the act of feeding their infant. The studies generally identified some overarching themes that were consistent. Firstly, women reported that their confidence in their ability to breastfeed impacted upon their experience of breastfeeding, for example, duration and satisfaction. This fits well with the both self-efficacy and breast feeding self-efficacy

theories which provide a conceptual framework upon which to hang these findings (Bandura, 1977; Dennis, 1999). However, some research goes further in exploring in more detail how women might experience challenges with breastfeeding and the meaning this has for them. For example, it is also suggested that mothers' expectations about their ability to breastfeed not only impact how long they are able to feed their baby, but also impact negatively on emotional and psychological levels. This was demonstrated through studies that discussed how maternal identity can be threatened by mothers' negative breastfeeding experiences, with some women equating their ability to feed with good mothering. Therefore inability to feed was often found to lead to feelings of failure, lack of confidence and dissatisfaction with the whole experience, as well as an increase in emotional distress if breastfeeding is not possible (e.g. O'Brien et al. 2008).

The literature did appear to consistently report similar challenges to breastfeeding, defining them in different physical and emotional categories. An emphasis on a medical, scientific approach to breastfeeding was evident, through much focus on physical difficulties associated with breastfeeding such as breast and nipple pain, latch, milk supply and medical problems such as infections (e.g. mastitis, thrush). Further, emotional or psychological difficulties were described as distress, lack of confidence, low self-efficacy, negative maternal identity and a mismatch in breast feeding expectations and experiences. Other factors that were described in some studies, were issues related to breastfeeding in the workplace and modesty or embarrassment about breastfeeding in public. The latter issues, i.e. modesty, are interesting because they are generally not issues that are at the forefront of healthcare givers' agendas when offering support to women.

These findings are interesting when considering the possible impact on emotional well-being that women experience when encountering challenges to breastfeeding. Whilst research from a more positivist perspective provides a way in which to measure and quantify breastfeeding rates and behaviours, other research seeks to qualitatively explore women's experiences and the meaning that is attached to difficulties with which they are faced. These were considered and used to develop the research questions which will be presented below in section 1.9.

When considering the above literature in the context of supporting women in their breastfeeding journey in order to improve breastfeeding duration, it is helpful to explore how current support is experienced by women accessing services in the UK. The section below will present some research around women's experience of breastfeeding support.

1.8.3. Breastfeeding policy in healthcare. Current research around breastfeeding rates, durations and impact on psychological well-being seem to highlight the need for support from healthcare professionals. However, according to Hoddinott, Craig, Britten and McInnes (2012), recent provisions in post-natal care such as breastfeeding support services seem to be making women feel under more pressure to succeed with breastfeeding. Recent research suggests that current policy and guidelines on breastfeeding are actually unrealistic and unhelpful, where women are feeling under constant pressure to successfully breastfeed their babies, exclusively, and for longer.

Hoddinott et al. (2012) researched experiences of thirty six women and their families in relation to this with serial semi structured interviews. They found that there was a clash between women's covert and overt "infant feeding idealism" and what was actually experienced. Further to this, families' main priority was their

immediate well-being, which was an overriding factor in infant feeding choices, rather than any longer term health benefits. It was also found that feeding education was perceived as being overly technical and rules based, possibly undermining womens' confidence.

Within the Care Quality Commission (CQC) report of the 2013 Maternity Survey it was found that 85.5% of comments made on the topic of Infant Feeding were negative. Forty one percent of women felt inadequately supported in breastfeeding and felt that information provided was poor. A fifth of women felt they received inconsistent advice about breastfeeding, dependent upon the individual midwife's opinions, which left them feeling confused and anxious. Fourteen percent felt overwhelmed by the pressure of breastfeeding, often feeling "bullied into breastfeeding", and feeling isolated and guilty (CQC, 2013).

One explanation for this is that support offered to women is aimed at the physical act of breastfeeding; for example, establishing a good latch, timings of feeds, baby's weight gain and medical issues such as mastitis, rather than on giving women emotional support about their feeding difficulties or even supporting choices that do not include breast feeding

Leeming, Williamson, Johnson and Lyttle (2013b) explored how women make use of expertise from maternity professionals and other breastfeeding support workers. In this qualitative study, twenty two women were interviewed and completed audio diaries at two time points during the first five weeks in the post-partum period. It was found that women talked about their experience of using expertise in terms of it being either an empowering or a disempowering experience. Leeming et al. (2013) suggest that breastfeeding support workers should ensure that their expertise does not disempower women by leaving them feeling confused,

pressured or judged. Furthermore, it was suggested that women differ in their informational needs, and therefore if support is to be effective, information and advice given should reflect their individual needs.

Research has only recently begun to consider psychological factors in breastfeeding difficulties, and the impact of these on maternal wellbeing, this having been somewhat overlooked in past studies. The available research appears to highlight many assumptions in current guidelines for the support that is on offer to breastfeeding women. For example, middle class women are often thought to have fewer difficulties and considered more as “natural” breast feeders (Mahon-Daly & Andrews, 2002). The implications of this could be that these women may feel more pressure to breastfeed and possibly less likely to approach healthcare professionals if they are struggling.

Another assumption is that women who are breastfeeding are happy in their choice and not experiencing any difficulties. Women who have not chosen to breastfeed are often left out of research studies, and so the impact of making a decision not to breast feed is often not known, and could be a factor when considering post-natal distress as outlined in the current research literature. There also appear to be assumptions about what defines “difficulties”. Currently, many scales that measure infant feeding focus on physical difficulties and so emotional problems relating to the act of breastfeeding can go left unrecorded, potentially losing the opportunity to explore meaning in women’s experiences of such difficulties. Similarly, healthcare professionals tend to still use post- natal depression scales that do not specifically include questions about feeding, which can potentially mean any emotional difficulties relating to feeding are not discussed.

Some researchers (e.g. Hoddinott et al., 2012) suggest that healthcare professionals need to show sensitivity to the meaning and significance of breastfeeding to maternal self-esteem and the woman's perceived ability to mother; and that this can only be achieved through collaboratively working with women and their own support network where there is an acknowledgement of her breastfeeding goals, capacity, comfort level with her own body and her tolerance for breastfeeding difficulties. Nelson (2006) suggested that it was evident from a number of studies that this approach would have a greater impact on a woman's ability to breastfeed for longer than using the standardised packages of support that are currently adopted.

Another factor that is of importance and that was generally described across all of the studies reviewed is that of pressure to breastfeed. As recent media attention has highlighted, (e.g. UNICEF, 2012) the findings that increasing breastfeeding in women could save the NHS millions of pounds could further cause pressure from health professionals for women to succeed at breastfeeding. This pressure could potentially lead to an increase in emotional distress as well as breastfeeding difficulties. As Hoddinott (2012) suggests, current policy and guidelines could be unhelpful to women when dealing with the reality of breastfeeding. It appears that although the NHS is attempting to support women, perhaps this support is misguided, resulting in women feeling that they have limited choices in feeding their infant, and that they need to be successful in breastfeeding, with support seeming to be "one size fits all" in nature. However, the literature also points to internalised pressure that women may place on themselves to succeed in breastfeeding; for example in considering perceptions of the self as a mother, and the idea of woman and motherhood in the current cultural and social context. (Lee, 2008;Knaak, 2010)

These findings were also taken into consideration when exploring how women experience receiving information and interactions with professionals in thinking about the research questions and overall aims of the thesis.

1.9 Rationale for the Current Research

There is currently limited research that looks in detail at emotional difficulties in women who breastfeed. There seems to be a lack of clarity about what these difficulties may be, with many assumptions being made about what support women need. Often, it appears that such support can be misplaced or misguided, with the emphasis being on the physical aspects of breastfeeding and the beneficial impact on the child. Little attention is given to how breastfeeding challenges are defined for women, and what this means for them as well as for their babies.

This study therefore, will explore women's experience of breastfeeding in an attempt to understand in more detail the emotional impact of breastfeeding, taking into consideration the positive aspects of breastfeeding as well as the challenges. For example, assumptions are made that women who are breastfeeding and not reporting difficulties, as historically defined, are coping well with their choice to breastfeed and have no emotional difficulties relating to feeding. Focusing research on those mothers only reporting difficulties risks excluding those whose experiences are as of yet, undefined under the umbrella of "breastfeeding difficulties". It is therefore necessary to broaden the line of exploration to include women in general who are breastfeeding in order to explore their personal perspectives without influencing the data with too rigid a priori themes.

The current study sought to keep in line with previous research studies that have utilised a qualitative methodology in order to explore issues surrounding breastfeeding, feeding in general and women's emotional as well as mental health.

According to Sofaer (1999), qualitative methods: “Help provide rich descriptions of phenomena. They enhance understanding of the context of events as well as the events themselves. In addition; qualitative methods can indeed help to identify patterns and configurations among variables and to make distinctions. Thus, qualitative research not only serves the desire to describe; it also helps move inquiry toward more meaningful explanations” (p.1102).

The following research questions were therefore explored within the current study where the aim was to add to the literature around breastfeeding experiences in women and the meaning they place on the challenges they encounter with this.

1.9.1 Research Questions

- What are women’s experiences of breastfeeding?
- What are women’s perceptions of the emotional impact of breastfeeding?
- What are women’s perceptions about breastfeeding difficulties, and how are these defined for them?
- What does it mean for women to experience difficulties with breastfeeding?

1.9.2. Reflexive Statement. As the researcher is central to qualitative research, it is important for the researcher to be reflexive throughout the research process and consider this in all aspects of the study being undertaken. Below, the researcher will give an introductory reflection on their position and initial thoughts about the study. Subsequent excerpts from the researcher’s reflective journal will be placed in boxes throughout the sections within the paper.

June 2012

As a mother and a trainee, when the opportunity of exploring breastfeeding as a piece of research arose, it was obviously extremely interesting to me both personally and professionally. Through my personal experience of breastfeeding my daughter, and through meeting and talking with other mums when I was myself a new mum, it had become apparent to me that breastfeeding was an extremely emotive experience and subject, something which I had not perhaps appreciated before becoming a mother. I felt strongly that breastfeeding and the way in which women's experiences of it impacted their emotional well-being would be a worth-while field to explore in more detail. I'm aware that I have a personal connection to this topic, and it is an emotive subject for me too, but I can surely use this as an advantage in putting my energies into a method that might make my personal connection part of the research project? I wonder if a qualitative study would fit with this? I definitely think that choosing a topic to explore that I am interested in will help the whole research process!

July 2012

I've been chatting to another mum and fellow trainee. We were sharing experiences of breastfeeding and I came to thinking there are just so many assumptions that are made around it by healthcare professionals. For example, the assumptions that if you're breastfeeding with no 'difficulties' and baby is putting weight on etc, then all is ok. I don't think anyone ever asked me how I felt, because things were seemingly 'ok'. And I didn't think I had the right to complain that in fact I was feeling trapped, tired and stressed, that despite all my efforts, my baby wouldn't take a bottle so I could not have a break at all. I tried on a couple of occasions to tell the health visitors at the weigh in clinics how I was feeling but was quickly rebuffed by remarks such as "count yourself lucky" and reassurances that as baby was doing well, I had nothing to be bothered about. So I ended up feeling really guilty for not being ecstatic that my baby was an "excellent breast-feeder" and just wanting breastfeeding to end.. My friend was saying she had very similar feelings of frustration, and that it can really get you down...I'm wondering how many other women this is the case for...?

January 2013-After meeting with a breastfeeding co-ordinator

Are you kidding me?! I didn't realise that there was guidance saying you couldn't give advice to women about formula or basically say anything that can discourage women from breastfeeding! So what about the women who don't want to or can't breastfeed for some reason? It seems really dictatorial. I'm sure it's all based on evidence-must look up what the UK Baby Friendly Initiative guidance says in more detail, because it would appear there are really specific rules about the information women are and are not allowed to be given. I'm finding myself getting really annoyed about this, which is funny, because at the start of this research process I was relatively 'pro' breastfeeding but increasingly I'm feeling that as a woman, the fact that some information is censored in case I don't make the 'right' decision and choose to breastfeed, extremely patronising! What happened to informed consent?! INFORMED consent!! Conversations with some of the breastfeeding coordinators in some of the trusts have been interesting-they said they are slowly moving towards not asking women before they have their baby what their feeding intentions are, because they are preoccupied with the birth and so perhaps cannot attend to conversations about feeding very well. So why do the same trusts still hold breastfeeding classes antenatally?? Also, the baby friendly guidance is apparently meant to not 'put women off' breastfeeding by going into detail about the potential difficulties-again not informed, but just seems to me, ridiculous-it's like saying we should censor One Born Every Minute in case it puts people off reproducing!! Someone is missing the point a bit here I think. In my experience, the desire to breastfeed is just something that happens when the a baby is born (or not I guess), it's connected to your emotions, just like your desire to have a baby is instinctive so how can anything you say to a woman to convince her otherwise override that? I don't know, maybe it can.....but I doubt it.....

Chapter 2: Methodology

2.1 Overview of Chapter

The following chapter will firstly outline the aims of this research as discussed in Chapter 1. The research design as well as a justification for the method chosen will then be discussed. The procedure undertaken to collect data will be outlined in detail and an overview of Interpretative Phenomenological Analysis (IPA) will then be provided. The specific method of data analysis will be presented to finish the chapter.

2.2 Research Aims

The purpose and aims of this research were to explore the ‘lived’ experiences of first time mothers who were breastfeeding. The study aimed to gain further insight into how women experience breastfeeding difficulties and the impact and meaning of these for them.

2.3 Research Design

This section will present the rationale for using qualitative methods to conduct the study as well as the rationale to utilise IPA as a specific method of data analysis. An overview of IPA is given as well as a description of the philosophy underpinning it. Epistemology is briefly discussed and researcher’s position is outlined.

2.3.1 Rationale for qualitative research. This study utilised a qualitative methodology in order to explore issues surrounding breastfeeding, infant feeding in general and women’s emotional health regarding these issues.

Howitt and Cramer (2008) describe how a qualitative method is indicated when there is little research into the topic, where there is a lack of clarity over the research questions or where the use of a more structured approach, for example the use of measures, may discourage individuals from participating.

Qualitative methods come from the standpoint that the researcher is central to the sense that is made from the issue that is being explored. Here the position taken by qualitative researchers is that it is not possible to directly observe or measure behaviour, but instead only others' perceptions of the experience they have had. As Bannister et al. (1994) describe, qualitative research aims to capture internal sense or meaning making and how that impacts behaviour; is an "exploration, elaboration and systemization" of the meaning of a particular phenomenon and is the "illuminative representation" of the meaning of an issue or problem.

For the current study, the researcher was interested in exploring in depth the experiences of women who were breastfeeding and personal meanings that experience held for them. Through reading both qualitative and quantitative research related to the topic are, it was felt that qualitative methodology would be the most appropriate way of researching experience and meaning for breastfeeding mothers; in order to add some depth and insights into discussions around the act of breastfeeding where breastfeeding duration and rates are currently emphasised in the research field. As the research questions set out below will describe, the researcher was interested to understand more about how women's experiences of breastfeeding and challenges of these seemed to cause so much distress for some, and the reasons that this subject seems still such an emotive, and at times, taboo subject in our society.

This research aimed to keep in line with previous studies in the field, as discussed in Chapter One, where qualitative methods have been adopted explore issues surrounding breastfeeding and breastfeeding difficulties.

2.3.2. Overview of IPA. IPA attempts to understand lived experiences, how participants make sense of these, and explores the meanings these experiences hold. It is interested in people's subjective perspective on an event, and does not attempt to

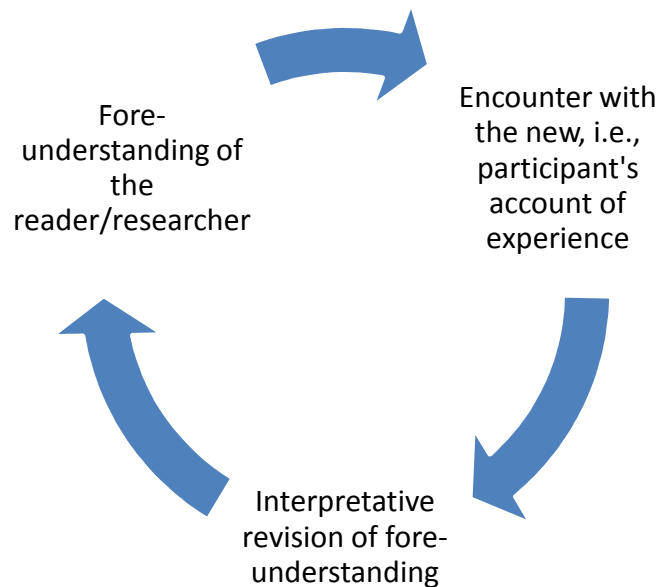
produce objective data about the event itself. IPA takes into account the idea that true knowledge about another person's experience cannot be directly or completely understood, and that the researcher's own conceptions about the other's world is significant when they are making sense of participants' experiences through an interpretative activity. There are three main theoretical underpinnings of IPA; phenomenology, which is the philosophical study of 'being' or experiences; hermeneutics, the theory of interpretation; and idiography, the idea of the particular. These concepts will be described briefly below.

2.3.3. The study of experience. Husserl (1859-1938) developed the idea of 'transcendental/descriptive phenomenology' and defined it as the 'study of the essence of conscious experience'. He posited that in order to engage with phenomena in the world, it was necessary to put aside, or transcend, ones' own personal experience or content of consciousness, putting one's usual understanding of the world aside. He named this usual state of mind as the 'natural attitude', which he described as a 'mindless' state in which people are concerned about everyday assumptions about how things are. Through the use of thought experiments and exercises, Husserl described how there could be a more reflexive move away from this natural attitude in order to attempt to understand things as we experience them. He called this a 'Phenomenological Attitude'. He also talked about how it was possible to engage in 'bracketing' off past knowledge, culture, context and history in order to access the essence of a given phenomenon as it presents itself to consciousness. Here, biases and prejudices about the world, along with rules and expectations are put aside, with the aim of focusing on immediate experience. Spinelli (1997) termed this as 'un-knowing', where interpretations of experience would therefore be more adequate.

2.3.4. Hermeneutics. Heidegger (1889-1976) disagreed with Husserl's reductionist stance (which maintains that complex phenomena are best understood by analysis which breaks the phenomena into their fundamental, elementary aspects) on the study of consciousness, arguing that it is not possible to separate oneself from the world one is in and that there is an 'essence' or phenomena to know or uncover in a positivistic (objective and observable) sense. Heidegger posited that the only observations that can be made are from one's own position, and that the best that one can manage in research is an *interpretation* of the phenomena.

Heidegger developed hermeneutic/existential phenomenology with a focus on Hermeneutics (theory of interpretation) and an emphasis on "worldliness", which is concerned with relatedness to the world and relationships within it. He posited that in order to understand something we have to interpret it first. It is therefore necessary to understand what our personal experiences and our "embeddedness" in the world brings to the interpretation. Heidegger called these our "fore understandings" (also referred to as "fore-conceptions"). An awareness of these preconceptions or fore-understandings can be developed through the reflexive process throughout the research. IPA utilises the Heideggerian approach to reflexivity by adopting the concept of the Hermeneutic Circle (Figure 1, Godamer, 1975) to describe the iterative process through which a new understanding of a whole reality can be developed by means of exploring the "detail of existence".

Figure 1. Hermeneutic Circle Diagram, adapted from Gadamer, 1975).



It is posited that the researcher always brings their fore-conceptions to the encounter and that the phenomenon is seen in light of these. Fore-understandings might not become apparent to the researcher until they are presented with “the new” and so IPA encourages researchers to remain open to preconceptions emerging during the process. Fore-understandings will therefore be continually revised in this cyclical process as new understandings of the phenomena emerge. There is also an idea that there is a dynamic relationship between the part and the whole, where the meaning of the part might only become clear in the context of the whole. This is evident in the process of analysis, for example, in analysing a single word embedded in a sentence, or an extract within a complete text and so on (Smith, Flowers and Larkin, 2009). In engaging with the participant and their understanding, the researcher facilitates the process of bracketing, through becoming more aware of their own pre-conceptions. Here, a ‘double hermeneutic’ process occurs, where the researcher is making sense of the participant making sense of the phenomena being explored.

IPA's connection to hermeneutics and its' description of phenomenology as an interpretative activity is what defines it as an interpretative phenomenological approach. In attempting to tackle the notion of bracketing, Smith et al. (2009) describe it as 'something that can only be partially achieved' and as a 'cyclical process'. They suggest that in order to develop a phenomenological attitude, the researcher must adopt an 'open attitude' where they are open to a shift in understandings, and open to their own preconceptions being obliterated. The researcher must also respect others' 'truths' as they are told, and respect the fact that we can never really fully understand another's experience.

In order to enable the researcher to be conscious of their own preconceptions about the subject and the data, a reflective journal was used in the current research as an aid when the researcher was making interpretations. As Ortlipp (2008) points out:

“Rather than attempting to control researcher values through method or by bracketing assumptions, the aim is to consciously acknowledge those values. Keeping self-reflective journals is a strategy that can facilitate reflexivity, whereby researchers use their journal to examine “personal assumptions and goals” and clarify “individual belief systems and subjectivities”. (p.695)

The researcher will present excerpts of her reflective diary throughout this paper to provide the reader with some insights into how the researcher developed an awareness of her fore-understandings, how these may have impacted how the research was conducted and thoughts and interpretations about the data gathered.

2.3.5. Idiography. The idea of “Idiography” within IPA is concerned with the particular and with developing an understanding of the meaning of individual life rather than attempting to generalise or develop universal causal laws (Lamiellm, 1987, cited in Smith et al., 2009). In contrast to a nomothetic approach (the study of

scientific laws), IPA's idiographic position offers "detailed, nuanced analyses of particular instances of lived experience" (Smith et al., 2009, p.37). IPA commits to a position of the particular in two ways. Firstly the approach offers detail through systematic, in-depth analysis, in attempting to understand how particular experiential phenomena have been understood from the perspective of particular people, in a particular context. Secondly, it makes a commitment to the single case in its own right by examining a small sample which is purposive to the phenomenon being explored. Here, each case in a sample is treated as a single case analysis before analysis is drawn across cases. The method of analysis will be explored in more detail later in this section.

2.3.6. Epistemology. When considering using qualitative methods in approaching a particular topic, it is important to consider epistemology in formulating the research questions and deciding upon appropriate methods to explore these. When using a quantitative approach, the assumption is that there is a 'truth' that is there to uncover in an unbiased, objective way, and therefore a positivist, reductionist position can be taken where empirical data can be collected for this aim. In contrast, the epistemological position required for conducting qualitative research rejects the idea of the researcher as being positioned outside of the research, rather viewing them as part of the research through shaping the way it is conducted. It is also concerned with the rich descriptions around a person's lived experience. As such, there is a distinction between 'method' in a quantitative sense, which is concerned with a 'recipe' of what is to be done or a "specific research technique", and "methodology" in qualitative research, which encompasses philosophical and theoretical commitments in a more "general approach to studying research topics", giving a strategy or plan of action which are more epistemologically informed (Silverman, 2003). It is therefore

essential that the researcher has clear objectives about what it is possible to find out about the topic, and that this is embedded within a wider understanding of the epistemological position, which will be further explored below.

IPA attempts to maintain an ‘epistemological openness’ but is hermeneutic phenomenological in its epistemological position. IPA researchers generally tend to argue a position which lies somewhere between critical realist and contextual constructivist and thus is flexible in terms of being able to accommodate the researcher’s own perspectives in approaching their research.

A critical realism position is one way of locating one aspect of hermeneutic phenomenology, and holds that human beings are bound to a reality that is independent of our consciousness and thoughts but that the meaning we make of this reality is influenced by our social experiences. (Eatough and Smith, 2008)

Constructivists use the metaphor of construction to summarise the epistemological position that all knowledge is built by individuals (Cobern, 1993) and contextual constructivists emphasise a contextualised reality, where it is assumed that all knowledge is context specific.

The researcher’s position in engaging with this research fits best with the position of critical realist, holding the idea that there is an objective reality that exists outside of individuals’ thoughts but that our social experiences and contexts influence the meaning we make of that reality. The researcher acknowledges, however, that they are engaging in hermeneutic, interpretative phenomenology in conducting their research, as this is the methodology that IPA is based upon and in providing the “tools” to approach the work of the research study.

As a psychologist, the researcher is interested in the study of other human beings; in understanding rather than explaining experience. Breastfeeding holds

multiple meanings for people, and the researcher's position, which is in keeping with IPA, is that that meaning can only be known through interpretation. This stance, then, leads to selecting a methodology most closely aligned to the researcher's theory of knowledge, and thus IPA .

2.3.7. Phenomenology. The current research was based on a phenomenological approach, which is: "Concerned with the relationship between the reality which exists outside our minds (objective reality) and the variety of thoughts and ideas each of us may have about our reality (subjective reality)." (Spinelli, 1995, p.31)

"Phenomenology" is a term to describe a philosophical movement and a range of research methods that is concerned with the study of 'being' and/or experience. It argues that we experience the phenomena of the world, rather than its 'reality', and posits that each person's experience of the world shares 'common variables' but that no individual experience can be fully shared by any two people. The principal task of phenomenology, therefore, is to 'strip away' the interpretational layers added to the unknown stimuli of our experience in order to arrive at a more adequate, if still approximate and incomplete, knowledge of the 'things themselves' (Husserl, 1931).

2.3.8. Rationale for choosing IPA. Qualitative research focuses on meaning, sense making and communicative action, which is consistent with the IPA approach to analysing qualitative data. IPA is consistent with the epistemological position of the research questions being explored in the current study as the objectives are to explore the perceptions and views of the participants, which reflects both the interpretative and phenomenological aspects of IPA (Smith et al., 2009). The research questions explored here are directed towards phenomenological material and focus on participants' understandings of their experiences, and are open and exploratory in

nature. In line with the enquiring, curious nature of this study, an interpretative phenomenological approach was used to explore experiences of breastfeeding. This allowed for a freedom and flexibility in the data obtained, developing 'bottom up' themes that arose as a result of the data rather than being predetermined before the interviews.

The main focus of the study, therefore, was in exploring how women experience breastfeeding in general, and how they make sense of any challenges that they encounter. Using IPA allowed an exploration of themes without imposing the researcher's biases or preconceptions and assumptions about what these experiences were before data were collected, whilst allowing for the researcher's position and perspectives in the process of interpretation of data, which will be discussed further later in this chapter.

2.4 Research Procedure

This section will provide a detailed description of the procedure adopted to recruit participants to the study. It will then go on to describe how interviews were conducted and how data were captured. The section will also discuss ethical considerations that were made by the researcher in designing the research. Finally, the method of analyses used will be described. All relevant documentation for obtaining ethical and local research and development approval for participating research sites can be found in appendices G-H, together with all research materials used to collect data (Appendices A-F).

2.4.1. Ethical approval. Ethical approval was sought from an NHS Research Ethics Committee (REC) prior to any commencement of research activity. Approval was also sought from the local NHS Research and Development (R&D) departments

in the Trusts from which participants were recruited. A favourable ethical opinion and R&D approvals were granted.

2.4.2. Participants. Participants were recruited through NHS Maternity services via postnatal breastfeeding clinics. This differed to the initial plan for recruitment where women would be approached both in the ante natal period as well as the post-natal period. The change in recruitment plan and implications of this is discussed further in Chapter 4.

Sampling from NHS services was decided upon to ensure that women from a range of socio-economic backgrounds had the opportunity to participate in the research. Recruiting from other organisations such as the National Childbirth Trust (NCT) or La Leche League may have introduced biases as most members of these organisations are typically white, middle class women who may hold certain attitudes toward breastfeeding typical of that group. For the purpose of the current study, it was felt that it would be beneficial to include mothers from all backgrounds in an attempt to gain a picture of the breastfeeding experiences of women who access usual NHS services. A total of six women were recruited to the study, aged between 31 and 35 years old.

2.4.3. Inclusion criteria. In line with previous research samples, participants were first time mothers of babies up to six months of age, who were currently (at the time of interviewing) breastfeeding, had breastfed in the past, or who had attempted to breastfeed their baby at least once. The term “breastfeeding” used here is in keeping with the definitions outlined within Chapter 1, and includes feeding expressed breastmilk from either the breast or from a bottle. Where “exclusive breastfeeding” is referred to, that again includes feeding of expressed breastmilk, but that no other milk substitutes or solids are given. For the purposes of the inclusion criteria, women were

required only to have engaged in breastfeeding, either current or in the past. The sample age range began from 18 years. No upper age limit was imposed.

The rationale for recruiting women with babies under six months old was that it is usually (as per guidance) around six months when women begin to wean babies onto solids. Therefore, recruiting after six months would potentially mean that women were not as closely engaged in their experiences of breastfeeding, nor would they be as likely to be accessing post -natal services.

2.4.4. Exclusion criteria. Participants were required to understand written and spoken English; those who did not were excluded from the study. This is because participants were required to engage in the interviews without the need for interpreters. The use of interpreters would make adopting an IPA approach difficult due to the language used by participants having to go through an interpreter. This could potentially disrupt the analytic procedure that is essential in IPA; by adding a third layer of interpretation to consider rather than focusing on the data arising from the conversation between the participant and researcher, where the interpreter would also become part of the research context.

Women who had not attempted to establish breastfeeding were also excluded from the study. This is because the interview asked explicitly about their experience of breastfeeding therefore at least one experience was required for participants to be able to engage in a conversation about this.

As part of the qualitative methodology, interviews were required to be recorded so that in-depth analysis of the data could be conducted. Therefore participants who did not give consent for their interview to be recorded were excluded from the study. Consent issues will be discussed further below.

2.4.5. Sample Size. According to Smith et al (2009), the primary concern of IPA is with a detailed account of an individual's experience, and so IPA studies benefit from a concentrated focus on a small number of cases, where quality, rather than quantity, is the issue. For Professional Doctorate research, it is recommended that a sample of between 4 and 10 interviews is adopted due to successful analysis requiring 'time, reflection and dialogue' which larger datasets are likely to inhibit amongst less experienced researchers (Smith, 2009). A sample of six participants was recruited to the study.

2.4.6. Participant demographics. The table below presents demographic information about the participants recruited. Pseudonyms are used to protect identity. Where the method of feeding is described "exclusive breastfeeding" means that the baby is only fed breast milk and no substitutes are used. "mixed feeding" describes mothers who use a combination of breastfeeding, expression of breast milk given in a bottle, and supplementing breast milk with formula. A more detailed description of the participants is included in Chapter 3.

Table 1. Participant Demographics

Participant	Age	Ethnicity	Age of baby	Method of feeding
Helen	33	White British	5 months	Exclusive Breastfeeding
Anne	35	White British	4 weeks	Exclusive Breastfeeding
Emily	31	White British	3 weeks	Mixed feeding
Rachel	33	White British	5 weeks	Exclusive Breastfeeding
Susan	33	White British	12 weeks	Exclusive Breastfeeding
Jayne	35	British Other	5 months	Mixed Feeding

2.5. Recruitment Procedure

Participants were recruited from NHS run postnatal breastfeeding classes and groups. The researcher attended these to present the research, inviting participants to ask questions. If participants were interested in the research they were provided with an information sheet and contact details form (Appendices A-B) to be returned to the researcher either immediately or by post at a later date using stamped addressed envelopes that were provided.

Recruitment posters (Appendix A) were also displayed in the antenatal clinics of participating research sites. Posters provided a brief summary of the research and included the contact details of the researcher. Participants were invited to make contact by email or telephone if interested in the research for further information. Those who made contact via an advertisement were also sent an information sheet prior to an interview being arranged, once inclusion criteria had been checked via a telephone conversation or email correspondence with the researcher.

When the potential participant had access to the information sheet for at least 72 hours, the researcher then made contact to ascertain if the participant still wished to take part and arrange an interview. At this point the researcher gave the participant the opportunity to ask any further questions about the study and ensure that inclusion criteria were met. The researcher then arranged to visit the participant at home in order to conduct the interview. As interviews were unstructured in nature, they lasted between 1 and 1.5hrs. There was provision for participants to opt to complete the interview in the clinic setting, however all participants recruited preferred to conduct the interview within their home. A buddy system was adopted when carrying out the interviews in participants' homes to ensure the safety of the researcher. Here, a colleague at the University of East Anglia kept in contact with the researcher. Interviews were carried out in accordance with the University's Lone Working Policy guidance and conducted within working hours (See Appendix K for policy guidance).

Informed consent was obtained before commencing the interview (consent will be discussed in 2.6.1). Following the interview, participants were offered a short debrief about the nature of the study and provided with contact details of helpful organisations for further support if this was required. Participants were also asked if they would like to receive a copy of a final summary report of the findings.

2.5.1. Interviews. The research was an exploratory qualitative study using individual interviews. Interviews were unstructured and utilised open-ended questioning following a topic guide (Appendix I) to allow the participant to determine the direction the interview took and to allow for a richer, more natural conversation to develop (Kvale, 2007). This method was adopted to keep in line with the phenomenological approach and to using an interpretive phenomenological analysis where the researcher, through their involvement in the interview is engaging in hermeneutic phenomenological research by exploring the participant's lived experience with them. (Smith, 1996).

In IPA, one-to-one interviews are the preferred method of data collection and lend to an in-depth, personal discussion (Reid, Flowers, and Larkin, 2005). One-to-one interviews are also easy to manage and are helpful in the building of rapport with the participant, where the participant has the space to think and speak and be heard. Interviews also allow the researcher and participant to engage in a dialogue where initial questions may be modified depending on the participant's response. The researcher is able to follow up any interesting ideas from the participant in order to explore these further, for example, the interviews allowed opportunity for the researcher to probe for more information about a point, which again allows for data that is richer in depth of meaning.

Utilising an unstructured approach helps to facilitate the participant's priorities where the researcher gives importance to the exploration of what the participant wishes to bring to the conversation and avoids directing the interview towards other areas that might not be pertinent to that individual. This method also limits the danger that the analysis will merely reflect the key topics already identified if using an

interview schedule, and allows for “unanticipated and unexpected” findings (Smith et al., 2009).

Conducting an unstructured interview in terms of set questions or topics does benefit from some management of the conversation and ensures that the researcher follows up on participants’ responses that may be of interest to explore in more detail. Here, the researcher noted key ideas from participant responses in order to return to them for further exploration, therefore setting a ‘participant led’ structure to the interview.

In order for the researcher to refine the interview technique, the first interview was treated as a ‘pilot’ in that the recording was listened to by the researcher with a critical ear so as to pick up on helpful or unhelpful techniques, for example, instances where interesting lines of inquiry were followed up or ignored, where the researcher interrupted or asked any leading questions. This process aided the researcher in keeping these in mind for subsequent interviews. Although the first interview was used to refine the technique, data were included and analysed as research data as part of the whole sample.

The interviews lasted for around an hour, although there was flexibility in this, dependent on how the interview had developed. Conducting the interviews on a one-to-one basis in the participants’ homes allowed for an interesting insight into their lives and experiences. Babies of the women interviewed were also present, and at times, women were feeding, or breaking to feed their infants. Interviews proved to be emotive for most women. Being face-to-face allowed a wealth of non-verbal cues to be picked up and explored, which the researcher feels lent itself to the interpretative approach. Overall, the intimate nature of the data collection process meant that the

researcher was privileged in being able to access the participants' accounts of their lived experience in their own setting.

In terms of the data collected through the interviews, IPA requires a verbatim account of the data. The interviews were therefore audio-recorded and then transcribed by the author in four cases and by a transcription service in two cases (where second edits were completed by the researcher). Notable non-verbal utterances were also recorded on the transcript (for example, laughter).

2.6. Ethical Issues

The researcher considered the following factors when designing and implementing the research methodology used in the study. As mentioned previously, full ethical approval was sought and granted before commencing the research.

2.6.1. Consent. Informed consent was sought and obtained from participants. Participants were provided with an information sheet at the point of presentation about the research or they were sent one in the post or via email if they made contact in response to a poster advertisement.

Participants completed a consent form (Appendix D) which they initialled to indicate that they had seen the information sheet and had had opportunity to ask questions of the researcher. Participants were also asked to consent to their interview being recorded for the purposes of research, details of which were provided in the information sheet. They were then asked to sign to say that they consented to take part in the study. Participants had access to the information at least 72 hours before informed consent was obtained.

2.6.2. Confidentiality. Participants were assigned a participant number in order to keep written interview notes anonymised. Interview notes were stored separately from participants' identifiable information. Pseudonyms were used in the

transcription of interviews and transcripts were identified by using participant numbers. Participants' identifiable information, e.g. name, contact details, GP details, were stored separately from all other data, i.e. interview notes and recordings. These data were recognisable only by participant number. Electronic versions of data were stored on encrypted memory sticks and recognisable by participant number.

Due to the nature of qualitative research, there are limits to confidentiality due to the use of direct quotes used in written reports. This was clearly explained to participants in the information sheet and any identifying information was removed from all quotes.

Participants were also made aware of limits to confidentiality in regard to duty of care. Participants were informed prior to commencing the interview that if, during the interview, the researcher felt that there may be some cause for concern about the participant's well-being, then they would be required to contact the participant's GP to inform them and recommend that the participant received follow up care from their healthcare professionals.

2.6.3. Distress Management. The researcher recognised that the sensitive nature of the subject matter approached through the interviews could be difficult for some and cause the participant to feel distressed. Participants were made aware of the nature of the research and that they would be asked to discuss their experiences of breastfeeding prior to consenting to take part. Participants were encouraged to share only what they felt comfortable to do so and were reminded that they could stop the interview at any time or choose not to answer a particular question. The researcher took care to give opportunities during the interview for the participant to take a break or to stop the interview, and to check if the participant was happy to continue. Further to this, the researcher offered a de-brief at the end of the interview and provided

contact information of organisations that could offer support should the participant feel they needed these.

2.6.4. Right to withdraw. The participants were informed that they had the right to withdraw from the study at any time and without giving a reason. Participants were informed that in this instance data already collected would be kept and used in the research unless the participant indicated that they did not wish for it to be used.

2.7. The Analytic Procedure

Analysis using an IPA method is a ‘bottom up’ approach, meaning that codes or themes were generated from the data, rather than using theory to develop a priori themes to apply to the data. This section will outline the process set out by Smith et al., (2009) which was adopted by the researcher, whilst acknowledging that the nature of IPA is idiographic and that there must be some flexibility and creativity within the guidelines to enable the interpretative process to develop.

2.7.1. Transcription. The interviews were transcribed in most cases by the researcher. For two of the interviews, a transcription service was utilised due to time constraints during the recruitment phase of the research. There is agreement amongst IPA researchers that transcribing interviews allows the researcher to become ‘immersed’ in the data, and allows a detailed familiarisation with the participant and what they have said during the interview. However, within the IPA literature, it is also considered that a second edit of the transcript by the researcher themselves whilst listening to the interview would allow similar immersion in the data (Hefferon and Gil-Rodriguez, 2011). The researcher therefore ensured that a second edit was performed on the professionally transcribed interviews and so was equally familiar with all data gathered.

2.7.2 Data analysis. After transcription, the following steps were employed in analysing the data (taken from Smith et al, 2009, p.81):

Step 1: Reading and rereading the transcripts in order to immerse oneself in the data.

Step 2: Initial Noting: Examining the semantic content and language on an exploratory level, noting anything of interest in the transcript.

Step 3: Developing Emergent Themes: mapping interrelationships, connections and patterns across emergent themes.

Step 4: Searching for connections across emergent themes and fitting these together (development of “subthemes”).

Step 5: Moving on to the next case and repeating the process for all transcripts.

Step 6: Looking for patterns across cases; Examining themes in more detail and making interpretations (development of “superordinate themes”).

Each transcript was taken in turn and transferred onto a table format (see Appendix I for an example) and a hard copy was printed so that the researcher could begin noting any initial thoughts in the right hand column. This “exploratory coding” enables the researcher to attend to three different types of comments in the transcript: descriptive, linguistic and conceptual (Smith et al., 2009). Differing methods of doing this can be utilised. For example, one can choose to read and annotate the transcript several times, focusing on one of the types of comments in turn, i.e. focusing first on descriptive comments, then linguistic, and then conceptual. The researcher in this case, however, chose to attend to all three as they became apparent when going

through the transcript, which felt a more natural way of capturing what was being noticed at the time of reading.

Following the exploratory coding phase of analysis, the researcher then moved on to note emergent themes in the left hand column of the table beside its' corresponding section of transcript. A process of clustering these themes into "subordinate themes" then began, where quotes were taken from the transcript to evidence themes.

Once the researcher was satisfied that emergent themes were clustered into appropriate subordinate themes which captured the essence of the transcript, they moved onto the next case to begin the process again. After all transcripts were analysed in turn, cross case analysis was then performed to begin to identify common themes. The researcher this time went back through the emergent themes to identify patterns in the transcripts and noted similarities as well as differences between the participants' accounts. The researcher's reflective log was used to note thoughts during this process. "Superordinate themes" were then developed through the abstraction of themes across the transcripts. The researcher kept a log of this process where themes and clusters were revised during the development of superordinate themes (see Appendix I for an example). To ensure that the researcher's interpretation of themes was embedded within the participants' accounts, an extract of transcript with exploratory coding and emergent themes was reviewed by the researcher's supervisor.

Overall the process did fit with the researcher's idea of the hermeneutic cycle: only once engaged in the process of analysis did it become evident that the researcher had some pre-conceptions about the material, and how noting these at the time may have influenced how analysis of the next case was approached. Such reflections again

were logged, and reactions to the themes as they emerged were noted. During the process, the researcher also became aware of a phrase heard during an IPA training session urging novice IPA analysts to remember the “I” in IPA, in that the researcher is as much a part of the data as the participants themselves, and so the researcher’s reactions and responses in interpreting data are key in developing a satisfactory analysis. Therefore the researcher referred to these reflections and considered them when making interpretations during the process of writing up the analysis section. An excerpt will be provided in the box below.

2.7.3. Validity and quality. When considering how validity and quality are assessed in qualitative research, it is important that criteria are appropriate for these methods. According to Smith et al., 2009, a number of qualitative guidelines are too simplistic or prescriptive to be useful in assessing the quality of qualitative research. Instead they suggest that guidelines presented by Yardley (2008) give more general and helpful criteria which can be applied to any qualitative research study, regardless of theoretical orientation, and guide the researcher to a number of ways in which they can assess quality.

These criteria, adopted by the researcher and considered in relation to IPA as suggested by Smith et al. (2009), will be discussed further in the following sections.

2.7.4. Transparency and coherence. Transparency in the context of qualitative methodology refers to the clear description of research processes adopted in conducting a study. In this study, the processes, as described in detail in this chapter, allow transparency of how the research was carried out in this case. Again, in keeping with Yin’s (1989) idea of independent audit, the researcher kept a good record of evidence that led from initial documentation to the final report, for example, notes, recordings, annotated transcripts and tables of themes which were used in the

analysis. Paper trails of ethical and departmental approval are also provided in the appendix section.

The researcher also attempted to maintain transparency about their own position in relation to conducting the research. This is demonstrated through the use of the reflective diary, from which extracts have been provided. This allows some “reflexive validity” (Stiles, 1993) where the researcher considered their own fore-understandings and reviewed these as the research progressed where attention was paid to the way in which their thinking developed through interaction with the data.

Presenting excerpts from the reflective diary also assists in developing coherence in the research, by providing a narrative around it which gives the reviewer another insight into the process of research alongside the presentation of data and results.

2.7.5. Impact and importance. This principle suggested by Yardley (2000) refers to the way in which the validity of a piece of research is really tested in the way it can tell the reader something ‘interesting, important or useful’ (Smith et al., 2009, p.183). Here, the researcher’s aim is to conduct a piece of research that has some utility or impact, either on development of theoretical or socio-cultural understanding, or in practical terms for policy makers or professionals in the community. It is hoped that the current study may add to the literature around breastfeeding experiences and aid in developing recommendations that could be taken forward in the field of postnatal care for women.

In sum, Smith et al. (2009) suggest that IPA is a creative process and therefore any criteria being considered should be applied flexibly. They argue that there should be a balance between achieving a high quality piece of research and recognising when it is ‘good enough’, which, for the novice researcher, can prove a challenging task.

However, in this case the use of supervision was of great importance in developing the researcher's skills in conducting good quality research.

February 2014-reflections after attending IPA workshop

This training has been so enlightening, got me really thinking about how I'm going to go about conducting interviews with my participants, I'm so glad I came at this point in the process!

So I've been thinking about self-disclosure. Do I disclose that I'm a mother? This could potentially throw up all sorts of dynamics in terms of power issues in the interviewing process? It's enough considering power balance in the interaction just participants knowing I'm a researcher/psychologist-if they were aware that I'm also a mum with my own experiences of breastfeeding would that affect how they respond? They might put me in an 'expert position' and so might modify how they talk or answer questions? Don't know.

What Elena said in the session was really helpful: "Same, other, it doesn't matter, but we need to notice it and reflect on it". She recommended a way to deal with disclosure is tell participants that any questions they have about you can be discussed after the interview in the de-brief, saying something like "I'm more than happy to tell you more about myself when we're done". I think I'm going to try this. I'm also going to have to bear in mind that I need to remain as neutral as possible in my responses and that the feel of the interview is quite different to that of a clinical interview-I've a feeling this is going to take some practise! It was helpful seeing a demonstration of this by the workshop facilitators. The good thing about this training that it has helped demonstrate some the ideas about the hermeneutic cycle, in that I realised I wasn't aware about my fore-understandings until I was presented with new information! Didn't know what I didn't know! Also, have revised my fore-understandings with this new information and I'm guessing that my interviews with my participants will give me a similar experience- at least I now know what I'm to be aware of! Hermeneutics in action!

Chapter 3: Results

3.1 Overview of Chapter

This aim of this chapter is to provide a rich narrative of the shared experiences of the participants through the analytic process. This includes the development of emergent themes from the participants' accounts resulting in the identification of three super-ordinate themes.

A descriptive summary of the participants interviewed is first presented in order for the reader to be introduced to the individuals and to provide some context in which to base their narrative. An interpretative narrative will then accompany the presentation of super-ordinate themes, by providing examples and extracts of the participants' accounts. Subthemes within the superordinate themes have been identified in order to describe and encapsulate the shared lived experiences of participants as interpreted by the researcher.

The superordinate and subthemes are presented in a diagram (Figure 2) to represent the analysis as whole in relation to the research questions being explored. The analysis aims to draw together themes that address the aims of the study by interpreting how participants talk about their experiences of breastfeeding, their perceptions about breastfeeding difficulties, the emotional impact of these and what it means to them to experience difficulties with breastfeeding.

The chapter will then progress through each superordinate theme in turn and provide a deeper, richer representation of the themes and relate these to the overarching aims of the study.

3.2 Summary of Participants

This section will provide some information about the participants who were interviewed. Pseudonyms are used in order to protect participants' identities. Pseudonyms are also used in the transcript excerpts where participants have referred to relatives or friends.

Heidi: A 33 year old married woman with a 5 month old daughter. Heidi is White British from a middle class background. Heidi, a housewife at the time the interview but her family owned and ran a business in which she had previously worked. She is educated to degree level. Heidi was exclusively breastfeeding at the time of the interview. The context of her breastfeeding experience was that she had been told previous to her daughter's birth that medication she was taking to prevent a potentially fatal blood clot may have prevented her from breastfeeding at all due to the risk of it being transferred to the baby through the breastmilk. However, shortly before birth she was told that breastfeeding would not pose a risk to her child. Heidi had initiated breastfeeding at birth and this had been successful.

Anne: A 35 year old woman with a 6 week old daughter who was co-habiting with her long term partner. Anne was a nurse and was on maternity leave. Anne had had difficulty conceiving a child and was considering IVF when she fell pregnant naturally. Anne was breastfeeding her child exclusively at the time of the interview.

Emily: A 31 year old married woman with a 3 week old daughter who had started breastfeeding but had encountered some difficulties. At the time of interviewing, Emily was expressing and supplementing with formula with a view to re-establish breastfeeding. Emily is White British and is educated to diploma level, her profession being a nurse.

Rachel: A 33 year old married woman who was exclusively breastfeeding and was contemplating beginning expressing for her 4 week old son due to finding being unable to share feeding with her husband and relatives constraining. Rachel is White British and is educated to diploma level. She is a Veterinary Nurse who was on maternity leave.

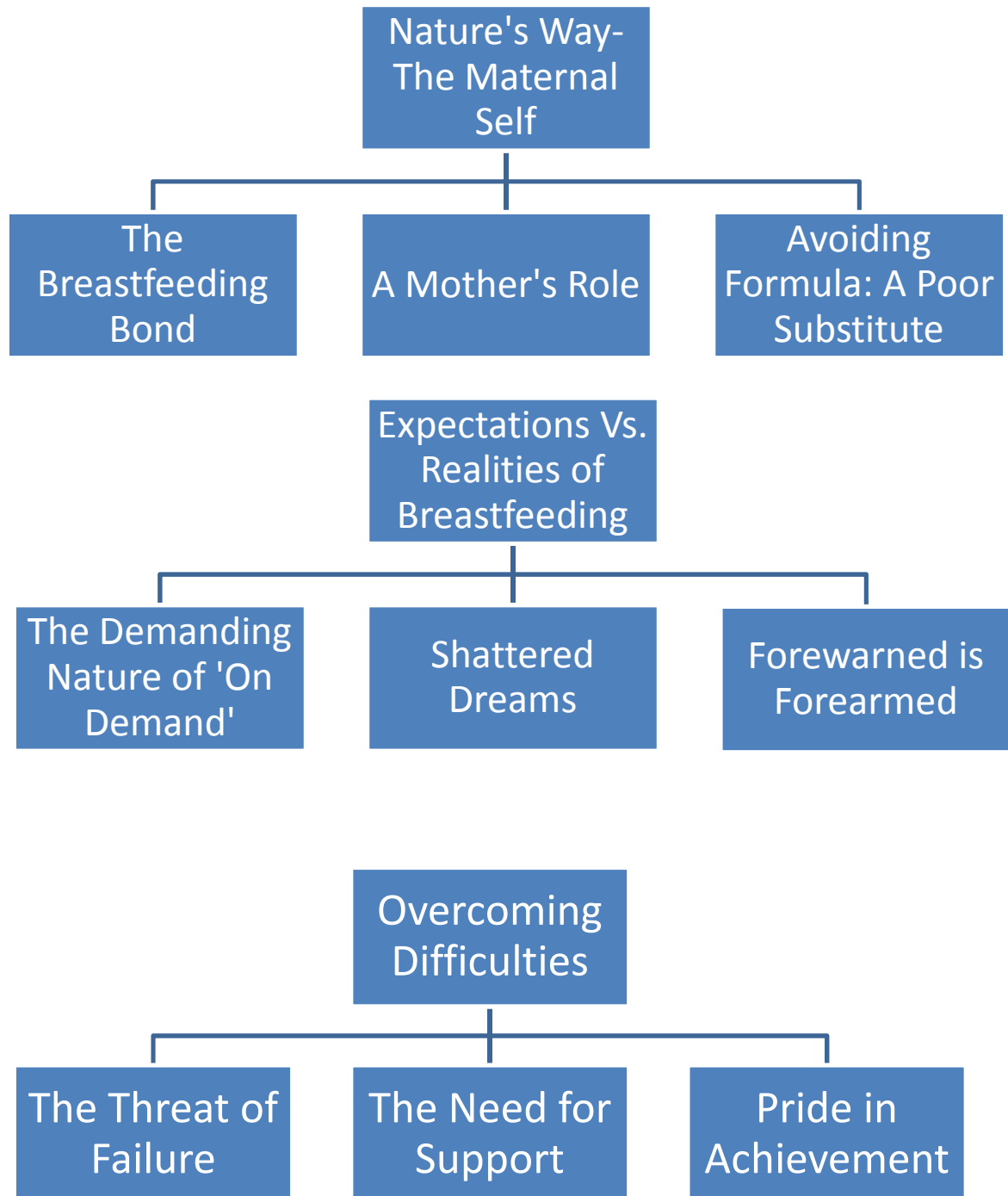
Susan: A 33 year old married woman who was exclusively breastfeeding her 12 week old son. Susan is White British and is a primary school teacher on maternity leave, educated to bachelor degree level. Susan had experienced some difficulties in the first weeks after birth and had sought the advice of many breastfeeding support workers and counsellors in her efforts to succeed at breastfeeding exclusively. Susan was also opposed to using other aids to feeding, i.e. expression and the use of formula milk.

Jayne: A 35 year old married woman who was breastfeeding her 16 week old son as well as expressing breast milk. She was also thinking about beginning to introduce formula. Jayne is educated to Doctoral Level (Psychology PhD) and is employed as a University Lecturer. Jayne encountered difficulties with breastfeeding her son due to a severe tongue tie which was not detected in the first weeks and required correction when he was around six weeks old.

3.3 Superordinate Themes

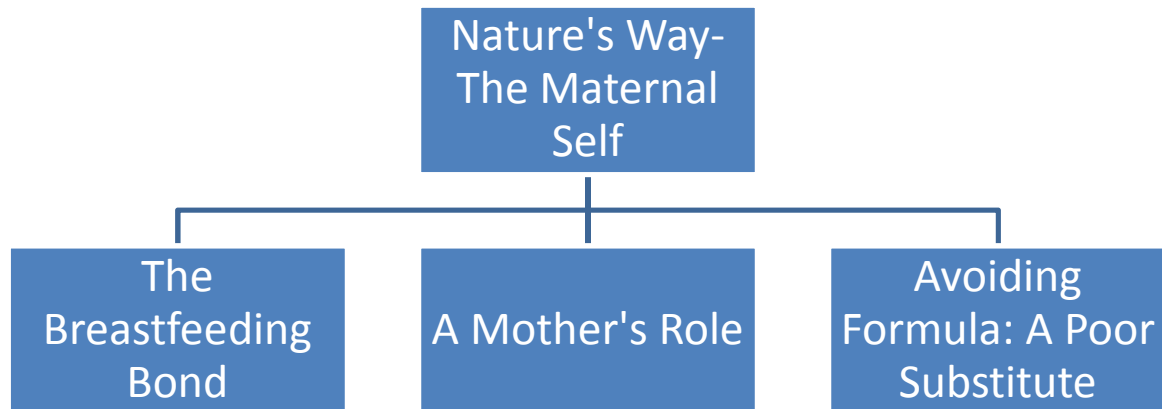
The figure below presents the three superordinate themes along with the subordinate themes relating to each one.

Figure 2. Superordinate Themes



3.4. Superordinate Theme 1: “Nature’s Way-The Maternal Self”

Figure 3. Superordinate Theme 1



The first superordinate theme that was present across all of the six participants was the perception of the self as embracing the maternal role as nature intended. As Susan put it:

Well it’s a little bit like cave woman, it’s instinct. I just think this is what my body is for, what breasts are for. This is what I’ve been created to do. I’m a woman, and this is what mums, this is what women should be doing. This is my calling. This is how breastfeeding should be. (Susan, P.14)

Here Susan talks about her “instincts” as a woman, which she describes as a ‘calling’ With this, she talks about the desire to mother, of which breastfeeding is a part, the ‘natural way’ by the rejection of modern intervention, almost getting back to basics: “I don’t like the thought of expressing and feeding with a bottle. I don’t like the idea of using any kind of plastic teat at all. I worry about nipple confusion. I just think; breastfeeding, you use a breast, you don’t need to use any of the modern day equivalence.” (Susan, p.15)

Anne also echoed this idea of the “instinctive” and natural act of breastfeeding: “It’s an amazing process, and you create this baby, you grow this baby, you birth this baby, you then feed them and give them everything they need and it’s like everything she’s got, I’ve given to her.” (Anne, p.28)

Anne also stated: “it is a natural thing to do, it’s instinctive. This is what we do.” (p.41) All six participants shared the perception that the desire to breastfeed was an “instinctive, natural” process of being a mother, and that this was a powerful drive when approaching feeding their infant. The act of breastfeeding also seems for the participants to be tied up with the notion of the maternal role, that breastfeeding is simply ‘what mother’s do’ or are ‘supposed to do’. “It’s the most natural thing you can do and the best thing for your baby to do and I always thought I would do it.” (Emily, p.19)

Throughout the interviews, it became evident that the participants’ experiences of breastfeeding directly impacted upon their identity as a mother, which led them to question their competence and ability not only as providers for their babies, but also as a mother and as a woman, as nature intended. Within this overarching theme of the idea of the natural maternal self are three subthemes which explore the ways in which the participants perceived their role as mother through their breastfeeding experiences. These are discussed individually in more detail below, although there are inevitably some overlaps found across subthemes that are clustered together within the overarching superordinate theme.

3.4.1. “The breastfeeding bond”. All the participants interviewed talked about the bond with their baby, the majority holding a strong belief that breastfeeding resulted in a close connection with their child which could not be replaced or substituted by using bottles to feed their baby. For mothers who were exclusively

breastfeeding, the belief appeared to be that the presence of the bond between them and their child would not be there if they were not breastfeeding, and that led the researcher to question whether this idea would lead the mothers to feel pressure to succeed establish, maintain and succeed at the act of breastfeeding: “Oh it’s so nice because you get that closeness, that bond, and everything with them. Whereas you don’t get that when you’re feeding them with a bottle.” (Anne, p.23)

Rachel also talked about the bond which she felt breastfeeding provided. Here she seems to be emphasising, through her repetition of the word “reliant”, how the connection between mother and child is second to none, that the baby needs the closeness that the mother provides through breastfeeding. This again was a hugely emotive and important aspect of breastfeeding for the participants, but for Rachael in particular, who was experiencing difficulties with breastfeeding her baby. It was interpreted that Rachel felt that being able to successfully breastfeed was crucial to establishing the mother-child relationship, in the way that it was meant to exist.

I can see that it can be a wonderful bonding experience because, you know, you have got both a physical and emotional connection with your baby and you are basically, you’re the one providing the food that is making your baby grow. You’re not reliant on anything else and you know, you also, you do during the feed have that eye to eye contact and you do get that feeling that they’re solely reliant on you. (Rachel, p.22)

Rachel also alludes to being able to fulfil her role in providing for her baby through breastfeeding when she mentions that she is, by being able to breastfeeding, ‘not reliant on anything else’. This can be interpreted as her desire to “do it the natural way” as she states later on in the interview, rejecting the idea for the need for external intervention. Although there was a clear idea from Rachel that she would

prefer to keep her method of feeding “natural”, an underlying theme around personal achievement and failure was particularly salient for her, and perhaps also led her to the idea of not wanting to rely on anyone else in her efforts to breastfeed.

However, as the interview progressed, Rachel did question the idea of the bond with baby being dependent on the success of breastfeeding, coming to the conclusion that the bond is affected more by the personal meaning attached to the process of breastfeeding rather than the feeding act itself:

I think you would still be able to have that bonding time because you know, you still get that eye to eye contact whilst you know, you're bottle feeding and you can still have that quiet time.... But whether I personally would feel the same sense of achievement, stroke, satisfaction that I was able to do it? I wouldn't. I think that for me it's more about my own personal sense of achievement. (Rachel, p.23)

This quote is interesting because it highlights how ideas about breastfeeding appear to be at times, unconscious to some respect, in that it is only through discussion about the topic that one's true understanding of the meaning of breastfeeding and their experience of it become apparent. This idea is reflected in the way IPA describes “fore-understandings” (Smith et al. 2009) as discussed in Chapter Two. It is only with discussion and re-evaluation of the subject matter that Rachel discovers her fore-understandings and revises them, which demonstrates a hermeneutic cycle, in which the researcher is involved. Rachel moves here towards thinking about the personal meaning of breastfeeding in relation to achievement and satisfaction rather than with the bonding aspect.

Jayne also questioned the idea that breastfeeding equated to a better bond with the child: “It’s my bond with my son. Nobody else can feed him, it’s something between me and him and nobody can replace that” (Jayne, p.6)

Here she seems to go through a process in her mind that automatically seems to go down a route of thinking that her bond with her child is dependent on her ability to breast feed. She however, quickly reaches a conclusion that this is not the case:

I don’t think there’s anything in it.... The bonding is a secondary aspect....People that say the whole bonding aspect (of breastfeeding), then I think well, if that’s the case then fifty percent of everybody on this planet would have some real deep-rooted issues and attachment problems, and we don’t. We don’t, it’s just equally we’d get that with breastfed and bottle fed babies. So I think on a psychological aspect, that’s complete crap. (Jayne, p. 21)

Jayne’s comment here perhaps reflects how her experience in psychology helps her to reflect on her experience and question her stance around the idea of the bond with baby being reliant on breastfeeding.

As mentioned earlier in this section, the idea of bond for the majority of the women seemed to be a powerful notion: that they must ensure that feeding is successful in order to preserve that closeness and connectedness to the baby. Conversely, the idea of using bottles seemed to represent a sense of distance or detachment from the baby:

So I do feel that there is more closeness involved with breastfeeding than there is bottle feeding. And also, like, Simon’s parents will come and visit and I’ll be like, ‘Oh, are you hungry?’ And then just pass her over to his mum and just do my own thing. I think that you do take yourself away from them more and I

think the breastfeeding bond makes you not want to leave them; because that's how I feel.(Anne, p.44)

The bottle here seems to symbolise the detachment from baby, in also opening up the opportunity for others to feed their baby. This was deemed as a negative thing, where the mothers were not happy to yet share the feeding of their baby, instead wanting to keep baby to themselves, even for just a while: "I didn't want to share it. I felt like I didn't-I felt I'm not ready to share this yet. This is my thing and this is the one thing I can do" (Anne, p.25)

Again, this seemed to be tied up with the idea that feeding is a mother's role, and something which only they can offer to baby, which should be preciously reserved to themselves, for as long as possible. Interestingly, the women who were breastfeeding at the time of the interview seemed to be more concerned about the idea of the bond with their baby being contingent on the feeding, whereas the women who had been using bottles, either with expressed milk or formula to supplement were not as fixed on the notion that the use of the bottle was impacting upon their connection with their baby.

In some cases, the idea of involving the baby's father in feeding was a positive outcome of breastfeeding difficulties, and was deemed not only as a help to the mothers in practical terms, but actually as a bonding exercise with the baby for the fathers themselves. In contemplating this idea, it appeared that at times that some mothers' uncertainty about the impact of breastfeeding on bond led to some contradictions in their account, where they would talk about the bonding experience of breastfeeding, whilst also talking about bottle feeding as bonding for father and baby. This leads to questioning whether these comments could be interpreted in terms of the act of feeding as opposed to the act of breastfeeding specifically, where

the process or act of providing for their child in whichever way was a bonding experience. Moreover, it could be interpreted that the bond between mother and baby was about the mother's relationship with the act of feeding, where her beliefs about it are a factor in determining the experiences for both mother and child. For example, Rachel engages in some thinking around the idea that perhaps the bond lies within the mother's mind rather than the vessel by which the baby receives its milk:

My friend has got twins and she bottle fed them and I remember feeding one of hers and, you know, you could still have it as a really nice emotional time, which is why I kind of think for me, it's more about my own personal sense of achievement.....I kind of think, you know, it's not worth being upset every feed, and you know, not wanting my baby anywhere near me. It's not worth feeling like that for the sake of being stubborn and wanting to do it. (Rachel, p.24)

There were also some inconsistencies in individuals' accounts as they tussled with the idea of the breastfeeding act creating a better bond than any other feeding method. Some participants talked about the bond being created by the ability to gaze into their baby's eyes when breastfeeding and that this would not be possible with bottle feeding. Again, these tended to be the participants who had not used bottles and so were going on some examples of others they had observed feeding their baby whilst faced away from them.

However, some of the participants who had not used bottles also talked about how they were unable to always look into their baby's eyes due to the size of their breast making it difficult, or, with the older babies, that they were more interested in gazing around the room as they had become more aware of the world 'beyond Mum'. This raised interesting ideas about how the perception of the bond is potentially powerful in itself where one could see that individuals' ideas could become self-

fulfilling prophecies; for example that if women are expecting that “something is missing” (Heidi, p.22), then it will be. This raises concerns about the messages women receive about breastfeeding and what is at stake if they do not succeed with it.

The subtheme ‘Breastfeeding Bond’ summarises how breastfeeding is perceived by the participants to be essential in enabling a bond between mother and baby. Within this were ideas about what a mother’s role is and how the participants could live up to those ideas, and what they ‘should’ be able to do for their baby. Overall, this subtheme did appear to include the participants’ more positive associations and experiences with breastfeeding, in the way that they discussed how breastfeeding allowed them a sense of closeness or connectedness that they felt was unique to their relationship with the baby. However, some contradictions as described above do highlight how complex a notion this is to some, in the way that discussion of this topic led to questioning their ideas. Although there are overlaps between the subthemes, it was felt that the idea of the mother’s role deserved further attention as it was such an important aspect of the participants’ experience, and therefore will be discussed in more detail below.

3.4.2. “The mother’s role”. For many of the participants there was a strong sense that a mother ‘should’ be able to provide for her baby without the need for intervention and help. This felt as though it was imperative for the fulfilment of the role as mother, and for it not to be achieved had a huge impact, as Heidi describes in her account of her feelings about being told she might not be able to breastfeed her child due to medication she had to take to prevent a potentially life threatening disorder that causes blood clots in pregnancy: “For me it was the end of the world...” (Heidi, p.24)

Heidi talked about her need to provide for her baby herself, through breastfeeding, and that the idea of this not being possible for her felt catastrophic.

The sense of the ability to breastfeed as being so important and meaningful in terms of the perception of what a mother's role is, was shared across all participants interviewed. There seemed to be a sense of desperation around being able to breastfeed, and along with that an internal pressure to 'get it right': "I just thought, 'I must be doing this wrong, this isn't normal'. I just want to get it right" (Rachel, p.4.)

The way in which participants expressed their determination to get breastfeeding 'right' and their devastation when it didn't go according to plan, was interpreted as breastfeeding almost being a gauge of how 'good' a mother the participant judged themselves to be. Some participants felt alongside this that others might make a judgement about their approach to mothering based on the method of feeding their baby. Here the inability to breastfeed successfully led some to feel the need to ensure that other people knew that not breastfeeding was not down to their choice. It was as though the act of taking a bottle out to feed their child were proof that the mother was in some way letting their baby down, by not providing for them, or even 'depriving' their child of the breast milk they needed. "If you explain, you know, explain the situation, I think they'll understand (other mums) I've not just given up but that I've tried but I've had quite a struggle with it." (Emily, p.19)

The feeling of being observed or thought about negatively by other mothers was also evident in Heidi's account: "...she's just in the middle of feeding and you can see some mums looking over and you think "What are you thinking there?", and it does make you feel a bit awkward." (Heidi, p.27)

This idea of experiencing an internal and external pressure was echoed in the way that the mothers who were exclusively breastfeeding talked about the other

mums. For example, several mothers used the word 'should' in respect of mother's breastfeeding their baby: "It's a natural thing, it'd be unnatural not to want to do it. Women should do it" (Susan, p.10)

Further to this, some of the breastfeeding mothers appeared to struggle with the notion that other women might not have this 'natural' desire to breastfeed: "It's a natural thing to do, it's instinctively," this is what we do". I don't understand, I can't understand anyone who'd want to formula feed their babies." (Anne, p.42)

Along with the idea that a mother's role was to provide for their baby, came the idea about what breastfeeding fulfilled in terms of being a woman, the function of a woman's body and breasts. Susan expressed her perception about this particularly strongly: "I just think this is what my body is for, this is what breasts are for, this is what I've been created to do. I'm a woman and this is what mums, this is what a woman should be doing. This is my calling." (Susan, p.14)

The language used in this quote from Susan really captures her passion about her ideas of what breastfeeding means to her. For Susan, breastfeeding is not only about being a mother, but about being a woman. The expression of her describing it as her 'calling' seems to emphasise her need and desire to embrace motherhood and womanhood.

The ideas explored within this subtheme seemed to prove an emotive one for the participants, where the ability to breastfeed did appear to be appraised as meaningful in terms of fulfilling the role as a mother, or at least for Susan, a woman. The idea of having to 'get it right' leads to the way in which some participants described their efforts to 'keep it natural' which, by default seemed to point to avoiding using milk substitutes at any cost. This will be explored in the next section.

3.4.3. “Avoiding formula: A ‘poor’ substitute”. Along with the idea of breastfeeding as being inextricably attached to the role of themselves as mothers, the participants also shared the notion that formula was a poor substitute for breast milk, and something to be avoided. Formula was spoken about as an absolute last resort, when all other options had run out: “...there’s nothing else I can do as it is anyway, I can’t, you know, produce enough, I can’t express enough milk for her so the only other option is the formula.” (Emily, p.16)

It could be interpreted that formula in some way represents how the ‘natural’ way of feeding the baby, a concept which seems to be so important and synonymous with the mother’s role, has somehow not come to pass. It seems that formula is symbolic of the idea that the mother has had to engage with the outside world in providing for their child. This is demonstrated by the way in which Emily described how the act of going to the shop and buying the tub of formula was so difficult:

I just got into a complete state, I was like “I can’t feed my own baby” and I just got to the point where I just had to say, like, “I’ll just have to use formula” basically, because there was no choice really....even just buying the formula made me tearful. (Emily, p.17)

The use of formula, for Emily also seems to represent the lack of choice in her feeding options. Emily describes here having had a ‘plan’ about how she would feed her child and how that was not possible. The lack of choice, and perhaps then the lack of control, seems to be embodied by the bottle of formula milk; unwanted and unwelcome.

Some mothers discussed their view that formula was being something to be avoided:

All those things that those mums were complaining about, I didn't have a chance to complain about. And I was just there just stuffing in a bottle and he was done....I've probably made formula evil for a little while, which it isn't at all. But, for me, in my thinking, it's just not something I wanted to do at all and I wasn't very happy that I did. (Jayne, p.8)

When the mothers talked about the benefits of breastfeeding they seemed to hold the belief that formula could not live up to breast milk, and so having to substitute became a 'second best' option. Here, again, the act of going out to purchase the formula is synonymous with a sense of failure for the participants. Formula, then is interpreted as a representation of the failure to provide the 'best for baby' that all the mothers described wanting so desperately to be able to do.

However, one mother, Jayne, also talked about formula as something that can represent choice about feeding: "I'm not saying there's anything wrong with formula, because I'll probably go to formula now because Mummy's had enough. But maybe mixed feeding now..." (Jayne, p.4.)

Here it seems that Jayne is stating that formula for her might represent some kind of option or even 'back up' if and when she feels that she cannot continue with the breastfeeding. Her anticipation that 'mummy will have had enough' when thinking ahead can be interpreted as her idea about having a break or way out of continuing breastfeeding or expressing, which she also talks about being difficult for her:

It is actually madness, I'll be honest. If you exclusively breast pump and breast feed when you are expressing, you are mad! Because, honestly, honestly, it's just so-it's just you don't have any sleep because when you are supposed to be resting you've got a pump attached to you. (Jayne, p.5)

Later, she talks about being able to use the mixed feeding method of both breast feeding and bottle feeding in a positive light, giving her the option to share feeding with her husband:

So for me I think I've got the best of both worlds because Chris will feed him in the morning when he goes to work and then when he comes back he'll do his bath and I'll give him his milk and then I get a bit of time. (Jayne, p.25)

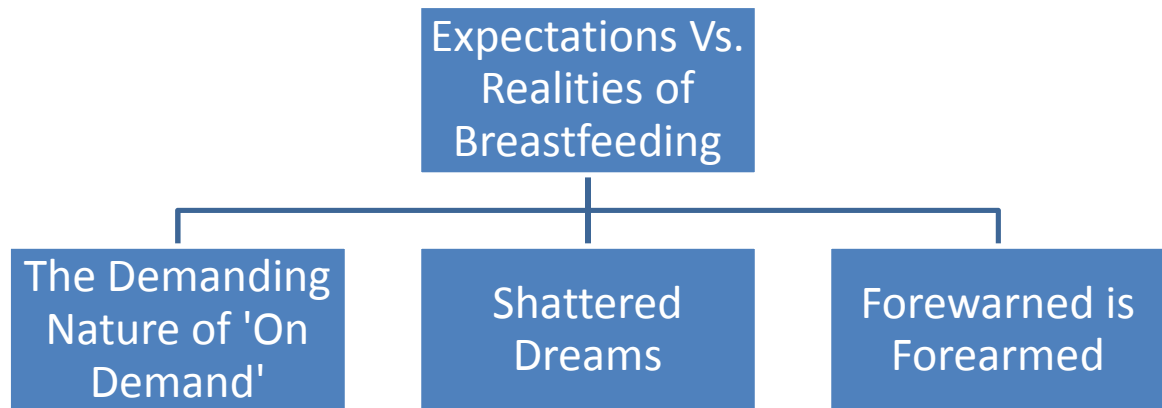
Jayne's ability to think about the positives of mixed feeding, or the use of bottles and formula are perhaps due to her being some months down the line from her difficulties with breastfeeding, and so she possibly has some more distance from her distress at that time, unlike some of the other participants who were very early on in their breastfeeding journey.

This subtheme, overall, encompasses the experiences that the participants share with regard to their perception of the use of formula, and the meaning that holds for them. This, as discussed across all three subthemes, is associated with the perceptions the participants have of themselves and others as mothers, what a role of a mother 'should' be and how that is linked to the desire and the ability to breastfeed their baby, as nature intended. The following section will explore the second superordinate theme where participants' expectations of themselves as breastfeeding mothers are further explored.

3.5. Superordinate Theme 2: Expectations Versus Realities of Breastfeeding

This section will present the second subordinate theme through exploration of the subthemes developed within it, as shown in the diagram below.

Figure 4. Superordinate Theme 2



Many of the women talked about having had preconceived ideas of how breastfeeding might be for them. These appeared to be based on family contexts and also on observation of other mothers and babies:

My upbringing myself, er, 'cause I was breastfed and my other siblings were breastfed as well, my brother and sister were breastfed, and um, as a child I remember having discussions, conversations with my mum about breastfeeding 'cause I was interested in it. (Susan, p.1)

Susan, in this excerpt, seems to be talking about breastfeeding as being part of her life from when she was growing up, that it was a natural part of her observations of mothering and that it was spoken about openly with her mother.

Anne, however, spoke with a tone of real surprise and astonishment apparently in the realisation that breastfeeding was not as easy when attempting it herself as she had anticipated it to be. Her idea that 'they just suck' was challenged through her own experience. Although she talked about her time on a maternity unit as a student nurse

and observing people establishing breastfeeding, this was not enough to prepare her for her personal experience of breast feeding her own baby.

I learned that babies are born, and they just put a bottle in their mouth and they suck. If you put them on the breast, they suck...And I'm like, 'surely it's not that difficult'. And that was when I learned and I was thinking 'God, it's not, it really isn't that easy. (Anne, p.35)

As well as participants' own observations and ideas about breastfeeding it appeared that shared stories with other mothers also seemed to be a powerful source of information; the day to day anecdotes giving strong messages about the way breastfeeding will be. The subthemes explored below encompass the way in which the participants described their actual experience of breastfeeding in comparison to what their ideas of that process were prior to having their baby. Further to this, the participants also shared their thoughts about how the experience of the reality of breastfeeding could be better managed for others.

3.5.1. "Shattered dreams: it was meant to be easy". As the participants seemed to be wedded to the idea of breastfeeding as part of a mother's natural role, they also seemed to have the expectation that this 'natural and normal' process would 'just happen' without the need for much thought, concentration or effort:

So I'd always seen, literally, women that you know, would just be like 'my baby's hungry' and whop the baby on and carry on their conversations and they'd walk around the house, or they'd sit there and there would be no evidence of pain or discomfort, or any particular amount of concentration.

(Rachel, p.6)

Moreover, there appeared to be a shared view by the participants that the baby would instinctively 'know' what to do when born and there was a sense that they would lead the way and almost 'teach' their mother what to do:

What I realised was that he wouldn't know what to do as a baby. I just thought, a baby comes, a newborn baby and they know what to do, they know how to breastfeed. I'm the one learning, he's going to teach me. But it didn't work out that way at all because he hadn't a clue what was going on (laughs) and I hadn't a clue what was going on! (Susan, p.4)

Susan clearly spoke of her surprise in finding out that breastfeeding was not as easy as she had thought it would be. She repeatedly, throughout her interview, used the phrases: 'nobody tells you' and 'shock' in describing how powerful the realisation was that breastfeeding was more difficult for her. Rachel also spoke of this feeling during her interview: "I was having to solely concentrate on putting him on, keeping him on and really just focusing on making sure he had a good feed...so that came as quite a bit of a shock, really."(Rachel, p.6)

Susan goes further than this in describing her shock at breastfeeding difficulties being like having 'shattered dreams', which brings about a powerful image of her ideas and beliefs, hopes and expectations being broken apart and dispelled:

I was just clinging on to this romantic idea still that it would just be so easy and I didn't want it- it was like it was a dream of mine and it had been shattered a little bit and I was in denial that that was the case, sort of. (Susan, p.14)

Susan also talks about having a 'romantic' ideal about breastfeeding, again, bringing up images for the interviewer of a perfect mother and

child content and happy in their feeding. She mentions the word 'denial' in the excerpt above which can be interpreted as her need to avoid the pain of reality as well as the pain of the feeding act itself, where Susan's illusion of a perfect feeding experience was not actually the reality.

The idea that the reality of breastfeeding, although "natural and normal", was not as easy as expected was echoed by others. For example, Jayne talks about realising that there is an instinct to want to breastfeed but that this does not translate necessarily to the knowledge of how to practically feed successfully: "You think it's something really instinctual, but actually, it's not. The 'wanting-to' for me, it was instinctual to give my own milk, but I hadn't just learned the technique" (Jayne, p.3)

This subtheme demonstrates how the participants all had preconceived ideas of what breastfeeding would be like based on their upbringing, their observations, and even the conversations they had with their peers. This appeared to be that breastfeeding would be easy, and would take little effort to establish and maintain. It is therefore little wonder that they also shared experiences of shock when the reality of breastfeeding did not meet up with their expectations of how easy breastfeeding would be, and that, in fact, breastfeeding is an arduous and demanding task. The difficult task of breastfeeding is addressed within the next subtheme.

3.5.2. "The demanding nature of 'on demand'". All of the women shared the experience that breastfeeding was demanding in both a physical and emotional sense. Rachel talked about the 'emotional rollercoaster' of breastfeeding, characterised by the ups and downs in feelings at times when breastfeeding was going well or becoming more difficult: "So yeah, it's been a rollercoaster..."(Rachel, p.5)

Some of the women talked about 'vicious cycles' of breastfeeding, which involved both mother and baby. Here it seemed that the more the mother tried to

breastfeed successfully, the more stress the baby would demonstrate, being fussy or crying on the breast. This in turn would then lead to more negative emotions in the mother, and so the cycle was continued.

I was told when she was not latching on properly to take her off and put her back on. Then she would get really stressed and once you've taken her off she wouldn't go back on; then she wasn't feeding enough then she was hungry an hour later and wanting to feed again then in got into this kind of cycle....the pain and soreness makes me miserable which affects her.(Emily, p.4)

The idea of the relentless nature of breastfeeding was also shared. Here four of the women interviewed described the length of time taken in a feed and how there was little in the way of a break:

No, I'm not feeling this wonderful bonding experience because either it's painful or he's crying or he's latching on and off and then getting windy and it was frustrating. And I think when they're cluster feeding or having to feed every two hours but actually, that one feed has taken...By the time you've fed them, changed them, winded them, put them back down, that's taken an hour so you're actually only getting an hour's break before having to do it all over again. (Rachel, p.5.)

Expressing also appeared to be a demanding process, with some having expressed throughout the day and night:

I was quite honest and I said 'I can't cope with this expressing'. I said; 'It's three hours out of my life a day when people are doing the housework, or just resting, or just chilling, or relaxing'. And I said; 'I'm sitting here while he's (baby) playing on the mat with a pump in my hand' and I said; 'I think it's just impeding us the time that we can spend together now.' (Jayne, p.22)

Emily shared this experience, as demonstrated in the following quote:

It takes an hour and a half to two hours 'cause there's not enough time in the day to do that and at night I'm already getting up to feed her obviously in the night and then spending an hour on the breast pump...just draining, completely draining me. (Emily, p.29)

Here, Emily's use of the word 'draining' is used to describe the literal act of draining the breast of milk, but also seems to describe the 'completely draining' nature of expressing on top of feeding and looking after her baby. There is a sense that the pump is symbolic of the draining of energy as well as breast milk for Emily. The idea of "on demand" was discussed by the majority of the participants where they talked about the need to be responsive to the baby's needs. Again, some spoke of this as a tiring, draining process. Some participants also gave a sense of isolation in responding "on demand", where the responsibility could not be shared with others:

He [husband] hasn't done many feeds, I've done them all really, and the only time we've given her bottles is when I've gone out for one meal...so you don't get much of a break really. I could do with more of a break really, definitely, but then my family live far away and Dave's working. (Heidi, p.63)

Some of the women, however, talked about turning to expressing in order to have a 'break' where their partners or husbands could lend a helping hand:

I am going to start expressing so at least hubby can do a feed for me either in the night or in the evening, um, you know, so that I can just get a little bit more sleep really, so we are going to be doing some expressing to give us a little bit of a break. (Rachel, p.24)

This subtheme has demonstrated how, contrary to the participants' expectations, breastfeeding was experienced as a demanding, draining process which requires great effort and energy. Participants also allude to the realisation that they were in need of some respite from this and seemed increasingly more open to exploring means by which they could take a well-earned and much needed break. There was a sense when interviewing participants that they wished someone had informed them of the realities of breastfeeding, so that their preconceptions were perhaps not so far from the reality they experienced. This is explored in the following subtheme.

3.5.3. "Forewarned is forearmed". Within this subtheme, the women shared the idea that they felt they could have been warned in advance about the potential difficulties that could arise with breastfeeding. In some cases this did not relate specifically to difficulties, but rather what to expect when approaching breastfeeding in reality.

Rachel talked about her sense of anger and frustration that she wasn't warned, feeling that this could have potentially prevented some of the negative emotions she talked about during her interview when feeding was not progressing well:

It would have been nice if somebody had just given me the heads up when I was still pregnant about what sort of difficulties I could encounter and actually say to me, 'do you know what, don't expect it to be just as easy as putting your baby on.....it would have made a huge difference when it was so painful and he wasn't feeding properly, because you know, my automatic thought was 'I'm doing something wrong, it's completely my fault. (Rachel, p.7)

Heidi talked about the idea that difficulties are not spoken about, wondering whether it is to not 'put people off' breastfeeding. Rachel however, didn't feel that hearing about the difficulties would have changed her plan to breastfeed

I do wonder if people knew the reality of the pain, the cracked nipples, the bleeding nipples, the engorgement whether people would just be like...why would I even put myself through that? I don't think it would have put me off because I would have been like "No, I can do this". But at least I know these are the things to look out for. (Rachel, p.17)

Susan talks later on about how she feels she wants to dispel the romantic notions others might have about breastfeeding, almost so as to help others avoid the pain of the reality of her shattered dreams:

So now I'm a lot more realistic about the whole thing and I've got a number of friends who are expecting....and they all ask me about breastfeeding. So I've said to them all the same thing, you know, it's not as romantic as you kind of think it is and sometimes you'll be there with tears streaming down your face because it's hurting so much. (Susan, p19)

There was a sense, when talking to the women that information given to them when they were pregnant was lacking in terms of informing them of the common problems associated with breastfeeding. However, some of the women indicated that their focus at the time of pregnancy was more on the process of giving birth and that feeding at that point was not on their list of priorities. Some also spoke about the experience of being 'taught' about establishing a latch with the baby prior to having given birth, describing this as something that was detached from them in terms of meaning, due to them not having had the experience of having breastfed a baby.

Well I think when you're pregnant, you're more worried thinking about the birth than the actual baby arriving....so I guess after the birth and she arrived safely and you're okay and everything is okay health wise, I guess the next biggest thing is feeding, isn't it?(Emily, p.13)

Here there is a sense that Emily's headspace was preoccupied with thoughts about the safe arrival of the baby, and of the birth itself where she was 'closed off' to thoughts about feeding or breastfeeding, let alone anticipating any difficulties with feeding that could potentially be encountered. There was a sense that the preoccupation with getting through the process of birth was the only thing that the participants could engage in thinking about, which is understandable given the amount of uncertainty that surrounds the process of birth itself, for both mother and baby. This has implications when thinking about women's potential ability to hear information from others about feeding and the pitfalls of feeding prior to giving birth: "We only looked at one position and we practised with dolls. It was the rugby ball position...it would have been lovely to explore the other positions. It's almost a shame they didn't do that session after he had been born."(Susan, p.5)

This comment from Susan was almost a passing comment about the need for a session with healthcare professionals within the maternity services after the birth of her son, but it appears that this could indicate the sense again that her experience of receiving information was a little lost on her at the time of the antenatal session. It seems this might have been more beneficial to her post-natally when she perhaps was more focused on the process of feeding.

Others shared the idea that a more real depiction in the media of what breastfeeding is like in reality would be beneficial. Anne mentioned popular television programmes and how they might portray breastfeeding to the public. Also,

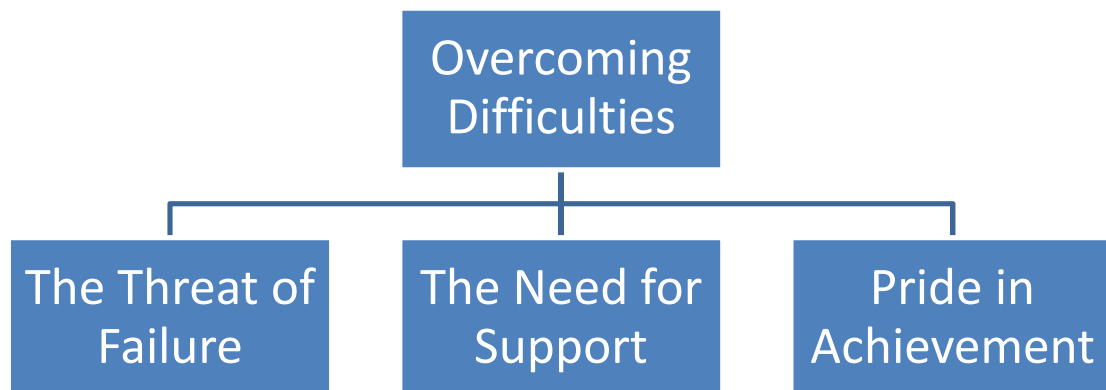
she picked up on a focus on birth in some of the “reality” television programmes which do not include any stories or images around establishing feeding the baby or establishing breastfeeding.

Through interviewing the participants, there was a strong sense of “If only we knew...” where many spoke of their belief that if they had been forewarned about the realities and potential difficulties associated with breastfeeding, then it would have impacted upon them in a positive way. Contrary to this, however, is the idea that women may not always be open to hearing information about feeding, so long before it is a pertinent issue for them. The overall superordinate theme seems to point to the notion that knowledge, for some, is power. Once difficulties are brought to light, it seems that the participants were keen to get some assistance in overcoming these, which is discussed below within the third superordinate theme.

3. 6. Superordinate Theme 3: “Overcoming Difficulties”

The third superordinate theme will explore the way in which women talked about difficulties with breastfeeding through the subthemes indicated in the figure below.

Figure 5. Superordinate Theme 3



All of the women interviewed talked about facing some kind of difficulties very early on in their breastfeeding experience where participants identified problems with establishing a 'good latch' from the moment of birth. Other problems, as the weeks progressed, were around pain associated with nipple damage or with infections. Those who were interviewed very early on (for example, Rachel and Emily, whose babies were only a few weeks old) were still very emotionally connected to their experience of difficulties as they were current to them at the time of the interview. As discussed in the "Expectations versus Realities" theme (Section 3.5), difficulties were often an unexpected experience for the participants, and came as a 'shock' where they thought breastfeeding would be 'easy'. The subthemes below will further explore the way in which the women talked about their experience of difficulties, and how they managed to overcome them, with the surmounting of difficulties bringing a sense of pride and achievement: "Breastfeeding is like climbing a mountain." (Susan, p.21)

As well as the sense of pride felt in overcoming the difficulties when beginning breastfeeding, all of the women talked about support in achieving this being a necessity which was "worth its weight in gold" (Rachel, p.28).

The first subtheme examines how the participants expressed feeling as though they needed to be successful at breastfeeding, and used the word 'failure' throughout the interviews to describe how they felt when feeding did not turn out as planned. There was a sense of responsibility that the participants seemed to take on, where 'failure' was deemed to be 'my fault' rather than associated with factors external to them. The subtheme of "The Threat of Failure" below addresses this idea in more detail.

3.6.1. "The threat of failure". As discussed earlier in this chapter, many of the women talked about the need to 'get it right' when referring to succeeding with

breastfeeding. For most of the women, there seemed to be a pressure to not let the baby down, and that they needed to provide for their child. Some talked about failure as 'not being an option' (Susan and Jayne).

For Anne, succeeding in breastfeeding was also hugely important in almost making up for her feeling that she had somehow failed at the birth when she and her baby had had quite a traumatic delivery:

I felt quite, I don't know, a bit inadequate, or something. And I felt like I'd kind of let her down in such a way. So it was like 'I've got to get this breastfeeding right, I've got to do it for her'. And that's what it became about. It was about doing it for her and making sure that she was getting what she needed. (Anne, P 12)

Jayne shared this sentiment, by talking about the way she and others had viewed her as someone whose life had been punctuated by a series of failures, and that breastfeeding was her chance almost to prove herself and others wrong about their perceptions of Jayne's inability to mother:

Everything that I've done has literally had some element of failure attached to it....It's just I want to be a success at being a mum because I can't fail him. I cannot fail my son. I can fail myself with anything but not my son, because he's the best thing I've ever done. (Jayne, p.20)

Within that threat of failure was also the idea of needing to fulfil the role of mother for the women, in providing the best for their baby which overlaps with the earlier theme discussed earlier in the chapter (Section 3.4.2). Again, failure to succeed at breastfeeding appears to be associated with what it means for the women's identity of being a mother, that not being able to breastfeed perhaps means that they have not quite achieved 'good mother' status.

For Rachel, it seems to go further than that. She talks about feeling that her baby 'doesn't need me' when feeding does not go well. This could be interpreted as a feeling of rejection from baby to mother, where the baby is almost acting in a way that sends a message to the mother that she is failing and is not doing a good enough job:

When I've had a really bad (feed)...he's ended up crying and I've just felt so frustrated I've just handed him to my husband because I've just felt; I can't comfort him, he doesn't want me, nothing I do is making him any happier, you might as well have him. So it has just made me go 'he doesn't need me, he doesn't want me. (Rachel, p.23)

Rachel was quite emotional when recounting this experience. For her, there was a powerful perception that her baby could not be comforted by her, the mother who *should* be able to do that, and so came to the conclusion he did not want her or need her. Rachel later talked about how she came to thinking that this was not a situation in which she could continue: "When I felt those feelings a few weeks back I just thought this isn't right, I shouldn't every time he cries think 'no, I don't want him on me', sort of thing." (Rachel, p.24)

Here it seems that Rachel is almost getting into a rejecting cycle where her interpretation that the baby does not need her leads her to feel that she doesn't want the baby near her, perhaps to avoid the painful emotions those thoughts bring about. This is further emphasised when she says:

I didn't want it to ruin our relationship, you know, if it was awful for me on a daily basis.....I didn't want to start feeling, you know, resentful of...I didn't want to feel like I didn't want to feed my baby and it was when I started having those feelings when I thought, do you know what, when I don't even

want to put my baby anywhere near me for a feed, that's not a good feeling to have. (Rachel, p. 25)

Despite feeling very emotional about the impact of the difficulties, Rachel had good insight into how she was perhaps entering into a negative cycle with her baby around feeding. This seemed to allow her to step back from her experience and think about other possibilities or strategies that did not put so much pressure on the mother-child relationship. Rachel also spoke about her sense of failure around feeding:

I felt like it was admitting that I couldn't do it and I didn't want to admit that I can't feed my baby, because you know, it's something that I should be able to do. I should be able to feed my baby. So as much as I wanted to say, you know 'I can't do it', I didn't want to say 'I can't do it' because I didn't want to admit it. (Rachel, p.8)

She went on to talk about the notion of pursuing a perfect feed, something which was also shared by some of the other mothers:

We both (referring to husband) had to go away, get some information, practise that and also, kind of accept that we might not ever be able to get this text book feed where he never clicks, and he never slips, and once he's latched on he stays latched on. (Rachel, p.10)

This seems to add more pressure to the women's experience of 'getting it right' where there is an idea of a 'right' and 'wrong' way to feed a baby, which fits into a standardised set of instructions to be followed in order for breastfeeding to succeed: "It is kind of upsetting that it's just me that hasn't managed to get things right with it". (Emily, p.11)

Here, Emily is referring to her own disappointment about breastfeeding failing, but is also alluding to her sense of failure when comparing herself to other mothers, who were seemingly successful at breastfeeding their babies.

3.6.2. “In need of support”. All of the participants shared the experience of looking for help when facing difficulties in establishing and continuing breastfeeding. They all described seeking the guidance and advice of various professionals: midwives, health visitors and peer counsellor volunteers. Susan talked about pursuing the advice of one particular health professional, whom she had heard would be able to help her with her issues: “I went to a breastfeeding support centre, support, you know, drop in session because I heard that this ‘breastfeeding guru’ went there and she’s just brilliant and I’d heard about her and I thought: ‘this is what I need’.” (Susan p.16)

Other sources of support for some of the women were from peer relationships, where many talked about shared stories and experiences with other mothers: “You turn up and there are other mums there and they’re saying ‘well yes, this happened to me! That happened to me too!’ And somebody else was saying; ‘Me too, this is exactly the same experience that I’m having’It’s a relief really, to feel like I’m not my own and I’m not kind of unusual and that other people battle, and have the same battles that I’ve had.”(Susan, p.35)

Here Susan describes a sense of relief in knowing that her experience is shared by others. The relief seems to be in the knowledge that she is not isolated in her ‘battle’ with breastfeeding and that together with others’ understanding she can move forward. A shared understanding is mentioned elsewhere when Emily talks about her experience of going to support groups: “They all kind of shared sort of experiences and stuff so they kind of all understand that I’ve not gone ‘Oh that’s not worked out’

and stopped it. They understand that it's a kind of, you know, things have been difficult and I've been trying..." (Emily, p.11)

However, Emily also talks about the support in the group almost as a double edged sword, where comparisons can be made, and she feels almost the 'odd one out' in her use of formula when the other mums are breastfeeding:

Most of them end up feeding the baby during the couple of hours that we get together whereas I go to the fridge and get a bottle out and you know its....It's kind of worked out for them but it hasn't worked out for me. (Emily, p.12)

Emily was faltering during this excerpt in the interview when she was talking about how hard it was to be around other mothers who were seemingly getting on fine with breastfeeding, the act of getting up to get the bottle out from the fridge a clear message to the others that her breastfeeding story was different.

Apart from Emily, the participants shared the experience of having found support from others invaluable, in being able to lean on others for advice, or simply having someone there to talk to when needed. This support seems to have given some motivation to continue, which is discussed in the next subtheme where the sense of pride, that overcoming the difficulties brought, is examined.

3.6.3. "Pride in achievement". This subtheme explores more positive experiences with breastfeeding in the way participants expressed the sense of pride and achievement in having continued with breastfeeding, now that difficulties were being surmounted: "I suppose I view it, you do feel proud of yourself that you have provided all of that for them."(Heidi, p.31)

Along with this sense of winning the 'battle' was a real determination from the participants that they would achieve their goal in the end. There was a strong sense in

all the mothers interviewed that breastfeeding was something they had to persist with, especially in overcoming any problems encountered. Many shared the idea of not being able or allowing themselves to ‘give up’: “I’ve got the bottles in the cupboard ready in case I need them, but I guess I’m just not ready to give up just yet.”(Rachel, p. 26)

The need for strength to continue was shared also, as Rachel described having to “dig deep” (p.30) to carry on breastfeeding. This phrase seemed to evoke powerful images of someone struggling to find the last bit of energy from within them, with which to “battle” on. Susan also talked about the decision to start breastfeeding as not being one she could easily turn away from: “No matter how tricky it is, I’m not going to throw that away. It’s really important to me” (Susan, p. 33)

This quote, when revisiting the transcript, left the researcher wondering what Susan was referring to when she used the phrase “not going to throw that away”. This was interpreted as Susan’s fear that her ideas, or her ‘ethos’, that breastfeeding was the best thing to do for her baby, but also for herself as a mother and as a woman, would be compromised, and possibly discarded or discounted. Susan’s determination felt as though she had the need to protect this meaning for her, and that any difficulties would not cause her to discontinue breastfeeding. Heidi refers to her experience of breastfeeding as a journey with ups and downs, one which changes as the baby grows. “I suppose carrying on with it. I’m quite proud of, because that’s another thing that the NCT doesn’t tell you or the breastfeeding counsellors don’t tell you is that it changes.”(Heidi, p.56)

Again, as discussed within the Expectations vs. Realities theme (Section 3.5.), Heidi hints at the lack of forewarning about how the nature of breastfeeding is not static, and that it evolves with the baby.

Emily however, presented as an exception to having overcome difficulties as she, at the time of her interview, was in a current struggle with her breastfeeding experience, and was in the process of seeking support with re-establishing breastfeeding her baby. However, Emily talked about coming to terms with the fact she would be happy to have given breastfeeding a ‘good go’ before having to move on to formula feeding, and did share the determination with the other participants: “I was so determined that I’d just do breast and that I’d just carry on with it and I was so determined with it that I would just crack it and it would be okay. But it hasn’t quite gone to plan.” (Emily, p.17)

Emily here repeats her use of the word ‘determined’ which was interpreted as her need to convey the message that she was really trying to succeed with breastfeeding, and as she had discussed earlier in the interview, ‘not just giving up’ out of choice.

As well as feeling proud in having achieved through their own determination, the participants also shared a positivity that their difficulties, although stressful, emotional and ongoing (for some), were surmountable, and also, and most importantly perhaps, not due to their being inadequate as a mother. “It’s getting easier and we can have some lovely feeds, and yes, sometimes it’s not so good but at least I don’t feel rubbish about it, someone has told me that it’s not something I’m doing wrong”. (Rachel, p.28)

It seemed that rather than seeking the “perfect” or “textbook” feed that some of the participants referred to, they had, with time and support, learned that the act of breastfeeding was individual to them and their babies. It seemed that this process of acceptance that breastfeeding was not going to be easy and perfect at all times allowed some of the participants some relief in taking the pressure off to “get it right”

all of the time and therefore begin to enjoy the experience.

Overall, this superordinate theme captures the way in which the majority of the participants interviewed were able to emerge from their difficult experiences feeling more content about their breastfeeding journey, and possibly reflects the way in which the early days of this experience presents with many ‘highs and lows’ which require some kind of “strength” or persistence to get through the challenges. The timing of the interviews in relation to how breastfeeding lived experience was discussed is perhaps pertinent here, where women who were ‘closer’ to the challenges were possibly more preoccupied with the more difficult aspects of feeding, whereas those who had more distance from these early challenges perhaps had more space to reflect on the more positive aspects of the overall breastfeeding experience.

3.7. Other themes

There were some themes that were noted that were not captured under the superordinate themes described above, as they were not generally shared across the group, but are perhaps pertinent enough to explore due to the nature in which they stood out when analysing the themes across the data set. Some of these additional themes were of particular importance to individual participants, and some were themes that were shared by one or two other participants when noticing similarities and differences across the cases.

Heidi talked about feeling awkward about feeding in public, this particularly related to taking advice from her father who had advised her that she should be modest and ‘cover up’ when feeding. Heidi seemed to talk about this in a way that was interpreted as her feeling pressure to consider others’ comfort and needs above her and her baby’s with regard to breastfeeding. This subject did not emerge in other

interviews in terms of direct worries about feeding in public, however Anne did talk about the lack of portrayal of breastfeeding in the media, for example, on television and wondered why that might be; feeling that breastfeeding should be promoted more in the media.

This leads to another theme of protecting the breastfeeding 'ethos' which Susan discussed passionately. Her own beliefs being that it was important as a mother and a woman to breastfeed in a 'natural' way without intervention in terms of using bottles or pumps.

Another theme that stood out and again only discussed by one participant was that of breastfeeding and the impact on body image. Here, Heidi talks about the change in her breasts due to breastfeeding, and seeming to feel self-conscious about this. Although this was not discussed in detail, it does perhaps highlight how some women perhaps face having to accommodate physical as well as psychological changes when giving birth and breastfeeding, in relation to the perception of their breasts being something used to nurture and provide for their child, challenging perhaps their previous perception of breasts as objects of sexual desire.

These themes are perhaps important to consider in light of some of the feminist perspectives outlined earlier on in chapter one.

January 2013

Ok, I've been thinking about breastfeeding a lot lately, not just because of the thesis but because I am pregnant! My tutors have joked that this is one way of getting into the research! But seriously, I am really aware that the topic of the thesis is becoming more pertinent and personal to me so I feel I need to really use my diary to capture my thoughts.

One thing that has occurred to me since becoming pregnant for the second time is that I have been introduced to a dilemma in thinking about my feeding decisions with this baby, which wasn't there the first time around. In order to complete my training and not have to skip a year I can only have 6 months off (I'm due in June) so I really need my baby to be able to take a bottle in order for me to return to work when he is 6 months old or it's going to be really really difficult to leave him. Cue copious amounts of guilt! I'm sure this is perhaps what millions of women thinking about the way in which they will feed their baby might be experiencing. Will I be depriving my baby? 'Good mums don't do this' etc etc. Think these are things to bear in mind when I come to doing interviews, although I know I need to 'bracket' off my own feelings about this too...

September 2013

So I gave birth to a beautiful baby boy on 11th June and, lo and behold he is a bottle fed baby! I can't quite believe that I'm returning to this journal with a completely different experience than I could have ever imagined. I'd assumed having breastfed my little girl for 15 months that I would just breastfeed my second baby. Not the case. Unfortunately, due to quite a traumatic birth for us both, and baby having to spend his first 5 days of life in neo natal intensive care, we have ended up at a point where we are using bottles. His being tube fed for this period, be it with breast milk and formula meant that he just never established a latch, and I couldn't deal with upsetting a poorly baby by persisting for the two weeks the consultants told me it could take for him to 'get it'. So, I spent the following 6 weeks pumping breast milk within an inch of my life before finally giving up. And spent the next 6 weeks feeling incredibly guilty, DESPITE the fact I knew that I 'could' breastfeed and it was probably due to my baby's rocky start and not being able to establish a latch (my daughter latched straight away). All of a sudden I am aware that I need to justify myself for not breastfeeding (even in this journal entry!), to midwives, to health visitors, to gp's and to family and to friends...and to myself?? Oh, and helpfully, the only support group for mums with a newborn is a "breastfeeding café" so I can't go as a bottle feeder. As I reflect on the last couple of months I remember feeling a bit isolated and left to it in terms of working out all the stuff about formula and expressing-its' true, they don't tell you ANYTHING about feeding options that are not breastfeeding! I'm using advice from online forums and sites rather than the professionals on my doorsteps. Their answers to my questions are so vague, and as I know, intentionally so probably. I finally realise what I've heard and read so far about mums who can't breastfeed, how awful you feel about it, and how there's not really any support to help you out of that feeling. Food for thought.

Chapter 4: Discussion

4.1. Overview of chapter

This chapter will begin with an overview of the findings from the current study and will then consider these in relation to existing theory and literature. Consideration will then be given to issues regarding the quality of the current research, with methodological limitations being explored. Clinical implications for the research findings will then be presented along with ideas for future research in the field. The chapter will end with final conclusions and reflections about the study.

4.2. Summary of Research Findings

This study aimed to explore the lived experiences of breastfeeding for first time mothers, with an interest in how they made sense of any difficulties they encountered with breastfeeding.

Analysis of data resulted in three superordinate themes which captured the mothers' experiences in terms of their sense of the "maternal self", "expectations versus realities of breastfeeding", and in their experience of "overcoming difficulties".

The idea of the maternal role being embraced as nature intended seemed to be a powerful theme that was common across all the participants' experiences, emerging from their narrative around what breastfeeding meant to them. In particular, some participants referred to breastfeeding as an "instinctive, natural act" that women "should" do, something that defined them as women and as mothers; and so seemed to be tied up in their identity as such. One theme that was particularly strong across the participants in relation to their role as a mother was the feeling that breastfeeding was linked to their bond with their baby, and led to them questioning whether bond

was dependent on the ability to breastfeed, where the act of breastfeeding was synonymous with a feeling of closeness and connectedness with their child.

The mother's role was discussed by participants in terms of them having a notion that there were things a mother "should" be able to do in that role, and that there was a "right" or "wrong" way of doing it. This was related to the act of breastfeeding where there was a sense that a mother's role is to provide sustenance, nurture and comfort for her baby, and so they should be able to breastfeed successfully and for as long as possible.

This seemed to be imperative for the participants to feel that they had fulfilled their duty as mother. This, then, appeared to lead to a significant amount of perceived pressure to achieve this, where pressure was not only experienced internally, but there was also a perception of external pressure, be that from peers, professionals or social/cultural rhetoric around breastfeeding, highlighted and emphasised through the media (for example Facebook, television programmes and newspaper articles).

In order to maintain this "natural" state of breastfeeding, and in order to fulfil the mother's role as "nature intended", participants expressed that the idea of any substitute to breastfeeding was something negative, and something to be avoided at all costs. There was an impression that formula was a substance that could be interpreted as a representation of failure in breastfeeding and perhaps, a failure to achieve what a mother or a woman "should" achieve in providing for her child on a basic level. In fact, one participant (Jayne) did refer to the idea that she had almost "demonised" the use of formula and discussed the thought of using it initially as "evil". Further to this, some participants also talked about the sense of shame they felt having to use bottles in front of other mothers who were breastfeeding their babies, seemingly without

difficulty. This seemed to trigger feelings of inadequacy and disappointment in them, again highlighting a sense of failure to successfully breastfeed.

Another theme that was shared across participants was about what their expectations of breastfeeding were prior to giving birth, and how this compared to the discovered reality afterwards. Commonly, across participants was an experience of the impact of how reality contrasted with a “romantic” view of breastfeeding as being a natural, instinctive, and relatively effortless experience.

Participants spoke of their “shattered” dreams (Susan, p.14) where these ideals or pre-conceptions were dashed quickly and unexpectedly within hours of giving birth. Along with this experience, participants also seemed to feel strongly that having more information which gave them a realistic picture of breastfeeding, may have saved them from their “rollercoaster” of emotions that came from struggling to establish breastfeeding and the realisation that it was not going to be as “easy” as they had imagined. This may suggest some implications for professionals which will be discussed in section 4.5.

The third theme that encapsulated the participants’ experiences was the way in which they talked about “Overcoming Difficulties”. Here, participants were again interpreted as having the threat of failure hanging over them when they encountered problems with breastfeeding. This idea overlaps somewhat with the previous theme of achieving the natural role of a mother. Here, however, the internal struggle to “get it right” appeared to lead to significant emotional distress in the early days of feeding. In this desire to avoid perceived failure, all participants described seeking support in their breastfeeding journey mainly through peers, friends or healthcare professionals and volunteers. One participant referred to pursuing a “breastfeeding guru” which emphasised to the researcher a sense that success in breastfeeding was achievable

through external, professional intervention. Participants seemed to place great importance on the support received, and that the power of information about what was “normal” was “worth its weight in gold” (Rachel, p.28). This support and advice seemed to act as a turning point for many of the participants, where they were able to persist and persevere through their difficulties and managed to establish a more settled routine of feeding that was achievable in the long term. All participants, bar one who was experiencing difficulties at the time of the interview, seemed to share a sense of pride in their determination to succeed with breastfeeding and being able to find the internal strength to continue through difficulties in order to “get to the other side”.

4.3. The Research Findings and theory

This section explores some of the main findings of the study in relation to the theory and existing research that was explored in previous chapters. The topics being considered here are those that were of particular interest to the researcher in terms of answering the research questions and addressing the aims of the study; and which seemed to be the most powerful themes that emerged from the synthesis of the participants’ experiences.

4.3.1. Maternal Identity. The findings of the current study are supported by theories and research on maternal identity and this will be set out in this section.

Firstly, theorists who discussed maternal role attainment or “becoming a mother” (Rubin, 1967, Mercer, 1980) posited that women undergo “psychological work” during pregnancy and birth in order to accommodate an ideal image of themselves as mothers into their existing “self-system”. This includes ideas about qualities and traits that they might deem desirable in fulfilling the new role. A threat to this sense of new

identity as a mother may occur when facing challenges around breastfeeding, as found in the results with the participants of the current study. Here, distress seemed to be related to the sense of failure that women perceived when struggling to breastfeed, which was related to a judgement about what kind of mother they might be. This seems to be explained well by Lee's (2008) work on maternal identity and infant feeding where it was suggested that women who have to formula feed in the current cultural context feel they have to justify their decision to do so, as this has been constructed as "bad" in terms of a feeding method. Women may then struggle to maintain a positive sense of themselves as mothers which was evident in the way the women in this study talked about themselves as feeling they had "failed" or "let down" their babies.

The idea of "identity work" a mother may have to do in order to accommodate her use of formula feeding in her beliefs about being a "good mother" is interesting in relation to the current findings. This is reflected in the way that the participants discussed their coming to terms with using bottles or formula later on in their breastfeeding journey, tying in with the idea of a "risk" that women face "moral collapse" when feeding with formula (Knaack, 2010).

The findings that negative feelings regarding maternal identity were experienced when encountering breastfeeding difficulties appeared to be reflective of findings within the existing literature suggesting that maternal identity was impacted by women's breastfeeding experiences (i.e. Schmied and Barclay, 1999). Breastfeeding did appear to be perceived by the women interviewed in the current study as the "measure of the mother" as described by Blum (1999). The participants in the current study also discussed feelings of disappointment and of experiencing breastfeeding as distressing at times when they were struggling to overcome problems.

The current findings also support research by Williamson et al. (2011) as they correspond with their overarching theme of breastfeeding difficulties being a ‘threat’ to maternal identity, where the ability to feed the baby appeared to be an “essential part of motherhood”. In the current study, participants expressed the need to breastfeed as being what a mother and a woman “should” do, reflected in the superordinate theme ‘Nature’s Way-The Maternal Self’.

The findings also fit well with the existing research about constructions of motherhood (i.e. Lee, 2008) in terms of the conflict between breastfeeding being a “natural” part of mothering, yet also requiring expert guidance. This experience of the “medicalisation” of breastfeeding (Marshall et al., 2007) did seem to add to the feeling of surprise and confusion expressed by participants in the interviews when considering their roles as mother in relation to there being a “right” or “wrong” way to breastfeed. This was particularly so when they had been given the message that breastfeeding is meant to be an instinctive and natural part of mothering by healthcare professionals or by peers who have had a relatively straight forward experience with breastfeeding.

Further, the research by Wall (2001) on the moral construction of motherhood in relation to infant feeding appears to be supported and emphasised by the current findings. For example, the findings lend well to the suggestion that current healthcare interventions can in one way be helpful or empowering, but also that they can also be experienced as “oppressive” or controlling, where information is centred around the benefits of breast milk, and mothers are treated as “disembodied providers of milk”. Again, this lends to some consideration of the clinical implications of the findings, which will be discussed further in section 4.6.

In light of the discussion above around maternal identity, the current research appears to provide some critique of breastfeeding self-efficacy theory. This theory (Dennis, 1999) discussed women's experience of breastfeeding in relation to how confident they are in their ability to breastfeed, with a strong focus on the act of breastfeeding, and how this is learned and accomplished. The related scales developed to measure breastfeeding self-efficacy have been shown to predict outcomes in terms of breastfeeding rates, and have provided some explanations of why some women cease to breastfeed in the face of challenges, whilst others persevere. However, the theory does not go as far as to explore what low confidence around breastfeeding means to the woman in relation to how she might conceptualise this and what the consequences of having 'low breastfeeding self-efficacy' might be, other than in terms of 'emotional distress' or negative psychological difficulties. Maternal Identity theory, therefore is perhaps a more useful theory to explain the findings of the current study.

Whilst breast feeding self-efficacy theory may provide some useful insights into the processes involved in the duration of breastfeeding, it perhaps falls short of providing a depth of meaning in terms of exploring women's lived experiences of breastfeeding that might be essential in understanding what motivates or discourages women to continue breastfeeding. Maternal identity theory, however, does seem to be able to address this and offers a way of thinking about women's breastfeeding journeys that includes considering what changes a woman might undergo psychologically in order to accommodate her new role as a mother and all the challenges that go along with that new role.

4.3.2. External pressure to “get it right”. This refers to the way in which participants talked about pressure from both within themselves and from external sources to succeed with breastfeeding. As described above, the internal pressure appeared to come from the need to satisfy participants’ sense of the maternal role in providing for their child.

The external pressure, however, seemed to come from a perception that other women would judge them if they did not breastfeed their baby, and that bottle feeding was something to be ashamed about, and something which highlighted the women’s sense of failure and feelings of inadequacy. These findings support ideas presented in previous research (i.e. Hoddinott & Pill, 1999; Hill & Hauck, 2007) who highlighted that difficulties with breastfeeding were associated with lowered self-confidence and feelings of failure, as well as feeling pressured by professionals to breastfeed their babies.

An interesting finding from the current research is the way in which the participants talked about the need for support and expert guidance in overcoming difficulties encountered with breastfeeding. Although participants primarily described this in a positive way, and being mindful of the fact that half of the sample was recruited from a breastfeeding clinic where mothers would go to access such support, there was still an interesting discourse around the way in which participants felt the information given to them fell short of preparing them for such difficulties. It was interpreted that the participants who self-selected to volunteer for the research interviews were using their participation in the research as a way of providing some feedback about the care they received regarding breastfeeding prior to and after giving birth. The consensus seemed to be the perception that the information did not go far enough to warn women about what to expect when breastfeeding in terms of

the reality of what it would be like and what the difficulties would be that were most likely to occur. There was a definite feeling that such information may have been helpful in anticipating such negative and distressing emotions when encountering problems, whereas the participants' experience was that they attributed these difficulties as failing in some way in their role as mother. These findings support the work of Hoddinott and Pill (2012) who suggested that current policy for support around breastfeeding was "unrealistic and unhelpful" where women feel under pressure to breastfeed exclusively, and education is too technical and "rules based" in nature.

This also ties in with ideas around moral constructions of motherhood, where researchers refer to the medicalisation of breastfeeding, and therefore women feel that they need to look to 'experts' in order to succeed with breastfeeding. (Knaack, 2010)

Overall, the findings explored within this theme fit with the suggestion by Leeming et al. (2013) that the use of expertise can be an empowering or disempowering experience for women, which, as the current study also suggests, can lead to feelings of distress, a lack of confidence, confusion and questioning of the participant's identity as a mother.

Ideas about how women might be "forearmed" in helpful ways will be discussed later in this chapter (section 4.6). In summary, the discussion of theory relating to the research findings of this study aid in providing a framework on which to understand or explain the ways in which women discussed their lived experience of breastfeeding. It is also important to consider the context in which this research sit, as well as consider how this might also shape theoretical understanding and concepts. This will be explored briefly in the following section.

4.4. Context of Research Findings

The current findings appear to support the theory of maternal identity and distress associated with threats to this. However, it is also helpful to consider the findings in relation to the current context as this may impact women's view of themselves as mothers also. As discussed in Chapter One, ideas and attitudes about infant feeding have changed significantly over the past Century and more so over the last thirty years, with the advent of WHO guidance and Baby Friendly Initiatives to increase breastfeeding rates. Further, in today's cultural context, breastfeeding is once again at the forefront of media attention, with emphasis on financial gains to be made for the NHS if breastfeeding practises were to continue to the recommended duration.

However, conversely there also appears to also be some kind of backlash in the media over the last two years whilst this research was taking place, where women have been speaking out about their feeding decisions and how they feel about them in relation to the expectations they perceive there are regarding breastfeeding. This has been particularly evident in tackling the public feeding taboo where women have demonstrated and "named and shamed" those establishments that have been unsupportive of women breastfeeding by asking them to leave their premises. Discussion around this lends itself to feminist positions of empowering women to make their own choices around feeding and tackling the notion of breasts as sexual objects (e.g. BBC News, 2014, Mirror, 2015).

The idea of empowering women in their choices is pertinent in the way the participants in the current study talk about having more complete information at the right time, so as to prepare themselves with the realities of breastfeeding, thus feeling better able to face the challenges that the task can pose. The exploration of women's

experiences in this study perhaps builds on some of the ideas that women have a right to making a fully informed choice, and need to be given a voice in relation to how they feel about infant feeding and what this really signifies to them. Again, this perhaps has implications around how support might be shaped in a way that is meaningful and helpful to those women who feel they require it when starting out their personal breastfeeding journey, which will be explored further in section 4.6.

4.5. Evaluation of Methodology

The following section will present the considerations the researcher made in designing and conducting the study in order to maintain criteria suggested for validity and quality in qualitative research that was described in Chapter Two (Yardley, 2008). The section will also provide a critique of the methodology that was adopted.

4.5.1. Sensitivity to context. Yardley (2000) suggested a number of ways in which qualitative research could be assessed according to its sensitivity to context, by taking into account the socio-cultural situation in which the research is based, the existing literature around the topic being explored and the material from the participants themselves.

The choice of adopting IPA as a methodology by which to conduct the research in itself can demonstrate sensitivity to context. Here, the decision to utilise IPA was made according to the wish to stay close to the “particular” in terms of the participants’ experiences, by adopting a way of collecting data that did not place an emphasis on imposing a priori themes whilst also being mindful of the researcher’s position in terms of the interviewing and analysis process. IPA offered a useful way to think about the interactive and idiographic nature of data collection in qualitative research, where the process of gathering and analysing data was considered just as an important part of the methodology as the findings. The researcher attempted to hold in

mind that a “good interview” meant “good data” and therefore maintained an empathetic stance in the interviews, being sensitive to the emotive nature of the topic and staying with the participant throughout the conversation. Again, this meant the flexibility that IPA allows in conducting interviews was a way to remain sensitive to context.

The analysis process allowed attention to detail through the reading and re-reading of transcripts, noticing themes and the researcher’s own preconceptions and development of ideas, which immersion in the data produce. Demonstrating themes through the presentation of verbatim extracts from participants’ interviews gives the participants a voice. Interpretations have been offered in the analysis as a “possible reading” of the data, and more general claims were offered with some caution (Smith et al., 2009, p.184) which again also shows a sensitivity to context.

4.5.2. Commitment and rigour. The researcher was committed to the research and spent time reviewing literature in the field as well as going to talk to healthcare professionals about the subject of breastfeeding. An attempt was also made to understand the theoretical underpinnings of IPA as well as learning about the specifics of the methodology in practise, again through reading and attending a training workshop endorsed by Jonathan Smith at the very early stages of the research process.

The commitment that the researcher can demonstrate in the use of IPA overlaps with some of the ideas discussed in the section above, on sensitivity to context. Here, the researcher, in undertaking the in-depth interviewing and analytical process that is involved in IPA research, showed a commitment to the participant and

the data, in paying close attention to the participants in the interviews, and through the immersion in the data that arose from them.

In considering “rigour”, or maintaining “thoroughness” of the study, it was important to include in-depth interviews and for the researcher to pick up on participants’ cues to enable them to “dig deeper” and explore themes in detail as the interview progressed. Again, the analysis was undertaken in a systematic way, but allowed idiographic engagement and sufficient interpretation to take place in order to fulfil the requirements of IPA methodology.

Part of ensuring rigour in methodology included considering the sample in relation to the research questions being explored. Interview technique and analysis, especially for a novice researcher in IPA, was important. Here, the researcher considered Yin’s (1989) ideas about conducting an “independent audit” where the researcher puts in place checks to assess validity of the research. In this case, the research supervisor was able to conduct some so called “mini audits” (Smith et al., 2009, p.184) by reviewing initial annotated transcripts to ensure themes related to the text being examined. The supervisor also reviewed drafts of the analysis in order to assess validity in terms of themes: through checking participants’ verbatim quotes in relation to the interpretations being offered by the researcher.

4.5.3. Limitations. When evaluating the methodology adopted to conduct research it is important to reflect upon the limitations of the research and how this might impact any conclusions that can be drawn from the results.

Recruitment. The first consideration to make was the recruitment procedure, which differed to the method initially planned. At first it was proposed that recruitment would coincide with another trainee’s project and therefore participants would be approached ante-natally as well as post-natally. It was felt that recruiting

ante-natally would allow participants to be recruited prior to having any experience of breastfeeding and so enable exploration of experiences at differing time points. .

However, due to delays in the research approvals process it was not possible to recruit women in the antenatal period, due to the timings of the expected date of delivery in potential participants occurring outside of the required recruitment phase of the study.

Therefore the recruitment method was changed to enable recruitment to be carried out through the use of advertising posters in the maternity clinic areas as well as through attending post-natal breastfeeding clinic drop-in sessions run by healthcare professionals and peer worker volunteers. This meant that the women recruited through the breastfeeding clinic (n=3) were potentially more likely to have been experiencing difficulties, hence their seeking support at such a clinic. However, the other three participants were self-selecting participants who responded to the posters in other clinics and so were not seeking support for breastfeeding problems or issues. Further, during the interviews the self-selecting women indicated that they were interested in giving their opinions about breastfeeding and perhaps were motivated instead to participate by the desire to provide feedback to professionals in a safe and anonymised way.

Researcher's Position. Another factor to consider here was the researcher's position and relationship with the research and the topic area. The researcher was aware from the outset that there was a personal connection to research, and therefore an attempt was made to use this in a positive way and adopt the IPA stance of being aware of preconceptions and "bracketing" off their own thoughts, feelings and ideas about the subject when conducting interviews, whilst also maintaining reflexivity throughout by the use of the diary. When conducting the interviews, the researcher attempted to remain neutral and not give too much information about themselves to

the participant before the interview. However on some occasions, the participant specifically asked or assumed that the researcher had experience of breastfeeding, and an honest answer was given. This could have influenced the way the interview progressed; the participant could have felt that the researcher was holding an “expert” position and so could potentially make a judgment about their own experiences. Whilst this was not apparent during the interviews, and the participants appeared to get immersed in their own narratives, this is a factor to consider. The researcher expanded more upon their own position after the interview, within the de-brief if this was deemed necessary or if the participant had further questions in relation to the study.

Data Collection. Another area that could be considered as a limitation is in the conducting of the interviews themselves. The researcher used a topic guide for the first interview in order to act as a prompt to remind the interviewer to ask around certain areas which would assist in answering the research questions. However, this was not carried forward in the subsequent interviews as it was felt that the interviews would progress better being led by the participants and that this would allow for richer, more in-depth exploration of themes, rather than being distracted by set questions. However this meant the way in which the first and subsequent interviews were conducted differed.

Whilst this could be seen as a limitation in terms of not being able to ensure consistency across all interviews, this method is in keeping with IPA philosophy, in that each participant was treated independently, as a separate “case”, and attention was paid to the “particular” in terms of being led by participants’ narratives. It is also in keeping with IPA in that the nature of conducting such interviews means that the researcher, with each interview, revises their previous fore-understandings, as

demonstrated in the discussion about the hermeneutic cycle in Chapter 2. Therefore the researcher takes forward a slightly altered perspective and method of conducting the interview with each new participant. It is therefore vital in conducting research using this methodology to acknowledge the researcher in the process of collecting data, where it is not possible to truly separate the ‘I’ from participants’ accounts of their experiences.

4.6. Clinical Implications

The results of this study suggest that women who breastfeed may experience some psychological distress if faced with the demands of mastering this task. The results showed that the participants reported that difficulties with establishing breastfeeding caused feelings of inadequacy, guilt, despair and frustration, (as presented in chapter three) leading in some cases for women to question the impact of this on their relationship with their baby, and their perception of themselves as “good enough” mothers, thus creating a cycle of negative feelings associated with the whole process of breastfeeding.

These findings potentially have implications for the way in which healthcare professionals think about and monitor mothers in the postnatal period. Currently the emphasis is on benefits of breastfeeding for baby appears to override a consideration of what the impact of breastfeeding and breastfeeding difficulties might be on women’s emotional wellbeing.

Participants in the current research spoke clearly about the need for more realistic information about the nature of breastfeeding. Their perception of the existing education was that it emphasised the benefits of breastfeeding but that discussions of possible pitfalls or difficulties associated with breastfeeding was actively avoided,

with the belief being that healthcare professionals think that women may be “put off” by more realistic information.

The implication of this is that women are often provided with incomplete information which does not prepare them for what to expect when commencing breastfeeding. The participants, through the theme of “expectations vs. realities of breastfeeding”, expressed the way in which their ideas about perfect or “textbook” (Rachel, p.10.) and natural feeding were “shattered” (Susan, p.14), giving rise to a flood of negative emotions. This finding, which supports the existing research into breastfeeding difficulties, suggests that health policy makers would benefit from paying attention to the way in which information is provided to women when making decisions about breastfeeding, when it is possible to empower women in their breastfeeding journeys by giving a realistic perspective on what breastfeeding may be like. Although there appears to be some anxiety about whether giving this kind of information will prevent women from attempting to breastfeed their babies the current support and information appears to have not been successful in raising exclusive breastfeeding rates in the UK.

A further clinical implication of the research is around the underlying perceived feeling of pressure the participants in this study reported experiencing from healthcare professionals to breastfeed. Although it is difficult to generalise to all women, it appeared that there was a perception that women’s ability to mother was being judged on whether or not they chose to breastfeed. This perhaps points to a more subtle way in that interactions between women and professionals occur which would possibly be a helpful area to explore further. Inconsistencies in information given to participants were reported in this study, as well as elsewhere in the literature where the messages women feel they receive about breastfeeding at times can lead to confusion. The way

in which support services are currently set up may also emphasise the feelings of inadequacy and isolation expressed by participants. For example, support groups are labelled 'breastfeeding support' and so women who are not breastfeeding or not intending to breastfeed exclusively are seemingly not invited to attend. The researcher's personal experience of such services meant that they were excluded from support groups and feeding cafes due to method of infant feeding that was adopted. Again, this could potentially have an impact in terms of enabling women to feel encouraged to seek advice, support and reassurance that they are doing a "good job", even if they are not breastfeeding.

Overall, as existing research also suggests, breastfeeding promotion that focuses on biological benefits of breastfeeding, or the physical act of it without giving enough attention to psychosocial factors may create a "moral dilemma" for some mothers, and therefore educational and supportive interventions should take these factors into consideration so that women are assisted in making informed decisions about feeding (Guyer, Millward and Berger, 2012).

In considering the current findings that women's sense of maternal identity is compromised when facing challenges with breastfeeding, as well as the way they discussed the need for more realistic and balanced information about breastfeeding from healthcare professionals, this might lend itself to thinking about more helpful ways to offer support for women. It seems that there is a need to facilitate the woman's "identity work" at the most sensitive time in this process, soon after their infant's birth, in order to enable her transition to her role as mother without much in the way of emotional distress or without undermining her sense of her being a "good mother".

One suggestion about how this might be practically achieved might be in normalising the challenges that women might face in the early days of breastfeeding, and encouraging women to talk together about their fears, their expectations and their experiences with one another.

The participants interviewed in this research seemed to have ideas about when and what support might be useful for them in terms of infant feeding, and so it seems logical that mothers should be involved in developing their own packages of care around antenatal and postnatal support. This might take the form of more antenatal breastfeeding workshops focusing more on potential challenges that might be faced in the early days of breastfeeding, as well as the opportunity to make contact with a breastfeeding “buddy”. Access to a peer support group to allow women to explore infant feeding might be of use, whichever method of feeding is chosen in order to be inclusive of all mothers. Further, healthcare professionals should not make assumptions about what a woman might be feeling in relation to her breastfeeding experience, and so should be curious about what women individually might need, being mindful that each person’s relationship with the idea of infant feeding might be different, and so advice and support must be tailored accordingly. Overall, the suggestion from the current research is that there needs to be a sensitivity around the topic of breastfeeding where a consideration to meaning for the individual is key, if the aim is to support that woman in feeding her child, be that with the breast or otherwise. The wider political, cultural and social focus on increasing breastfeeding rates might remain; however, this does not mean that the way in which support is shaped cannot be adjusted so that women feel more empowered in their experiences.

4.7. Future Research

Given some of the discussion around information presented to women about breastfeeding and the question about whether information is helpful or unhelpful may lend itself to further research in terms of the type and method of education being delivered through maternity services. Here it would be useful to assess the impact of receiving information about breastfeeding at differing ante and post-natal time points, with, for example, detailed and realistic discussions occurring in both the antenatal as well as the postnatal period. It would be interesting to explore whether providing information that women find more helpful and realistic has an impact on their experiences of breastfeeding, their breast feeding self-efficacy and outcomes in terms of uptake and length of time exclusively breastfeeding. A useful way of developing such information giving sessions would be through consulting with mothers themselves, so as to give a user-led perspective on advice and support that they would deem beneficial to them in terms of providing good feeding support.

An intervention that may also be derived from this would be for there to be more general feeding support offered to women, rather than such services be exclusive to breastfeeding mothers . This could then be evaluated in terms of how useful women found this in supporting their feeding decisions, their emotional wellbeing and reported breastfeeding self-efficacy. It may also be beneficial to conduct further research with healthcare professionals, as their perspectives about how women absorb, utilise and seek information would be helpful in order explore questions about whether giving information on the realities of breastfeeding does indeed “put women off” and has a negative impact on breastfeeding rates and uptake.

Another area that may be interesting to pursue in terms of future research would be exploring the role of the media on breastfeeding views and ideas relating to

maternal identity and self-efficacy. Currently breastfeeding features regularly in the news, either in terms of the potential health benefits and the need to breastfeed or in terms of a 'backlash' to advice being given that 'breast is best'. Although this was beyond the scope of the current research, it was noted that the way that the media portrays pregnancy and birth related issues, as highlighted by one participant, fails to discuss in any depth the struggle that can be faced when women are attempting to breastfeed. Social media is also appears to be a source of potential support or distress for women, with many women holding strong opinions about breastfeeding which may be aired in these forums. These women were referred to comically as the 'Breastapo' by one participant during her interview (Jayne) and it would make for interesting research to explore the impact of some of the interactions over social media might have on women.

Public feeding is also at times discussed in the media, usually following an outcry that a woman has been prevented from breastfeeding in public. Whilst this was not a theme which emerged across all the participants, one or two mentioned the need to breastfeed discreetly in order to not cause perceived offence to others. The idea of "socially sensitive lactation" (Leeming et al., 2013a) has recently begun to be explored in more detail and it may be useful to build upon these ideas in order to gauge attitudes about breastfeeding amongst the general public, where the message to embrace breastfeeding is at odds with disapproval to doing so in the public arena.

4.8. Final Conclusions

The overall conclusions drawn from the interpreted experiences of the participants who took part in this study are comparable with existing research in the field of breastfeeding experience. These findings include the idea that most women do

experience a real desire to breastfeed their babies so as to fulfil their perceptions of what it is to be a good mother.

Following from this there appears to be a sense that the ability to breastfeed impacts on a woman's sense of maternal identity, which in turn is a source of significant emotional distress if breastfeeding is not possible or is difficult. During difficulties women are also faced with grappling with the conflict between being able to provide for their child without the need for intervention (due to it being a natural process) and the idea that breastfeeding is rule based and in need of medical intervention or attention in order for them to be able to 'get right'. Whilst the latter might be the case in circumstances where there are problems in the physical aspects of breastfeeding (i.e. mastitis), it seems that women may be faced with a 'no-win' situation, where the need for support or help can further undermine an already fragile and new sense of self as mother and possibly sense of breastfeeding self-efficacy, due to the nature and tone of the interventions currently being provided through Baby Friendly Initiatives. It is therefore suggested that health policy makers and providers bear in mind the emotional difficulties that breastfeeding experiences can bring about when considering long term aims to increase breastfeeding rates and reduce NHS costs. Here it is suggested, in support of existing research, that a more 'mother-centric' view is required when thinking about the bigger picture in terms of breastfeeding and its benefits.

4.9. Final reflections

Whilst this has been a really, really interesting piece of research, I feel that I have perhaps only just begun to scratch the surface of this issue, which is possibly much broader than I have scope for in this piece of work. I am aware that my work underlines perhaps what has been observed by other researchers recently, that the pressure about breastfeeding women are facing when pregnant and giving birth cannot surely be helpful for anyone. When thinking about the old saying 'breast is best' I automatically feel like countering that I prefer the saying 'happy mum, happy baby', which I think might be a more helpful stance for policy makers to bear in mind if they would like to get a handle on post-natal distress and the huge implications in terms of ripple effects this surely has on the baby and other family members for years to come. However, I have also come to thinking, through my own personal experiences during the course of this research, and through talking with many women that the pressure to breastfeed comes as much from within as it does from the outside, and perhaps us women could do more to support each other in our feeding experiences.

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Appendix A: Recruitment Poster

Breastfeeding Experiences, Recruitment Poster - Version 2.2 - 11/12/2013



UEA
University of East Anglia

BREASTFEEDING RESEARCH

**Are you pregnant or have you had a baby
in the last 6 months?**

Is this your first baby?

Are you breastfeeding or planning to breastfeed your baby?

**Have you tried breastfeeding your baby at least once in the
past?**

**Would you be interested in participating in a study about your
breastfeeding experience?**

We are looking for women to participate in interviews to find out more about women's experiences of breastfeeding. Participation in the study would involve an interview with a female researcher and would take 1-1.5hrs.

**Participants in the study will automatically be entered in to a
prize draw for £50 Mothercare vouchers!!**

Please contact Mariam Errington (Trainee Clinical Psychologist, University of East Anglia) for further details

E-mail: m.errington@uea.ac.uk

Tel: 07857963599

PARTICIPANT INFORMATION SHEET
A Qualitative Exploratory Study of Breastfeeding Difficulties

Researcher: Mariam Errington, Trainee Clinical Psychologist

We would like to invite you to take part in our research study about Breastfeeding Experiences. This sheet provides you with information about the study that will help you decide whether you would like to participate. We will be happy to discuss any of the information with you and answer any questions that you may have.

What is the study about?

Previous research, using interviews, has found that women often report feeling pressure to breastfeed and often feel their ideas, thoughts and feelings about themselves are affected if they are not able to do so. This research aims to find out what women's experiences of breastfeeding are and what, if any, are the difficulties they encounter when breastfeeding, or attempting to breastfeed their baby. The research will also explore whether there is an impact of breastfeeding difficulties on women's emotional wellbeing and ideas about themselves as mothers. The findings from this study will be helpful in increasing our knowledge about the experience of breastfeeding for women.

Why am I being asked to participate?

We are aiming to recruit around 10 mothers who want to breastfeed or are currently breastfeeding to participate in this study. You are being approached as you are pregnant and have reported that you intend to breastfeed your child, or because you have had a baby in the last 6 months and are breastfeeding or have attempted to breastfeed your baby at least once.

Do I have to take part?

Participation in the study is entirely voluntary. It is up to you to decide whether you would like to join the study. We will describe the study and go through the information sheet if you wish to do so at your antenatal clinic or breast feeding class, as well as at your home prior to the interview. You can also contact us over the telephone to discuss any aspect of the study further.

If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason. This will not affect the standard of care you receive from your usual antenatal or postnatal services, or affect your legal rights.

What will happen to me if I take part in the study?

If I am hearing about the research before I've had my baby (Pre natal):

If you are interested in taking part in the study and have not already given birth, you will be asked to give consent to be contacted by the researcher when your baby is around 3 months old.

Once you have consented to be contacted, we will contact you to arrange a convenient time to interview you. We understand that it is possible that you might not want us to make contact with you in a few months' time. We would like to check with your Health Visitor or GP before making contact whether, in their opinion, they think you would be in a position to participate. We will send a letter to your Health Visitor or GP explaining that you are interested in participating in this research, and will ask them to complete and return a brief questionnaire indicating whether they feel it would be appropriate to contact you for the interview. We will not ask the Health Visitor or GP the reason why they might not feel it is appropriate to contact you, or ask for any other information about you.

The researcher will then arrange to see you at home at a time that is convenient for you. Interviews will last between 1 and 1.5 hours. There will be opportunity to ask any questions you may have before the interview begins. Prior to beginning the interview we will ask you to read and sign a consent form indicating that you would like to participate in the study. Interviews will be recorded so that they can be analysed for the purposes of the research study. After the interview, there will be a short debrief where you will be invited to ask any further questions and give any feedback about the interview process. You will also be provided with the contact details of support services should you wish to make use of those.

If I am hearing about the research after I have had my baby (Post Natal):

If you have had your baby within the last 6 months, and are interested in participating, we will ask you to fill in a contact details sheet so that you can be contacted to discuss this further and to arrange an interview.

The researcher will then arrange to see you at home at a time that is convenient for you. Interviews will last between 1 and 1.5 hours. There will be opportunity to ask any questions you may have before the interview begins. Prior to beginning the interview the researcher will ask you to read and sign a consent form indicating that you would like to participate in the study. Interviews will be recorded so that they can be analysed for the purposes of the research study. After the interview, there will be a short debrief where you will be invited to ask any further questions and give any feedback about the interview process. You will also be provided with the contact details of support services should you wish to make use of those.

Expenses and payments

All participants who complete interviews will be entered into a prize draw for £50 worth of Mothercare vouchers. Travel costs can be reimbursed.

Are there any disadvantages and risks in taking part in the study?

While there is no immediate risk to you of taking part in this study, we are aware that this can be a sensitive subject for some people. Also, it is possible that we could detect significant low mood or distress through our

interview with you. If this was found to be the case we would in the first instance discuss this with you and provide you with the contact details of support services that may be helpful. We would also like to contact your GP to let them know about our concerns.

If at any time point you would like further support around any aspect of pregnancy, childbirth, parenting or feeding, we would recommend that you contact your midwife, Health Visitor or GP. Alternatively you can contact the National Childbirth Trust (NCT) helpline 0300 330 0700, who are able to offer practical and emotional support in all areas of pregnancy, birth and early parenthood.

Are there any benefits to taking part?

Participation in this study may not benefit you directly, however, we hope that the information from this study will help other women who plan to breastfeed and further our understanding of women's experiences. This may help to inform how healthcare professionals can best support women when they breastfeeding or are planning to breast feed their babies.

What happens when the research has finished?

The researcher will prepare a report about the findings of the study which will include a summary of all participants' results. Direct quotes will be used in some reports but all identifiable information about individuals will be removed so that the quotes remain anonymous. The findings will be written up as part of the researchers' Doctorate Thesis. A brief summary report will be written and you will be offered a copy of this report if you would like one.

What if I change my mind about taking part in the study?

If you decide to withdraw from the study you can do so at any time without giving a reason. We would like to include data collected up to the point of withdrawal in our final analysis, however, if you would rather all data were withdrawn and destroyed we would be happy to do this.

What if there is something I'm not happy about during the study?

Any concerns can be raised with the researcher, who will do her best to answer questions. If you remain unhappy you can contact the researcher's supervisor at the University of East Anglia on the contact details given below.

What about confidentiality?

Data will be stored using coded participant numbers. Identifiable data (i.e. consent forms, contact details) will be stored in a locked storage system. Interview recordings will be stored electronically on an encrypted storage system, accessible only by the researcher. Paper notes will be stored in a locked filing system, accessible only by the researcher and supervisor. Data will be stored for 3 years following the completion of data collection at which point it will be disposed of securely.

Interviews will be transcribed (written out word for word) by the researcher. The researcher may also use a transcription service (a company that types out recorded interviews) to help with this. If such services are used, the transcript will be kept confidential between the company and the researcher, and will comply with confidentiality rules. The researcher and her

supervisor are the only other people that will read through the transcripts and listen to recordings of the interviews.

Contacting other professionals.

We will be asking you to consent to us making contact with your Health Visitor and/or GP and for their contact details. As explained above we would like to contact your Health Visitor/GP to check that they would be happy for us to contact you to participate in an interview based on their knowledge of your pregnancy and subsequent health. We will not ask Health Visitors or GPs to give reasons should they advise us that this would not be appropriate.

If at the time of interview there is indication that you may be having difficulties with your mood or may be in need of some support, we would like to contact your GP to inform them of this. We will contact you before we make contact with your GP in order to inform you that this is our intention.

Can I see the results of the study?

The study is being conducted as part of a Doctoral training programme in Clinical Psychology at the University of East Anglia. The study will therefore be presented as a doctoral thesis for assessment. The researcher may also publish the findings in a peer reviewed journal. A brief report of the findings will be sent to all participants following completion of the study for their information, if they wish to receive this.

How is the research funded and organised?

The study is funded by the University of East Anglia and organised in collaboration with NHS services in Cambridge and Peterborough.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Research Ethics Committee.

Further information and contact details

If you have any further questions regarding the research, or would like to speak further with the researcher please contact:

Researcher

Mariam Errington

Trainee Clinical Psychologist

E-mail: m.errington@uea.ac.uk

Tel: 07857963599

Research Supervisor

Dr Imogen Hobbis

Clinical Tutor in Clinical Psychology

E-mail: I.Hobbis@uea.ac.uk

Tel: 01603 593581

Postal address for all researchers

Elizabeth Fry Building,
Norwich Medical School,
University of East Anglia,
Norwich Research Park,
Norwich, NR4 7TJ

Appendix C: Consent to Contact sheet

Breastfeeding Experiences: Participant contact details: version 1.1; 11/12/2013

Participant Number :



PARTICIPANT CONTACT DETAILS
A Qualitative Exploratory Study of Breastfeeding Experiences
Researcher: Mariam Errington

Name

Address

Preferred contact telephone number

E-mail address

GP name and address

Health Visitor name and address

Appendix D: Consent Form

Breastfeeding Experiences : Consent form : Version 1.1 ; 11/12/2013

Participant Identification Number:



CONSENT FORM
A Qualitative Exploratory Study of Breastfeeding Experiences
Researcher: Mariam Errington

Researcher: Mariam Errington (Trainee Clinical Psychologist, University of East Anglia)

Please initial in the box to indicate that you agree with the statements below.

- 1. I confirm that I have read and understand the information sheet (version 1.1; 11/12/2013) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- 3. I agree to the researcher contacting my GP prior to my being contacted and the reasons for this have been explained in the information sheet.
- 4. I agree for my interview to be recorded and have understood the information provided about data storage and confidentiality.
- 5. I agree to take part in the above study

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

When completed 1copy for participant and 1 copy for researcher file.

Appendix E: Demographic Questionnaire

Breastfeeding Experience : Demographic Questionnaire Version 1.1 10/2/14

Participant number:
Site Number:



DEMOGRAPHIC QUESTIONNAIRE

**A Qualitative Exploratory Study of Breastfeeding Experiences
Researcher: Mariam Errington, Trainee Clinical Psychologist**

This questionnaire has been designed for use in this research. It was designed in order to give us background information about the women who have participated in the research.

It will be helpful if you can complete the information as fully as possible but if there are any questions that you are not happy completing please just leave them blank.

Date of birth_____

Marital status

- Married
- Co-habiting
- In a relationship
- Single
- Divorced
- Separated
- Widowed
- Other
- Would rather not say

Education

- No formal qualifications
- GCSE's/O-levels (or equivalent)
- Apprenticeship
- A-levels (or equivalent)
- Certificate of higher education
- Diploma of higher education, foundation degree or HND
- Bachelors degree (or equivalent)
- Masters degree or postgraduate qualification (e.g. PGCE)
- Doctoral level qualification

Please describe your ethnicity below

Occupation (or occupation prior to taking maternity leave)

When is your baby's Estimated Due Date (EDD)?

(We will use this information to calculate when to send you follow up measures)

THANK YOU

Appendix F: GP Letter-Cause for concern

Breastfeeding Experiences: GP contact cause for concern: version 1.1; 11/12/2013



University of East Anglia
Norwich Medical School
Department of Psychological Sciences
Norwich, NR4 7TJ

Researcher: Mariam Errington
Telephone
07590023334
Email
m.errington@UEA.ac.uk

<insert

date>

Dear <Insert name of GP>

A Qualitative Exploratory Study of Breastfeeding Experiences

I am writing to you regarding one of your patients <insert name>.

<insert name> has consented to participate in the above named study being conducted by a researcher from the University of East Anglia as part of their Clinical Psychology Doctorate.

As part of the study, participants are asked to take part in an interview focusing on their experiences of breastfeeding and any difficulties with this that they may have encountered. The interview also aims to explore how difficulties might affect emotional well-being in the post natal period and perceptions of themselves as mothers.

During the interview <insert name> presented as experiencing some low mood/distress (insert as appropriate) which gave an indication of possible depression or anxiety for which further assessment and/or support may be helpful.

I have discussed with <insert name> that their presentation has given me some cause for concern about her well-being and I have encouraged her to seek further support from yourself, her midwife or health visitor. They are aware that I am sending this letter to you to inform you of my concerns.

If you have any further questions regarding this please do not hesitate to contact me.

Yours sincerely,
Mariam Errington
Trainee Clinical Psychologist

Appendix G: Ethical Approval letters

NHS
Health Research Authority
NRES Committee East of England - Norfolk
Nottingham REC Centre
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS
Telephone: 0115 883 9525

11 April 2014

Mrs Mariam Errington
6 Framlingham Road
Peterborough
PE2 8UF

Dear Mrs Errington

Study title:	A Qualitative Exploratory Study of Breastfeeding Experience
REC reference:	14/EE/0159
IRAS project ID:	142491

The Proportionate Review Sub-committee of the NRES Committee East of England - Norfolk reviewed the above application on 11 April 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Tracy Leavesley, NRESCommittee.EastofEngland-Norfolk@nhs.net

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.r4forum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication times).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Advertisement	1.1	11 December 2013
Covering Letter	Letter from Marian Errington	04 April 2014
Evidence of Insurance or Indemnity	UEA	02 April 2014
GPI/Consultant Information Sheets	Letter - Version 1.1	11 December 2013
Investigator CV	Marian Errington	06 March 2014
Investigator CV	Imogen Hobbs	
Other: Participant Contact Details	1.1	11 December 2013
Other: Cause for Concern	1.1	11 December 2013
Other: Informing of Participation	1.1	11 December 2013
Participant Consent Form	1.1	11 December 2013
Participant Information Sheet	1.1	11 December 2013
Protocol	1.1	10 February 2014
Questionnaire: Demographic	1.1	10 February 2014
REC application	142591/591404/1/338	07 April 2014

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website. Information is available at National Research Ethics Service website > After Review

14/EE/0159 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Michael Sheldon
Chair

Email: NRESCommittee.EastofEngland-Norfolk@nhs.net

*Enclosures: List of names and professions of members who took part in the review
"After ethical review – guidance for researchers" [SL-AR2]*

*Copy to: Mrs Sue Steel
Mr Stephen Kelleher, Cambridge University Hospitals NHS Foundation Trust*

Appendix H: R&D Approvals

Cambridgeshire Community Services 
NHS Trust

04/07/14

Mrs Mariam Errington
Trainee Clinical Psychologist
Elizabeth Fry Building
University of East Anglia
Norwich
NR4 7TJ

RMG Office
Lockton House
Clarendon Road
Cambridgeshire
CB2 8FH
camstrad@cambridgeshire.nhs.uk

Direct dial: 01223 725466

Dear Mrs Errington

Re: L01380 A Qualitative Exploratory Study of Breastfeeding Experience

REC No:

This research governance approval is in relation to primary care acting as a patient identification centre (PIC) for your research study. Your proposal has been reviewed by the Medical Director of Cambridgeshire Community Services NHS Trust.

I am pleased to inform you that Cambridgeshire Community Services NHS Trust has agreed to acting as a PIC for the following research.

This is subject to the enclosed standard terms and conditions and conditional upon you notifying the research governance team of any changes to the study-related paperwork.

Unless we hear from you within a month of this letter, we will assume that you are abiding by these conditions.

This research governance permission letter is not an indication of acceptance of any on-costs to the Trust e.g. travel costs, research costs, drug costs, or clinical referral costs and service support costs – these will not be met by the Trust. For clinical trials of interventional medicinal products/devices participants need to be aware that in primary care the prescribing policy and formulary applies therefore participants cannot expect to continue on the research trial product/device on completion of the trial within primary and community care services. It is the researchers responsibility to comply with ethics guidance with regard to post study medication arrangements in primary care, with regard to the study patient information sheets and consent.

The organisation hosting the research and the research site retain the responsibility for the conduct of the research in accordance with current regulations and hold the responsibility for the research participants at the research site. Trust agreement is subject to the above and:

- All the necessary permissions being in place at the host NHS organisation/research site and full research management and governance approval by the host NHS organisation
- Full research ethics committee approval
- Notification of any amendments to your project, please ensure that these are submitted to the RMG office and that any changes are not implemented until approval has been received

- Letters of access or honorary research contracts with the Trusts being in place in advance in the event that the research team need to visit sites in primary or community care
- The research team keeping the RMG office informed of primary care's contribution to screening and identification of potential participants on request
- The research team notifying the RMG office of any research-related incidents
- The conduct of the research following the agreed protocol in accordance with host organisation and policy and procedures in particular in regard to data protection, health & safety, information governance standards, incident reporting and the EU Directive for Clinical Trials, associated regulations and updates

The Trust does not indemnify the research site, the host organisation or the participants in relation to the conduct or management of the research; the responsibility for indemnity arrangements rests with the study Sponsor. The research team may contact the PCT RMG office for advice in relation to queries on RMG, or the Trust RMG lead in relation to local Trust policy if required.

You will be required to complete basic monitoring information during the course of the research. It is mutually beneficial that we know primary care's contribution to this study in terms of numbers of patients screened and identified to encourage future collaboration. Cambridgeshire Community Services NHS Trust reserves the right to withdraw research management approval for a project if researchers fail to respond to information requests.

We would welcome feedback about your experience of this review process to help us improve our systems. May I take this opportunity to wish you well with your research and we look forward to hearing the progress and outcomes for the study.

Please contact the RMG team should you have any further queries.

Yours sincerely,



Dr David Vickers
Medical Director
Cambridgeshire Community Services NHS Trust

cc: Mrs Sue Steel

The Queen Elizabeth Hospital 
King's Lynn
NHS Foundation Trust

The Queen Elizabeth Hospital
Gayton Road
Kings Lynn
Norfolk
PE30 4ET
www.qehkl.nhs.uk

Research and Development

Dr Parvez Moondi
Chair of the Research Governance Committee

R&D Co-ordinator -- Karen Lupton
E-mail: karen.lupton@qehkl.nhs.uk

Tel: 01553 214571

Mariam Errington
University of East Anglia
Norfolk

Tuesday 3 June 2014

Dear Mariam

R&D ID: 11/14
REC: 14/EE/0159
TITLE: A Qualitative Exploratory Study of Breastfeeding Experience

Thank you for sending the following documentation relating to the above study:

- R&D 142491/596170/14/104
- Protocol version 1.1
- REC approval

This study has been reviewed by the Trust's Research Governance team and we can confirm that the Trust is willing for this work to take place.

Please liaise with Jayne Cozens regarding the conducting of your research activities at our site.

I would like to take this opportunity to remind you that the Trust manages all research in accordance with the requirements of the Research Governance Framework and the Trust's Standard Operating Procedures.

In order to comply with the above, if the study is not completed within one year from the date of this letter, a report summarising the progress of the study should be submitted to the R&D Office. In the case of multi-centre studies this is usually provided by the Chief Investigator/Clinical Trials Unit. Alternatively, we can supply a blank form for you to complete: please contact us for a copy.

**YOU ARE REQUIRED TO NOTIFY OUR R&D OFFICE THE DATE OF THE
FIRST PARTICIPANT SCREENED AND THE FIRST PARTICIPANT RECRUITED FROM OUR SITE -- IF APPLICABLE**

On completion of the project, please forward to the R&D Office any "final report" relating to the project -- e.g. report from Chief Investigator/Clinical Trials Unit, copy of any published article, etc. Any reports resulting from the study, which may be produced at a later date, should also be forwarded, to ensure a complete record is held here.

If our department can be of any further assistance please do not hesitate to contact me.

Yours sincerely



Dr Parvez Moondi, Chair of the Research Committee

CC Jayne Cozens, Community Breastfeeding Midwife,
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Hinchingbrooke Health Care

NHS Trust

Hinchingbrooke Park
Huntingdon
Cambridgeshire
PE29 6NT
Tel: 01480 847512

Mrs Amy Shayle
6 Copse Way
Cambridge CB2 8BJ

21st May 2014

Dear Amy

Re: Breastfeeding Expectations and Experience
REC No: 14/EE/0158
R&D No: 001/MAY14

I am writing to confirm that the above project has been reviewed by the Hinchingbrooke R&D committee and has been approved to proceed as a Patient Identification Centre (PIC). Documents reviewed were those reviewed by the Research Ethics Committee (REC) and are listed in the REC letter dated 16th April 2014. Approval is subject to compliance within the research governance framework.

You are reminded that the study must follow the approved protocol. Please note that any protocol amendments or changes to information provided in your original application form must be submitted to the R&D Steering Group for further review and approval.

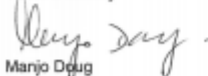
You are also reminded that it is your responsibility to comply with the law and appropriate guidelines relating to the Data Protection Act 1984, Health and Safety Act 1974 and the Caldicott guidelines. You are also asked to comply, in a timely manner, with project monitoring and auditing requirements of the Trust and to notify the R&D Steering Group of any serious adverse events, incidents or near misses involving participants or staff involved in this research project.

It should be noted that data from non medicinal studies will be archived for 7 years and then destroyed and medicinal studies will be archived for 15 years and then destroyed, unless otherwise negotiated with the Trust.

Principle Investigators will be asked to submit to R&D monthly accrual rates or nil records for each study which will be used to complete annual accrual reports.

Thank you for your co-operation.

Yours sincerely



Manjiv Dugg
R & D Manager

Research and Development Department

R&D ref: A093294

04/06/2014

Mrs Julie Taylor
Box 230
Addenbrooke's Hospital

Box 277
Addenbrooke's Hospital
Hills Road
Cambridge
CB2 0QQ

Direct Dial: 01223 348492 Ext: 58492

Switchboard: 01223 245151

E-mail: katrina.gatley@addenbrookes.nhs.uk

rdenquiries@addenbrookes.nhs.uk

www.addenbrookes.org.uk

Dear Mrs Taylor

Re: A Qualitative Exploratory Study of Breastfeeding Experience

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

I am pleased to confirm that Cambridge University Hospitals NHS Foundation Trust has reviewed the above study and agree to act as a **Participant Identification Centre (PIC)** referring potential participants to the relevant research teams based at the University of East Anglia.

Please note that as a PIC the Trust does not provide indemnity for this study.

Sponsor: University of East Anglia

Funder: PhD study award

End date: 25/11/2014

Protocol: Version 1.1, dated 10/02/2014

The project must follow the agreed protocol and be conducted in accordance with all Trust Policies and Procedures especially those relating to research and data management.

Please ensure that you are aware of your responsibilities in relation to The Data Protection Act 1998, NHS Confidentiality Code of Practice, NHS Caldicott Report and Caldicott Guardians, the Human Tissue Act 2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.

Members of the research team must have appropriate substantive or honorary contracts with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold a suitable contract.

Innovation and excellence in health and care

Addenbrooke's Hospital | Rosie Hospital

NHR – Cambridge Biomedical Research Centre | Academic Health Science Centre – Cambridge University Health Partners

V5 Feb 09

If the project is a clinical trial under the European Union Clinical Trials Directive the following must also be complied with:

- the EU Directive on Clinical Trials (Directive 2001/20/EC) and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Regulations 2004;
- the EU Directive on Principles and Guidelines for Good Clinical Practice (EU Commission Directive 2005/28/EC); and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Amendment Regulations 2005;

Amendments

Please ensure that you submit a copy of any amendments made to this study to the R&D Department.

Annual Report

It is obligatory that an annual report is submitted by the Chief Investigator to the research ethics committee, and we ask that a copy is sent to the R&D Department. The yearly period commences from the date of receiving a favourable opinion from the ethics committee.

Please refer to our website www.cuh.org.uk/research for all information relating to R&D including honorary contract forms, policies and procedures and data protection.

Should you require any further information please do not hesitate to contact us.

Yours sincerely



Louise Stockley
Research Governance Manager

Direct dial: 01733 67914/7919/7912
E-mail: R&DDepartment@psh-tr.nhs.uk

Peterborough City Hospital
Edith Cavell Campus
Bretton Gate
Peterborough
PE3 9G2

Date 11th July 2014

Tel: 01733 678000
(If DOI prefix extension number with 67)

Mariam Errington
Trainee Clinical Psychologist
Cambridge and Peterborough NHS Foundation Trust,
Elizabeth House,
Fulbourn Hospital,
Cambridge, CB21 5EF

Dear Mariam,

Ref: R&D/2014/23
Title: A Qualitative Exploratory Study of Breastfeeding Experience
REC Ref: 14/EE/0159
Sponsor: University of East Anglia

With reference to your completed research application, I am pleased to inform you that the main research proposal has been approved by the Peterborough and Stamford Hospitals NHS Foundation Trust.

This approval is subject to compliance with the Research Governance Framework and the Peterborough and Stamford Hospitals NHS Foundation Trust Research Governance Policy and Procedures. Copies of both documents can be found on the R&D intranet site.

You are reminded that the study must follow the approved protocol. Please note that any protocol amendments or changes to information provided in your original application form must be submitted to the R&D Committee for further review and approval.

You are also reminded that it is your responsibility to comply with the Law and appropriate guidelines relating to the Data Protection Act 1984 and Health and Safety Act 1974.

You are asked to comply, in a timely manner, with project monitoring and auditing requirements of the Trust and to notify the Trust Research & Development Committee of any unexpected serious adverse events/reactions, incidents or near misses involving participants or staff involved in this research project. You are also required to inform the R&D Department when key milestones are reached in the study (initiation visit performed, closed-in follow-up, closed to follow-up, and close out underway) and any key changes in personnel.

www.peterboroughandstamford.nhs.uk

Thank you for your co-operation.

Yours sincerely

Dr M Sivakumaran
Chairman
R&D Committee

Appendix I: Examples from Analysis
Extracts from initial transcript checked by supervisor and extract from Part 5.

Part 1. 2

can you interpret like this. I thought you needed to stick to actual content

Maintaining the natural state	P. OK, when I actually, I had a natural birth, and it all went fairly well actually. I had a really positive experiences of pregnancy, bir.	natural.
Striving for an end result of birth	Painful and tiring and everything, but it went really well. But the final, in the end it was an hours pushing and it was really good...and then they gave me Erin straight away and they did the skin to skin	surprise? unexpected Positive labour intense
Developing a close bond	R. Yeah P...immediately and then sort of we had a bit of time just to kind of let her settle in and I think it was about an hour after she'd been born, maybe sooner, the midwife suggested trying to get her to feed, so she took to it amazingly. She latched on really really well and just got on with it absolutely fine. And then I'd spoken to one of the mums in my NCT group, had their daughter premature and she, she was only a few weeks early but she	Positive ending. hard work resulting in a good outcome. Relief Baby given immediately. Importance of this? Proximity, closeness. Bond? Is this not imposing your knowledge of why skin-to-skin is important? Use of word 'immediate' Time with baby, time for mum and baby - protected Setting in, being together - bonding guided by midwife attempt to feed - as above - equally could be delight, bemusement etc achievement - a surprise? amazing natural? no effort? Comparing notes with other mums premature, difficulties not ready early
Time period getting to know each other		
Expert care & expert guidance		
The wonder of nature		
Establishing a latch		
Importance of relationships with other mums		

Support from peers

Part 5

different to other parts

Structure is Part 7

Structure

Traditional, old fashioned views	well. And also, in a funny kind of a way, I'm a traditionalist, I like to do things in an old style. I don't like kind of, I don't like the thought of expressing and feeding with er, um a bottle. I don't like the idea of using any kind of plastic teat at all. I worry about nipple confusion. I just think breastfeeding you use the breast, you don't need to use any of the modern day equivalence. Although I know tonnes of people do. All my female mummy friends, they all use, they all express and they all give bottles and use dummies, some of them. But I just wanted to just keep it as natural as possible. And that's just come from me, that's just what I wanted to do. But started from the birth, when it first happened, well, thinking about the training that I'd had first of all, 'cause I did NCT, I did the National Childbirth Trust course and there was just one breastfeeding session and the lady talked a lot about the importance of a good latch and I listened very carefully and listened very intently and I thought 'Well this is it, this is the answer, if you can latch your baby on correctly and sort that out, perfect, you're fine'. So anybody else that said 'Oh I struggled with breast feeding, I found it really hard; oh it was really painful. Oh you're going to find it really tricky' (in a mocking tone) I just thought 'Well you're just silly, you just didn't latch your baby on properly, it wasn't a good enough latch, you've got to get some support'. Um, but then this was me going by theory but when it actually comes to the practise, it was kind of a big shock that I did find it very very hard and I still find it very very hard and er, and I didn't um, get upset about that, I didn't get emotional about it, not once actually. But er, it was just a big shock, I thought 'Oh ok, now I see what all these other experienced mums are going on about'. I remember, I'm a teacher and my deputy head said to me 'Nobody tells you this, but I'm telling you now, breastfeeding hurts! Nobody says this: It hurts!' And I thought nobody said that to me, my mum never said that to me,	traditional - old style - maybe ways of doing things don't like modern - plastic artificial? Worry - breast - natural no need for modern As natural as poss Bf class latch - careful listening leaning emphasis on latch - all will be fine. expectation Perfect Anyone with difficulties - need not deny it properly - need support to be shown how. Shock Very very hard detached from emotion Nobody tells you... Other mums, own mum.
Keeping Feeding as natural as possible		
Natural vs. modern day - natural?		
Being taught to establish a latch		
Shock that more difficult than thought		
Shock of reality of BF		
Nobody tells you		

Shock to others.

Extract from transcript showing exploratory coding

Part 5.

<p>Expect It would happen</p> <p>Not having a clue</p> <p>Reviewing Inconsistent care advice</p>	<p>my nipple' and she said 'No, you just put him on anyway, just put him on' and I was like 'But there's nothing there! He's not going to be sucking in anything.' And she helped me get him to latch on and he did a couple of sucks and fell off then did a couple sucks then fell off and I still couldn't see any colostrum and to this day I never once saw one drop of colostrum and it was just this mystery, er, juice that was apparently coming out of me and that was quite weird, I didn't expect that. There were all of these things that I just didn't realise. Um...and then, um, he, what I then realised also, it didn't hurt to start with, actually, but what I realised was that he wouldn't know what to do as a baby. I just thought a baby comes, a newborn baby and they know what to do, they know how to breastfeed. I'm the one learning, he's going to teach me, but it didn't work out that way at all because he hadn't a clue what was going on (laughs) and I hadn't a clue what was going on! And between us we were really kind of battling um, to properly breast feed and er, during my labour I had lovely midwives and they were really great and I was really happy with the birth and the way I was treated, um but the bottom line was that the hospital which was Hinchinbrooke er, towards the end of June they were really busy and the extent was that when I rang them up and said I was in labour and wanted to come in they tried to put me off and said 'Don't come in yet, see if you can potter at home a little bit longer' is what they said. 'Have a bath'. When I got into the hospital, I realised they had to call in extra staff because I'd turned up, um, and they were really super busy so, the birth was really fine but afterwards, the postnatal care on the Lila ward, it was just so hectic, it was so busy, and then it was unfortunate then because I got inconsistent care. I had my call button and I would press my call button and people would come and every time it would be a different person and I was trying to do this</p>	<p>'Mystery juice' - colostrum Didn't realise things → part</p> <p>Expectation that Baby will teach mum - must learning → Similar part 4</p> <p>No clue - Battle to breast feed good midwives</p> <p>Busy hospitals. / midwives</p> <p>Inconsistent care different person</p>
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Example of clustering themes across cases

Expectations & Features of BF

The demanding nature of an demand

Forewarned is forearmed

It was meant to be easy

The Need for Support & Guidance

Part 1 Seeking Help & Support

Part 2 Support / shared experiences for

Part 3 The need to persevere / understanding from others

Part 4 Support & guidance

Part 4. Digging deep to keep going

Part 5 Together in the Battle / need of

support / ~~total going back~~ persevering with BF

Part 6 In need of support

Overcoming Difficulties

Part 1 1st O.D.

Part 2 Helplessness in loss of control

Part 3 The need to persevere

Part 3 Acceptance

Part 2 Pride in success

Part 4. Pains & Diff. / The threat of failure

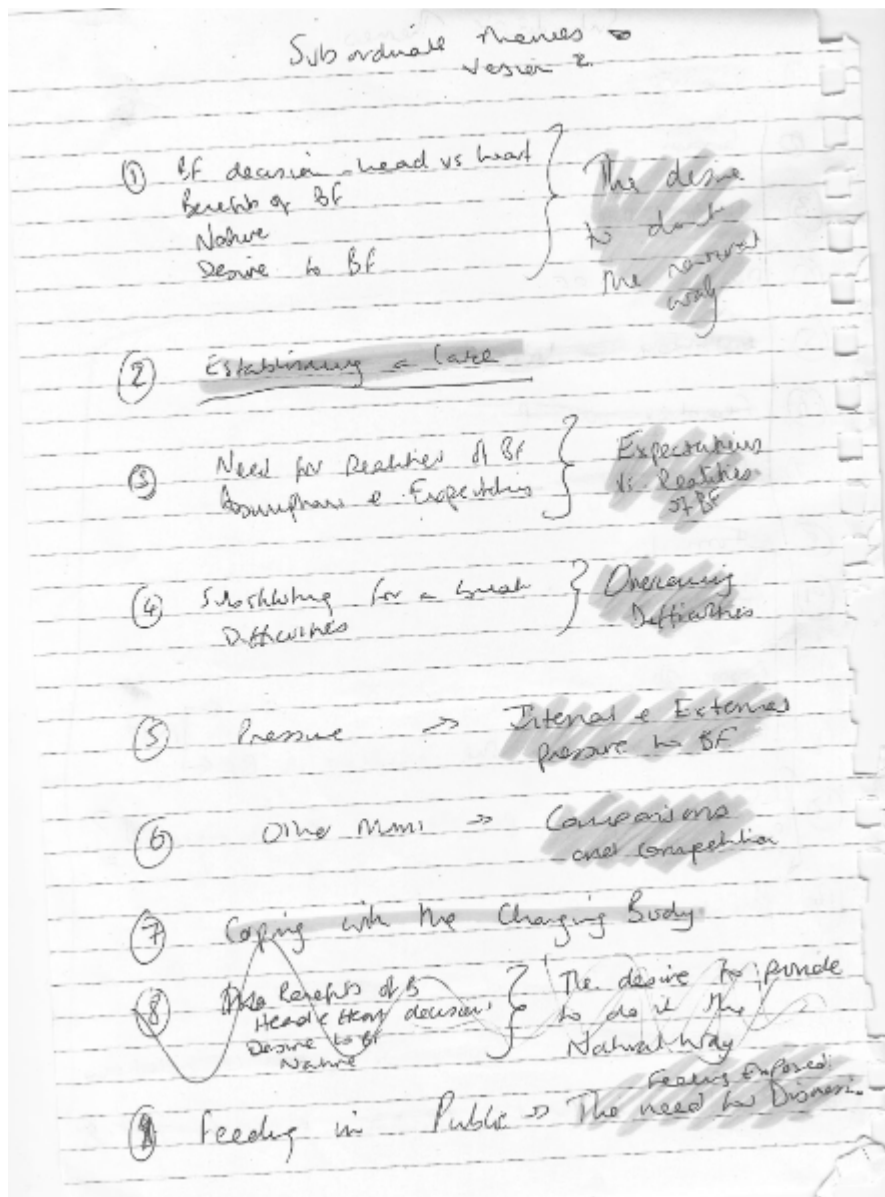
" " Digging deep to keep going

" " Exhausted roller coaster of diff.

Part 5. The Struggle to overcome diff.

Part 6: Achieving BF success / ~~avoiding~~ ~~failure~~

Example of development of subordinate themes from emergent themes



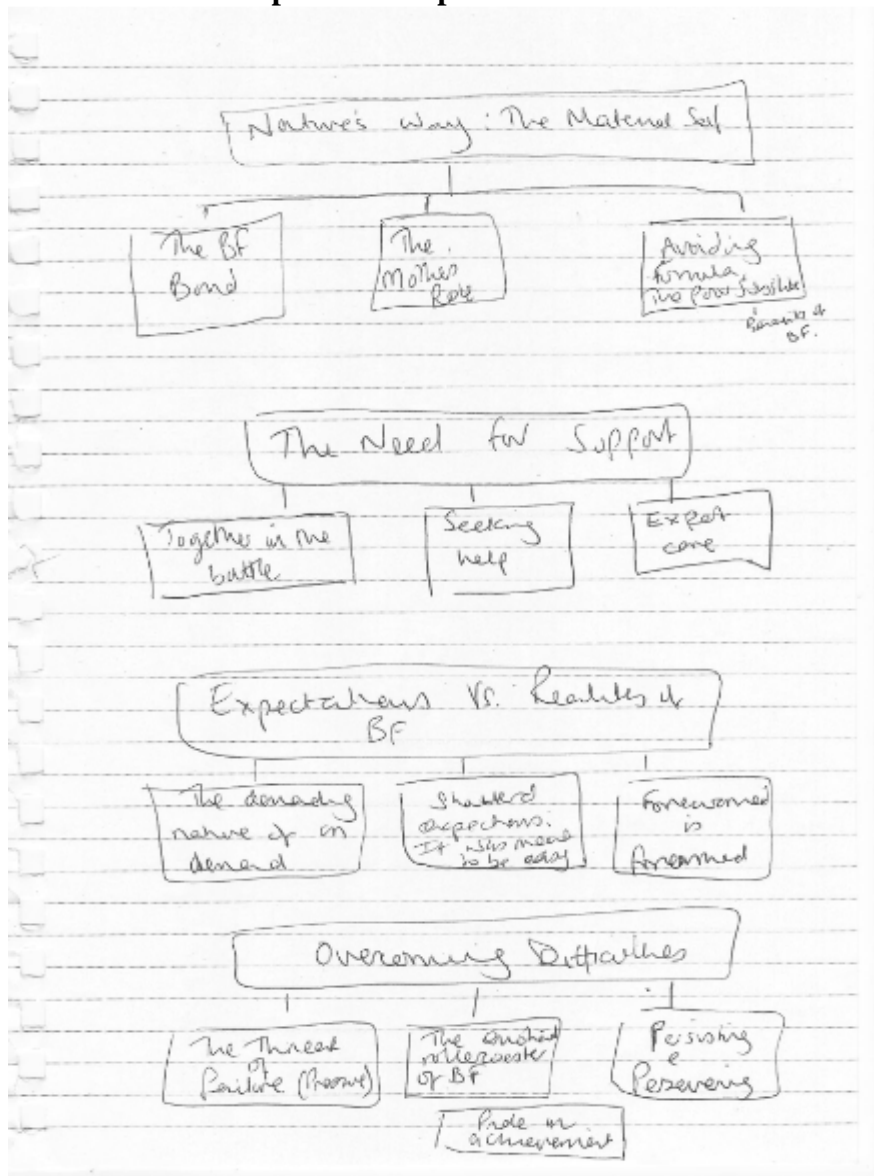
Example of theme table

Participant 2: Clustering emergent themes

<p>Difficulties</p> <p>Pain of physical problems Establishing a latch Struggle in establishing breastfeeding Exclusive expressing Diminishing milk supply Avoiding pain and misery Devastation in difficulties Inability to overcome difficulties Expressing an undesirable solution Loss of choice about feeding through problems Vicious cycles for mum and baby Loss of control over BF Not all problems are surmountable</p>	<p>Support</p> <p>Seeking support Support in hospital Support from peers Understanding from others Sharing difficulties Family support The need for reassurance Helpful reassurance from professionals</p>
<p>Expectations and Assumptions</p> <p>Expectation about feeding Unexpected that desire is enough Coming to terms when it doesn't go to plan Expectation that it will just happen Expectation that it would be alright Unexpected outcomes Assumption that all problems can be fixed The need to be realistic about breastfeeding outcomes Not getting hopes up Unexpected difficulties</p>	<p>The problem with formula</p> <p>Difficulty in giving baby formula Feeling bad about giving formula Accepting the need for formula Perception of formula as inferior to breastmilk Feeling the odd one out in use of formula</p> <p>Differing perspectives Breast vs. Bottle No choice about giving formula Upsetting process of giving baby formula Giving formula not an easy option Others not getting the problem with formula Formula as the only option Formula as a poor substitute to breastfeeding</p>
<p>Breastfeeding as a bonding experience</p> <p>Connection to baby Fear about Loss of connection through bottle feeding Closeness to baby Feeding as a bonding experience</p>	<p>Mother's role</p> <p>Desire to breastfeed BF an exclusive role of mother Sharing feeding with loved ones Personal meaning of breastfeeding Unnaturalness of not wanting to BF Baby's basic needs of love and security Giving baby the best start Pain at not being able to feed as a mum Exclusive breastfeeding exclusive to</p>

	mum
<p>Helplessness in loss of choice Realisation that breastfeeding not working Difficulty in not having a choice Upset in Inability to get it right Upset in being unable to provide for baby Sadness about not providing breastmilk Helplessness in inability to produce enough milk Having a feeding plan</p>	<p>The need to persevere Giving it another go Anxiety about trying again Needing to prove not giving up Hope about getting back on track with feeding Determination to crack it Giving it 100%</p>
<p>The need to justify self Justifying actions to others Explaining self to others Wanting others to know use of bottles not a choice Feeling sensitive to other's opinions Comparing self to Breastfeeding mums</p>	<p>Benefits of breastfeeding Breast is best Breastfeeding = no worries Financial benefits of breastfeeding Decision to BF natural Breastfeeding best for baby Breastmilk as protective for baby</p>
<p>Negative emotions Feeling inadequate Feeling bad in not giving the best thing for baby Preoccupation with feeding Hopeless about milk supply Stress as a maintainer of difficulties Needing to get it right Feeling unable to feed baby</p>	<p>Acceptance Relief in the Realisation that I've done my best Wait and see-going with the flow Not being hard on yourself</p>

Development of Superordinate Themes



Appendix J: Topic Guide

Topic Guide

- General health since birth of baby
- How mother is currently feeding
- Breastfeeding experiences since birth (e.g. Tell me about how breastfeeding is going for you?)
- How decision to breastfeed came about
- Positive/Negative experiences about feeding
- How any difficulties with breastfeeding have impacted the women
- Changes to feeding-discontinuation of breastfeeding and experience of this
- Worries or stresses around feeding, exploration of emotions
- Support had (i.e. partner, mother's groups, midwives, health visitors, breastfeeding consultants)
- Views about participating in the research

Appendix K: UEA Lone Worker Policy
UEA Doctoral Programme in Clinical Psychology
Lone Working Guidance Notes for Researchers
Conducting Data Collection Off-Campus and Working Alone

These guidelines are primarily intended to help assure the safety of researchers who conduct interviews alone with participants, particularly when such work is undertaken off campus. Compliance with this guidance should assist in:

- Protecting researchers by reducing their risk of exposure to physical threat or abuse.
- Protecting participants by providing researchers with advice on best practice in this area.

Please note that as well as this document, as employees of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), trainees conducting their thesis research with NHS patients should consult the CPFT document 'Working Alone in Safety' (can be found on Blackboard).

1. Design of Research and Risk Assessment

Before undertaking data collection as a lone researcher, particularly off-campus, a risk assessment should be conducted taking into account the key questions below to minimise the risks in undertaking research work on behalf of the university. It may be necessary to amend or redesign proposals following such an assessment. See FMH Researcher Safety Checklist.

Method: Is it necessary to collect data in a one-to-one context, or would an alternative methodology be more appropriate?

Interview location: Where should interviews take place? A public place may be a safer option than the participant's home (but consider confidentiality).

Participants: Who are they? Are they members of a vulnerable or potentially dangerous group?

2. Preparation for Lone Working Off-Campus

- Knowing in advance the location of hubs of activity such as shops, pubs, schools or the local police station may provide researchers with a possible escape route should this be necessary.
- Researchers should be aware of any social or cultural tensions in the area.
- If travelling by car, researchers should consider the safest place to park, e.g. A well-lit area after dark.
- If using public transport, researchers should check its reliability and also carry the telephone number of a reputable local taxi firm.

3. Precautions When Conducting Interviews Off-Campus

3.1 Personal Safety

The personal safety of researchers working off-campus is paramount and should be considered more important than the successful completion of the interviews.

Researchers **SHOULD NOT:**

- Enter someone's home if they feel uncomfortable or unsafe.
- Enter a house if the person they have arranged to see is not there.
- Undertake an interview or assessment in a bedroom.
- Give a personal telephone number or address to an interviewee.

Researchers **SHOULD:**

- Not attend the research appointment if they feel uncomfortable or unsafe.
- Upon arrival, explain their research role and the conditions of confidentiality to the interviewee(s) and offer them the opportunity to ask questions.
- Consider an appropriate exit strategy (what to say etc) should they wish to terminate an interview early.
- Take steps to leave a situation immediately if they feel unsafe or uncomfortable.
- If researchers are conducting their research with clinical populations, where possible participants should be seen on NHS premises. If participants need to be seen off NHS premises (e.g. at home) then visits should only take place within working hours and not at weekends.
- Adopt a friendly and professional manner when conducting interviews but be careful not to be over-familiar.
- Ask for household pets to be shut in another room if their presence during the interview is a cause of concern.
- Follow procedures outlined in their ethics application and research proposals in the case of participant distress or disclosure.

3.2 Maintaining Contact

It is essential that researchers conducting off-campus interviews maintain contact with a nominated colleague/buddy (usually another trainee).

The Researcher should ensure the nominated colleague knows the following:

- Name and address of interviewee(s)/destination.
- Researcher's mobile telephone number.
- Time of leaving the office.
- Method of transport to interview location (car registration if appropriate).
- Time of interview and expected duration of visit.

Researchers should contact their buddy when they arrive at the interview location, particularly if this is out of hours. The Researcher should inform their nominated colleague where they are and who they are with. If at any point during the interview, the researcher feels unsafe; they should remove themselves from the situation if at all possible. If it is not possible to vacate the premises, researchers should excuse themselves, go to another room, and call for assistance using their mobile phone. Codes may be agreed in advance to convey the need for support in a confidential manner, e.g. "Cancel all of my appointments for the rest of the day". At this point, if possible, the nominated colleague should ask the following question:

- Are you safe?
 - If NO, the buddy should contact the Police. Senior members of staff (Ken Laidlaw, Sian Coker, Margo Ononaiye should also be informed once the Police have been contacted). The following telephone numbers can be called 8am-6pm on weekdays:
 - Sian Coker:

- Margo Ononaiye:

Once the interview has been completed, the researcher should contact their nominated colleague at an agreed time to let them know they have left safely. If the interview is still in progress when the deadline for contacting their nominated colleague approaches, the researcher should contact their nominated colleague to inform them.

If the deadline passes and the researcher has not been in contact, their nominated colleague should ring the mobile phone of the researcher. If there is no answer, the nominated colleague should ring again 10 minutes later. If there is still no reply, senior members of staff (Ken Laidlaw, Sian Coker, Margo Ononaiye) must be informed using the telephone number above, who will then decide on the appropriate course of action.

3.3 Mobile Telephones

All researchers who conduct off-campus interviews should have a mobile telephone. Mobile telephones should be left switched on throughout the interview. Researchers should bear in mind that mobile telephones are sometimes out of range and cannot be depended upon entirely. The telephone number of the nominated colleague whom the researcher is buddying with could be programmed into the mobile telephone in advance using a shortcut key.

3.4 Personal Alarms

All trainees may consider the use of a personal alarm. These can be purchased directly from Police stations. Trainees may also wish to consider the use of personal safety apps for smart phones, such as 'bsafe' (<http://www.bsafapp.com/>) and 'StaySafe' (<http://www.staysafapp.com/staysafe-personal/>).

3.5 Identification Card

All researchers who conduct off-campus visits should carry an official identity card with photograph (NHS ID card or UEA Campus Card). It is good practice to invite interviewees to check the card.

4. Debriefing and Support Following Off-Campus Interviews

Researchers should use research supervision to discuss and reflect on safety issues.

Any incidents that occur during the interviews should be formally recorded and dealt with immediately. Serious incidents should be discussed with the Primary

Supervisor in the first instance and documented appropriately (e.g. to ethics committee). Supervisors will then discuss this with a senior member of staff and the appropriate course of action will be determine