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Women's experiences of early and long-term breastfeeding in the UK.

Cathryn Britton

Submitted for the Degree of Doctor of Philosophy

University of Durham, Department of Anthropology

2000

Abstract

A considerable amount of research has been undertaken about breastfeeding in the UK from a scientific or policy orientation. However only a small amount of research has focused on women's experiences of breastfeeding. Within this study the *actual* experiences of women were investigated and the women placed foremost in the research question. The women in this study used both conceptual and authoritative knowledge to make sense of, and manage their breastfeeding experiences.

Firstly, the experiences of women who had breastfed in the first four months of motherhood were explored with specific attention to the meanings and significance of the letdown reflex. This bodily sensation related to breastfeeding features in the medical discourse of breastfeeding management but women's actual experiences have been neglected. In this study social, biological and emotional entities became integrated into the women's experience of breastfeeding to give meaning to, and make sense of, this embodied sensation.

Secondly, the meanings of breastfeeding for women who had experience of long-term breastfeeding (up to the age of four years) were investigated. Previous breastfeeding research in the UK has concentrated on why women stop breastfeeding in the first few months, not why they might continue. In this study the continuance of breastfeeding was associated with the belief that it was 'natural' and symbolic of being a 'good' mother. The dominant opinion in the UK is that long-term breastfeeding is inappropriate so some women in this study would continue their long-term breastfeeding as a clandestine activity.

For both groups, the social context within which their breastfeeding activity took place was influential. Many women found their social network supportive but also a source of conflict. The women developed strategies to deal with these conflicts which were often based on their 'intuitive knowing' how best to mother their child.

Women's Experiences of Early and Long-term Breastfeeding in the UK

Cathryn J. Britton

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Submitted for the Degree of Doctor of Philosophy

University of Durham

Department of Anthropology

2000

- 8 MAR 2002

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Declaration

I confirm that no part of the material offered has previously been submitted by me for a degree in this or in any other University.

Statement of Copyright

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Acknowledgements

This thesis is dedicated to my son Tom, who has grown up with this piece of work and provided the stimulus for its conception.

My sincere thanks go to Dr. Catherine Panter-Brick and Dr. Luisa Elvira Belaunde, Department of Anthropology, University of Durham who have provided supervision, support and inspiration during this thesis. Thanks also to Ian Robinson, Department of Human Sciences, Brunel University who supervised the initial birth of the thesis.

Further thanks go to the Department of Health Studies, University of York, who have supported my studies. Special thanks to my midwifery colleagues; without their friendship and support this piece of work would not have been possible. Pip Austin and Karen Hyman provided an invaluable transcription service which was partly funded by the Innovation and Pump Priming Fund at the University of York.

To all my friends who have helped in a variety of ways - to say thank you does not seem enough. Without their offers of child care, encouragement and I.T. skills, this thesis may never have been completed. A big thank you to you all.

Finally, my grateful thanks to all the women who gladly gave me their time and provided the rich accounts of their experiences.

Preface

The subject of this study arose from a personal and professional interest in infant feeding. Through my childhood I saw my mother breastfeed my siblings and had discussions with my mother about child rearing practices; I never doubted that I would breastfeed if I had a child of my own. It became apparent to me at an early age that I was interested in midwifery and intended to become a midwife in adulthood. This I achieved when I qualified as a midwife in 1982. During my experience as a midwife I have interacted with many new and experienced mothers. It became apparent that some women had definite views as to whether they would breastfeed or not but some were ambivalent. During pregnancy, birth and parenthood part of the midwife's role is to provide advice and support to a woman so she may make choices and decisions about her passage to motherhood, enabling the woman to have a fulfilling experience. For most of my professional life as a midwife I was a childless woman, having no personal experience to draw upon. The knowledge I gained for my profession was through an education programme, which was predominantly science based, and through sharing the women's experiences and listening to their stories.

In 1994, while I was resident in the south-east of England, I gave birth to my first child, a son. I intended to breastfeed and successfully accomplished this for two years. During my pregnancy, birth and transition to motherhood there were many instances when I became aware of bodily changes and sensations. I reflected back on my interactions with women and felt I had a better understanding of the descriptions they gave me about their experiences. During my pregnancy I met other women who were expecting their first child and we

regularly met following the births of our babies. As with most support networks, discussions would often revolve around confirming the normality of the individual's experience and exchange advice and support about child rearing issues.

Since many new mothers are concerned that they provide adequate nourishment for their baby, infant feeding was a topic of conversation which was widely debated. From these conversations I became aware that there were oppositions between the women's expectations and the realities of breastfeeding in the early weeks. The women often consulted 'authoritative texts' to make sense of their experiences but were also being influenced by the opinions of others.

As I talked at length to these women my interest grew in how they were making sense of the bodily changes associated with breastfeeding, how they were 'learning' about breastfeeding, and what meanings they attributed to their experience. Those women who became established breastfeeders soon realised that they might have to encourage their infant to wean. For many women this may coincide with the cessation or reduction of breastfeeding activities. After completing the data collection for the first part of my study I moved to the north-east of England. Preliminary analysis of the initial data led me to question why some women, like myself, chose to continue breastfeeding into the child's second year.

My professional and personal experiences of childbirth and infant feeding had a deep impact on me. During my academic study of anthropology I realised that

my fascination of the meanings, beliefs and lived experiences of breastfeeding would be a topic I could devote myself to for PhD studies.

Chapter One
Introduction

This study is an ethnographic exploration of fifty-one women's experiences of breastfeeding. It is a study which could be classified as anthropology 'at home' (Jackson 1987) as both the investigator and the participants reside in the same society - with the further factors that I am a mother and a midwife therefore I bring my own personal experiences and professional background into play.

There is an abundance of research into breastfeeding. Most of this has a scientific or policy orientation directed by or for health professionals. Very little research has focused on women's experiences. Within this study the *actual* experiences of women are investigated and the women placed foremost in the research question.

The research focuses on two different samples of women, one who discussed early breastfeeding experiences and the other who had experiences of long-term breastfeeding. For the purpose of this study the term *early breastfeeding* is used to denote those women who breastfed during the first four months of motherhood. *Long-term breastfeeding* is the term I used for women who had breastfed a child for longer than 18 months. The importance of the samples is that they represent women's views at two different stages of breastfeeding. The data were collected by in-depth interviews.

Why another study of breastfeeding?

The predominant approach of biomedical research and medical authority to investigate the study of breastfeeding has left some important questions unanswered. Absent from much of the literature is an in-depth study of the personal and social experience of breastfeeding to women in the UK. The emphasis of this study is placed on women and their personal experiences of an activity commonly encountered by women. There are many texts which provide a macro account of the cultural norms and practices of breastfeeding in different societies (for example Marshall 1985, Maher 1992, Baumslay and Michels 1995, Blum 1999). However no other study has provided an in-depth investigation into the experience of bodily sensations associated with breastfeeding, and in particular the letdown reflex, and the meanings these have for a woman. Thus this aspect of the study contributes significantly to the study of the body in anthropology.

Breastfeeding does not take place as an isolated event but is influenced by the social world of the woman. Women are exposed to a variety of social and cultural influences which influence their chosen feeding method (Gabriel et al. 1986, Morse 1990, Isabella and Isabella 1994, Hall 1997). The attitudes and opinions of family members, friends and health professionals are likely to affect the uptake and continuation of breastfeeding (Giugliani et al. 1994, Humenick et al. 1998, Hoddinott and Pill 1999). This study provides an insight to the perceived influence of others, such as family, friends, health professionals and the media on the women's breastfeeding practices.

Furthermore, the study of a group of *long-term* breastfeeding women is an original contribution to the present knowledge of breastfeeding. The number of women who breastfeed long-term in the UK, while small[1] (Foster et al. 1997), is a significantly under-researched group. Much can be learnt from women's experiences about why they choose to continue breastfeeding; how they manage the problems and conflicts that they encounter; and how long-term breastfeeding can be better supported for future women.

The objectives of this study are thus to research:

- Women's actual experiences of breastfeeding
- The influence of the social world on the breastfeeding women
- Experiences of long-term breastfeeding beyond babyhood.

Narratives

> The interview 'cannot provide the mirror reflection of the social world but it can provide access to the meanings people attribute to their experiences and social worlds' (Miller and Glassner 1997:100).

Because it was important for me to get a sense of how these women felt about their breastfeeding experiences it seemed sensible to engage in in-depth interviews to produce their narratives. Narratives are complex expressions of subjective experience (Conrad 1987), representations which impose order on the

[1] In the Infant Feeding Report 1995 (Foster et al 1997) 14% of survey (in the UK) were breastfeeding their infant at 9 months of age. No statistics are collected for breastfeeding after this time however with the rate in decline of breastfeeding within this study it can be assumed that a significant proportion of these mothers would have ceased breastfeeding by 18 months of age.

experiences and make sense of events and actions arising from it (Reissman 1993). Narratives are not created in a vacuum; the process takes place not only in a cultural context but is also dependent on the interaction with others such as kin and friends, as demonstrated in chapters 3 and 5. The narrative is a good tool to use for the exploration of issues of the body. The medical and lay narratives are often synonymous but the use of language is profoundly different. The lay narrative often uses figurative language to convey meaning to others which is adequately illustrated in chapter 3. The use of narrative has been used extensively by others to gain an understanding of how an individual experiences illness (Kleinman 1988, Bauby 1998, Elwyn and Gwyn 1998, Picardie 1998). The use of women's narratives has also been used to understand women's experiences of childbirth (Oakley 1981, Kitzinger 1987, Brown et al. 1994, Cosslett 1994) and breastfeeding (Brown and McPherson 1998).

The reflective narrative gives a unique insight to how a woman makes sense of and manages her breastfeeding experience where everyday routines and relationships previously taken for granted become disrupted. Sometimes these changes require a fundamental reconstruction of the woman's sense of self and identity. Narrative is the means by which such changes can be brought about, since personally constructed stories about self provide a space in which values can be reasserted and new roles described (Skultans 1998). The women's narratives are pivotal to the development of this thesis. From their narratives emerged the concerns about the body, the breast, babyhood and breastfeeding promotion which became the main constructs under discussion in this thesis.

Theoretical Perspectives

Four main theoretical perspectives that underpin this study are: the lived experience of the reproductive body; the societal images and notions of the breast and breastfeeding; the meanings of infancy, childhood and weaning; and the influence of policy discourse on breastfeeding promotion. These perspectives reoccur within the chapters and will be developed throughout the thesis.

Body

The study of the body in medical anthropology is concerned not only with the physical body of an individual but also the social world in which the body exists. Douglas (1973), O'Neill (1985) and Scheper-Hughes and Lock (1987) have all discussed the 'multiple body' where the focus is not only on the individual body but how it might be deemed both social and political. This latter point is particularly important in biomedicine where there is regulation and control of the body. Much has been written about how individuals make sense of their body during episodes of health and illness (Kleinman 1988, Martin 1989, Sault 1994 and Cunningham-Burley and Backett-Milburn 1998).

Within each society an individual learns the cultural norms related to their body in everyday life such as; bodily adornment, heath and illness, private and public parts of the body and interpretation of bodily functions. The way the body is managed in everyday life and the impact it has on others must also be considered. For example, both emotional and physical control of the body will gain meaning from

and be interpreted within cultural norms (Lupton 1998, Featherstone and Hepworth 1991).

In recent years the reproductive body has received attention. in the disciplines of anthropology and sociology. The medicalization of childbirth has been widely debated (for instance Oakley 1984, Davis-Floyd 1992, Kitzinger 1992) where childbirth has been defined as a 'problem' which needs to be controlled by experts and monitored by technology. Turner (1992) suggests that medicine, law and religion are preoccupied by the regulation of the body. In the UK there is no law regulating breastfeeding practices however this has happened elsewhere.[2] In the UK the biggest effect on the regulation of the breastfeeding body comes from medicine with advice given by health professionals. In this study the way the women's lactating bodies are managed and regulated becomes evident in chapters 3, 4 and 5. Within these chapters several issues are investigated such as the management of body fluids, management of self in public places and managing the complexities of breastfeeding an older child.

In British society individuals learn from an early age that the body needs to be managed and disciplined (Shilling 1993). Drawing on the work of Elias (1982) the body has been subjected to the 'civilizing process'. During the course of socialisation most natural functions have been classified as offensive and distasteful. Body fluids fit into this category very well - the sight or smell of body fluids such as urine, faeces or menstrual blood may be seen as 'matter out of place' (Douglas 1984). Individuals expect to be in control of their bodies so

[2] In the USA there are many legal cases involving breastfeeding. Examples include the effect of breastfeeding on custody and visitation rights, the right to breastfeed at work and breastfeeding in public places. Consequently breastfeeding legislation in the USA has been developed in order to promote and encourage breastfeeding (Baldwin 2000, Baldwin and Friedman 2000).

if the body goes out of control it can be viewed as problematic, not only for others but by the self too. Women have been socialised to control and render their body fluids invisible (Britton 1996). During breast feeding the presence of leaking milk is contained by the use of breast pads. The control of decency may also become an issue when the breasts become public during breastfeeding. An individual's interaction in everyday life is dependant on the management of their body through time and space. However the concern about the public display of the breast during breastfeeding seems in direct contradiction to the media representations of the breasts in the popular press.

Embodied knowledge is knowledge gained from an individual's experience with, and perceptions of, their body (Pálsson 1994, Hastrup 1995, Abel and Browner 1998). For the women in this study this was achieved by the current experience of breastfeeding or from previous experiences. Contributions to that knowledge may also come from other people's accounts too. Women use various forms of experiential knowledge to retain a critical distance from medical authority (Abel and Browner 1998). Not only may biomedical authority validate a woman's subjective experience where the medical discourse may help explain the sensation and feelings but also the experiential knowledge can be used as a basis for accepting or rejecting the biomedical paradigm (Abel and Browner 1998). Many women will seek medical advice during pregnancy to inform them about what to expect which helps to shape their experience. However the reality of the experience may be different. In chapter 3 it is demonstrated that the women often legitimised their experience by discussing it with others to confirm the normality of this experience.

Embodied knowledge may be the basis for some women rejecting dominant medical models of birth and child care. Those women who have previous experience of breastfeeding may reject biomedical advice about the management of their breastfeeding experience. Also, during the ongoing process of breastfeeding a woman may modify her ideas about the dominant ideology of weaning the baby from the breast 'early' because of her sense of embodiment and belief in her ability of 'knowing' what is best for her child (see chapters 4 and 6).

Embodiment has the potential to provide shared experiences however. these experiences may be experienced and perceived as different both within and between cultures. Mauss (1973) discusses how different cultures have 'techniques of the body' which shape ideologies within a society. In relation to the reproductive body Mauss (1973) gives several examples where taken for granted attitudes of one society may not be reproduced in another such as giving birth. In British society the medicalization of childbirth has encouraged women to give birth in beds lying semi-recumbent. In other societies this position is an enigma. Another example is the carrying of the child. In some societies techniques of child transportation are geared to keep the child close to its mother (e.g. on her hip) yet in other societies (such as Britain) an apparatus such as the pram is mostly used. Mother-child proximity (i.e. sleeping and carrying practices) is closely linked to breastfeeding duration and gradual weaning (Panter-Brick 1992, Quandt 1995, Ball et al. 1999).

In the UK, the birth of a child often brings remarks from first-time parents like 'it has been a real shock', 'my life has changed', 'it has changed my world'. Life before a child may have had a 'taken-for-grantedness' about it. However this mutuality of the world can be disturbed by parenthood. The 'being-in-the-world' will have a different meaning. The embodiment of mothering affects most aspects of the woman's life as it is an experience of totality which permeates from the body into the social world affecting everyday activities (see chapters 3 and 5).

Women are not only exposed to, and affected by, conceptual medical knowledge but they will also draw upon their own and other's experience of a phenomenon. This experiential knowledge has been labelled 'authoritative knowledge' by Jordan (1978, 1993). Authoritative knowledge is not confined to childbirth but is also relevant in other issues which affect women's lives. However it seems that women commonly try to draw on the knowledge of those closer to the experience, such as breastfeeding, rather than those considered high status and powerful authorities in the public domain of knowledge and truth (Belenky et al. 1986). Therefore they may talk to family and friends to gain truth about the experience which can involve the exchange of storytelling. Those who have previous experience of the situation may be seen as important to help guide the woman on her journey through the phenomenon. However the consequence of seeking advice from others can be that there is conflict and opposition between the views of the woman and others. When these conflicts involve significant people in the woman's life huge difficulties can arise.

The work of Merleau Ponty (1962) and Csordas (1994) has contributed to the knowledge of how the experiences of the body affect an individual's perception. In everyday life we may not experience our body as an object. It is when a situation occurs which brings the body to the fore (which could happen in health or illness) that we may pay attention to it and talk about it. This process leads an individual to try and 'make sense' of the body that has been objectified. The descriptions of embodied experiences can provide a gateway into the lives of others however placing these experiences within the context of their social world will enhance the ability to access the selves of others (Good 1994).

The experience of the body is not just a personal encounter but affects the individual's social world, infiltrating their everyday activities and how they manage their body in everyday life (Good 1994, Billington et al. 1998, Nettleton and Watson 1998). The embodied experiences of breastfeeding demonstrate how women live 'in' and 'through' their bodies. Sensations encountered during breastfeeding are more than physical feelings; they carry meanings associated with nourishment and the ability to be a 'good mother'. Emotions associated with breastfeeding, such as embarrassment, are constructed through the individual's social relationships with others. Embarrassment provides an example of how the body mediates the relationship between self-identity and social identity (Shilling 1993).

Breast

The breast in everyday life has received attention from various disciplines such as medicine, sociology, anthropology, psychology and politics. The focus has been on the 'unwell breast', for example, breast cancer (Dawson 1990, Fallowfield 1991, Wilkinson and Kitzinger 1994, Straughan and Seow 1995, Becvar 1996); the 'well breast' featured in health promotion (Cirket 1992, McConville 1994, Stoppard 1996); breasts and sex (Richardson 1990, McConville 1994); and the breast and cosmetic surgery (Davis 1995, Allen and Oberle 1996). Societal notions of the breast and breastfeeding in the UK are embedded in a cultural context which shapes people's opinions about the breast and attitudes towards breastfeeding activities. The visual and print media in any culture depict the 'desirable' female body, such as the appropriate shape and size of the breast (Thapan 1997). Those women who are dissatisfied with their breasts have sought assistance from surgeons for reconstructive surgery to enable them to achieve the desired shape and size of their breasts. The breast may also be perceived as an erotic body part where it is represented in pornography and the media as an essential feature for attracting heterosexual men.

However these views are not universal. Dettwyler (1995a) has produced a convincing argument against the notion that male attraction to the female breast is a universal phenomenon across all populations of the human species. Dettwyler's analysis of cross-cultural studies demonstrates that there is little cross-cultural evidence to support the opinion that breasts play an important role in sexual behaviour but is should be remembered that the main study she

considers was written in the 1950s (Ford and Beach 1951). There is no evidence of more recent surveys having been conducted to monitor any change in sexual behaviour. The focus of Dettwyler's argument is to demonstrate that breasts are not intrinsically erotic in humans but such views are gained from learned behaviour. If a contemporary cross-cultural survey similar to that of Ford and Beach (1951) was conducted which demonstrated a shift in behaviour towards the eroticising of the female breast then this would substantiate her viewpoint.

Cross-cultural accounts provide evidence of societies, such as the UK and North America, where there is a strong association of the breast with sex (Dettwyler 1995a, Van Esterick 1989, Anderson 1983). The sexual nature of the breast in the UK means that breastfeeding is ultimately bound up with female sexuality and might be an important factor in a woman's success in breastfeeding. On the other end of the continuum there are societies, such as Mali, where the breast is not considered sexually arousing during sexual intercourse (Latteier 1998). There are also those societies where the breast is seen as both sexual and maternal, which enables a breastfeeding culture to exist within a society that sexualises the breast (Latteier 1998).

The breast may not only be associated with nutrition and sexuality but also have an important function in strengthening kin ties. It might be considered that breastmilk will transmit important qualities to the infant (Skeel and Good 1988, Creyghton 1992). In Mali a mother who does not breastfeed her infant is considered to have relinquished kin ties to her infant (Dettwyler 1988). In those

societies where breastfeeding the infant is not confined to the infant's mother, milk kinship might be formed (Fildes 1988, Khatib-Chahidi 1992, Harrison et al 1993). The breastfeeding women might not be biologically related to the infant but through the breastfeeding act a powerful bond is created where the term 'second mother' might be bestowed on the woman (Vincent 1999). According to Altorki (1980) if a woman wet-nursed an infant both she and her husband would become 'milk parents' creating a foster relationship which had important consequences in kinship relations such as marriage.

During her life cycle a woman will experience many changes to her breasts through puberty, childbearing and the menopause. There are very few accounts written about women's views on their identity during the changes that occur during breastfeeding. In chapter 3 it becomes evident that women's breasts are different when lactation is experienced. Prior to pregnancy some women experience breast changes in relation to their menstrual cycle e.g. breast discomfort or pain and/or fluctuations in size. During pregnancy and lactation women may experience these features however the meaning will be different e.g. normality of breast and nipple pain, breast size equating to fullness and adequacy of lactation. In health, a woman will not experience leakage from her breasts until she experiences pregnancy. For a primigravida[3] the leaking of a body fluid from the breast was a new experience (see chapter 3). For some women the uncontrollability of the flow of breast milk is problematic and needs to be managed by the use of commercial products.

[3] Primigravida is the term given to a woman having her first pregnancy.

The breast features as a sexual object in many areas of everyday life. Although the public discourse related to the breast is portrayed as strongly sexual, lactating women may become concerned about the effect pregnancy and breastfeeding will have on the beauty of their breasts. A long-standing myth used against breastfeeding was the perceived relationship between breastfeeding causing sagging breasts (Fildes 1986, McConville 1994). In fact it is the effect of hormones produced in pregnancy that is responsible for the changes in breast size and shape, not breastfeeding (Llewellyn-Jones 1983, Stables 1999). Pregnancy may alter the perception of the woman and those around her to the functions of the breast. In chapter 5 it is made clear that the essentially private, sexual view of the breast becomes replaced during breastfeeding by a more public, nurturing purpose. Difficulties that women perceive about the exposure of their breasts while breastfeeding in public settings are related to the male gaze and the inappropriate exposure of the breast in this context.

Foster et al. (1997) reported that 40% of mothers (with breastfeeding babies aged 4-5 months) recounted that they had problems finding somewhere to feed their baby in public places (table 1. 1)

Table 1.1

Whether breastfeeding mothers ever had any problems finding somewhere to feed their babies in public places: a comparison between 1990 and 1995.

	1990	1995
	%	%
Had problems	44	40
Did not have problems	39	49
Did not feed in public places	17	11
Ref: Foster et al. 1997		

Mothers in 1995 who were breastfeeding at 4-5 months were both less likely to have had problems, and more likely to have tried to breastfeed in public than the 1990 sample (Table 1.1). However the figures for those women who had *ever* breastfed[4] are not so encouraging (Table 1.2).

Table 1.2

Where mothers (who had ever breastfed) preferred to breastfeed when in a public space.

	Proportion stating %
Prefer a mother and baby room	29
Prefer to breastfeed without going to a special place	10
No preference	11
Never breastfed in public places	50
Ref: Foster et al. 1997	

These figures demonstrate that in 1995 a large percentage of women preferred not to be in the public gaze while breastfeeding. Unfortunately, this report (Foster et al 1997) fails to address why the women preferred not to breastfeed in public so it is unclear whether this is personal preference, embarrassment or

[4] The term 'ever breastfed' refers to any breastfeeding activity regardless of its duration.

other factors. However, further evidence in this report indicates that 97% of the women wanted better facilities in public places to enable them to breastfeed (Foster et al. 1997: 84). Although the term 'better facilities' is not defined in this report, anecdotally this usually means better *secluded* facilities, away from the public gaze.

Babyhood

Within the disciplines of psychology, sociology and anthropology there is little consensus about the definition of infancy, toddlerhood or childhood (Harris 1993, Papalia and Olds 1995, Gittens 1998, Panter-Brick 1998). There is a sense that these are 'taken for granted' notions which everyone will understand. However, age is a common feature that is discussed when debating these definitions. This probably emanates from the influence of developmental psychology which first produced models and stages of child development (James et al. 1997).

In this study both babies and toddlers feature who have very different needs and require different aspects of care and nurturing from their mothers. A baby is generally regarded as physically and socially immature whereas a toddler is less so. In the UK babyhood is equated to dependence where the ingestion of breastmilk is not questioned. When the infant becomes a toddler the acts of independence (such as walking, feeding itself, vocalising its needs) is the antithesis of dependence in babyhood. Babyhood is an anomalous state (Murcott 1993) where the baby is placed at the margins of society. A child is part of the adult human society but cannot participate in it in the same way as

older individuals; not yet social but needing to be socialised. From birth, the social experience of the child will help shape it as an individual and enable it to learn about their culture.

From birth onwards the infant and mother engage in a synchronised exchange (Stern 1977) like a dance; the baby indicates a need so the mother responds, for example offers her breast. The baby becomes satisfied, so the mother becomes satisfied. During babyhood this synchronised exchange contributes to reciprocal attachment (Isabella and Belskey 1991). Breastfeeding clearly contributes to this attachment. However it is not only the infant who becomes attached during breastfeeding but the mother also. The discipline of psychology has contributed 'attachment theory' (for example Bowlby 1969, Klaus and Kennel 1976, Ainsworth et al. 1978) as having an influencing effect on parenting and children. However, cultural differences between societies must be acknowledged since 'attachment' is culturally driven and the degree of attachment will have different meanings in different cultures (Grossman and Grossman 1981, van Ijzendoorn and Kroonenberg 1988, MacPhee et al. 1996, Schwalb and Schwalb 1996).

The infant-mother relationship of attachment is deeply researched however the focus of attachment seems to be on the consequence for the infant rather than the mother. There is much discussion about how differing parenting styles affect the developing child (Raphael-Leff 1991, Hewlett 1992, LeVine 1998) and indeed in this study the long-term breastfeeders were conscious of this. Despite extensive searching no psychological studies were located which

investigate the role of breastfeeding in promoting secure attachment. However, Fergusson and Woodward (1999) claim to demonstrate an association between breastfeeding and closer parent-child relationships. There is also much written on the close, child-centred relationship (Becker and Becker 1994) which resembles the parenting styles of the long-term breastfeeders. In the psychological literature there is general agreement that by 7-8 months of age an infant has focused its attachment behaviour on specific individuals (Schaffer 1995). By this time most mothers, in Britain, have usually stopped breastfeeding. The mothers who are still breastfeeding at this time may be more motivated to continue as their infant clearly demonstrates its need to be close and comforted by its mother. What seems important here is the social experience of the mother. The mother's parenting style may affect the infant's development but the social experience of parenting may also mould the mother's choices as a caretaker. If she believes strongly that the infant is benefiting from the continuance of breastfeeding then she is more likely to continue; however those social structures around her may influence her otherwise if she is receiving conflicting messages. The impact these contradictory messages have on the woman will depend on the nature of the relationship she has with the person and her perception of their credibility (see chapter 6).

During babyhood there is an expectancy and tolerance that the baby will be breastfed. It is not thought 'deviant' for a young baby to breastfeed since it is acknowledged that all babies need milk feeds, either breast or formula milk. However, generally it is deemed 'deviant' for a toddler to have breastmilk feeds

because not all children do this in toddlerhood. If a child behaves in a way that is deemed inappropriate for its age this will give rise to concern amongst families and health professionals. Often these behaviours are modelled on adult life styles such as sleeping through the night, ingesting foodstuffs and using toilet facilities (Ribbens 1994).

In cross cultural research it is found that certain values, such as independence or interdependence, will be promoted in some cultures. There is a general opinion that Western societies tend to value independence more than interdependence (Kitayama and Markus 1994, Cross 1995, Tafarodi and Swann 1996). These values will often guide childrearing practices and are themselves transmitted to the young by those around them. As can be seen in chapters 4 and 6 when differences in opinions occur about child rearing practices conflicts can occur which might impinge in the woman as being contrary to her notion of 'good mothering'. These societal norms dictate and encourage parents to enable their child to achieve these norms at an appropriate age. With the subject of breastfeeding there are strong societal opinions about the suitable length of time the child should have access to the breast and when weaning should take place, yet variability of individual women's behaviour.

Furthermore, within medical, nutritional and anthropological literature there is no single definition of weaning. This arises because weaning is not an event but a process often comprising two parts; the gradual introduction of weaning foods and the cessation of breastfeeding (Almedom 1991, Lee 1996, Mabilia 1996). In many academic texts the term 'weaning' is often used without definition or

explanation. In the UK the term 'weaning' tends to focus on the introduction of supplementary food stuffs whereas the French term *sevrage* offers a clear distinction from the UK term by denoting the complete cessation of breastfeeding (Almedom 1991). In babyhood breastfeeding is promoted as being the best form of nutrition for a child but as the child gets older breastfeeding becomes problematic. The following are commonly debated. Does breastmilk offer adequate nutrition to a six-month old child? Should a breastfeeding toddler be fed in public? Does breastfeeding a toddler promote inappropriate dependence on its mother? The public health message produced by the government and reinforced by health professionals is that breastfeeding is right and proper until four months of age after which the child should be encouraged to take supplementary foodstuffs, and 'weaned' by six months of age (Health Education Authority 1992, Department of Health 1994, Lilly 1995, Anderson 1997). By six months of age it seems to be inconsequential whether the infant is still breastfeeding or not. The acknowledgement of breastfeeding after nine months of age is negligible in the public health literature. The central concern is about the health of the infant ensuring it gets enough nutrition for bodily growth and development (the child is usually weighed regularly to monitor this). With weaning comes control of the infant's daily timetable where 'adult-style' meals, namely breakfast, lunch and dinner, are prepared and given to mimic the construction of the adult's day.

Breastfeeding Promotion

Breastfeeding is promoted as a health concern and the dominant message in Britain is that 'breast is best'. There is a public health message that women

should breastfeed their infants and considerable debate exists as to how health professionals and lay organisations can best support the breastfeeding mother. However, the discourse is primarily targeted at mothers in the early weeks of breastfeeding where there is an expectation that women will breastfeed for between 4-6 months after which supplementary foodstuffs are introduced. From this time on breastfeeding is lost from the public health arena. Although there is a public health policy to promote breastfeeding it appears there is no official interest in breastfeeding rates after nine months of age (Foster et al. 1997). Long-term breastfeeding is not visible in the public health discourse within Western societies.

It is useful to consider breastfeeding within an historical context to understand the prevailing attitudes towards infant feeding. The provision of nourishment to an infant other than its mother milk is not a new phenomenon. Throughout world history there are accounts of infants being given breastmilk from other women (wet-nursing) or milk from animals (Fildes 1986, Fildes 1988). Between 1500-1900 the use of wet-nurses in England was common place especially amongst the wealthy. Although uncommon in England, some industrialised nations were using wet-nursing as an alternative to maternal breastfeeding until at least the 1940s (Fildes 1988). Historical records suggest that infants were commonly given foodstuffs, such as bread and broth, as a complement or substitute for breastmilk (Fildes 1986, Apple 1987). The introduction of artificially formulated milk from animals became widely available in Europe, Australia and the Americas during the late 1800s when the scientific community became interested in the subject of infant nutrition (Apple

1987, Latteier 1998). During the Second World War national dried milk was introduced to encourage women into the workplace and following the war the infant formula industry became very competitive with intense marketing strategies equating bottle-feeding with affluence and consumerism. The marketing of artificial formula milk has received considerable attention as a main cause of the global decline in breastfeeding (Palmer 1993, Van Esterik 1989). Human lactation as an unreliable body function became a cultural truth that has persisted to the present day (Wolf 2000).

The 'bottle feeding culture' became a part of the medicalization of infant feeding where scientists and doctors became 'the experts'. Various practices were introduced to control and regulate infant feeding where predictability and measuring the baby's intake became important, which arose from the bottle-feeding culture (Dykes 1997). As women were encouraged to approach the management of breastfeeding from a scientific paradigm it caused a lack of confidence in the woman's ability to nourish her baby. This lack of confidence in breastfeeding remains in the UK today (Renfrew et al 2000). Despite the known health benefits of breastfeeding there remains prejudicial attitudes against breastfeeding with the UK. Many people that a woman comes into contact with during her reproductive life have been exposed to the 'norm' of bottle-feeding, it is clear that the social milieu is a major influence on the woman's ability to breastfeed.

In the UK there has been a public health movement to promote the uptake of breastfeeding following the decline in breastfeeding worldwide since the 1960s

(Ebrahim 1991, Palmer 1993). With growing international concerns about the decrease in breastfeeding prestigious organisations and local governments have become involved in an attempt to improve breastfeeding rates. The policy discourse about breastfeeding in the UK has been informed by the global view that breastfeeding should be supported and the rates, globally, should be increased. In 1989 the World Health Organisation (WHO) recommended infants should be exclusively breastfed for 4-6 months, then breastfed with appropriate and nutritionally adequate complementary foodstuffs until the age of two years or beyond (WHO 1989). The United Nation's Children's Fund (UNICEF) sought to encourage breastfeeding globally for at least six months (UNICEF 1990). Although the WHO have publicly supported the continuance of breastfeeding for at least the first two years of an infant's life this has been ignored in the public health discourse of breastfeeding. The main focus of breastfeeding promotion tends to be placed on initiation of breastfeeding rather than its continuance.

Research has been conducted to investigate why women choose not to breastfeed or give up early (Thomson 1989, Wylie and Verber 1994, Hoddinott 1998). A key focus of the research studies has been to investigate the link of socio-demographic variables to the decline in breastfeeding (Clements et al. 1997, Foster et al. 1997). The outcomes of these studies demonstrate that women who are in the higher social classes, have remained in full-time education until 18, live in the south-east of England, are all more likely to breastfeed. While statistical analysis can be useful to indicate associations between socio-demographic factors and infant feeding choices, they are unable

to explain the choices made by individual women (Bauer and Wright 1996). Differences in breastfeeding uptake cannot be explained by socio-demographic variables alone; cultural and behavioural factors may be important and have received little investigation (Dykes 1998). The contribution of this study provides an insight into some of the issues and conflicts that shape women's breastfeeding experiences which have been neglected in other studies.

Over the last century, significant changes in the management of childbirth have resulted from the medicalization of childbirth (Oakley 1993). As in other aspects of childbirth, there was a shift in 'ownership' of breastfeeding from women to 'expert' health professionals. This resulted in a loss of collective knowledge about breastfeeding in the community and gave rise to the management of breastfeeding by the 'experts', which had a disempowering effect on individual women (Oakley 1993). Inappropriate regimes have been imposed on women to 'help' them manage breastfeeding. These included the separation of mothers and babies, rigid timing regimes for the frequency and duration of feeds, and the use of supplementary formula milk feeds when the mothers' milk was deemed inadequate. Over recent years breastfeeding has remained in the domain of the health professionals who see it as their duty to inform women about its benefits to them and their infant, and consider strategies which will effect the incidence and duration of breastfeeding. Traditionally the common approach used is a health education model which relies on the imparting of information to change others' behaviour. However, a more critical approach has been incorporated within the health education dialogue with the emergence of evidence-based practice which challenges the

medicalization of infant feeding by investigating best practice. Rigid feeding regimes, separation of mothers and babies and the casual use of infant formula milk have been found to be inhibitory to successful breastfeeding (Woolridge and Fisher 1988, Woolridge 1995, Ball et al. 1999) which has resulted in a shift to a more flexible, baby-led approach.

Nevertheless, health professionals' social attitudes to breastfeeding can affect information they impart to women and this has been particularly significant when previously held professional knowledge has been found to be detrimental to the success of breastfeeding (Welford 1995). Some health professionals have had difficulty incorporating the flexible baby-led approach, leading to conflicting advice and dissatisfaction for breastfeeding women.

In an attempt to provide contemporary research evidence to improve breastfeeding practices and equip health professionals with knowledge, skills and attitudes to enable women to breastfeed successfully several initiatives have been implemented both globally and in the UK. Following the development of 'ten steps to successful breastfeeding' by the WHO and UNICEF (1989), shown in table 1.3, the 'Baby Friendly Hospital Initiative' was launched globally. The aim of this initiative was to encourage maternity units to implement the 'ten steps to successful breastfeeding', evaluate their achievements and then have an external assessment prior to the Baby Friendly Award. The award is dependent on health professionals being conversant with current research and motivated to enable women to achieve optimal breastfeeding for their infants.

Table 1.3

'Ten Steps to Successful Breastfeeding' - WHO/UNICEF (1989)

EVERY FACILITY PROVIDING MATERNITY SERVICES AND CARE FOR NEWBORN INFANTS SHOULD FOLLOW THESE 'TEN STEPS TO SUCCESSFUL BREASTFEEDING'.
1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10.Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
Ref: WHO/UNICEF 1989

In the UK, a joint initiative between the Royal College of Midwives and the Health Visitors Association developed the 'Invest in Breast' programme which aims to unite health professionals in promoting and sustaining breastfeeding more successfully (Kendall 1999). National Breastfeeding Awareness week is an annual event whereby breastfeeding is promoted by health professionals and lay organisations. During this week information about the benefits of breastfeeding are disseminated to the public by the display of posters and leaflets in public areas. Breastfeeding-friendly initiatives are often launched at this time such as 'You CAN do it here' (National Childbirth Trust 1998) a publication identifying public venues where breastfeeding is supported.

Several research studies have concentrated on evaluating how health professionals can encourage and support women to breastfeed (Garforth and Garcia 1989, Thomson 1989, Chalmers 1991, Rajan 1993, Barnett et al. 1995). In recent times a reflective approach of how values and attitudes held by health professionals may influence their support of breastfeeding has emerged (Barnett et al. 1995, Dykes 1995, Howard et al. 1997). Those health professionals who have positive experiences of breastfeeding may feel more equipped to support the breastfeeding woman whereas those who have negative or no breastfeeding experience are more likely to advocate the use of supplementary feeds and encourage early weaning (Barnett et al. 1995).

To evaluate the 'success' of breastfeeding promotion the British government has monitored the incidence and patterns of breastfeeding by conducting five yearly infant feeding surveys since the 1970's (Martin 1978, Martin and Monk 1982, Martin and White 1988, White et al. 1992, Foster et al. 1997).[5] From these reports it is documented that in 1975 breastfeeding initiation rates in the UK were 51%, falling to 24% by six weeks postpartum (Martin 1978). During 1980-1990 there was an insignificant change in rate. In the latest infant feeding survey an improvement in the initiation rate was demonstrated from 62% in 1990 to 66% in 1995 (Foster et al. 1997). Although the initiation rates may seem to have improved it is important to realise that these rates are based on babies who have *ever* breastfed. This includes those babies who were put to the breast on one occasion only. A more realistic picture of breastfeeding trends can be seen by looking at prevalence of breastfeeding in the UK from birth to

[5] The data for these reports were collected during 1975, 1980, 1985, 1990 and 1995. The publication dates are different due to the time taken for analysis and publication.

nine months (see table 1.4). This shows a steep decline in breastfeeding in the first week of birth followed by a steady decline in the following months. The reasons for stopping varied with the duration of breastfeeding (Foster et al. 1997).

Table 1.4

Prevalence of breastfeeding at ages up to nine months in the UK: 1990 and 1995.[6]

Age of baby	1990	1995
Birth	62%	66%
1 week	53%	56%
2 weeks	50%	53%
6 weeks	39%	42%
4 months	25%	27%
6 months	21%	21%
9 months	11%	14%
Ref: Foster et al. 1997 – based on 5,533 women in 1990 and 5,181 in 1995		

The main concern about improving breastfeeding globally is its association with promoting child health and child survival. Many research studies have concentrated on the physical health benefits to the infant. However there is indisputable evidence that breastfeeding offers significant health benefits to both the breastfeeding woman and her infant. There can be no dispute that there are health benefits linked to breastfeeding. Physically and mentally there are associations with enhanced well-being for breastfed infants. Many scientific studies have been conducted to demonstrate a positive correlation with breastfeeding and subsequent health in childhood. These include studies which have demonstrated a reduction in gastrointestinal infections (Howie et al. 1990), respiratory infections (Wilson et al. 1998), ear infections (Duncan et al.

[6] There are no national data in the UK regarding breastfeeding rates after nine months of age.

1993, Aniansson et al. 1994), allergic diseases (Lucas et al. 1990, Saarinen and Kajosaari 1995), and insulin-dependant diabetes mellitus (Virtanen et al. 1991, Karjalainen et al. 1992, Gerstein 1994). These studies were conducted comparing the health of the breastfeed baby against the health of a baby given artificial formula milk. There is also evidence that infant-parent co-sleeping and breastfeeding may reduce the risk of Sudden Infant Death Syndrome (McKenna and Bernshaw 1995, McKenna 1996 and Gordon et al 1999). Other studies have demonstrated that breastfed children achieve higher scores in standardised tests which measure mental development than those children who have been fed artificial formula milk (Lucas et al. 1992, Rogan and Gladen 1993, Temboury et al. 1994).

Although breastfeeding is usually promoted as an infant health issue there is little doubt that there are health benefits for women too (Dermer 1998, Labbok 1999). For women who have a history of breastfeeding scientific studies have demonstrated a lower incidence of premenopausal breast cancer (Chilvers 1993, Newcomb et al. 1994), ovarian cancer (Gwinn et al. 1990, Rosenblatt et al. 1993), and hip fractures in the older woman (Cumming and Klineberg 1993).

The medical/scientific approach to breastfeeding in policy discourse is dominant in the UK and little attention is given to the social and cultural values which underlie a woman's reason to breastfeed. Nevertheless there is evidence that without an understanding of cultural attitudes the medical message is often unable to permeate to the wider audience. Despite women's knowledge that breastfeeding can be health enhancing some women choose not to breastfeed.

In order to promote breastfeeding health professionals have used the dominant discourse of medicine to encourage an increase in breastfeeding. Strategies used are to provide information about the health benefits and use scientific research to underpin advice about appropriate management of breastfeeding concerns. The question then becomes: if breastfeeding is so good, why don't more women do it and for longer?

The reasons why some women do not to breastfeed or breastfeed for a limited amount of time are multiple and complex. Breastfeeding is socially constructed and exists within a woman's social world. It is not an isolated event that can be readily assigned to scientific rationale alone. Other issues which effect women's lives and have received little attention in the medical approach to breastfeeding are societal and cultural influences that will affect a woman's choice to initiate and sustain breastfeeding. Women may experience conflicting roles as mother, wife and wage earner. Women who feel unsupported by their partners in their breastfeeding choice are less likely to be successful in breastfeeding (Palmer 1993, Isabella and Isabella 1994). In the UK many women return to work after the birth of their baby. For some the return to the workplace makes breastfeeding problematic, as the promotion of breastfeeding in the workplace is not seen as a priority for employers. The absence of breastfeeding facilities during the working day, limited or no access to the infant and difficulties in expressing and storing breastmilk all contribute to the early cessation of breastfeeding for most working women. Many women believe that if they do not continue to express their breasts during the day their milk supply will cease. In the policy discourse the promotion of breastfeeding

is focused on the early weeks of the activity, not as a long-term activity. The promotion of breastfeeding is targeted to the infant's first six months. From the time supplementary foods are expected to be introduced there is little attention to promote breastfeeding activities.

Outline of the Chapters

In chapter 2 the methodology and sample used in this study are presented. Two groups of women were investigated for this study. The first sample comprised thirty-five women who reported their experiences of breastfeeding in the first few weeks following their baby's birth. The second group were sixteen experienced breastfeeding women who nursed at least one child to the age of eighteen months. Ethnographic open-ended interviews and conversations were used to gather the data.

My background of working in the health care sector could be viewed as advantageous or problematic to the aims of this study. On one hand my professional knowledge of the health care system and concerns of women who are breastfeeding helped me to interpret and understand the issues the women discussed with me. Conversely to reveal my professional status to the women could have had a negative effect in their explanations of their experiences or in them being truthful about their relationships with other health professionals. I do not believe I have been compromised by my 'insider' knowledge but consideration has been given to these issues.

Chapter 3 discusses the lived bodily experience of breastfeeding. Breastfeeding women may find themselves confronting a barrage of new sensations and emotions for which they are unprepared. Within this chapter I investigate how women perceived the sensation of 'letdown' and how this impacted on their lives. Underpinning the analysis is the source of knowledge that women use to make sense of their bodies. On one hand they use medical discourse as a source of knowledge to gain an understanding of their bodily sensations but this is often in conflict with their embodied knowledge. The conceptual language provided by biological medicine tends to iron out the diversity of experience. In this chapter the women's use of figurative language to express their experiences gives richness to the individual accounts.

The control of bodily fluids is an important social necessity. During breastfeeding many women experience the leaking of milk from their breasts which can be seen as positive, if attributed to good milk supply, or negative if the body is apparently out of control. The presentation of self is analysed when the women discuss the significance of their leaking bodies and the strategies they embark upon to lessen the embarrassment of the leaking body.

Chapter 4 reviews the experiences of women who practice long-term breastfeeding. In this chapter it is central to consider the definition of 'long-term' and meanings of infancy, childhood, and weaning to understand the social forces which effect the woman's breastfeeding experience. Breastfeeding over the long-term is unusual in the UK. The circumstances and reasons why these women continued to breastfeed are investigated. Societal opinions about

long-term breastfeeding do not generally support the activity. Opposition to the activity caused conflicts which resulted in the women having to clarify the meaning of being a good mother.

Chapter 5 investigates the women's perceptions of breastfeeding in public and private spaces. In this chapter the public arena is generally taken to be the space outside the domestic place and the private domain is generally situated within the domestic locale. However this is a narrow definition, as women will often encounter episodes when their domestic space becomes public depending on who is present within that space. The public area that features in this study is the movement into areas to conduct everyday activities such as shopping. Public spaces that were once familiar to the women when childless may be negotiated as different spaces once they entered the status passage of motherhood. Many women feel anxious about where and how breastfeeding should be undertaken in public. Some women will develop an awareness of facilities they may use in order to create a private space within the public arena. As women were interacting with others, often strangers, within the public place they were acutely aware of others reactions to their breastfeeding activity and concerned about their own embarrassment. For some women this prevented them ever breastfeeding outside their homes. Even in the domestic setting, the women may manage their breastfeeding in different ways according to who was present in that space. Important considerations for the women when breastfeeding in front of others are the relationship to the other (kin, friend, guest or stranger); the sex of the other; their partner's views about breastfeeding in front of others.

Many of the women wanted a general change in attitude from society at large which would make breastfeeding in public a more acceptable activity. Several media accounts reinforce the concerns that British people have about breastfeeding in pubic. An illustration of these accounts which have appeared in newspapers is given to demonstrate how social regulation is reinforced by these media accounts.

Chapter 6 presents a discussion related to authoritative knowledge, where a distinction is drawn between the acquisition of conceptual knowledge and embodied knowledge. Women will use conceptual and authoritative knowledge to make sense of their breastfeeding experiences. These women not only have to struggle with their own beliefs of these competing ideologies but also with the views of others, such as kin, friends and health professionals.

The impact of breastfeeding on a woman 'being a mother' is explored. For many women the success of breastfeeding was intrinsically linked with their vision of 'good mothering'. When the women encountered conflicts from others about their breastfeeding practices this ideology of motherhood was under threat. Many women were guided to make decisions about their breastfeeding activities by using intuition and their authoritative knowledge.

The social network within which the woman existed was important to reinforce her beliefs or pose areas of conflict. Family, friends and health professionals were all seen as being capable of giving support but conversely they could be antagonists if views about breastfeeding were in contention. In an attempt to

reinforce social order attempts might be made to regulate the woman's breastfeeding activity by the use of myths to demonstrate the 'harm' that could befall the breastfeeding woman or her child if she continued breastfeeding.

In the concluding chapter, chapter 7, I show that 'motherhood' and 'conflict' are recurrent themes which bind the chapters of this thesis together. Throughout the chapters illustrations are given about how women perceive their breastfeeding to be closely associated with their views of motherhood. Each chapter reports the conflicts experienced, how breastfeeding women made sense of these and the strategies they negotiated to overcome their difficulties.

Chapter Two
Methodology and Sample

A central concern of anthropology 'at home' is the perceived lack of distance needed for analysis and reflection; however 'just as distance is not a guarantee of objectivity, familiarity is not knowledge' (van Dongen and Fainzang 1998: 247). Anthropologists conducting research 'at home' will have a comprehensive knowledge of their own culture and society but it is precisely this knowledge and familiarity that can make anthropological fieldwork problematic. One difficulty of conducting anthropology 'at home' is making the familiar seem strange. Some authors suggest that prior to conducting fieldwork 'at home' anthropologists should conduct fieldwork amongst a culture other than their own in order to experience the distancing required for the fieldwork (Nakane 1982, Ellen 1984, Perin 1988). Srivivas cited by Sarsby (1984) suggests that to experience another segment of one's own society can create awareness and detachment by becoming the 'outsider' within one's own society. However Britain is not a homogenous community. Living in one area of Britain does not mean that a British anthropologist will have an awareness of the cultural diversity which occurs in another area of Britain. What seems important is not where an anthropologist comes from but how they unravel and assimilate the reality that they encounter.

I have worked amongst childbearing women in Britain for several years. One could assume I had knowledge of the 'birth culture' and had 'embedded' myself into the issues that childbearing women encountered. However, women I met during my work came from wide ranging social, racial and ethnic groups. Therefore I could never assume that the value system I held would be shared by women I encountered. This approach became more evident to me during my study

of anthropology which commenced in 1988. It could be said that while I have been participating in an ethnography of birth and child rearing practices for many years, my study of anthropology has enabled and equipped me to look at my familiar world as strange.

Data collection

Participant observation was not conducted with the women in this study. I realised it would be very difficult to conduct a participant observation study of breastfeeding women and chose to conduct interviews with women to elicit an understanding of their experiences. These interviews are different from conversations extracted from informal interactions. An interview is bound by rules of interaction and requires skills that are different from those employed in everyday conversation (O'Connell Davidson and Layder 1994). They are both forms of social encounter and can be affected by the environment within which the interaction takes place and the social characteristics of the researcher (O'Connell Davidson and Layder 1994). The interview is not a chance encounter but an interaction initiated by the researcher with a goal in mind, that of data collection.

Two data collection periods are included in this study. The first data collection occurred during 1995-1996 when women's views of the initial experiences of breastfeeding were sought. My original plan was that the findings from this group would be the ultimate focus of my study. However after preliminary analysis of these data several questions occurred to me: why did some women continue breastfeeding long-term and were there issues that enabled or

constrained them in this activity? This led me to recruit a second sample of women. The second data collection occurred during 1997-1998 when women's views of long-term breastfeeding were sought.

The data for this study were collected by conducting ethnographic interviews to facilitate women to talk about their breastfeeding experiences. Different methods were used to collect data from each of the two sample groups. The primary method for the first group was the use of focus groups. For the second group the data was collected by individual interviews. All the interviews constituted women talking about their experiences in the form of narratives. The interviews were open-ended and wide ranging in their content in an attempt to explore how breastfeeding practices are related to the social lives of the women. The investigation included how the women made sense of breastfeeding in their daily life, in relation to their family and kinship network, in their interactions with health care providers and managed conflicts over breastfeeding decisions.

In order to discuss the differences in the recruitment and data collection, each group will be presented separately. Similarities will be noted between the two groups of women. They are predominantly white, middle-class women and the majority are married. With the first group there are more primiparous women (having borne their first child) in the sample and conversely in the second group there are more multiparous women (having borne more than one child).

The Sample

A summary demonstrating comparative data of the women in the early and long breastfeeding groups is provided in table 2.1. More detailed information about the two groups is supplied in appendices 1 – 7.

Group One – Early breastfeeders

My first data collection took place in the south-east of England and concentrated on exploring the initial experiences of breastfeeding women. Six focus groups and three individual interviews were conducted. The criterion for entering this study was any woman who had experience of breastfeeding. Thirty-five women aged 20-39 feature in this first sample. The majority (94.3%) is White Caucasian[7]. Over two thirds of the women were primipara (Table 2.1).

I had anticipated using the Registrar General's Classification of social class to indicate the social standing of the women but felt this was inappropriate as it conventionally uses the husband's occupation rather than that of the woman. The occupations of the women are provided in appendix 1. Several women classified themselves as housewives without reference to previous employment opportunities. The majority of this sample (over two-thirds) is married.

[7] All the women are residents of Britain but four had different nationality. One woman came from Yugoslavia, one from Jamaica, one from India and one from the United States of America.

The age of the babies at the time of the interview ranged from two to forty weeks (Table 2.1). The duration of breastfeeding ranged from five days to ongoing. All the women in this sample had their babies present during the interviews. At times it was necessary for another woman from the group to attend to the baby if it started crying or needed stimulation while its mother was conversing.

Table 2.1.

Characteristics of the Sample Women.

	EARLY BREASTFEEDERS	LONG-TERM BREASTFEEDERS
Number	35	16
Age		
- Mean	29.3 years	36.18 years
- Median	29 years	36 years
- Range	20-39 years	30- 43 years
Occupation		
- Housewife	9	1
- Other	26	15
Marital status		
- Married	23	14
- Co-habiting	11	1
- Lone Parent	1	1
Parity		
- Primipara	24	4
- Multipara	11	12
Child's age		[8]
- Mean	17.14 weeks	2 .5 years
- Median	16 weeks	2 years
- Range	15 days – 40 weeks	11 months to 3 .25 years
Breastfeeding duration		
- Range	5 days to ongoing	Up to 4 years

[8] These figures relate to the last child the woman breastfed. For some of these children breastfeeding was ongoing. The women would also refer to long-term breastfeeding of the siblings who were now 27 months to 17years of age. They are not included here.

Out of this sample most of the women were currently breastfeeding. Five women had terminated breastfeeding completely and were now giving their baby artificial formula milk. These women had breastfed for 5 days, seven weeks and sixteen weeks. A further three women were feeding their baby both breast and artificial formula milk.

Recruitment for Group One

In order to access respondents for this study I approached facilitators of postnatal groups and youth groups, community centres and GP surgeries. I also advertised the study in the local papers and on local radio. It was easy to access women via postnatal groups which had originally been organised by health visitors. They constituted a purposive sample (Bernard 1995). However, I was interested to talk to women who may not attend these groups, hence my attempt to make contact with other women in the community.

Once the women had registered an interest in being part of the research study I explained that I was interested in hearing about their breastfeeding experiences and requested permission to tape-record the conversations. All the women were aware that they could opt out of the study if they preferred and all consented to the conversations being tape-recorded.

Thirty-two women were recruited from postnatal groups. These groups were easy to access as they were already formed groups therefore women knew each other and had experience of talking about the parenting with others. The use of pre-existing social groups to investigate health issues has been used in other studies

(Straughan and Seow 1995). The pre-existing social groups may facilitate cohesion of the group members. By using these groups it may be possible to observe fragments of interactions that approximate to naturally occurring data that might have been collected by participant observation (Kitzinger 1995).

Generally women who attend these groups are motivated to attend and value the social support of health professionals and other women who are not kin. In the medical literature the term 'postnatal' refers to the first six weeks following birth. However the postnatal group remained a cohesive group until the women felt confident they no longer needed the support of the group which often existed until the baby was six months old. Women often left the group if they returned to work which occurred between four and six months following the birth. Seven postnatal groups of women are included in this study.

I made contact with three general practitioner (GP) surgeries, the local social service department and housing department to try and gain access to women who had recently had a baby. I requested permission to put up posters asking women to contact me if they were interested in finding out more about the study. This strategy was an attempt to place the decision making with the woman to opt into the study rather than the professional deciding who would be suitable to recruit. Very little co-operation was gained from these services. A gatekeeper effect operated where I was told that either the organisation could not be seen to validate my research or the women in 'their care' would not want to talk to me. This latter response arose particularly in relation to gaining access to teenage women who were receiving assistance from social services or local

housing initiatives. After a lengthy meeting at a GP surgery, the practice manager contacted me to say I had permission to display a poster in the waiting room about my research but I left the area before this could be displayed.

I contacted the local newspaper group who published a half page feature about my research and followed it up three weeks later with a small insert reminding women of the existence of the study. The paper was distributed to four local areas and recruited responses from seven women. Three of these women were interviewed individually. The other women either did not respond to my request to arrange an interview time, cancelled the appointment or were not suitable for inclusion to the study.

Two local radio stations were approached. One invited me to participate in a phone-in programme to advertise my research interests and placed the details of the study on a help-line number. This method generated no response from the listeners.

Group Two – Long-term breastfeeders

I conducted my second data collection in North- East England. My aim was to elicit the views of women who had personal experience of breastfeeding a child over the age of eighteen months. Sixteen women between the ages of 30-43 years feature in this sample (table 2.1)[9]. Four are primiparous and twelve are

[9] See Appendix 2 for details regarding age occupation, parity and marital status.

multiparous. The majority of the women are White Caucasians (93.75%).[10] Appendix 3 provides the ages of the children borne to the primiparous women and their duration of breastfeeding. The multiparous women had between 2-4 children in their family[11]. Appendix 4 and 5 gives a detailed breakdown of the breastfeeding histories of the multiparous women indicating that all the children borne to these women had been breastfed for various durations. Within group two, four women were pregnant at the time of interview.

As with the first group I recorded the occupations of the women rather than that of their husband/partner. The women's occupations are provided in appendix 2. All but one of the women classified themselves as having a work-based occupation, although most of these women were either not currently employed or in part-time work.

At the time of interview 10 women were breastfeeding 11 children (one set of twins). These children were aged between 11 months and 3 ¼ years of age. All the multiparous women had previously breastfed other siblings for various durations[12]. Those who had previous experience of long-term breastfeeding would often reflect on their breastfeeding histories and include these experiences in their narratives.

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[10] As with the first group all the women were residents of Britain however one woman is from Germany, another has a Pakistani parent and one woman is married to a man from Japan.

[11] See Appendix 4 for a table demonstrating the length of breastfeeding by birth order in the families of the multiparous long-term, breastfeeders.

[12] Details of their breastfeeding histories are provided in Appendix 5.

Recruitment For Group Two

Recruitment into this group was potentially more difficult than the group of early breastfeeders as women breastfeeding the older child are not as evident. Unlike the early breastfeeders I was unable to utilise the Health Visitor in gaining contact with this second group of women as many Health Visitors are unaware of women's breastfeeding status. Initially I placed an advertisement about the study in a local National Childbirth Trust[13] newsletter. This requested that women interested in talking about their experiences of long-term breastfeeding contacted me to find out about my study. Five women contacted me after seeing the advertisement. Some of these informants then informed other women they knew who were breastfeeding long-term about the study so a snowball effect was created which lead to a further six interviews. I also contacted the leader of a local group of the La Leche League [14] to explain my interests and investigate whether she could help in the recruitment. At a local group meeting she informed women about the existence of the study, and provided a contact number for me so women could opt into the study if they wished. Two women were interviewed from this contact, and a further three women were interviewed after they told them about my study.

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[13] The National Childbirth Trust (NCT) is a lay organisation that offers support in pregnancy, childbirth and early parenthood. This organisation provides written information; antenatal classes; postnatal support groups and breastfeeding counsellors. Leaders of the groups and counsellors have to have formal training before they can function in their role. This organisation also campaigns for improvements in the maternity services.

[14] La Leche League (LLL) is a lay organisation that offers information and support to women who want to breastfeed their babies. The providers of this help are mothers who have experience of breastfeeding. People who join the LLL have access to newsletters, recent research on breastfeeding matters and personal contact through local groups. A system of leader accreditation is in place which enables a leader to speak with authority on behalf of LLL to anyone with a breastfeeding query.

The data for this group were collected by individual interviews in a familiar setting. Fourteen women were interviewed at home and two women chose to be interviewed in the workplace for convenience.

Building Rapport

Before I started this study I considered whether I should divulge to the women that I was a midwife and I had experience of breastfeeding. Both these facts could have a biasing effect on the responses I gained from the women (Lee 1993).

The initial interview group from the early breastfeeders sample was comprised of women whom I had known before and after the birth of our babies. These women were aware of my professional status and had first hand experience of my breastfeeding activities. For the other groups within the first sample, and for all the long-term breastfeeders I introduced myself to the women as a researcher undertaking a study of women's experiences of breastfeeding. At the beginning of the interviews I did not volunteer to either sample groups that I was a midwife. However during the course of the interviews I was asked on a couple of occasions whether I was a health professional to which I replied that I was. I did not disclose initially that I had personal experience of breastfeeding.

My reason for not disclosing my professional status was an attempt to elicit the true opinions of the women about their encounters with health professionals. I did not want to establish myself as an 'expert' (Ellen 1984). My assumption was that if they knew I was a health professional who had knowledge of the hospitals and

staff they had encountered this may have limited the openness of their responses. However I felt it important to be truthful if asked directly whether I was a member of the health profession. On the two occasions I divulged my professional status I was not aware that this information affected the rest of the verbal exchange.

I was also aware that knowledge of the researcher's personal experience of breastfeeding could affect the interactions with the women. If it was known I had personal breastfeeding experience I might have been perceived as 'part of the group' and to have a shared insight to the views being expressed. My experience may have been utilised by the group which would have deflected from the views of the women. I decided not to inform the women initially that I had breastfed. Several women did ask me if I had personal experience of breastfeeding to which I gave an honest reply. Following this the women would sometimes ask me 'Did this happen to you too?' 'What do you think about this?' 'What was your experience?'

Deciding how much self-disclosure is appropriate is a concern of researchers. If one is not being frank and honest about oneself then it is hard to expect others to be honest and frank in return (Hammersley and Atkinson 1995). However the researcher will often make decisions about what information to volunteer to prevent bias in the data. It was important to try and build a rapport with the women so they would feel comfortable contributing in the interview. One group from the first sample was familiar to me so we had had the opportunity to develop rapport over a period of time. For the other women it was important that I gained some trust from them at the beginning of the interview.

The first interaction I had with the women was important. I took a few minutes to outline my research interests, giving reassurance about confidentiality, and giving the women an option to withdraw from the interview at any time (Hammersley and Atkinson 1995). I made it clear that I was interested in the women's individual views and would value the contributions they made as unique to them and important to the development of a greater understanding in breastfeeding research. During the women's narratives I demonstrated interest in what was being said and encouraged the women by verbal and non-verbal cues. It was important for me to remain impartial and not to show judgement or prejudice about what was being expressed.

Confidentiality

In many research studies the names of the individuals who take part are changed (Lee 1993). This study is no exception. Prior to each interview I told the women that all the data would be classified as confidential, available only to the transcriber and myself. I explained my aim was to publish articles about my research study and my PhD thesis would become accessible to other researchers and students via the university library. I asked the women if they would like their names changed in the text to which the majority said they would. A small number of women were not concerned if their true identity was explicit in the study but as the majority had asked names to be changed I did this for all for consistency. I suggested the women could nominate their own but all suggested I could be responsible for the allocation of the pseudonyms. When a preliminary paper of this study was published (Britton 1997) I circulated it to

members of one focus group. There were no criticisms of the content as the women reported it represented their experiences, however it was interesting that one woman said 'she was pleased she could not see herself in the text'.

Data Analysis

The narratives were recorded, transcribed and interpreted. When the spoken word is transcribed into text the result can be disappointing. The inference, emphasis and rhythm of speech is lost when speech becomes text. The representation of spoken language is similar to the photograph which supposedly pictures visual reality (Mishler 1991), it is an interpretative practice.

The transcripts were sorted into thematic categories as discussed by Bernard (1995). These themes were developed by manual organisation and reorganisation of the data which is a crucial part of the research process but very time consuming (cf. Okley 1994). For the second group I initially began coding the transcripts of the interviews manually then I used the computer software package *Atlas.ti* (Muhr 1997) for the coding of these transcripts. *Atlas.ti* is particularly useful in managing the data as transcripts, memos and codes are accessed easily (Barry 1998).

The transformation of 'the field' into the 'text' is partly achieved by means of the narrative construction of everyday life (Hammersley and Atkinson 1995:250). Throughout this thesis quotes from the women to explain and express their social worlds are used to illustrate the analytical issues. There is a danger that isolated quotes can give a fragmented picture of the women's experiences,

remove them from the subject and reduce the experience to small events rather than being seen in a social context. Direct quotations are used to add richness and give the reader a better insight to the issues that concerned the women. This approach also demonstrates the meaning that the women ascribed to their experiences which gave rise to my theoretical interpretations. To help place the women in context brief pen-portraits have been provided for the early breastfeeders in appendix 6 and for the long-term breastfeeders in appendix 7.

Chapter Three
Breastfeeding – The Early Experiences[15]

From the interviews with women in the early weeks of breastfeeding it became obvious in their narratives that these weeks of breastfeeding were problematic for many women. There were physical, social and psychological concerns associated with the activity. Physical concerns, for example, focused on whether the breasts would make enough milk for the baby or whether the woman's diet was adequate to nourish the infants. Social concerns involved the impact the baby and breastfeeding had on everyday life such as the challenge of incorporating infant care within the pre-existing necessities of everyday life e.g. housework, shopping, maintaining social relationships with others. Psychological issues focused predominantly on adequately attending to the needs of the infant and being a 'good mother'.

The way women perceive and experience their reproductive body may alter as a consequence of their childbirth experiences. Central to this chapter is how the altered idea about the body, in this instance the breast, affected these women's experiences. Breastfeeding is an embodied state yet can be disembodied especially at times of difficulty. The embodiment of breastfeeding is an example of how women use experiential knowledge in making sense of this bodily process.

In the early weeks of breastfeeding the perceived success or failure of this activity was a predominant topic of conversation. It became apparent to me that a major

[15] This chapter contains text and quotes from previously published work (Britton 1997, Britton 1998a, Britton 1998b).

part of the conversations were centred around the experiences lived through their bodies. This included the sensations they felt and how they monitored the well-being of their infant through their capacity to satisfy the needs of their infant through their breasts.

The management and regulation of breastfeeding was a dominant theme which involved learning about breastfeeding and experiencing the embodiment of breastfeeding. Women's preoccupation at this time is with nourishment of their infant so they would look for clues that they were accomplishing this successfully. Most of the women had become aware, during pregnancy, that there was a mechanism associated with lactation which would enable a woman to breastfeed successfully providing she followed certain rules. These rules informed the woman of the correct way to hold her baby; the correct position of the baby at the breast and the correct way to disengage the baby from the breast once the breastfeed was complete. A health professional was usually the person who would take responsibility for instructing the woman in the 'correctness' of breastfeeding.

An important part of the biological mechanism of lactation involves the letdown reflex [16]. In physiological terms, letdown is a neuro-hormonal response produced by stimulation of the nipple during breastfeeding, resulting in the flow of milk from milk-secreting cells in the breast tissue to the baby's mouth. It is considered to be a universal response, even if a woman is unaware of its

[16] The letdown reflex may also be called the draught reflex or milk ejection reflex. The women in this study commonly used the term 'letdown' rather than the medical term 'letdown reflex'. The former will now be used throughout the text.

occurrence. However, letdown is not governed by the hormonal response alone but it is also affected by psychological experience. Almost all the women had gained some scientific, medical knowledge about letdown before the birth of their baby. As letdown was discussed at length by many women and seemed important to them in their early weeks of breastfeeding, letdown has been used to provide a framework with which to discuss the dominant theoretical perspectives of the thesis.

Feeling 'Letdown'

In pregnancy and the early weeks following childbirth women are subjected to a powerful discourse that their bodies are unable to adequately cope with the reproductive process without the help from medicine and health professionals. The breastfeeding discourse follows this tradition where there are countless books informing women how to breastfeed. Much time is spent during the antenatal period instructing women of the 'way of breastfeeding'. The emphasis tends to rest on enhancing the scientific basis of breastfeeding. The knowledge of the endocrine physiology of lactation encourages health professionals to instruct women how to stimulate the milk supply and ensure it is transferred appropriately to the infant. Letdown becomes part of this breastfeeding discourse. It is another example of how a natural sensation has become medicalised. The health professional 'expert' is needed to help explain and make sense of this. By impressing on women that letdown is necessary for successful lactation it then has to be monitored and watched out for.

Women who choose to breastfeed may find themselves confronting a barrage of new sensations and emotions for which they are unprepared. Letdown is one such example. Although women may have some theoretical knowledge of this sensation they report they are unprepared for the 'feeling'. It is only through this actual, lived experience that they can start to make sense of and understand the importance of letdown in the breastfeeding discourse. An examination of this process, in its wider cultural contexts, provides an excellent illustration of the need to transcend narrowly reductionist accounts of embodied human experience (Shilling 1993, Csordas 1994, Lyon and Barbalet 1994). In this study it became evident that the letdown reflex was responsible for many of the concerns and conflicts that the women were experiencing. Indeed, the woman may monitor her ability to adequately nourish the infant by recognising the presence or absence of the reflex. The focus of letdown in this chapter lends itself to discussions about the body, acquisition of knowledge and its centrality in the 'correct' nourishment of the baby which may influence the concept of mothering.

Expectations – Acquisition of Knowledge

Women often want to be prepared for childbirth before the event therefore seek knowledge from different sources, such as friends, family, books or health professionals (see chapter 6). The medicalization of childbirth has transferred the authority of childbearing to medical 'experts' rather than with women. Much of the information women receive about breastfeeding and, in this case, letdown comes from a scientific point of view. During childbirth preparation

classes and in 'authoritative' texts, the women received information which informed them that this reflex was necessary for the physiology of lactation.

Most of the women in this study had not had contact with breastfeeding before their personal experience of breastfeeding. Few women had actually seen another woman breastfeeding her infant or talked to others about their experiences. Therefore, prior to the event, the women in this study tried to gain information to prepare them for the experience. This information is gained from a variety of sources, for example books, friends, family and health professionals (Britton 1997, Britton 1998b). The discourse of medicine tends to reproduce a hierarchy of knowledge, presenting scientific evidence and professional knowledge as superior to learning by experience. It neglects the variability and personal significance of experience that in many cases leads to a contradiction between expectations and the reality of breastfeeding.

As most women in this study were exposed to the media during their pregnancy it was, for some, an important source of information about breastfeeding. Media constructs of breastfeeding are predominantly rooted in the discourses of health professionals' forms of knowledge. Even in women's magazines health professionals are often used to give 'expert' advice on health issues signifying the authority of professional knowledge over that of personal experience. Many childbearing women consult books, leaflets and magazines during pregnancy to gain an understanding of the expectations of breastfeeding. Videos describing the physiology of breastfeeding and showing women feeding their babies are often used during antenatal classes and are available commercially. For some women

this was the first time they had seen the image of a woman breastfeeding. There are many books available about pregnancy and childcare, which are seen as important sources of fact and up-to-date practices. These books are usually directed at the first-time mother and are concerned almost exclusively with infancy or the pre-school child (Urwin 1985, Hays 1996). They usually represent motherhood as fulfilling, satisfying, and important (Marshall 1991) and depict babies who are content and parents who cope without problems, though the images may be far from reality (O'Connor 1993). The account of motherhood given by experts is constructed as being more reliable and legitimate than any other.

For the women in this study these media representations of breastfeeding sometimes contrasted sharply with their experience as new mothers feeding their baby in the early weeks. The pictures of new mothers in books and videos seen antenatally, constructed for them a powerful image of normal motherhood which the women reflected upon after the birth of their baby. The media depiction of the breastfeeding couple is often romanticised and portrayed as blissfully unproblematic. Pictures of women breastfeeding their infants usually contain a standard pose. The mother is portrayed as being in control. The baby has latched to the breast, trouble free, and provides beautiful eye contact with its mother. The mother looks adoringly at her infant and she is shown beautifully dressed with make up applied and hair styled accordingly. These images do not fit with the lived experience of the women in this study. Some of the women felt angry that these serene pictures were used to promote breastfeeding.

> 'I think the photographs are misleading, these women sitting there, made up to the eyeballs, you know, they are sitting there with a cup of

tea in one hand and this baby on the other and you know, do they look like that at four in the morning?.....I think that's a little bit misleading.' Kate

In modern industrialised societies the transmission of traditional women's lore has declined through the fragmentation of kin networks by social and geographical mobility. Women often reside away from their kin networks making it more problematic for relatives such as mothers, sisters, aunts and grandmothers to be available to advise and support newly birthed women. As kin members might not live local to the woman this might result in her moving into other social groups in order to obtain support and advice about childrearing practices. These social groups might result from contacts through employment, leisure pursuits and childbearing activities such as antenatal classes and contact with health professionals.

Many women have neither had the opportunity to observe other women breastfeeding, nor spoken to other women about it before their own experience. Women may refer to textual accounts of breastfeeding information to help them make sense of the sensations they are experiencing and understand the bodily changes they are witnessing. In both medical and lay literature[17] letdown is described mainly in biological terms. The texts concentrate on the physiology of the letdown reflex, its function and the sensations the woman may feel.

[17] Medical texts are those primarily written for and used by health workers but may be consulted by mothers. Lay texts are those written expressly for mothers, but the authors are commonly health professionals or psychologists.

Physiologically, letdown is described as a neuro-hormonal reflex which can be inhibited by psychological influences (Jolly 1977, Llewellyn-Jones 1983, Palmer 1993). The function of the letdown reflex is explained as being necessary for the flow of milk from milk-secreting cells to the baby's mouth (Renfrew et al. 1990, Ebrahim 1991, Royal College of Midwives 1991, Health Education Authority 1992). Writers often place alongside the scientific explanations of letdown details of the sensations a woman may feel, as guidance as to how she can monitor her body. The sensations of letdown are not, however, described consistently across different medical texts. They have variously been described as: 'a tingling sensation or heaviness' (Ebrahim 1991:12); 'sharp pain' (Ebrahim 1991:15); 'needle-like pain', 'tingling sensation' or 'no sensation at all' (Royal College of Midwives 1991:2). In the lay literature letdown was often described as a pleasant sensation: 'Some women feel....a tingle in their breasts....others will not feel it at all' (Renfrew et al, 1990:73); '(a) sensation of milk rushing in' (Jolly 1977:77); '(a) tingling sensation of the milk pouring from within the breast' (Palmer 1993:28). Even Maher (1992:30) suggests it is pleasurable and fails to investigate the differences between women either individually or across cultures. Hence women are exposed to a proliferation of monolithic discourses which are often in contradiction with each other.

Expectations versus Realities

When examining how the women made sense of the sensation of letdown the interrelationship of biological, social and emotional factors are well demonstrated. This section provides the women's descriptions of letdown where they linked their expectations about the sensation with reality, the here and now. The women's talk

in this section helps to demonstrate the embodiment of breastfeeding. Through their discussions with others the women seek to confirm the normality of their experience. It becomes evident that conflicts between expectations and realities occur. Some images and descriptions of lactation may encourage unrealistic expectations of breastfeeding.

Describing the Sensation

When describing the immediately embodied experiences of the letdown sensation many women struggled to find words to describe the sensations they felt, often using figurative language to illustrate their meaning. The women used spoken images derived from other areas of experience which may resemble common ground of experience that they think they share with the listener. Metaphors and other analogical imagery help the individual to make sense of their world and to convey the actual experience in a culturally meaningful way (Fernandez 1986, Low 1994). Several authors have given examples of how individuals use metaphors to describe chronic illness and distress (Sontag 1979, Radley 1993, Jenkins and Valiente 1994) as well as 'normal' bodily processes (Martin 1989). The women assimilated these new experiences into their familiar experiential world, the figurative language provided maps for the outer edges of subjective experience. Their use of analogies relates to two categories of experience: the descriptions of the initial sensation of letdown and the flow of milk from their body.

The descriptive terms such as 'tightening' and 'tingling', occurred in the books the women had read to describe the initial sensation of letdown. Some women

reproduced these terms in their narratives, as it was the dominant discourse available to them (Martin 1989), however it was evident to them and to me that they did not necessarily convey the feeling adequately as the women would add further layers to the description to communicate the individuality of the sensation.

> 'It is difficult to describe it. It was almost like a tightening and a, a sort of tingling, tightening, as it occurred. Quite intense, but very gentle.' Gillian

For some women this type of description was inadequate and they might speak more graphically or pictorially to ensure the listener begins to understand the nature of the sensation for the individual. The images they used involved examples that were potentially harmful such as glass and electricity.

> 'It was as if small shards of glass were being drawn through the breast, you know, an intense sort of feeling, yeah, as though a pane of glass had been cracked inside you and was being forced out.' Andrea

> 'It is a tingly sensation with an edge to it....something like sparks going off inside you. As though little electric currents are going off inside you that can set your teeth on edge.' Rebecca

When letdown occurred, some women would see visible changes in their breast associated with the reflex action. One woman noticed the lobular structure of breast tissue under the skin which is usually invisible either prior to lactation or when lactation becomes established.

> 'There is this feeling you get inside when you know it's coming. Then it wells up causing your breasts to go hard as rocks, and you can see the breast under the skin, all bumpy and lumpy. It is this intense tightening that is like a cramp but different, something you've never experienced

> before. And you think "this is coming from inside me!", it's wonderful, but boy! it can be uncomfortable sometimes.' Helen

Uncomfortable sensations, described as 'bursting', 'pain', 'hurt', were not expected by the women which led them to wonder whether the sensation was normal.

> 'I don't know how to describe it. It feels like a, I don't know, like a very strong tingling sensation. Yeh, sort of like pins and needles or like a, don't know, like a sort of, I don't know, it's really hard to explain actually. Sort of a tingling, and sometimes it hurts if your breasts are very full. And then you wonder if everything is all right.' Sarah

Although the subject of the letdown reflex does occur in many lay and medical texts the feelings of this sensation is largely omitted from the body of knowledge. In the quote below Abigail describes her concern about the strength of feeling related to the sensation and checks out the normality of her sensation with another.

> 'That's one of the things in the early stages that I wished they'd mentioned at the antenatal classes, and in some of the literature I read. I found the letdown reflex incredibly painful and it came as a complete surprise because I thought it would be, yes I thought there'd be some sensation but nothing as strong, or in my case painful, and when I repeated this to a friend she said "Oh yes, red hot wires brushing your nipples" and I said "Yes! That's it!" I thought yes, that's put it into words now. That might've put me off if I hadn't been so determined to do it. I can understand why mothers who are undecided would find that physical discomfort sufficient to deter them. So I think a little bit more warning about that. And yet some mothers feel nothing at all... [pause] Yes, that was a complete surprise.' Abigail

During the interviews women remarked, with surprise, on the wide variations in women's experiences, believing that other women would be perceiving, or describing, a similar sensation. The women often used imagery associated with flow and movement when talking about the passage of their breastmilk.

> 'I'd say it was tingling. I mean, you'd have the feeling of moving obviously, the milk moving through when she was feeding.' Sharon

> 'It was a flooding sort of, especially when you were full; you could feel it sort of draining.' Tracey

Within their accounts the women would sometimes use analogies to everyday life to describe the flow of milk in the breast. Although the women were aware there was not literally a pump in their breast, they used mechanical descriptions or the 'plumbing' model of the body (Helman 1994) to visualise the passage of their milk.

> 'Well, I always imagined it would be like, I mean it sounds silly, but it would be like petrol when you had to, you put the pump in, then you press the thing, then it goes, it clicks-in sort of thing. I always imagine I feel a pumping sensation.' Charlotte

> 'I expected to feel some movement inside, like a drainage or something maybe. When he went to drink it would just sort of squirt out, you know, in a sort of stream sort of thing. It was like the breast was pumping it out and I had to get him plugged in quick so that he could get the milk. Sometimes it [the milk] came out so fast it was like an overflow, and he'd be covered with milk - so messy! Penny

In these descriptions the women were drawing on scenes from everyday life to convey to the listener what their body felt like. They were using the familiar to

make sense of unfamiliar sensations. As the embodied experience of letdown is highly variable, it is reproduced in language by grappling with terms that give meaning to the user and convey the individual experience to others. The use of analogies and imagery helped the women to make sense of the sensations and provided illustrative accounts of these embodied experiences.

The Significance of Letdown

In the early postnatal weeks, the breastfeeding act is intrinsically bound with nourishing the infant. The rhetoric at this time focuses on the baby thriving and gaining weight, which is dependant on its nutritional intake. The significance of the women's experiences of breastfeeding goes further than being solely the transmission of nutrients to the infant. They begin to experience their body in ways that are different from the pre-pregnant state and try to make sense of changes they are experiencing.

In the medical discourse letdown is very significant for the adequate nutrition of the infant therefore it is inevitable that women try to identify clues they may use to gauge whether their bodies are functioning normally. However several women were confused about when they should first expect to feel the letdown sensation.

> 'They [books] describe it that you'll definitely know when it is happening and I sat there and thought, 'oh I wonder when this will happen'....I was conscious that something was going to happen but it took several weeks... I was thinking 'oh I wonder if I have got a let-down' and then it did happen.' Daphne

The texts the women consulted documented the function of letdown but failed to indicate when it might be first experienced. This led to confusion and concern as some women expected to feel the sensation of letdown soon after birth but did not experience it until several weeks postnatal.

> 'It was about six weeks before I was ever, ever aware of a letdown. I mean I used to think quite often she wasn't getting any milk because I, I wasn't feeling something all the time. I thought that I'd feel the whole time when the milk was coming out and I was...amazed that she'd put on any weight, because I used to think, Oh she's just sucking and sucking air.' Stephanie

Some women may not feel the sensation at all. If they have an expectation that this should happen to them its perceived absence might jeopardise their success in breastfeeding, as there could be a concern that the body was not lactating sufficiently. One woman in the study was concerned about her lack of awareness that letdown was occurring.

> Angela – 'I can honestly say I didn't feel anything.'
> CB – 'Were you expecting to feel something?'
> Angela – 'Yes, a great rush like a waterfall. But nothing'

The perceived absence of the reflex created some anxiety and bewilderment about how the baby could be nourished, especially as it is promoted as being necessary for the physiology of lactation.

> 'I felt as though it was about five weeks until I really got my milk through. Until then she hadn't been taking it very well, she probably wasn't getting much, then I started to feel full... getting that ache and a sort of pins and needles pain..but it took me five weeks, I was very worried that she was getting nothing.' Dympna

Physiologically the reflex is unconditional in the early weeks of breastfeeding therefore the child is being nourished but the sensation is not felt by the mother. It is not until the reflex becomes conditional that the sensation is felt and may be affected by psychosocial influences.

When, after a few weeks, the majority eventually felt the sensation of letdown, the women often expressed relief that they had a sign, even though the sensation may have been uncomfortable, as they viewed this as an indicator that the infant was receiving milk and would become satisfied. A couple of mothers in the study blamed the lack of success with breastfeeding on the fact that they had not felt letdown and assumed, therefore, that the baby had obtained insufficient milk. The women sometimes doubted their ability to feed their baby, even though the baby appeared content and thriving, because they placed greater emphasis on the sensations occurring (or not) in their body. One woman, though, was unconcerned:

> 'I certainly don't feel this reflex thing at all. But, I mean, he certainly seems to be getting the milk, he seems satisfied.' Jean

This woman demonstrates her trust in her body to nourish her infant successfully. The satisfaction of her infant provides the woman with a cue that her lactation is adequate. Other women looked for cues from their baby to monitor the occurrence of letdown, for example: a satisfied baby during feed and after, noises baby makes, movements and actions of babies.

> 'You can see that they are actually getting more, can't you? The gulping noise. I find that, you know, when he starts to gulp you feel he's getting a good feed. It means something, to actually feel it.' Helen

The following accounts describe how women were aware of different behaviours of their infants which they attributed to the altered flow caused by letdown.

> 'She's not frantic any more, it's obviously there, she's more controlled.' Daphne

> 'She makes moaning noises when it hasn't come and that stops as soon as letdown comes in.' Ailsa

> 'He bashes the breast, until it occurs, it's almost like he's demanding it to come in, he's sort of saying 'come on, give me my milk now!' Vanessa

During childbearing a woman will experience significant changes in her breasts. With the process of lactation the woman will be trying to make sense of new sensations. Medical discourse is often used to provide explanations to guide the normality of the experience however women will often seek the opinions of others, such as family or peers, to confirm normality. In breastfeeding the body of the woman is not distinct from the infant's body. A woman may look for clues that her body is functioning properly by means of observations of the body of another.

Letdown - 'A Mind of its Own'

The previous section has demonstrated how women embody the sensation of letdown. However there were several circumstances, such as leaking of breastmilk, when the women would disembody letdown especially when it was

associated with embarrassment and shame. One consequence of letdown is that milk can leak from the breast at any time which may be construed as embarrassing or undesired particularly when occurring at an inappropriate time. On these occasions the women would learn how to manage and regulate their body to minimise the negative consequences. It becomes evident that the women were keen to maintain control of their body to avoid being discredited in public.

The leaking of breastmilk is primarily associated with lactation. After the birth of her first child a woman becomes aware of a new body fluid which has not been experienced before. This section of the chapter examines firstly how the women in this study described and coped with milk leaking from the breast and secondly, how the emotional self becomes more visible within the discussions of the unpredictable nature of letdown and associated embarrassment particularly in the context of bodily control, presentation of self and the leakage of body fluids.

The expectation that letdown would occur during the process of feeding the baby was usually welcomed by the women. However, the delayed response or ill-timed occurrence of letdown led some women to disembody the sensation and refer to it as having a separate identity which needed to be controlled. The use of 'it' to describe letdown in the narrative was often employed. If letdown were troublesome to them, in terms of embarrassment for example, then the women would often bestow a personality on the reflex. At times it seemed the women saw letdown as mischievous.

> 'I had a very embarrassing situation. Suddenly, that was it; I felt it [letdown] and I thought 'Oh my God'. And there it was, leaked all over

the place. My breast pads had failed me. I had two big wet patches...I didn't want it to happen and it did, typical.' Theresa

Several women felt unprepared for the unpredictable nature of letdown which might not occur during the breastfeed as expected, or could occur unforeseeably in response to another baby's cry or for no apparent reason in a public setting. Rebecca talked of letdown as an independent being: 'it was on its own kind of schedule, a mind of its own'. One consequence of this unpredictability was that the mother might have had to 'work' at achieving the necessary response. A paradox of control in the context of breastfeeding is that to breastfeed effectively involves relaxation and *allowing, letting*, letdown occur, rather than trying to force it in an instrumental goal-centred way[18]. Some women recognised factors that inhibited letdown such as anxiety, anger or tiredness, and identified strategies to enable them to relax to encourage letdown occur.

'I found it [breastfeeding] very difficult in other people's company and I could feel I didn't get it that often and I think that's when my problems with breastfeeding really began. At Christmas we went down to my parents-in-law, who I don't know that well, and I found it really difficult breastfeeding in front of them. I could actually feel that I was never getting the letdown.' Stephanie

CB What were you expecting to feel?

'I thought it was just continuous. I just thought that when the baby was on the nipple it was just continuous milk. I didn't realise that it was anything to do with your emotional being. But I could tell as soon as someone came into the room, I could feel it stop. Because I'd be tense and I was

[18] Similarities can be seen with the male erection. It is well documented that erection failure can be associated with performance anxiety, stress and poor self image. The more a man wants the erection, the more elusive it may become.

embarrassed. All I could say was, when I was relaxed again it would happen. I had to really think hard, and encourage it to come and quite often I used to close my eyes and I'd think [pause] and then suddenly I'd feel a tingle and then a sort of filling up.' Stephanie

Another repercussion of its unpredictability was that their breasts sometimes leaked breastmilk which affected women in different ways. A few women experienced very little leaking of breastmilk while breastfeeding. While they were pleased to be spared the embarrassment of dealing with a 'messy' fluid, it caused some to wonder if they had sufficient milk to nourish their baby.

'I had minimal amounts of leaking, I mean at times when he would cry, yes, that would sort of stimulate it. But I don't think I ever had the quantity of milk that was sort of free to leak away, there wasn't that amount there. But in the shower and things it would leak from time to time but not, I don't think to the degree of being soaked or anything.' Rosie

For some women it was a reassuring sign of breastfeeding success, a reminder of their body's ability to nourish their baby.

'I only really leaked at night, it would be in the morning, that's when I'd notice it. During the day not too much really, I found the breast pads soaked up as much as came out. I mean, it sounds silly, but I used to be quite glad when I leaked because I used to think, oh yes, I've got milk. I was so paranoid that I didn't have enough milk to feed her, because, you know, people in the medical profession were making me feel that she wasn't putting on the weight that she should be and therefore it was all my fault. But I used to be really glad, I used to think, oh well I have got milk, and it's there and it was evidence, so....' Stephanie

'I didn't leak much anyhow apart from during the night if she hadn't woken up. It didn't bother me as I kind of felt I must be doing it properly.

> I felt sort of pleased that I had something to show. I was desperate to get those breast pads in (laughter). I had a friend that said, "You know I'd wake up in the morning and there was milk spurting everywhere", and I thought this was going to happen to me. It never did.' Daphne

For a couple of women, the idea that breastfeeding was 'natural' and leaking a part of the course of breastfeeding enabled them to transcend their worries about discrediting themselves in public.

> 'I don't think leaking ever bothered me though, I think if I've had a patch I've just thought 'Oh sod it' sort of thing, I think I've got to the stage where I just think well, this is natural and if other people don't like it they can lump it.' Ailsa

> 'My sweater would be wet down one side, but I never used to let it get me down or anything because I used to think 'Oh, it's just part of it'. The thing is, it wouldn't have bothered me, if I was at someone's house, I think people who know me would have totally understood.' Charlotte

Women found the prospect of leaking on one hand would confirm the presence of breastmilk and provide reassurance but on the other the visibility of their breastmilk became an embarrassment. Breast milk that leaks from the breast and is visible on clothes may be considered 'out of place' (Douglas 1984) as it has crossed a body boundary. All the women in this sample used breast pads inside their bras to absorb any leakage from the breast. They found it irritating that their clothes were sometimes stained by milk and embarrassed if this was seen by others, especially strangers.

> 'I was embarrassed by it because the whole front of my shirt was covered, I had no idea! It was just so obvious, and I was unaware it was there and I just wondered how long I had paraded around looking like

that, because I went through my breast pads like you would not believe it.' Rebecca

'I don't think I would have liked to have walked down the street with everyone else looking at me. I had very little leakage anyway but I mean I would have felt very embarrassed by it.' Penny

There were many accounts about how this aspect of breastfeeding necessitated being in control of an uncontrollable, unpredictable fluid by using devices (such as breast pads) to conceal the uncontrolled from others. This became an issue especially when in the public eye where the woman wanted to be successful at managing her body in public.

> 'Leaking has never really bothered me. I mean I still wear breast pads when I'm out. A couple of times it was quite embarrassing like, I'd open the door to the postman or something and I'd shut it and I'd realise like there's this big stain or something. He must have thought....but you know, it doesn't matter. It didn't bother me, no. I wouldn't say that I leaked that much that when I went out, I never leaked through the pad. It didn't bother me at all.' Tracey

'I am surprised I didn't drown in the night! I was so cold because I would wake up and be so wet. You know I never knew I was spurting....you know I just had to keep changing those breast pads. I think the worst thing about breastfeeding was sleeping with a bra on and having these things [breast pads] packed in you.' Rebecca

The discussions about the use of breast pads created an impression that the women invested trust in these products to protect them from embarrassing emissions, keeping breastmilk invisible from others. This enabled them to maintain the appearance of a well controlled civilised body, albeit one which has the capacity

to disgust (Lupton 1995). Breast pads are marketed as 'specially developed to control the *problem* of excess and leaking milk'; to 'protect your clothes from wetness and staining'; coloured white 'for greater discretion'; to 'ensure comfort and *security*' (my emphasis). Similar wording is used for the advertising of panty liners or sanitary wear; products concerned with incontinence or menstruation and associated with the fear some women have of leaking urine or blood in public (Britton 1996). Hence, these marketing strategies emphasise the avoidance of being discredited in public and the soaking up of unpredictable leaking female fluids.

> Jean: 'I don't actually think they [breast pads] work very well either.'
>
> Sally: 'Yeh, I've had a few accidents, they won't stay in. I kept thinking I had odd shaped boobs or something because they didn't fit.'
>
> Jean: 'And I couldn't understand why I had all these wet patches, you know, and some days I'd have, like, so many [breast pads] in there I'd be like Dolly Parton because I've big boobs, plus about five breast pads in there, and still they'd let me down.'

The visibility of the leaking milk on to the women's clothes caused some women distress. Parallels can be seen to the leaking of other fluids such as menstrual blood and urine when the body is seen as faulty or uncontrolled. One woman in the study was acutely embarrassed if others saw breast milk stains on her clothes and equated this directly with excretion.

> '[Leaking] is not very nice, it's sort of like wetting yourself really. You don't want stains round your clothes, especially if you've got a blouse or something on when it can really show up. Yeh, like I say, it's like wetting yourself, isn't it? It's an involuntary thing. You wouldn't want

people to see wet knickers in public, so you don't want people to see this either.' Sally

These accounts have illustrated how the body may be constructed as being out of control, discrediting and embarrassing the woman in public, an example of how normal physiological processes can be construed as violating norms of 'civilised' bodily comportment (cf. Goffman 1968, Elias 1978). The differences of bodily control illustrate how breastfeeding operates on the edge of human agency, in a context where medical discourses provide mothers with mixed messages about the individuality of control. On the one hand medical descriptions of letdown constitute it as a *reflex* determined by stimulus/response linkages and operating within the autonomic nervous system. This is reinforced by the mechanistic flavour of the hydraulic metaphors embodied in the terms draught, milk ejection and letdown reflex. On the other hand, health education discourse provides information to women in order to foster enhanced rational, individual and instrumental control over bodily processes (Lupton 1995).

Breastfeeding and Motherhood

A woman's transition to motherhood is not confined to the process of birth itself but includes other components associated with mothering. All the women in this chapter made a decision to breastfeed. Women usually make infant feeding decisions either prior to or during pregnancy (Oxby 1994, Purtell 1994). Their infant feeding decision will be influenced by several factors (Foster et al. 1997, Murphy 1999) however the commonest reasons for initially choosing to breastfeed are the health benefits to the infant and mother (Hawthorne 1994,

Foster et al. 1997). Not only are there physical benefits but psychological benefits too. Many mothers believe that breastfeeding is a step towards their concept of being a 'good mother' (Raphael-Leff 1991, Carter 1995, Tarkka et al 1999). For some of the women the sensations associated with breastfeeding accentuated their feelings of 'being a mother'. In the following quotes, two women provide examples of how their body provided a physical reminder of their mothering responsibilities.

> 'I went shopping on my own and left him [the baby] at home with Terry [her partner]. While I was at the bakery I could hear this similar cry to his and I felt this pins and needles sensation, it just felt like everything was going to burst. I felt I had to rush back home to see him for some reason, I just felt as though, you know, it's somebody trying to tell you something, your baby needs you.' Maggie

The physical sensation of letdown, accompanied by discomfort, was a significant reminder to these women that their baby might need them and contributed to the responsibility these women felt for the nutritive and emotional needs of their baby.

> 'And then, I had to go out so I fed her before I left and I rushed out the door and ran to the lift. I got apprehensive when I was out 'cos they [breasts] started to tingle, so I rushed back and said "is she alright?", like that. She hadn't moved, she was still asleep, you know. But I shouldn't 've done it, I couldn't leave her again. It wasn't right. I don't know what I'd 've done if she'd been screaming when I got back. It would break my heart.' Tracey

In this case there seemed to be an emotional association with letdown which was expressed as guilt for being a 'bad mother' when she was unable to attend to her

child. The letdown sensation acted as a significant reminder of the child's dependency on her, even though the child was content on her return.

Breastfeeding may present challenges to the view of 'good mothering' not only to the women but to those around them too. This is not only a concern for women breastfeeding their babies but also occurs for those women who breastfeed their children long-term.

Chapter Four
Breastfeeding the Older Child.[19]

There is no question that breastfeeding the newborn infant is seen as beneficial for both women and baby for nutritional, epidemiological, immunological, social and psychological reasons. In the early months of breastfeeding a mother may be positively influenced and supported by health professionals, family and friends. However, women in the UK who choose to breastfeed their infants into their second or subsequent years may find themselves under a barrage of opinions about the appropriateness of this activity. This chapter presents some findings from the experiences of the long-term breastfeeding women.

The issues that will be addressed within this chapter are:

- The women's views on why they continued breastfeeding
- Managing the cessation of long-term breastfeeding
- Societal opinions about long-term breastfeeding
- How diametrically opposed views led to conflicts.

The focus for this part of the study came after my initial study of women's experiences in the early breastfeeding period. It became apparent that there are some women who choose to, or find themselves, breastfeeding '*long-term*'. There is much written about the reasons why women stop breastfeeding in the UK (Wylie and Verber 1994, Foster et al. 1997, Hodinott 1998) however, why women may continue breastfeeding long-term is a neglected, under-researched activity. Although research is limited in the UK, there is a global research

[19] Part of this chapter was presented at a conference (Britton unpublished a).

interest in long-term breastfeeding in other countries which largely focuses on the protection against pregnancy provided by lactational amenorrhoea (Thapa et al. 1988, Jakobsen et al. 1996, Ramos et al. 1996, Bender et al. 1998[20], Salway and Nurani 1998, Cui et al. 1999); associations with child health (Mulder-Sibanda and Sibanda-Mulder 1999, Onyango et al. 1999); and weaning decisions (Almedom 1991, Mabilia 1996).

Much of the literature linking long-term breastfeeding with lactational amenorrhoea utilises a biological approach to investigate the length of time of breastfeeding, return of menstruation and timing of subsequent pregnancies. Although breastfeeding is positively promoted in other cultures as being beneficial for family spacing there is a distinct lack of importance placed on this biological function in the UK. In fact mothers in the UK are encouraged not to rely on this method at all and receive family planning advice within 10 days of the baby's birth to ensure they are aware of the methods of contraception available to them. In Britain breastfeeding is considered an unreliable method of contraception yet many studies have shown the impact of high intensity breastfeeding on the delay in ovulation (for example Jones 1989, Wood 1992, Ellison 1995).

Some research has been conducted on long-term breastfeeding in the U.S., such as a biological analysis of the age for weaning (Dettwyler 1995b); an investigation of the reasons for weaning (Sugarman and Kendall-Tackett 1995) and explorations of social stigma associated with the practice (Hills-Bonczyk et al. 1994, Kendall-Tackett and Sugarman 1995) but none in the UK. I undertook

[20] Bender et al. (1998) provide a comprehensive literature review of articles related to lactational amenorrhoea and family planning.

to contribute to the body of research by investigating the views and experiences of long-term breastfeeders in the UK. During my research activities it became evident in the literature from Britain and US that identifying a breastfeeding child after one year of age is considered 'long-term', 'extended' or 'prolonged'. This encourages the question long-term, extended or prolonged from what? The fact that this activity is debated at all indicates that it transcends a norm of British society.

In the UK, statistics are collected by the Department of Health to determine breastfeeding rates. However there is a lack of information about breastfeeding rates after 9 months. It appears that breastfeeding after 9 months is considered an irrelevant activity in terms of child health. Current governmental guidelines suggest that a baby should receive breastmilk for the first 4-6 months of life (Department of Health 1994), therefore breastfeeding after 6 months is not actively encouraged. Artificial formula milks are promoted as being equivalent to breastmilk in their composition. A widespread view in British society seems to believe that once taking nourishment from other foodstuffs the infant probably does not need breastmilk.

For all of the women in this part of the study the experiences of breastfeeding their first child affected their breastfeeding decisions for their subsequent children. 75% of the sample[21] breastfed their first child for at least one year. None of these women had made a conscious decision to undertake long-term breastfeeding. Several women said they had expected to breastfeed for a few

[21] Four primipara and eight out of the twelve multipara.

months expecting their child to wean itself from the breast. When this did not happen they were happy to continue. Two women had unsatisfactory breastfeeding experiences with their first-born and this influenced their breastfeeding decisions for the next child. Prior to their own experiences of long-term breastfeeding none of the women had witnessed other women breastfeeding past infanthood. They did not learn from other women until they actually encountered the experience themselves and some women then turned to literature and support groups to validate their decisions and gain information.

These women were aware that the nature of the breast contact they had with the older child had a different meaning in comparison to the breast contact in the earlier breastfeeding period. The frequency of breast contact should also be considered. For those women who were currently breastfeeding at the time of the interview 28.5% were only breastfeeding at bedtime and/or at waking; the others practised child-led breastfeeding when the child could have several nursings day and night. All these women had introduced their children to solid foodstuffs and other fluids while continuing breastfeeding. It was difficult to quantify the frequency of daytime nursings as they fluctuated according to the child's needs and the day-to-day movements of the mother and child. If the child was absorbed in other activities, such as play, then breast contact could be sporadic. For example, a child who needed comforting and was at home might breastfeed more than during a day when he/she was interacting with others and out of the home. One mother who was currently breastfeeding a two-year-old commented that her child could, in some circumstances, be breastfeeding almost continuously during the day, and several times during the night.

However another mother with a similar aged child tried to restrict the breastfeeds to night time only but would allow the child to suckle during the day if she became distressed. Although the women were largely child-focussed and led by the needs of their own child to a greater extent, it also became obvious that the breast contact generally occurred in the home rather than a public activity.

Women's Views on Why They Continued Breastfeeding

The first part of this chapter focuses on the positive aspects of long-term breastfeeding for both the women and their children. The investigation of the women's views regarding the reasons why they continued to breastfeed long-term provides an insight into the meanings that this activity had for the women. Consideration is given to determinants that shaped the women's views of their breastfeeding activity. The women's previous experience of breastfeeding seemed to influence their infant feeding choices with a subsequent child. In the narratives the women strongly identified with breastfeeding as being 'natural' and symbolic of being a good mother. When clarifying the benefits of breastfeeding to their child the women drew on biomedical facts, however the emotional benefit to the child was dominant. Although these women were ultimately focussed on their children, when they discussed their reasons for stopping breastfeeding, it became apparent that their own needs became paramount.

Therefore, within this section three key areas that were influential to the continuance of breastfeeding a child over 18 months of age will be discussed:

- Initial experiences of breastfeeding
- Breastfeeding as "natural".
- Breastfeeding and 'good' mothering.

This section concludes with a commentary on why and how the women stopped their breastfeeding activity.

Initial Experiences of Breastfeeding

When the women talked about their first experience of breastfeeding they seemed to be guided by the medical and societal norms that their baby would breastfeed for a few weeks or months. In their narratives they reflected back to their initial thoughts about breastfeeding and considered what they thought was an appropriate length to breastfeed.

> 'I hadn't envisaged it being more than sort of 6, 9 months, maybe a year, but I think by the time I got to 3 months I felt as though I was just beginning to get the hang of it, so I wasn't keen to introduce solids early.' Tina

> 'I think I thought I would do it maybe 6 months to a year....I hadn't really planned to go on this long anyway, but he'd obviously wanted to' Liz

In the popular literature available to women about baby care and infant feeding the dominant discourse is that exclusive breastfeeding is encouraged for the baby's first four to six months. According to UK governmental guidelines

(Department of Health 1994) exclusive breastfeeding is encouraged for at least four months with solid foods being introduced thereafter for nutritional reasons (McDade and Worthman 1998). Within the first months following the birth it is common for parents, usually mothers, to receive advice about timing the introduction solid foods. Often this advice concentrates on the type and texture of the initial foodstuffs with little attention given to the continuance of breastfeeding during this process. This is contrary to the view of the World Health Organisation (WHO 1989), which recommends that breastfeeding activities should be encouraged until the infant is two years old.

> 'When I was pregnant initially - I didn't know, I think I hadn't read enough at that point to – I thought children were weaned by themselves around 6 months I think.' Alex

Once parents are exposed to the discourse of weaning there is a social coercion to affect a transition to 'adult-type foods' and appropriate drinking vessels such as beakers and bottles (Morse and Harrison 1987, Lupton 1996). Objects associated with weaning such as spoons, beakers and bottles are visible markers of status and identity (Douglas and Asherwood 1979). These articles may act to demonstrate the civilising of the infant and provide a public statement about the development of the child.

The women's first experiences of breastfeeding long-term were largely positive and this guided the women to consider breastfeeding for as long as, or longer than, with subsequent pregnancies. One woman exclusively breastfed her first born for eleven months and found the subsequent introduction of fluids with a bottle problematic. With her subsequent children she believed she should

introduce fluids by bottle as early as possible to enable others to feed the baby if necessary. However this did not mar her commitment to breastfeed future children long-term.

Two multiparous women, who were committed breastfeeders, had unsatisfactory breastfeeding experiences with their first born.[22] With the second pregnancy these women had considered the importance of breastfeeding for them and explored the difficulties they had encountered to help breastfeed their second child more successfully. For one woman her whole child-rearing philosophy changed due to the experience. The following narrative is Linda's story which has been abridged from the original.

> 'I gave up {breastfeeding} at 8 weeks with him, I just found it increasingly difficult coping with a new baby, being a first time mum. Coping with the breastfeeding demands in the early weeks was very, very difficult at times. He was a big baby and was one of these that enjoyed nursing a lot, so I gave up at about 8 weeks. My husband was keen to help and said "I will help if you bottle feed him, I can help you." Obviously I look back on it and think I did so many things that I could have made easier for myself - like sleeping. When he went into a cot and things like that. I could have slept with him and I would have rested, he didn't like being put down, he wanted to be held.'

When I asked her why she didn't have the baby in the bedroom or in the bed with her for breastfeeds she replied:

> 'I didn't believe that. I suppose I was following the norms of our culture really in bringing up your children. You've got to show them who's boss, you've got to show them that they've got to sleep. I couldn't hack the

[22] Two other multiparous women curtailed breastfeeding at nine and eleven months of age reporting positive breastfeeding experiences.

crying it out business, we tried that {once}, going up every 10 minutes. We couldn't hack it - but then I was firmly against having them in my bed and said no way. And I found it difficult to feed him lying down. When I was pregnant with my second son, I felt I've got to get this lying down business sorted out because I realised that that would be the key to making my life a lot easier and while I was pregnant I'd read 'The Womanly Art of Breastfeeding' by La Leche League and that opened my eyes really. I thought wow, there's so much I can actually do to make my life easier, you know, with breastfeeding and coping with sleepless nights in the early stages. So we took him into our bed and then we brought the two year old into our bed as well. From him growing up sleeping alone, he was then sleeping with us because we had the baby in as well and he used to find it difficult to cope with. I think he felt quite isolated. And then when the third one was born it went the same way. But with my second son I became involved with La Leche League, because I was determined to break through that barrier which is always common with the early stages of breastfeeding. I thought I'm determined to get through that and then see how I feel. There I met people who did share their bed with their children – that's when we moved the older one in – they helped me realise that I had to follow my instincts.'

The initial experiences of breastfeeding were highly influential to these women in determining subsequent breastfeeding behaviour. With their first experience of breastfeeding these women did not have preconceived ideas regarding the anticipated length of breastfeeding – this evolved as they became more accomplished mothers and determined the importance of the activity to them and their child.

Breastfeeding As "Natural"

In this study, a dominant discourse that emerged was the women's concept of breastfeeding as being natural and its attribution to the positive image of motherhood. When the women discussed their reasons for continuing breastfeeding many of them (50%) specifically drew on the notion that the activity was 'natural' and contributed to their understanding of being a 'good mother'. Within the women's narratives they used terms such as 'I felt it was natural'; '...to me it just seemed natural, that's what it was there for... it just seemed the most natural thing in the world'; 'it's natural, there's no other way'; 'it feels like mother earth'. Although none of the women set out to breastfeed long-term initially, it seemed that their beliefs in 'naturalness' grew during the time they were breastfeeding and led them to question why others failed to breastfeed or curtailed the activity early.

> 'I think it's completely normal, if a mother has milk, has enough milk for her baby, she really ought to give it to him.' Gabby

The women's concept of breastfeeding as being natural was linked with their image of motherhood and good parenting. Some women expressed their personal satisfaction as 'knowing that you are doing the right thing'; 'when I gave her my breast, for me, that was the achievement of motherhood'; 'I was just looking after a baby, it was part and parcel of the whole picture'.

Breastfeeding and 'Good' Mothering

Women in this study had not witnessed other women breastfeeding toddlers, nor had they talked to other women about their experiences. It seemed relevant for me

to try and understand events in the women's lives that encouraged them to continue with this breastfeeding activity considering they had no role models or information to persuade them to continue.

Generally parents are anxious to perform child-rearing activities to the best of their ability. The woman's understanding of the benefits of breastfeeding to her own and her child's physical and emotional health reinforced her willingness to continue breastfeeding. The women discussed at length the advantages of breastfeeding their children long-term in terms of the impact of the activity on their child. When they discussed advantages of breastfeeding for their child there was an underlying message that this was also reinforcing their concept of being a good parent. The main themes that emerged are relevant to the social qualities of motherhood (Phoenix and Woollett 1991, Woollett 1991, Richardson 1993, Hays 1996). The women identified that breastfeeding contributed not only to their own need of fulfilment of mothering but also to their role of providing food, love, protection and encouraging independence. Each of these issues will be discussed from the woman's perspective, presenting her thoughts and feelings. In section two the issues will be revisited as each point was also a source of conflict with others for the women.

Personal Fulfilment of Mothering

One woman strongly equated her long-term breastfeeding activities as a positive representation of motherhood - "I mean for me mother represents - 'I'm the base' from which they go out into life". Another woman gained

personal satisfaction from breastfeeding but also felt encouraged that there was public knowledge of her achievements.

> 'I feel it gives me a sense of well-being, the whole sort of feeling that I've breastfed them for that long. It's an achievement - without doing it for an achievement at the time. I didn't think of it at the time - but now I'm very proud, I'm really pleased, and it backs up everything I feel. It's so nice to be able to talk about breastfeeding and when people say, "Did you do it?" I can say "Yes," and when they say "How long did you do it?" I can say "A year and a half and two years." I like that, that gives me a bit of a buzz to be honest, that I did it - I didn't do it for any sense of a buzz at the time, it was just the way you did it, it comforted you.' Patricia

This fulfilment can aid the sense of identity and status that the woman perceives she has achieved. Although long-term breastfeeding could be problematic for the woman and her family there was an overarching sense that it contributed significantly to the woman's self esteem.

Food

During the newborn period, the dominant belief of the women was that breast milk had predominantly nutritive properties. The women's views changed with the age of the child. As the children began to take solid foodstuffs the importance of breastmilk as a primary source of nutrition diminished. However 60% of the women believed their child was benefiting nutritionally from the breast milk. These women of two-year-old children were convinced of its nutritional benefit.

'He doesn't drink ordinary milk....so I feel that it is more balanced, that he gets it (breastmilk) regularly. I think it probably does actually do him a lot of good nutritionally.' Liz

'I know that the milk is very nutritious, I know he does need more than that – it is a bit of a circular thing, because at the same time I think if he wasn't feeding so much he would eat more.' Sophie

The nutritive value of the breastmilk became more significant when the child was considered a poor eater or was unwell.

> 'It made me feel good that I was still breastfeeding because they weren't eating much - and people would say "oh they're not eating much because you're filling them up with the milk".' Alex

The quote above highlights a common conflict that many of the women encountered. Some of the women suggested that health professionals 'blamed' the breastfeeding activity for causing poor weight gain in the child or for 'interfering' with the appropriate ingestion of solid foods.

The mothers who did not see breastmilk as nutrition still valued the properties of the milk and commented that although it wasn't 'food' the child might receive vitamins and fluid. However the most significant property of the breastmilk was described as 'liquid love' – the provision of comfort.

Love

The love and emotional attachment the woman felt towards her child(ren) was associated with their breastfeeding activity. The 'bonding' relationship that

developed between woman and child was significant in her drive to care for her child appropriately. The women spoke about the closeness of their relationship with their breastfeeding toddlers and felt they had a unique bond that had been strengthened by breastfeeding.

> 'The benefits to you with long-term breastfeeding - that would be the bond with your children.' Selina

Those women who had not successfully breastfed all their children spoke about differences they perceived in the closeness of their relationship with these children. They would comment that the relationship with those children where there was premature cessation of breastfeeding was not as close. Although these thoughts were important to the women it is impossible to know whether breastfeeding was the only influencing factor.

The most commonly discussed reason for sustaining breastfeeding was related to the provision of comfort. Many of the women spoke of their own feelings of comfort when breastfeeding. Victoria described her breastfeeding episodes with her children as 'mummy time'.

> 'I saw it (breastfeeding) as comfort and closeness, and this 'mummy time', and cuddly. It was just every bit for me as it was for them. It was the closeness, it was the comfort. It's just a loving thing – it's not a sexual thing, it's loving.' Victoria

However, the main focus was on how breastfeeding was a source of comfort for the child, or the woman's ability to provide comfort by the breastfeeding act.

> 'I know there must be something in it for her and I know that she wants that closeness and comfort with me.' Marie

'I think it's sort of giving them the chance for comfort really, and to feel secure - I believe it gives health benefits early on and obviously that's their food, but as time goes on I suppose it's more of an emotional thing really?' Ann

'...the other benefit was not so much physical, but psychological - at that age they're all falling over and it was easy enough to comfort her after a tumble or whatever by just giving her a feed, which is nice.' Eve

Most of the long-term breastfeeders would offer breast contact 'on demand' which might occur in response to the child's distress, habit or routine – at a particular time of day- or for no obvious reason. Women who conducted their child care in this way were bemused about the strategies non-breastfeeding mothers had to comfort their children.

'I don't know how other mums [not] breastfeeding cope with comforting their children in crisis.' Eve

The provision of comfort to the child is the area of most conflict for the women. Members of their family and others would offer opinions about the appropriateness of the activity in relation to the child's age. This aspect will discussed later in the chapter.

Protection

All these women were aware of the health benefits of breastfeeding which are commonly discussed with new mothers. It became obvious from the narratives that these women continued to believe that there were beneficial health properties in their milk. Although the women had mixed ideas about the

nutritive benefits of long-term breastfeeding they were convinced that breastfeeding was influential on the child's health. Most of the women believed the constituents of the breastmilk had prevented the child succumbing to infections.

> 'I felt it gave him some sort of protection, antibodies and whatever.' Victoria

> 'They had about 3 colds since they were born, they've been extremely healthy. They never get colds, really bad colds - I mean Melanie's had one, but it wasn't so bad. At the toddler group all the children seemed to be getting colds but they are really healthy. I mean the longer you feed them then the stronger the immunity - it is developing up until 5 or something.' Alex

There is scientific evidence to demonstrate that the child continues to receive immunological benefit throughout the breastfeeding period (Gulick 1986, Wray 1990). The women believed their breastmilk had many enhancing properties which benefited the sick child, such as antibodies, nutrition, fluid and comfort. Two children succumbed to serious illnesses in toddlerhood. Their mothers discussed how they gained consolation in breastfeeding them; not only as a comfort but also to provide fluid and nutrition.

> 'I thought at least she's getting this both in terms of fluid and the best possible food for her. And any sort of immunity advantage is probably minimal at this stage but at least there was a slight advantage.' Tina

> 'When they are poorly they just revert back to the breast – you don't have any worries, don't need to worry about getting food into them. The only thing he would take was breast milk. Although he vomited some of

> it up, he kept some down, so that was lovely to know that you could keep your child hydrated.' Patricia

Three women spoke about the health gains of long-term breastfeeding with particular reference to reducing the risk of asthma or eczema. Several women and their partners had a family history of allergies and for them breastfeeding was a way to minimise the risk to the child. Although there appears to be a reduced risk of allergies to infants who are breastfed (Golding et al. 1997), there is considerable debate regarding the long-term allergy prophylaxis provided by breastfeeding (Kramer 1988, Cunningham 1995).

However not all the women witnessed the health benefits of breastfeeding. Even though the women knew that there was evidence that breastfed children have fewer infections the following women had children who succumbed to numerous infections despite being breastfed.

> 'I don't know whether they've been healthier for it - I don't really know – they've been relatively healthy children, but ironically they've both had quite a lot of problems with their ears, which of course you know that breastfed babies are supposed to have less problems. Maybe it would have been worse, but I'm just so pleased that they've had it {breastmilk}.' Patricia

> 'My kids weren't a bit immune. The first two got everything before they were three months when they were solely breastfed. They got German measles, chickenpox....so....my immunity must be pretty poor. I know it's supposed to be good but it didn't work.' Tina

These women were in dissonance about what they had been led to believe would be the health status of their child but this was not borne out in reality. They made sense of this by suggesting the children would have been more ill had they not been breastfed.

Encouraging Independence/Character Forming

Interestingly, some mothers felt their children would benefit emotionally and become more independent by being breastfed long-term. This is a direct contrast to the popular view that the continuation of breastfeeding may reinforce dependence on the mother (Jackson 1992, Bates 1997, Moorhead 1997).

> 'I'm quite sure that in the future that all this investment will pay off and that they will be independent enough by the time they are 6 or 7, they won't need me at all as I've been working on the long-term picture rather than the short term.... I think it's teaching them that I'm there for them, that the world is a good place - they are loved - and I think it's going to give them great confidence in the future.' Alex

> 'The breastfeeding makes a very solid base for that exploration into the unknown....so I hope that it will support them to be more confident in the world.' Selina

Several women spoke about their perceptions of how breastfeeding had effected the personality of their child, what could be said 'character forming'. They would use words like 'strong willed', 'confident' and 'self-sufficient' as positive personality traits of their long-term breastfed children. Not only was

breastfeeding seen as influential of the child's personality but also some comments were made that the child's personality may dictate the need to have long-term breast contact.

> 'My personal view is that their personalities determine their breastfeeding patterns.' Patricia

Women who had not breastfed a child for as long as they wished remarked how they linked the personalities of their children with the differing breastfeeding activities.

> 'I am still very close to her but I do feel out of all my children the one that I perhaps have the most problem, personality wise, with was the one that only breastfed for 10 weeks...I don't have quite such a close bond with her' Victoria

> 'It's a much closer relationship - but then again, he's a different personality...he's very laid back, very easy-going, whereas Mary's a real worrier... you can analyse that as well and think well why? There could be a lot of reasons for that - but, yes, we certainly had a very close relationship because of it - and I think he's very secure in his life, he seems to be able to deal with most things that come upon him, really – I know you can't put it all onto the breastfeeding, but I'm sure it has influenced him.' Jackie

> 'I do sometimes think Brian's behaviour is the way it is because he didn't breastfeed long [8 weeks]...I don't know if it's the separation, the tactile deprivation that he had or whether it's just his personality – it's hard to tell - but it does make me wonder.' Linda

> 'I'm convinced that he would be different if I hadn't breastfed him - I can't tell you how, but I'm sure it was important that I did it.' Gabby

This group of mother was convinced that their breastfeeding activity had beneficial influences on the character of the infant and their prospective long-term relationship with their child.

When to Stop?

Within these discourses the women are often unsure how sevrage from the breast will take place. Although considerable attention is placed on supporting women to breastfeed, very little attention or guidance is forthcoming about diminishing breastfeeding contact. Some women were unclear whether this would be a mother or child led activity.

The women in this study had no preconceived ideas about how long they would breastfeed their children for but during their conversations they expressed opinions about the appropriateness of breastfeeding the older child. Many of the women thought it was appropriate to breastfeed into the third year but strong reactions were expressed by the women about breastfeeding a school aged child. The transition to school appeared to be a key factor in deciding whether it was still appropriate to breastfeed. This is interesting as almost all the breast contact these women had with their breastfeeding children existed in the home and therefore it could have been a discrete activity.

The opinions expressed were mainly about the feelings the women had about the activity. Some women had come across five-year-olds who were still

breastfeeding. Many of these women wanted to be empathetic but found it hard to justify the activity. Women who considered themselves to be pro-breastfeeding struggled with their beliefs when considering other women's breastfeeding histories. While they had breastfed long-term they acknowledged difficulties in supporting other women's breastfeeding activities which crossed their boundary of social acceptability.

> 'I've got a friend who is breastfeeding a 5 year old, and I feel uncomfortable with that. I would never tell her that because I feel that's appalling that I feel it, but I do. I suppose it's the society that we live in. And I think God, if *I* think it, (her emphasis) what do other people think. I do find that a bit peculiar, you know for a child of 5, but that's her prerogative and that shouldn't be for me to judge, but it's quite bizarre that I feel the way I do as I am so pro-breastfeeding, but I still feel uncomfortable about it.' Patricia

> 'Actually I remember being at a group and seeing some older children breastfeeding, about 5 {years old} and I thought that was taking it a bit far, you know.' Selina

This woman, Selina, had breastfed each of her four children for at least two years, the longest being until the child was four years of age. However when considering a child of 5 years breastfeeding she had a clear notion of what was acceptable.

> 'They are clearly not very small children any more - it just doesn't seem appropriate. Actually the child needs to move on – that's my perception - that actually some of the mothers are keeping their child from growing up in maintaining that.' Selina

One woman was empathetic but acknowledged that her view was unusual. She was aware that the societal norm would not encourage this point of view.

> 'I do know women who still do nurse 5 year olds when they are particularly desperate. I think a lot of people think that is rather sick, but for me it's not, it's healthy. I think it's healthy anyway, that they can come to you and something so simple and so natural that they can get so much benefit from, emotional benefit from, I think it's lovely.' Linda

Desperate situations might be classified as when the child is ill or needs comforting. The context of the mother-child interaction is providing comfort in response to an occasional need of the child; it is clearly not a regular, constant activity.

Not all the debate about appropriateness focused on the mother, some reference was made about how it may affect the child. This mother was concerned about how the child may feel different

> 'I don't know I would have gone beyond the school age, because I think that it may have made them feel different - because we don't do it, it isn't done in our culture really....though maybe I was happy to go along with it up to school age, yes I think I would have - I had no qualms at doing that - it would have stopped once they went into school.' Victoria

The experience of the following mother being in contact with other women who breastfed older children had a positive influence on her decision to continue breastfeeding.

> 'I was going to La Leche meetings and seeing older children still feeding. I saw a 4 year old girl who had come home from school and she was in her school uniform. She went to her mum and had a drink {breastfeed} and I thought this mum was a bit strange anyway. She

seemed like a very spacy kind of a person and I thought then that she was probably doing it for her own needs, you know, she needed this contact with her daughter. But now I realise that it's not the case, you couldn't possibly do it for your own needs, because I think as they get older feeding becomes less comfortable and they are sucking stronger, their mouths are bigger. It's not as pleasant as when they are a little baby, so I'm quite convinced that the older children get, the more patient the mothers are. But going to La Leche League and seeing the older toddlers nursing - I just thought that was really nice - that looks right and so I wanted to do that too.' Alex

Individuals form opinions about child rearing practices from a variety of sources such as their own upbringing, popular opinion and authoritative texts. In some cases, their views about appropriate childcare may only be challenged when the individual is confronted with similar issues in their own life. In the example above, it was not until Alex, herself a mother engaged in long-term breastfeeding, found herself in a similar position that she felt she could empathise with what she had previously seen as strange behaviour.

The Significance of Stopping Breastfeeding

Most of the women expected their children to wean themselves from the breast when they were ready. For some this occurred but for the majority of women they had to influence the cessation of breastfeeding, which for some was initiated by the opinions of others. The women had few resources to turn to for guidance about encouraging the child from the breast. The women stated that long-term breastfeeding was absent from childcare books and they had no experience of other women doing this. In the absence of the child taking control of the stopping process the women's needs became dominant in influencing

timing. Some of the women had, or were preparing to, return to work and felt it was appropriate to curtail breastfeeding. Many of the women felt tired of, and with, breastfeeding and felt the child had reached a suitable time in their development to cease the activity.

> 'I had got to a point where she would not sit down on my knee during a story without wanting a breastfeed.' Tina

> 'I did feel quite tired doing it this frequently....this is why I decide to stop, I thought it would do me good to stop.' Ann

> 'It was just for me {that he stopped}. I was getting to the point where I didn't want a baby or toddler feeding anymore. I had just had enough.' Patricia

However, the cessation of breastfeeding was clearly not an easy process for the women. They expressed many emotional feelings associated with the act of termination of breastfeeding which were related to the effect on the child and the effect on the woman. Some of the women felt guilty that they had instigated the cessation of breastfeeding as they were committed to a child led philosophy.

> 'I felt that I had upset her because I had taken away her thing that made her happy.' Victoria

> 'It's like them having a teddy and saying you can't have it any more, it doesn't belong to you.' Breda

Although several of the women had taken a lead in stopping breastfeeding they often felt saddened about their choice.

'I can remember that feeling - that's it now – I'm finished. I'll never breastfeed another baby and I remember that feeling of sorrow. I think it's such an emotional thing - it almost severs that particular bond, it's like the umbilical cord, you just cut that bit that can never be put back, however much you love them, however close you are to them. There's something - it goes beyond that and they are still part of your body. I think it's the emotional thing - I think books, are lacking on advice on that – how to wean them off. I think it's how mothers can cope with the weaning process, not just the child, because I think it affects the mother probably more - you suddenly feel yourself sort of drying up and it's an end of that era.' Victoria

'I felt a bit sad because at that point I wasn't planning to have any more so I thought this is the last time I am ever going to breastfeed – as it turned out I was wrong. Whereas when I stopped with Adam I was already pregnant so I knew that I would be doing it again pretty soon. I suppose that made it more difficult to say no when she wanted it.' Ann

'I must admit I was a bit disappointed because it was a nice habit.' Gabby

In order to encourage the child from the breast the women deployed strategies to ease the child from the breast (Table 4.1).

Table 4.1

Strategies used by the women to encourage cessation of breastfeeding.

Strategy	% of women who used this to influence cessation of breastfeeding
Child denied day to day contact with the breast	37.5%
Child naturally tailed off	31.25%
Parent went away for a weekend	12.5%
Child was sent away for a weekend	12.5%
Mother told child breastfeeding was painful	6.25%

One woman had been advised by a health visitor to encourage the child from the breast by pretending the activity hurt the woman.

> '{the health visitor} said that every time she came near me I should say "Ouch! That hurts!" She didn't want to hurt me so she stopped. I can always remember that look in her eye and I felt really guilty afterwards, that was awful.' Victoria

Some women tried to negotiate their child from the breast believing they could be persuaded to terminate the breastfeeding activity. One woman explained to her daughter that she could have unlimited cuddles and hugs during the day if she didn't demand a breastfeed. Some women used the age of the child as a persuading factor requesting that the child now demonstrated they were a 'big girl/boy'. The persuasive discourse was usually to say 'milk is for babies, you are not a baby any more'. One woman offered the child a gift, a pushchair for her dolly, if she demonstrated she was now 'a big girl'. The woman claimed this was a successful strategy as the child ceased to breastfeed after receiving the gift. Other women created a distance between themselves and their child to avoid breast contact. Either the woman went away from the home, or their partner or family member took the child away for a few days. This is similar to practices found in other cultures to influence separation from the breast where women may wear restrictive clothing to prevent the child accessing the breast (Dettwyler 1987); or use herbal preparations on the breast which have a bitter taste causing the child to reject the breast (Reissland and Burghart 1988).

The Social Context of Long-term Breastfeeding

In this section the focus will be on the social context of this activity exploring the reactions of others to their breastfeeding activity and how the women were affected by the conflicts which occurred. During the women's breastfeeding histories they had come across a wide range of opinions about *when is too old to breastfeed a child.* The women stated that they had heard from others when it was inappropriate to breastfeed. Common comments were that once a child wore shoes or could articulate what they wanted then the activity should stop. Another common thought was that once a child had 'a mouthful of teeth' then it was time to be off the breast.

The women often reported that their practice caused others to react, often with astonishment that they were 'still breastfeeding'. It seems central to this debate to consider why strong feeling arise about the appropriateness of this activity. For some there must be a notion of what can be expected of a child at certain ages. While these women felt confident and content with their decision to breastfeed, others could be the source of support or tension. In chapter 6 the influential opinions of others (family, friends, health professionals and strangers) will be expanded upon. The major conflicts that these women encountered were tensions which arose between their drive to continue breastfeeding and regulation by others who tried to persuade them to stop.

Regulating Long-term Breastfeeding

Within this section two key issues will be used to demonstrate the attempt by others to regulate the woman's breastfeeding activity.

- Breastfeeding and motherhood
- Media representations

Further discussion will incorporate how the women conducted their breastfeeding activities in a clandestine manner in order to protect from the opinions of others.

Breastfeeding and Motherhood

In the previous section the social qualities of motherhood, namely nutrition, love, protection and independence, were used to categorise reasons that encouraged a woman to continue breastfeeding her child. As breastfeeding is generally seen as primarily a source of nutrition conflicts arose when others doubted the importance of continuing the activity for the older child. For others, these were children who were taking solid food stuffs therefore did not now require breastmilk. It has been previously discussed that for many of the women their breastfeeding activity was not seen as essentially nutritive but largely for comfort and to promote their feelings of mothering. These qualities were not endorsed or seen as important by others. Conflicts often arose when the woman's motives to continue breastfeeding were questioned and they were exposed to the opinions of others. One of the most contentious issues was whether the child still *needed* breastmilk.

The women were not continuing to breastfeed their child primarily to provide nutrition. In the main, the general opinion was that health professionals were not supportive or knowledgeable about long-term breastfeeding. Health visitors gave opinions about links between sleeping patterns and dietary habits and the influence of long-term breastfeeding. The following account deeply distressed

this mother as she perceived several of her mothering skills being questioned by the health visitor. The health visitor felt the child should be putting on more weight and advised her to curtail her breastfeeding activity and feed him 'more appropriate' foods. As her partner had just left her she was trying to minimise the effect on her infant. She believed that continuing to co-sleep and providing breast comfort to her child would be beneficial in the circumstances.

> 'The one that I spoke to (health visitor) said that I should stop the night feeding, but at that time I had just split up with my partner and he'd just left. I was obviously feeling bad anyway and I thought that it was a bit much. His dad going and then me stopping feeding him and putting him in another room, which is what she said to do - yes she was suggesting that he should go in another room as that was why he wasn't eating. Liz

The way Liz dealt with this was not to follow the advice of the health visitor but consult with others.

> 'I didn't really co-operate - I mean I know she probably knows better than me really, but I just would talk to friends and things and I just didn't think that that was what it was. I spoke to other friends with children that don't eat and it didn't seem to have anything to do with whether they were breastfeeding or not. He's still in my room now. He does feed a lot at night and that was what they were saying - that he was getting most of his calories at night, that was why he wasn't eating, but it's maybe true to some extent, but I'd rather think the other way round – I'd rather get him eating properly first and then cut down.'

Health visitors told several women that a child who was waking in the night could be encouraged to sleep longer if the breastfeeding activity was discontinued. If a child was not showing much interest in foodstuffs then the health visitors might encourage the woman to curtail breastfeeding as the child

was seen to be 'filling up with breastmilk'. Weighing of the infant became a successful tool to encourage the termination of breastfeeding. Conflicts often arose where the woman believed her child was developing normally but the health visitor felt the child was not putting on enough weight. For the women who were persuaded to curtail their breastfeeding they reported that the child was still not a good eater and they failed to see the significance of advice. As many of the women did not equate their breastfeeding activity as primarily nutritive it is not surprising that their explanatory models were in conflict with those of the health professional.

Others did not acknowledge the comfort women believed they were giving their children by breastfeeding as important. In the narratives it became apparent that some women felt others equated this closeness as verging on the sexual. Several mothers felt others wanted to regulate their breastfeeding activity because there was a sexual inference associated with the activity. Few women had open dialogue with others about this aspect but had a sense that the image of an older child at the breast was constructed as sexual by society at large. The implication was that the women were doing this to satisfy their needs.

> 'That's how people see it I think, sex and perverseness... if you are putting a child to the breast to suckle, it's not really having a good feed so there is something perverse about the mother.' Patricia

> 'I think it is the culture and the social backgrounds that we come from. We find it very difficult to see a child at the breast at such an age... It's all wrapped up with some deep feeling that we have, breasts play a very sexual role in our country and we have got concerns regarding that. When

are they all right for feeding and when are they all right for sex? We can't combine the two.' Radio York 1998

In the UK the use of pacifiers and bottles are readily used to comfort a child but the use of the breast to fulfil this role is not deemed appropriate

Another form of social regulation was apparent in the form of storytelling. Several women had heard stories about school-aged children being breastfed. When the stories have not been experienced first hand it is difficult to know whether these stories are myths acting as a form of social regulation. They may act to demonstrate the child's dependence on the mother and social humility to the mother where she may be seen as an outcaste by society for continuing the activity.

'I was speaking to my children's great grandfather about breastfeeding – he's 86 - he told me this story. He remembers starting primary school and being in the playground and one of his friends... his mother used to come to the school railings at play time, at dinner time, to nurse him - and she used to nurse him through the playground bars. I thought, wow - in those days - in the 1920s - it was acceptable.' Linda

'Somebody said to me that they knew somebody that was feeding theirs at 7 {years}. I mean that really like repulses me, but I think it's a bit strange, I don't know why - but it's just like what people think, isn't it? That's what you've been brought up to think.' Breda

'Well my friend, she was saying that her Auntie did it {breastfed a six year old}. I mean I could not imagine, like Alan is 6. I couldn't imagine him coming in from school and {breastfeeding}. I think it's a bit strange – surely. My friend said that was really embarrassing, she said she

> remembers a family get together and this little child just jumped up on the mum's knee, 6 or 7, and just got it out, she said she was horrified – didn't know where to look or what to say.' Breda

The above 'stories' concentrate on common themes that have been reproduced by others, namely the inappropriateness of the activity and the consequence of the action – a child's dependence on her/his mother. It could be concluded that these stories operate as urban folklore. These myths reiterate and reinforce beliefs about the world (Kahn 1995), and provide a framework for dealing with ambiguous and anomalous events (Douglas 1984).

Media Representations of Long-term Breastfeeding

Not only did the women have to confront others' personal opinions about the appropriateness of their breastfeeding activity but they were also aware of media representations and the ensuing debates surrounding this issue. Several women reported reading newspaper reports about long-term breastfeeding, reading about surveys which promulgated society's opinions and hearing radio programmes which discussed the issue. The most commonly depicted reason for considering this topic was to elicit societal opinions about the appropriateness of breastfeeding the older child (Figure 4.1)

Figure 4.1

Newspaper headings demonstrating the debate around the appropriateness of long-term breastfeeding.

Why I'm still breast-feeding my son at the age of three.
Daily Mail 1997

Is breast still best at four?
Evening Press, York, 1998.

Should we breast-feed till they're six?
The Independent 1996.

So at what age should you stop?
The Mail 1997.

Clandestine Activity

As the women were exposed to a barrage of beliefs from kin, health professionals and society they might become secretive about their breastfeeding activity to protect themselves from those opinions. There are similarities with the issue of co-sleeping which raises issues of the appropriateness of a child sharing a bed with its parents (Medoff and Schaefer 1993, Byard 1994, Okami 1995, Moorhead 1998). In both these cases women might avoid talking to others about these issues or be untruthful about the fact they are continuing the practice, in order to avoid conflict. Some women in this study would rather lie to a friend or relative about constraints on her lifestyle (for example why she couldn't go out in the evening) than tell her she was needed to remain at home to breastfeed her child at night.

For some women long-term breastfeeding became clandestine where they would deliberately discourage breast contact in front of relatives and avoid talking about breastfeeding with health professionals (for further discussion see chapter 6). One woman even kept it secret from her partner because he was convinced the child was too old to receive a breastfeed at bedtime. The conflicts between their opinions became destructive so rather than cease the activity she continued and pretended to him that it wasn't happening.

Most of the women reported co-sleeping with their children whilst engaged in long-term breastfeeding. As discussed by Ball et al (1999) most of the children did not start off sleeping in the parents' bed but would move into the bed during the night, or the mother would move into the child's bed during the night, for

breastfeeding. Not only was breastfeeding a closet activity for many of these women but their sleeping arrangements could also come under the scrutiny of others if these activities became known. Many women, again, choose not to disclose their choices to avoid having to justify their actions or be subjected to contrasting opinions to their own.

In this chapter the focus has been to explore the meanings and beliefs associated with long-term breastfeeding for a group of women. Within the women's narratives it became evident that they did not necessarily set out to be long-term breastfeeders. The consequence of engaging in this activity was to strengthen their beliefs and views about breastfeeding and its association with 'good' mothering.

Consideration of the social context within which this activity takes place has been discussed. Aspects of this chapter will be revisited in chapter 6, with special emphasis on the conflicts the women experienced. In the next chapter, women's experiences of breastfeeding in public and private places are investigated.

Chapter Five
Breastfeeding in Public and Private Spaces[23]

In the early weeks of motherhood breastfeeding in front of others, in and away from home, can be problematic for some women. During the interviews all the women in this study participated in discussions about their views and feelings of breastfeeding in front of others. The lived experience of breastfeeding necessitates it to be an integrated activity in everyday life; it therefore impacts on the day-to-day reality. It emerged that many women were faced with uncomfortable feelings or concerns about this issue, although some had positive experiences to draw upon. As the women told the stories of their experiences, it encouraged others to contribute opinions and share knowledge of suitable venues in which to breastfeed.

The women made distinctions between breastfeeding in public (out of the home) and breastfeeding in private (their domestic space). However, deeper analysis of the data revealed there was not a clear division between the concept of public and private; these were not concrete categories. The temporal and spatial boundaries of women's activities may overlap, shift and change. At times the woman might create a private space in the public arena and conversely might have to negotiate a private space when the domestic place became public.

The first part of this chapter will focus on the women's descriptions of breastfeeding in public; the experience of breastfeeding within the home is

[23] The content of this chapter was presented at two conferences (Britton unpublished b, Britton unpublished c).

discussed next. In both sections it is clear that there are spatial and temporal issues which impact on the women. The third part of the chapter identifies contributing factors which have influenced the experience of breastfeeding in both public and domestic space. In each section the experiences of both early and long-term breastfeeders are incorporated.

In this chapter domestic space is defined as being the geographical boundary of the home, and public space refers to the space outside the home, because the women were in agreement that such differentiation of space was important. In this study, the public setting was predominantly associated with shopping activities and to a lesser extent leisure. The women's experiences in public places created experiential knowledge of gendered space and resulted in cognitive mapping of 'safe' breastfeeding areas. The social world of a new mother usually necessitates her taking her baby away from the home. However those public places that the woman encountered before childbirth, such as shopping areas, which were once familiar and taken-for-granted, were viewed as different spaces when the needs of the breastfeeding infant had to be considered. The public space does not exist simply as an external arena but exists in the interaction between its external characteristics and means of negotiation through individual experience. The ways in which problems are encountered, conceptualised, and coped with, lie at the heart of these negotiations. The difficulties the women encountered created conceptual as well as practical 'problem spaces'. This resulted in the creation of new cognitive maps in order to take into account the risks and dangers of public spaces.

The home is a complex construct embodying both material and ideological aspects; through its structures it both embodies and produces social reality (Twigg 1999). Privacy, security and identity are core values attributed to the meaning of the home (Allan and Crow 1989, Twigg 1999), where there is an ability to shut the door on the world outside or regulate those who may cross the boundaries of the home. However, for some individuals the home is not always a place of security but a place where they experience violence and social tensions (Bowlby et al. 1997). Certain areas of our home remain relatively hidden from others and are associated with personal life. The way the domestic space is organized will often be along the public/private axis (Allan 1989, Munro and Madigan 1993). The basic pattern of public/private oppositions are linked to other binary categories such as up/down, front/back, special/everyday. Some areas will be seen as more private than others. Rooms upstairs are generally seen as more private than downstairs. There is general agreement that the rigid use of oppositions to label spaces is unsatisfactory as there is little room for contest or contradiction (Lawrence and Low 1990). However the women of this study did use such oppositions.

The traditional way of looking at the public/private paradigm does not represent a static truth or capture the interactive nature of everyday life. Activities labelled 'private' because they are associated with home and family may actually take place outside of the home, so are they then 'public'? Hansen (1987: 107) contributes the importance of 'the social' in the public/private dichotomy. For Hansen (1987) 'the social' includes behaviours that are not

easily categorised as either public or private, which occur in both private and public space.

Breastfeeding in Public Spaces

> " Breastfeeding is far more acceptable in public places than it was even five years ago .....isn't it?" Vanessa

The public space could be problematic for both the early and long-term breastfeeders but for different reasons. In the early weeks of motherhood the women commonly expressed anxiety about going away from the domestic place because they had to manage and regulate their baby in a social setting, amongst strangers. The first time mothers, in particular, were conscious of their new role and had differing degrees of confidence in handling and managing their young baby. The public display of mothering, for some, was an anxious time where they thought others would be monitoring their skill. Breastfeeding for some women could be a public demonstration of how they coped with their baby and attended to its needs appropriately. All the long-term breastfeeders had some experience of breastfeeding the older child in public places but tried to restrict breastfeeding to the more private space of the domestic setting rather than in the gaze of the public. As these were experienced mothers they did not usually have the heightened anxiety displayed by the early breastfeeders but could have different concerns. They were concerned about the opinions of others concerning others' perception about the appropriateness of breastfeeding an older child in public. Since their children were older, the breastfeeding activity might be more visible and the size, noise and movement of the larger

child might draw attention to this activity. One woman felt very strongly about her right to breast feed a child of any age if she thought it necessary.

> 'I went into warrior mode when I breastfed in public places if anyone dared challenge me. For me it was about the right to feed my child. I am not having my child suffer for some sort of weird mentality. We see women's breasts being exposed all over the place for sexual pleasure but when a mother needs to feed her child they seem to find that upsetting.' Selina

In general this group of women had become aware of negative comments about the appropriateness of the activity in public - such as the child being too old, or disgust. Not only were there verbalised comments but the women detected non-verbal cues too such as grimaces and eye contact. One woman, Alex, who was breastfeeding three year old twins was very keen to breastfeed in public but 'schooled' her children in the appropriate etiquette.

> '....as they have got older they knew not to fiddle around and play, I've always said "don't play with the other side because that's (the other twin's) side", so they know to keep to their own side and not to fiddle about or mess about too much, keep my shirt down – so they are very co-operative – that's the advantage of the older child, you can advise them about the best ways of doing it.'

Another woman, Ann, preferred not to breastfeed in public but if it was necessary she would find a space that took her out of the public eye. If she was visible to members of the public, she felt concerned about her decency and therefore urged the child to breastfeed in a sedate way to minimise the impact of the activity.

> 'If ever I did feed her out in public I would insist that she kept really still and didn't sort of bounce around and do this jogging about, and

> wave her legs in the air because obviously I would be completely exposed...I would insist she lay almost across my knee like a little baby would have done.'

The women often felt responsible for the feelings of others and thought they should take other people's feelings into consideration, which was tantamount to agreeing that what they were doing was shameful. Some women clearly had conflicting feelings. On the one hand they felt they had a right to breastfeed when and where they wished but didn't feel comfortable doing it in public.

> 'I wish I felt more relaxed about it, or more strong in my conviction. I know it is right that I should be able to behave how I want in public but it's not easy.' Eve

Another woman was not embarrassed about feeding in public but felt a duty of care to others around her and felt respectful of their feelings.

> 'I've been conscious of gazers and I think it is important to take other people's feelings into consideration if you are in a public place which is why I did insist she wasn't too blatant about it.' Ann

Here again, the mother encourages the child to moderate its movement to ensure that attention is not drawn to the breastfeeding pair.

The discomfort of breastfeeding in public may rest with the fact it is not readily visible and women do not share experiences. One woman said:

> 'I feel that a lot of the problem is that we don't see other women breastfeeding in public. It's something that should be natural and a socialised thing you learn from watching your aunts and our mothers and other women. If that is taken from the public domain then where do women learn it? We are being fed a societal attitude that it is something unusual.' Selina

One woman recounted her feelings about observing a three year old breastfeeding in a public setting who was undoing the front of its mother's shirt. She felt uncomfortable by this, as she clearly perceived this as a vaguely sexual act. For her, there was a conflict of innocence and sexuality. Other women provided accounts of discomfort associated with sexuality, such as the unbuttoning of the shirt by the child, or the child 'playing with' the breast or nipple during the breastfeed.

Comments were also made about actual or perceived risk of exposure of their breasts in public. Although women may have felt comfortable exposing their breasts in other public settings such as the beach, the glimpse of the breast in a urban setting such as a shopping mall was considered inappropriate.

> 'I've got friends who let their children lift their tops, I really don't think I could handle that in public. It's not just the embarrassment of the child pulling away it's also the fact that your letdown reflexes come into play and you are sort of gushing everywhere.' Eve

From the long-term breastfeeders accounts generally there was a determination that they should be able to do this; however this was coupled with a hesitance and concern about their body in the public gaze, and the belief that they thought they should be discreet. Second time mothers tended to have more confidence than with their first child. With their first child they were more concerned about breastfeeding in public and might use facilities which took them out of the public gaze but with their subsequent child they reported they were more liberal about their feeding.

> 'I mean with Tim (second child) I was much more comfortable to (breastfeed) – it didn't worry me. I was more prepared to stand up for

myself by that stage. Whereas with Mary (first child) I remember feeling quite uncomfortable, even when feeding with family - certainly with being out and about in the public eye. I remember being very careful of where I fed her and certain places I would go where I would feel comfortable.' Jackie

One woman felt acutely aware of public opinion of breastfeeding the older child. Her child was three years old and she remarked:

'I decided I really couldn't breastfeed in public, that it wasn't fair on the public to breastfeed a child as big as this.' Megan

Other women reported they detected an air of disapproval about the activity even though they had no concrete evidence for this. The following quotes reinforce this opinion which comes from a sense rather than fact.

'As it's unusual to feed older children and people have strong views about it, people really seem to disapprove.' Liz

'I do worry about the general level of disapproval that there seems to be, that older children shouldn't be breastfed and certainly not in public.' Sophie

'I'm just aware of a sense of disapproval, maybe that's just my anxiety about it. People don't really notice what I'm doing and then they'll have a closer look and they'll go "I'm sorry" like I have got my trousers down or something – ridiculous.' Sophie

It should be remembered that these women were those who had persevered with breastfeeding even though they found it problematic at times. The perceived public opinion was tangible to them yet did not persuade them to cease breastfeeding; for other women it might influence them to curtail breastfeeding.

Despite the general feeling of disapproval within the public arena this woman felt it was important for her to make her stand.

> 'I don't feel I am a pioneer but I feel I have a social responsibility not to be frightened about feeding my babies in public when they are 5 (years old). Whether I would feel that confident when it came I don't know but at the moment I feel it is quite important and I feel quite strongly about it, If I do go out and he wants to nurse then I nurse him, wherever I am – apart from Marks and Spencers, because they don't like it – but I will nurse him wherever I find the need.' Linda

Many women encouraged their older children not to breast feed in public. It was perceived to be easier to provide distractions away from the breast when the child was older.

> 'As they have got bigger I must admit I would try to encourage them not to do it unless absolutely necessary or to be quite discrete about it because I have had people sort of stare at me and other kids pointing and commenting, which they will.' Ann

Creating 'Safety' in the Public Space

Some women felt anxious about where and how breastfeeding should be undertaken in public. Public space reflects a moral order which includes expectations of how a breastfeeding mother should behave. All the women in the early breastfeeders group discussed how they managed breastfeeding with regards to the shopping experience. This seemed highly important. Often it was an activity they did alone without their partner, friends or family. Shopping was also an activity they were expected to do, since being at home with a baby it was perceived they had the time for it. Equally, as the women might have been responsible for shopping prior to the birth of the baby or had enjoyed this

activity before motherhood they felt it was their role to undertake this task. All the mothers in this study remarked on how the nature of their shopping trips had changed since having their baby. A common remark was that the women went shopping out of necessity for essential items rather than browsing. What had been an opportunity for the expression of female pleasure, and an important component of the lifestyle of many women, was now transformed into a task of utilitarian necessity.

There was a general feeling amongst the women that the people in Britain are intolerant to women breastfeeding in public spaces. To reduce their concerns the women quickly developed the awareness of appropriate facilities, such as mother and baby rooms, which were seen as areas of 'safe refuge'. The safety of the space was determined by the fact it was usually frequented by other women with children, provided privacy away from the public gaze, and the women were less concerned about the behaviour of their baby in this more private arena. However the environment within the mother and baby rooms was not always ideal. Often the space was cramped and chairs for breastfeeding may be placed next to nappy bins. If the women were unaware of the availability of mother and baby facilities then they would gauge 'safe' areas in which to breastfeed, such as restaurants and cafes, or by negotiating an area with shop assistants. When seeking a safe, private area to breastfeed their baby a public toilet might be the only readily available place. All the women loathed being expected to breastfeed in such a place as they equated breastfeeding with nourishment rather than excretion. All these 'safe refuges' were welcomed by most women, some thought their presence contributed to the problem.

'...(the mother and baby areas) are beneficial for some but they have made it a clandestine activity.' Karen

The provision and use of these private areas reinforces the dominant societal opinion that breastfeeding should be undertaken in out of the public gaze and reaffirms to women that this is where they are supposed to be during this activity.

Information about these 'safe' areas was often gleaned from talking to other mothers about their experiences. Considerable exchange took place during the interviews about the facilities individuals had encountered with stories about helpful/unhelpful staff, sharing information about the availability of appropriate facilities to feed their baby (such as comfortable seated areas) to inappropriate facilities (such as the provision of a chair in the ladies' toilet). This informal networking was deemed important and significant to those women who were concerned about venturing out from their domestic space. Some women also referred to publications such as directories which identified 'breastfeeding friendly' shops and restaurants (National Childbirth Trust 1998).

The Juxtaposition Of Private And Public Spaces In The Home

In the everyday life of the women, when alone or with their partner, the home was seen as a safe, private place in which breastfeeding could take place. However the presence of others within this space may impose a reordering of the place to breastfeed. Those women, who would normally breastfeed in a 'day' area such as a lounge, may retreat to a more private area such as a

bedroom to breastfeed, rather than do this in the view of others in their domestic space.

Analysis of the data shows some interesting issues about breastfeeding in the domestic setting. One striking issue was that, within the domestic setting, public and private demarcations of space may change associated with breastfeeding in front of friends and family. How a woman managed breastfeeding perhaps on her own, with her partner present or in front of friends and family could be various. The domestic space may be seen as private space where a breastfeeding woman can choose where to feed her child. This may become disrupted when the domestic arena becomes public, such as guests invited into the home. A demarcation of public and private space might occur with the woman removing herself to a private space should breastfeeding be necessary. What is interesting here is that for some breastfeeding women their domestic space has different meanings depending who is present. This issue becomes complicated by factors influencing the woman's choice of feeding venue namely their relationship to the guest, the sex of the guest, and their partner's view on breastfeeding in front of 'others'. The woman's personal preferences also have to be considered as well as those who were invited in to the home. A re-evaluation of the use of private and public space might occur.

> 'At first I used to feel like taking him upstairs and then I thought I can't be doing this. I thought this is my house, I'm not going upstairs just because there's a load of people here. I thought if they are not comfortable about it, they can go and sit elsewhere.' Breda

The views of the women about breastfeeding in front of friends were various. Their opinions about the activity would depend on their personal opinion about

the appropriateness. Some women did not mind breastfeeding in front of females but preferred not to do so in front of males. Several women commented about their ease at feeding in front of others but their partner was not happy about them breastfeeding in front of other men, which might influence the woman's behaviour. Some women worked out strategies to enable them to feed in the same room but not be seen. In the following quote the woman uses an object to shield herself from the male gaze.

> 'We had a male friend visiting, he's a doctor, and I can tell you that my husband would've had a fit if I had breastfed in front of him. To enable me to remain in the same room as them I would use a swivel chair. If I sat in this chair I could swivel it around and breastfeed her in private and not be banished to another room where I would feel excluded from all the gossip.' Rebecca

In this case the woman felt she had created a private space for herself which satisfied her husband's desire that the breastfeeding should remain private, yet she could be included in conversations and feel integrated within the group.

Some women found it difficult to feed in front of male friends or male members of their family. They might excuse themselves from the public space to be in a more private place, often the bedroom to avoid the male gaze. One woman remarks on her feeling of a group of work colleagues visiting her soon after her baby's birth.

> 'Friends from work came to see me and whereas I didn't mind the girls some of the lads came and I did find that embarrassing.' Eve

Some women were determined to please themselves in their own home and did not alter their behaviour despite others' discomfort. These women felt it was

the responsibility of the 'other' to remove themselves from the room if they were embarrassed by the breastfeeding activity.

All the women felt content to breastfeed a baby in front of female members of their family however there were contrasting opinions about the gaze of male members. A few women had thought about breastfeeding in front of others during their pregnancy and thought it would be difficult to do in front of their own father.

> 'I am sure that before having her I would have been embarrassed about getting a breast out in front of my father but I don't think twice about it now and I have never said to him "do you mind?" He has to accept it and tough.' Amy

Other women also found it difficult breastfeeding in front of their fathers and father-in-laws. The explanations from the women either concerned themselves or the feelings of the male member. With the former, the women felt it was embarrassing or inappropriate for their father to see them doing this. This was linked either with their role as daughter and the socialisation of being encouraged to cover their developing body from male members of the household, and inappropriate in terms of the breast being seen as sexual and therefore not expected to be exposed to these male members. This awkwardness was managed by either the woman removing herself from the social situation to one of privacy or by carrying on regardless because she judged her baby's needs were paramount and she forfeited her own discomfort for her baby. With the latter, the women were conscious that the father/father-in-law was himself acutely embarrassed by the activity being conducted in his presence. Some of the male relatives had very little experience of observing their own wife's

breastfeeding activities and felt it might be inappropriate for them to be present while their daughter was breastfeeding. The woman's partner often expressed his personal opinion about her breastfeeding in front of his father. Some partners were indignant that this should not occur and might make comments such as - "You'd better not do that in front of my father".

For the long-term breastfeeders the breastfeeding activity often took place at night away from the gaze of others or could be manipulated to occur when friends and family were out of the domestic space by distracting the child. Managing the timing of the breastfeed according to those present was a key issue for many of the long-term group especially when they were aware of disapproval from members of the family. One example was a woman who was breastfeeding a two-year-old girl. The woman's mother let it be known that she thought it was perverse to breastfeed a two-year-old child. Within the domestic setting the woman would try to avoid breastfeeding the child in front of her own mother by engaging in activities which would distract the child. However there were times when the woman felt she had no choice but to breastfeed. If this happened her mother would try to drag the child off the woman's breast saying things to the child like; " you are a big girl now, you don't need that - its only for babies and you are a big girl now".

The tensions that arose between family members and the women were not confined to relatives but were also found amongst the women's partners who may feel that the activity had gone on for long enough. To avoid marital disharmony one woman pretended to her partner that she had ceased

breastfeeding their child at bedtime. As she was always responsible for putting the child to bed she could continue the clandestine activity out of the gaze of her partner.

Influencing Factors Which Shape The Public Act Of Breastfeeding

a) Temporality

The concept of time is a significant feature in childbearing; from the beginning of pregnancy, the clock starts. The progression of the pregnancy is recorded in weeks and days. Each stage of labour is timed; from the first contraction to the expulsion of the placenta and membranes. The woman's progression through the postnatal period is monitored by how many days she has completed since the birth of the baby. Infant feeding has traditionally been concerned with how often the baby wakes up and for how long the baby would feed. The 'good' mother was one whose baby woke up approximately every four hours, a time that was modelled on the pattern of infant feeding when formula milk was given. Only a decade ago mothers would receive instruction from midwives and health visitors regarded the frequency and duration of an individual breastfeed. Since that time the predominant model of breastfeeding relates to demand feeding which is more baby-led. There is an overall assumption in contemporary Britain that childbirth ought to correspond as nearly as possible to predictable rules and to codified factors (Pizzini 1992). However the bureaucratically organized clock-time will often be at odds with the natural rhythms and does not take into account individual variability (Adam 1992). Adam (1992) makes a good point that 'not just everything we do, but all of our body's physiological processes are *temporally organized and orchestrated*'

(Adam 1992:155 emphasis in the original). Time is important but it is 'clock-time' which is imposed on individuals which can, on the one hand, structure a person's life but on the other, be a form of control. Several women spoke of the importance of 'time'. For many of them journeys to shopping areas had to be highly organised. The once familiar space, of say the shopping mall, now had to be reconceptualised as the new status of motherhood presented new problems which had to be negotiated within that space. Most mothers paid considerable attention to planning a shopping event, for example, feeding the baby before leaving the home, completing the shopping tasks and returning to the home before the next feed was due. The women often used the word time to express their concerns, for example, trying to predict the time of the baby's feed, how much time it would take to organise and make a journey, and to time to be at an appropriate facility when the baby needs feeding.

> 'I think it is very difficult to organise your time. You have to watch the time and think I have to go now, I have to go home. He'll be ready for a feed by the time I get home.' Vanessa

As the breastfed baby often requires frequent and unpredictable feeds the women felt they needed to be armed with the knowledge of appropriate such as the mother and baby rooms. One woman who felt unable to breastfeed in front of others organised her shopping trips with military precision to ensure she could avail herself of a private area in which to breastfeed her infant.

> 'I had to plan my time, where I wanted to be, you know. So the shops that had free facilities, I always head for those. I felt panicky about where I'd be when she needed feeding. I worried that she'd start screaming in the middle of Argos, or something. I mean, for a while I didn't go out on my own 'cos, I thought 'what if she starts crying?' You sort of feel embarrassed that she'll be screaming her head off which is

> silly really. I always made sure I kept near Boots and Mothercare so I could always head for them, you know.' Sharon

Not only had the women created cognitive maps of the public areas to enable them to access a private place to feed her baby but time was also important to negotiate.

b) Embarrassment and Negotiation of Public Spaces

Many decisions related to infant feeding are made prior to pregnancy. Some women in this study formed strong opinions prior to the birth about whether they would breastfeed in public. However these views were changeable when the woman considered the effect this decision had on her views of motherhood and her freedom.

> 'Before I had Michael, I thought that I would only feed him at home but when he was born I changed my mind because I want to go out. I'd just go to Mothercare or I feed him in front of my girlfriends, not men.' Zosha

Zosha was adamant that she would never feel comfortable breastfeeding in front of a man other than her partner. Although Zosha had thought she would only breastfeed at home, she had found refuge in mother and baby rooms. These were the only places she would breastfeed in public. She went on to discuss with the group that she felt:

> '...people stare at a woman who is feeding her baby. I would not want to feel that everyone was looking at me, thinking oh, what is she doing!'

Towards the end of the interview Zosha contributed to the group once more eager to tell the other women of an experience that significantly influenced her views of public breastfeeding.

> 'Before I was pregnant, I was with some friends in a restaurant and one woman started breast feeding and I remember everybody looking at her in the corner and making comments. Everybody was leaving and looking at her, so in my mind I thought it wasn't a good idea.' Zosha

Disapproval and embarrassment by the general public shaped many of the women's views of breastfeeding their baby/child in public (especially the early breastfeeders) despite a lack of explicit negative reactions from members of the public. Perception of disapproval made women resort to finding 'safe' places for subsequent breastfeeds. Assumptions about the public appeared to come from interpretation about what others were thinking. For example, they interpreted non-verbal cues as signs of others displeasure of their breastfeeding activity e.g. people moving away from them, smirking, eye contact. Conversely, smiling was interpreted as being supportive of the activity.

Concern was also expressed about exposing the breast in public. Although a woman may breastfeed her infant discreetly she may feel concerned that people are aware she is doing it and be concerned about the inadvertent exposure of the breast to others. The public space became problematic when the baby or child drew attention to the breastfeeding episode by screaming, not being content at the breast and moving around, as the breast was more likely to be exposed in these situations. Even though women might believe it is their 'right' to breastfeed in public they might actually choose to go to a mother and baby room to avoid being discredited in public but also be in control of the breastfeeding duration. As the infant gets older it will engage more with its environment which might mean being interested in members of the public. The

diversion of the infant's attention might mean the breast contact becomes protracted and provides more opportunity for the breast to become exposed.

Keeping away from the gaze of male strangers was linked to the view that men may see the breast as primarily sexual and not functional.

> '....when I have stopped for coffee somewhere so I can breastfeed her, I pick a table away from men.' Daphne

Not all the women had experience of breastfeeding in the public gaze. Those that had gave responses which ranged from indifference to the reactions of others and at peace with their right to feed their baby when and where it was needed, to being profoundly embarrassed about being visible to others and affected by what they perceived to be disapproving looks by members of the general public. This latter point was emphasised if the mother felt the baby was drawing attention to the breastfeeding episode by its screaming, being difficult to position at the breast and by moving around which could aid exposure of the breast.

Three women in the early breastfeeders group had never breastfed their baby in a public place, and were adamant that they would never be able to do this. One of these women had breastfed her infant in a car, which she explained as creating her private space within the public arena. But this event caused her untold anxieties and she expressed the desire to never allow it to happen again. When asked why she did not feel comfortable she said it was because she never saw anyone else breastfeeding in public, for example a restaurant. Although she felt comfortable breastfeeding in front of people she knew (at home), she felt

embarrassed about doing it in public as she saw it as a social stigma. Another woman had the following account (the emphasis is hers)[24]:

> 'I **never, ever** fed Jack anywhere but at home, **ever,** I was too embarrassed. I wouldn't even have dreamt of it. It's just part of my Victorian attitudes I suppose. I'm not embarrassed about anybody else doing it, and I think it's perfectly acceptable. But it's other people's attitudes that I'm worried about. And I suppose people staring and seeing more of me than is modest. But I never, ever fed him out. In fact if I had to go anywhere, I went after a feed and came back within an hour or two, always. So I've no experience of feeding him in public at all. I wonder if maybe it's a northern attitude or something, maybe because you never, ever see anyone breastfeeding in public {in Sunderland}. I can honestly say I've never ever seen another woman breastfeed, apart from my sisters obviously in their homes but in public, never. I mean I can remember when my mum was breastfeeding my little brother and we had friends at home, I remember them being stopped from visiting because my mum was breastfeeding and then the other families in the street would say, you know, you can't go and visit because they've got a new baby in the house, because they didn't want their children to see my mum breastfeeding our baby.' Angela

All the women had experience of having to manage their body in the public arena. For some this was unproblematic and they would breastfeed in front of others whether in the home or in public places. For others the situation could be problematic. The early breastfeeders were often faced with a situation of immediacy where they had to act quickly to satiate their child. However the long-term breastfeeders might be able to employ skills in negotiation and distraction to manage the breastfeeding situation to suit the mother's requirements.

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[24] This woman makes reference to her birthplace which was Sunderland, NE England.

The Breast and Public Opinion

In the public arena, the opinions of others, such as friends and family, influenced the woman's confidence to breastfeed in front of them or her efforts to find an alternative venue. Friends might not directly verbalise their disapproval of the activity but might indicate it within a conversation.

> '....around my friends when the little one would come running and lift my shirt – I didn't get funny looks but I did find that it came into conversation a lot about when I was actually going to stop.' Victoria

The media has the capacity to influence public opinion. Within chapters 3 and 4 it has been demonstrated that the women were acutely aware of the media's interest on aspects of breastfeeding; its occurrence in public settings was no exception. The sexualisation of the breast through the media image has become commonplace in British society. Various newspapers, magazines and television programmes portray the female breast as sexual. In Britain there is a strong cultural preference for sexualised breasts. When women breastfeed they may be seen as transgressing the boundary between motherhood and sexuality (Young 1998). The media can also affect attitudes to breastfeeding (Henderson 1999). The media interest in breastfeeding often focuses on problems associated with breastfeeding in the social world. There have been several examples of how the media has encouraged public debate about the issue of breastfeeding in public. The results of opinion polls have been published in magazines that are targeted at female readers, such as Bella, which reported that most people do not think it is an activity that should be witnessed. The British Tourist Authority (1996) gave official advice to tourists visiting Britain that breastfeeding in public was not acceptable in Britain.

Newspaper articles target breastfeeding in public at cyclical intervals (figure 5.1) such as 'Breast is best but not in public' (Hunt 1996) which reported on women breastfeeding in a mall in Belfast who were seen on CCTV and asked to move as they were embarrassing others. 'Getting abreast of the new laws' (Gurdon 1997) reported on legislation that was passed to make it legal for a woman to breastfeed in public. 'Feeding frenzy' (Roberts 1999) documents that the editor of Debrett's Guide to Etiquette claims that 'it is bad manners to expel any liquid from any orifice in public and breastfeeding is no different'. 'What they say about breastfeeding in public' (Crewe 1998) an article that seeks to demonstrate contrasting opinions of support and contempt towards the issue. 'SHAME - I just wanted to breastfeed my baby, but this man threw dirty water at us' (Rees 1997) described the story of a woman who was breastfeeding outside a shop. The shopkeeper claimed the wall on which she was sitting was his space and that he disliked the breastfeeding activity. The woman wouldn't move so he threw water over her, the baby and pram. This man claimed that he saw breastfeeding in public spaces unacceptable, similar to urinating in front of others. These stories heighten the public debate about whether women should breastfeed in public or not. The newsworthiness of the subject means there is something to say about the subject. Breastfeeding in public is not a taken-for-granted activity in British society but one that has to be regulated and managed in relation to the opinion of others.

Figure 5.1

Newspaper Articles Debating Breastfeeding in Public Spaces

Within this chapter it has been demonstrated that there are fluctuations in the concept of private and public space even within domestic space. There may be a reordering of the space depending on who occupies that space at a given time and the dynamics of those people. Clearly breastfeeding in front of others has been a problematic activity for many women, which has been influenced by friends, family and the general public.

In the next chapter the discussion focuses on the women's use of authoritative knowledge and social networks. This chapter develops the issues of conflict which can become central to a woman's perceived success and failure of breastfeeding.

Chapter Six
Breastfeeding: Authoritative Knowledge and Social Networks.

'The power of authoritative knowledge is not that it is correct but that it counts.' (Jordan 1997:58)

Breastfeeding is not just a biological act but is socially marked and shaped. The phenomena of breastfeeding are essential aspects of biological and cultural reality. How women live breastfeeding experiences (their own choices plus advice they receive from others) will influence their own lives and those of their family for better, or for worse. From the previous chapters it has emerged that women learn about breastfeeding from several sources. The aim of this chapter is discuss and analyse how conceptual and authoritative knowledge are used by women to shape their breastfeeding experiences. It will become evident that not only do women have to struggle with their own beliefs of these competing ideologies but also the views of others. The views and opinions of significant others (such as family and friends) towards breastfeeding practices may differ to those of the woman. Consequently, the variance in opinions may cause conflict and be sufficient to affect the social relationship between the woman and those significant others.

This chapter begins with a review of the domains of conceptual ('expert') knowledge and authoritative knowledge. Learning about breastfeeding is not simply learning facts from the conceptual domain but also relies on the woman's experiential knowledge. The interface with others in the woman's social world will also be influential therefore a discussion about the use of support networks will be given.

From the data several themes emerged which illustrate the conflicts that can occur between the conceptual and authoritative domains. Firstly was 'being a mother'. In this section it becomes evident that breastfeeding can be embodied as a feature of 'good' mothering by the breastfeeding woman. The woman's management of her breastfeeding activities may confirm or conflict with others' views of good mothering. Many of the women spoke of 'intuitive' knowing about breastfeeding but these views could conflict with their own mother's 'knowing'. This conflict could put tensions on the mother-daughter relationship. Not only are mothers influential in giving information, support and creating conflicts but others such as partners, peers and health professionals are also significant. Finally the use of myths to regulate breastfeeding activities will be discussed. From the narratives it became evident that women received advice from others in an attempt to control breastfeeding or encourage its termination. Persuasive techniques could take the form of myths which might frighten the mother and would often be contrary to her views of being a good mother as they indicated she might be harming her child or herself.

A breastfeeding mother learns about and interprets the breastfeeding process occurring in her body. However the experience of the individual will be shaped by the influences of others such as: kin, friends, societal expectations, media representations and unrelated people such as lay organisations and health professionals. With the birth of the first baby a mother will gain new, unique experiential knowledge about herself and mothering which may be different from her expectations. The medicalization of birth in the UK has led to reluctance by both women and health professionals to acknowledge embodied

knowledge as an important influence in the development of the woman's life cycle.

In the UK the general dominance of Western biomedicine places the health professional in a role of 'expert'. This title will be bestowed upon the health professional because of the training and education process the individual has participated in. During the education process the health professional will have learnt the scientific rationale for aspects of health and disease, learning facts from a biomedical viewpoint. The dominance of allopathic professional knowledge in the medical field often results in the delegitimisation of other knowledge and the formation of 'cultural authority' (Starr 1982: 13-15). Where health professionals are seen as holding scientific 'truth', the 'facts', they have the authority to give 'credible' advice. Much has been written in medical anthropology about the dominance of the biomedical model which might neglect an individual's experience and interpretation of health and illness (Kleinman 1988, Kaufert and O'Neil 1993, Idoyaga Molina 1997, Skultans 1997). Health professionals will diagnose, treat and advise their clients based on scientific principles which provide the foundation for their knowledge base.

Midwives and doctors (in particular obstetricians and paediatricians) are seen to have expertise in the issues around birth and infant care. This expertise is seen by women to be gained from their training and experience (Bluff and Holloway 1994). In their study (Bluff and Holloway 1994:159-160), women claimed that: 'They [midwives] know best'; the women believed that the midwives' training and experience enabled them to make predictions and

suggestions about their care based on professional judgements which were 'accurate'.

In health professionals' interactions with a mother the acknowledgement of experiential and intuitive knowledge is often missing. Health professionals' knowledge of breastfeeding may be seen as superior to that of experiential or intuitive knowledge of the mother. This was particularly evident with the first time mothers in my study. The women gained conceptual knowledge from various sources: books, magazines, the media or personal interactions with midwives, health visitors and/or doctors. Experienced mothers drew upon their experiential knowledge, which could result in her avoiding professional contact to reduce receiving conflicting views about motherhood and childrearing. Experienced mothers had learnt strategies to 'deal with' health professionals and their perceived lack of understanding about feeding issues. These took the form of avoiding contact – not going to the weighing/baby clinics: avoiding asking questions that might raise feeding issues.

A central concern of anthropologists has been the privileging of biomedicine as a realm of knowledge separate from other cultural or social domains and perceived as objectively valid. During interactions with health professionals there is often a lack of priority allocated to the breastfeeding woman's experience of her body as a form of knowledge, and primacy is given to the health professionals who advise on the 'management' of breastfeeding.

Authoritative Knowledge

Jordan (1978) first brought the concept of authoritative knowledge into the anthropology of birth. From the outset it must be understood that Jordan does not see the 'person in authority' (such as a health professional) as necessarily having authoritative knowledge. Davis-Floyd and Sargent (1997) define authoritative knowledge as being:

> '...the knowledge that counts, on the basis of which decisions are made and actions taken' (Davis-Floyd and Sargent 1997:4).

The label 'authoritative knowledge' does not imply correctness rather it is intended to draw attention to its status within a social group. Jordan (1997:56) explains for any particular domain several knowledge systems exist. Some because they explain the state of the world better for the purposes at hand (efficacy), others because they are associated with a stronger power base (structural superiority), and usually both. Often people exist in a situation where there are parallel knowledge systems which the individual can use interchangeably (Kingfisher and Millard 1998). But sometimes one kind of knowledge gains ascendance and legitimacy. The legitimisation of one kind of knowing has the consequences of devaluing or dismissing other kinds of knowledge.

Becoming a Mother

The birth of a child not only marks the reproductive ability of a woman but also assists in her transition of social status from woman to mother. In those societies with high levels of infant mortality the ability to bear children who survive infanthood will be an important part of mothering (Jeffery and Jeffery

1996). Although maternal attachment is often seen as synonymous with motherhood there are accounts where this is not the case (Scheper-Hughes 1991). Scheper-Hughes (1991) provides an account of how attachment and bonding to the infant is a more gradual process for women in Brazil until they are sure the infant will survive.

Becoming a mother will not only achieve personal fulfilment for some woman but will also increase her social status (Kitzinger 1979, Gegeo and Watson-Gegeo 1985, Katz 1985). However there is evidence that for those women who do not experience motherhood (either through infertility, child death or chosen childlessness) negative social attitudes often prevail (McGilvary 1982, Franklin 1997).

Being a Mother

With the birth of her first baby a woman will enter the status of motherhood. Many women have ideas about what being a mother is and all will wish to fulfil this role to the best of their ability. However the subject of how to be a 'good' mother is widely debated in academic and media arenas. The usual measuring stick of being a good mother is the effect of an activity on the child(ren). Recently debates have centred around immunisation and working mothers as examples of good/bad mothering. Although the mother does not necessarily make decisions about immunisation alone, she is usually the person who is in dialogue with the health professionals who offer the immunisation programme. The recent MMR (measles, mumps and rubella vaccination) debate has centred

on research evidence of long-term ill effects by the administration of this vaccine. Parents have had to weigh up the body of evidence and make a choice about whether to have their child vaccinated or withhold the triple vaccine and perhaps place their child at risk of contracting a serious disease. Those mothers who refuse to have the child immunised will be seen as failing to give their child sufficient protection against killer diseases.

Women who re-enter the work force after having a baby are periodically exposed to research evidence of the benefits or disadvantages this has on their child. Often running parallel with this debate are opinions generated about the suitability of childcare schemes and their effect on a child's development. Not only does a woman have to consider the effect of her absence on the child but also consider the suitability of the alternative childcare provision. Both the examples above illustrate how appropriate or inappropriate mothering is focussed on the consequences of the child's physical, psychological and intellectual development.

During a woman's formative years she will be exposed to images of being a 'good' mother. These may come from her own experience of being mothered and other role models she encounters. Once pregnant she will continue to receive messages about appropriate mothering from individuals around her and may attend antenatal classes to learn conceptually about her role as a mother.

The qualities of being a 'good' mother are to provide nourishment, love, comfort and help the child attain its potential. Decisions about whether to breast

or bottle-feed the infant are often made before or during pregnancy. In early pregnancy women are given messages from health professionals and significant others about the appropriate method of infant feeding. For some women successful breastfeeding will fit in with their view of being a good mother.

From the analysis of my data it emerged that conceptual and experiential knowledge of breastfeeding impacted on women's views of mothering. The woman is central to the analysis so the impact of breastfeeding on her 'being a mother', the development of self will be addressed first. Following this section a discussion is given about the woman's intuitive 'knowing' about being a mother and how she takes control of decision making about her breastfeeding activity. Then consideration will be given to the influence of others in affecting the woman's view of 'good' mothering, with particular reference to the place of child health surveillance

The Impact of Breastfeeding on 'Being a Mother'

Issues of 'good mothering' are explicit within both groups of breastfeeding women. For the early breastfeeders the women were concerned with demonstrating their ability to mother appropriately by providing adequate nutrition and comfort for their infant. Similarly the long-term breastfeeders believed they demonstrated their mothering capabilities by providing love, comfort and security through the breastfeeding act.

Breastfeeding is more than nourishing and nurturing a child (mothering) it may also represents 'being a woman' to some women. The success of breastfeeding

may not rest solely with the need to provide adequate nutrition for the baby but more to do with the individual seeing herself as a successful mother.

When health professionals offered advice that did not fit in with the mother's views then she was in dissonance about what action to take. Often she would follow her own view knowing this might be a source of conflict with others but this was an important step to take to enable her to fulfil her need to be a good mother.

Some women believed that their maturity enabled them to make appropriate decisions about the management of their body.

> 'I thought if I was younger and if I was more easily influenced I would have been I am sure, because I am sure younger women would be influenced by an authority like a doctor or a health visitor - but luckily I'm old enough and I had had my own opinion about it - I thought, oh, it's okay.' Gabby

Victoria acknowledges her maturity and her experience of mothering three children to reinforce her belief that she is able to make appropriate decisions.

> 'I'm not one to listen to lots of people – I just do my own thing. I think a young mother is so vulnerable – everything knocks you for six....you feel so helpless....and I feel it takes a fairly strong person to stand up and say I'm doing this because I want to do it.' Victoria

Decision-making was important and some women resent others trying to influence their decisions. This often arose because the opinions of others were contrary to their own. They wanted to take control of the decision making process.

'I am more the type who wants to deal with - because I thought she (a health professional) can't help me - I had to do it – if I'm convinced that I don't want to feed him any more, then I have to take steps - I don't need anyone else.' Gabby

In the interviews, women would talk about the role their partner (husband, boyfriend, or co-habitee) played in a supporting or non-supporting role. As the partner was present during the day-to-day lived experience of breastfeeding his thoughts, feelings and beliefs about breastfeeding were important to the woman. The woman would want to be seen by her partner to be a good mother and would seek reinforcement from him that she was doing her best in this role.

'I mean I think my husband was fine about it and very supportive.' Ann

'....he said "after all it's your own decision" - he said "if you can't stand it any more you'll have to stop, otherwise continue"....I remember asking him once whether he would be proud if I continued or if he would prefer me to discontinue, although I knew it was my decision and I had to do it, and then he said yes and it helped me a lot - although he couldn't really help me - but it helped me a lot when he said he supported it.' Gabby

'I think I said I wanted to breastfeed and that was fine and he's very encouraging and he's very supportive in the fact that he knows how time-consuming it can be and how you need to sit down for a long time and give the child such a lot of attention and he's happy to do the housework and he'll come home from work and start cooking the tea because the little one wants to nurse a lot at teatime and in that way he's very, very supportive.' Linda

The support of the male partner was clearly important to the woman and many partners were supportive of breastfeeding in the early weeks and months. However conflict could occur when the role of mother affected her role as partner. The woman's identity may have changed to being one that was primarily mother, and for first time mothers this was her first experience of being a mother which could be consuming. Women who had breastfed their children long-term would recount situations demonstrating the impact of long-term breastfeeding on his life. Although the men were generally supportive it appeared that a time came when they wanted the woman 'back' to her former role as partner.

> 'When we have a low patch, like everybody does, I'd say that he's probably got fed up with the fact that it's getting me down or fed up that Molly has been demanding it at really some inappropriate times - I mean it's never inappropriate theoretically....but there always is an inappropriate time when it's impinging on your – you have to have some personal sort of space or life I suppose - I think he's got cross about it - but I think it's more because he feels that I haven't left any space for me and therefore me and him as well.' Marie

Another source of conflict could be the termination of breastfeeding. The partner often raised the question of when breastfeeding was going to stop. Feelings that long-term breastfeeding generated for him could be embarrassment or exclusion. The views of the partner were important to the woman but often placed her in a difficult situation where she didn't want to terminate breastfeeding because it signified to her a quality of being child centred and a good mother but she sensed that breastfeeding could lead to a conflict between them.

'He generally was [supportive of breastfeeding] but there were times when it did seem difficult and at those times he questioned whether it needed to be continued. When we were having difficult nights, you know, those nights when they are up maybe every other hour and he would question then whether I needed to be feeding him at that time.' Jackie

Intuitive 'Knowing' about Breastfeeding and Motherhood

When making decisions about breastfeeding activities the woman may be guided by her authoritative knowledge about what is best for her and her baby. The embodiment of breastfeeding led women to speak about 'knowing' what was best for their child.

> '...I know, because I'm feeding him I know that milk is very nutritious, that I know for him.' Sophie

If intuition clashes with clinical logic women may follow this clinical logic rather than their own 'knowing'. For a woman to follow her intuition rather than the dominant medical discourse requires confidence in her belief system and the ability to trust in her judgement (Davis-Floyd and Davis 1997). However, several of the women demonstrated a strong belief in their intuitive attunement. In some cases this might have occurred by previous experience, for instance, when the woman had ignored her intuitive knowing when making previous breastfeeding choices.

When the women received conflicting advice they may protest that they know better than the person offering the advice.

> 'She (health professional) said "He is a big boy, you have to give him solids, you don't have enough milk" and I felt insulted because it's simply not true.' Gabby

Tension between mothers and daughters may arise when the daughter wants to take independent action. Throughout life this tension can exist between the parent and child and even though the daughter has reached adulthood conflicts may still arise. Becoming independent, making one's own decisions and taking responsibility for the body can be construed as being within the private domain. But their activities have public implications as public knowledge of their breastfeeding activity will be seen by others and can generate ideas about being a 'good' mother and whether her behaviour is considered deviant.

The Influence Of Others In Affecting The Woman's View Of 'Good' Mothering

A central theme in this section is how others transmit to the woman what they believe 'good' mothering is. This is often expressed in ways that define whether the woman is nurturing the child appropriately. The influence of health professionals, mothers and friends are particularly evident in the women's narratives. A strong theme that emerged from the narratives was whether breastfeeding was benefiting the child, which was predominantly measured in terms of nutrition.

Nutrition of the infant is often seen as an important benchmark of good mothering. The weighing of infants is one way that health professionals can monitor if the infant is thriving. However the child's intake of food can be a

source of conflict if others feel the food source is inappropriate or that insufficient weight is being gained.

Health visitors were generally cited as being unsupportive of a woman breastfeeding her child long-term. The usual source of tension was the health professionals' view that breastfeeding was replacing 'proper' food. The health visitors would suggest strategies to discourage prolonged breastfeeding and conversely encourage the child to eat 'properly'. These women were often of the opinion that breastfeeding served more than nutrition as they saw it as a source of comfort for the child. Hence this dominance on nutrition did not fit in with their viewpoint and was difficult for some women to accept. Some first time mothers had heeded the advice of the health visitor and terminated breastfeeding before they intended. When these women had a subsequent child they regretted their previous decision.

> 'She was suggesting that he should go in another room [to avoid co-sleeping] as that was why he wasn't eating - I didn't really co-operate. I mean I know she probably knows better than me really, but I just would talk to friends and things and I just didn't think that that was what it was - I spoke to other friends with children that don't eat and it didn't seem to have anything to do with whether they were breastfeeding or not.' Liz

Mother

The beliefs, values and attitude of a woman's mother towards breastfeeding seemed significant for many of the women. Some of the mothers of the women in this study had died prior to the birth of the woman's first child. For these women there was a sense of loss that their mother wasn't available to advise

and support them at the time of birth or in the early weeks of child rearing. During the interviews all the women discussed the significance of their mother's input. For some it was very supportive but for others there was a conflict of views. From the narratives it appeared that there was a special significance of the mother's relationship to her daughter during childrearing.

After giving birth, a woman's mother often gave advice to her daughter or talked about her own experiences of childbearing, which can be seen as social reproduction of knowledge. The transmission of knowledge or infant rearing practices can either reinforce beliefs, provide continuity, or be contrary to modern views and therefore be viewed as old fashioned or out of date, signifying change.

As mothers have reared their children in a different generation practices that were relevant then may not be supported in the current day. These mothers gave birth at a time when bottle-feeding was popular and liberating. At this time it was popular to regulate infant feeding where the use of time made it an ordered activity. Mothers were encouraged to feed their babies four hourly and minimise the time they fed their baby. Discipline of the infant was encouraged by restricting handling, to avoid spoiling the infant, and by establishing the infant into a routine. Currently women are encouraged to be child-led by 'demand feeding', carrying, cuddling and stimulating their babies. If a daughter embraces this laissez-faire system of childcare it may diametrically oppose the views of her mother, as demonstrated by the following quote.

> 'I have a younger sister. I can remember my mum feeding her, and she said it had to be ten minutes on the left boob then ten minutes on the

right boob. When I told her you're told to keep going until they're obviously full she was horrified. She said "but you'll have a little bloater." And I said "well that is what they (health professionals) say, and when he has had enough that side, you're supposed to change sides." "What" she said "both boobs at the same time?" She couldn't believe it. She said "the difference in advice nowadays....ten years ago babies were sleeping on their fronts, then their sides and now they are on their backs. In another ten years they will be hovering over the top of the cot!" It's just incredible the way it's changed. I suppose because you do listen to your mother and what she says to you, and then someone else will tell you different, you just get very confused but you want to do what is right.' Theresa

This conflicting advice may cause difficulties with mother-daughter relationships as the older mother may feel her child- rearing competence has been called into doubt. Women often said they thought their mothers were interfering when they were giving advice that the daughter didn't agree with, yet at the same time some daughters saw their mothers as givers of support.

CB - 'Was your mother important in the advice she gave you about breastfeeding?'

Sally – 'She was, but then after a while she started to get on my nerves because it was too often. She was just driving me bananas. I just found it was too much. I think you end up taking too much advice and in the end you just do your own thing, you should do that from the beginning.'

'My mum used to be hanging around saying "it's best to breastfeed" but she didn't force me into it. I wanted to anyway, but she helped me in the first week, she helped me put him on the breast because I wasn't told to do anything by anyone else, so yes, she was quite helpful.' Wendy

From the narratives of the long-term breastfeeding women their mothers were important sources of support, advice and conflict. The dynamics within the family structures were, on occasion, altered because of a woman's breastfeeding choice - on one hand it might strengthen the kinship but for most women they had some experience of acrimony within the relationship.

The women below had been mothers for at least two years and had their own authoritative knowledge of childrearing. Tensions sometimes arose between the advice a mother gave when it was in direct contrast to the beliefs of the daughter. If mothers appeared to be critical of their daughters ability to be mothers then the women often felt their own experiential knowledge of mothering did not count. In these circumstances the women would often turn to friends or support groups to receive recognition of their worth from like-minded people.

> 'My mother – it's very disappointing, really, you know I've given her books - when you look at this - because she says she breastfed me until 6 months, but I wasn't fed at night and I was fed every 4 hours and I survived and I was a very healthy baby and I went right on to a drinking cup. I would like to have my parent's approval or my mother's understanding of what I felt was good parenting and I suppose it's affected my relationship with her and she always thinks she knows better and in some ways it's very undermining because I felt, because I was a pretty scatterbrained teenager she still thinks that what I'm doing is a scatterbrained, sort of lazy way of raising my children. I'm being very lazy in not bothering to wean them or I'm under-involving them because I just can't be bothered to discipline them in a way that she always has and to be in bed at 7 o'clock, you eat your breakfast, you don't eat anything else, you eat your lunch. I don't do that and that is the way I raise my children....but I do know what I'm doing, but she

tends to say that I don't. But it's nice to have people in La Leche League who are all educated people....fortunately they recognise and support a different way of child rearing.' Alex

When asked about how their mothers viewed long-term breastfeeding the women use words such as 'disapproving', 'perverse activity', 'embarrassed' to express their mothers' opinions. Some women spoke of their own mothers' lack of breastfeeding experience as being responsible for the lack of support or negative reactions to the activity.

'I deliberately don't talk about it to her - it sounds awful, but it's actually helped, I think... it's because she wanted to and she was fully breastfed herself, and I think her sister was, but she tried and had bad advice, particular problems, who knows – I'm not sure.' Marie

'....neither of them had successfully breastfed, so they were fairly negative about it. My mother was maybe more supportive than my mother in law, because I think she probably felt a bit embarrassed about it at times....' Jackie

Some women developed strategies to avoid breastfeeding in front of their mothers. This was to avoid further discussions about the activity or cause a rift in their relationship.

'I mean sometimes I must admit I try and sort of fob Polly off if my mum was there – "go away Polly, get away." I don't think she was negative about doing it in the first instance, but I think she thought it was the kind of thing that you did for only a few months and then that was it - potty train them at 6 months and you gave them solids at 2 months and all that sort of thing.' Ann

'....sometimes I'd try and distract them if I thought it was possible, but she would as well - she would say "oh don't be silly, you're a big girl, you don't need that - come here" - and tried to drag her off - and give her something else instead.' Ann

Social Networks

Social networks are important sources of information and social support. In relation to childbearing, existing social networks may be strengthened during pregnancy and the birth of a child. However parents may be pulled out of their existing social contacts unless those connections are maintained through enduring social structural roles such as kinship (Munch et al. 1997). New social networks can emerge during pregnancy when parents come into contact with other pregnant couples. Some mothers may perceive their social network to be completely in the hands of the health professionals for it may be to them they turn to for advice and support. Others may seek the advice and support of other 'experts' such as breastfeeding counsellors and/or rely on information for friends and family.

The workplace is often a source of social support. Support networks that had been made through the work environment may be missed when the woman considers the impact this will have on her during maternity leave:

> 'I thought I would miss that – having your work colleagues when you're at home – but I see them regularly, we have lunch at least once a month.' Fiona

Emerging from the women's narratives was a sense that the opinions of others mattered. This occurred at several levels. During discussions with health

professionals, family and friends women may ask direct questions to these individuals in response to a breastfeeding query they had. Other times these individuals would impart their thoughts and views in response to what the woman was doing, without being invited to do so. This was fine if the comment was in line with the woman's own thinking but unsolicited comments, which were in conflict with her thinking, could be a source of difficulty.

Women often look to others to validate their experiences; confirm they are 'doing it right'; and seek opinions of how they may deal with the various developments in their breastfeeding lives. It emerged from my data that important influences in the formulation of authoritative knowledge are the woman's mother, other family members, female friends and health professionals.

The Support of Friends

> 'Sometimes it (breastfeeding) is very hard and I feel I want to stop – and then I know it's the right thing to do. I suppose if I hadn't had the right kind of support - if I hadn't got friends who've had similar experiences or who've breastfed long-term ....then my experience would probably be very different and probably that's had more impact then any contact with the health professionals.' Sophie

The women commonly cited their peer group as being the most supportive of their breastfeeding activity. The women often sought the views of 'old' friends (who existed before the childbirth experience) and 'new' friends (those made before and after the birth) to help validate their beliefs and experiences of

breastfeeding. The peer group was seen as comprising people who would understand the 'modern' tensions that breastfeeding could evoke. Those women who had personal experience of breastfeeding where seen as having authoritative knowledge to confirm the 'normality' of experience. This was especially so when the friends had breastfed for a similar length of time.

> 'I had friends in the street, and I have another friend who actually fed all three of her children, she lives over the road. She had extended breastfeeding with all of them, which is just a coincidence that we happened to be friends - so I don't have a problem with that and my other close friend, she breastfed hers. And I got a lot of encouragement because I'd breastfed mine as well - so I don't really have many friends who are not - well I don't have any really that are not sort of aware of it and perhaps even involved in it themselves.' Linda

The views of peers were often sought to 'check out' information or advice they had received from health professionals or mothers. Some women who became disillusioned with the information they received from health professionals turned to a support group to gain help from like-minded people.

Even when friends did not share the same views there appeared to be more acceptance that a woman would know best. Friends did not use the same strategies as mothers to persuade the woman to change her breastfeeding practice, although they might pass negative comments.

> 'Well there's two camps really - people who say "are you *still* feeding Arthur?" And then the people who say "oh you're still feeding Arthur, that's great." The people who express astonishment, nobody's ever really said anything negative or hurtful or said I shouldn't – but they've sort of implied disapproval.' Sophie

More conflicts arose if the length of time seemed excessive where there was lack of understanding about why the woman would want to continue for so long.

> 'I know I had a couple of close friends there who couldn't understand how I'd managed to go on for so long and they kept on saying well get him off and use a bottle. If I'd complained about having a bad night and I'd been up 2 or 3 times in the night ... they'd say 'well you're still not feeding him are you during the night?' - so they were a bit horrified.' Jackie

Many women will be content to use friends and family as support systems. However for some the more formalised approach to support that might be gained from health professionals or lay organisations is often sought by women. These systems of support might be the only ones available to the woman or she might invest more trust in the help and advice that comes from the 'knowledgeable expert'.

Antenatal Classes[25] as Source of Information and Social Support.

Antenatally, women will often access antenatal classes organised by health professionals or lay organisations that are promoted as helping women prepare for birth and caring for the new baby. Lay organisations that some women in this study accessed were the National Childbirth Trust (NCT) and La Leche League. During these classes information about different topics (e.g. labour, infant feeding, care of the new baby) are discussed that might influence the woman's decision making regarding these issues. The assumption is that

[25] Other terms for antenatal classes are parentcraft classes or childbirth preparation classes.

information, understanding and knowledge may impart a sense of gaining some control over the body. One of the main benefits of these gatherings is the provision of a social network. Often long lasting friendships emerge from this initial contact through antenatal classes.

Much discontent was voiced by the women in this study about the content of antenatal classes. The majority of respondents suggested that too much time was spent on the labour experience and not enough on discussing breastfeeding and 'parenting' a new baby (cf. Urwin 1985, Nolan 1997).

> 'I was surprised at how little you got through parentcraft classes. I actually thought that was what parentcraft classes were all about; feeding, bathing, knowing what makes (the baby) tick....but they were all about labour.' Wendy

> '.....everything was geared up to the day you actually had the labour.' Sally

Some women who attended hospital-based antenatal classes felt that by being placed in the hospital environment the focus of the meetings concentrated on physiology (e.g. stages of labour, breastfeeding) and 'service provision' (e.g. types of pain relief available, routines and rituals) rather than exploring the agenda of the women.

> 'By the time you go to parentcraft classes I think you've read about labour....I had read the facts. And it's interesting because we did a little quiz to see how much we already knew. Most people were getting eight or nine out of ten and yet we still had another three classes on labour after that.' Kate

The organisation of antenatal preparation should make reference to basic principles of adult education, facilitate discussion and be based on an orientation to consumer needs (O'Meara 1993). Several women in this study supported the view that breastfeeding women should be invited to antenatal sessions, in order to provide an opportunity to talk about the practicalities of breastfeeding. Although the availability of meeting breastfeeding women via the antenatal class provision was unavailable to the women in the study they had the opportunity to do this after the baby was born via postnatal groups.

Postnatal Support Groups

After childbirth, the social network may be reinforced by the provision of postnatal support groups where mothers can meet other mothers to discuss child rearing topics (e.g. infant feeding, immunisations, weaning). Again these groups can be organised by either health professionals or lay organisations. Some women enjoy meeting others in groups, where the group have a shared interest – parenthood/breastfeeding - others do not. Fiona was the only woman in the sample who had extreme, negative views about postnatal support. She had attended NCT antenatal classes but found the values and attitudes towards childbirth opposed to her own.

> 'I wouldn't do it (attend NCT classes) again and I wouldn't recommend it to anyone. They seem to have a very peculiar view of childbirth.' Fiona

Fiona's strong opinions were probably influenced by choices she had to make about the mode of her child's birth. Following medical advice she agreed her baby would be born by caesarean section. When she raised this issue within the

NCT group she did not feel the NCT members were supportive as they prized the accomplishment of birth by the vaginal route. Despite her negative feelings about the organisation she attended a NCT postnatal support group but her views remained unchanged.

> 'I'm a great social animal but I am not one for just sitting around in groups talking about a subject. There is a woman who has taken on the mantle of the post-natal co-ordinator. There is a great long list of coffee mornings and this and that...she tried desperately to make friends all the time, it turns me the other way really – I'd rather sit in a cupboard under the stairs – so there you go. I know that I have done the best for my daughter so far and that's it – I don't need a counsellor to tell me, I don't need a coffee morning to sit round and talk about it – I know I have done my best.' Fiona

Fiona had intended to breastfeed for several months but terminated breastfeeding after two weeks due to pain and bleeding nipples.

> 'I had a bit of guilt but I think a lot of that was NCT guilt – instilled in you – it seems they think you must breastfeed until 3 years (of age).' Fiona

Lack of Support from Health Visitors

The health visitor is the health professional that women are likely to encounter for the first five years of an infant's life. Health visitors have a responsibility to monitor the welfare of the under-5s in the UK. The interactions between a woman and health visitor usually take place at the child health clinics (often situated in the health centre) or in the child's home. For the first time mother the interactions with the health visitor may, at the time, be seen as reassuring. Women will want confirmation that they are caring for their infant

appropriately and may seek guidance about childrearing issues. The women found health visitors supportive when the information they gave was close to their viewpoint, or the health visitor was willing to support the woman in her actions even though these might be different from her own. However when issues were raised that the woman felt were contrary to her belief conflict might occur.

The growth measurement of the infant is commonly used to denote well-being which means that nourishment is a key topic during the consultation. The health visitor is seen as an 'expert' on weaning issues and her advice may be sought to confirm the woman is feeding her infant appropriately. Women commonly talked about the role the health visitor had in influencing their breastfeeding activity. Although it could be a supportive role the women were particularly affected by tensions which arose regarding their breastfeeding activity. Some women felt they had terminated breastfeeding prematurely on the advice of the health visitor, when the health visitor had suggested that breastfeeding was preventing the child eating appropriately.

> 'I was actually talked into it by a health visitor, which I really regret bitterly.' Victoria

> 'I think there was this pressure then to get her onto a bottle – (it) was suggested by a health visitor .... I felt a lot of guilt with it ....looking back quite shortly after that time had I been more relaxed it would have worked itself out anyway, I would have continued breastfeeding, but at the time you feel pressurised and that made me make certain decisions.' Jackie

Although all the children who were breastfed long-term were taking solid food, the health visitor would often suggest reducing breast contact in order to increase the food intake of the child. The women saw breastfeeding the older infant as primarily a source of love and comfort, not nutrition, therefore the rationale for reducing or terminating breastfeeding was difficult for the women to understand. However the views of the health visitor were often taken seriously as she was the expert and the women wanted to be good mothers, in effect she was casting doubt on the her ability to nourish her child adequately.

> 'She's always been a really poor eater - I mean real food, as it were - and a couple of times the health visitor has suggested well if I did less breastfeeding maybe then she would eat more - that was at about the age of 1 and 2 - but it hasn't made any difference, she still doesn't eat much at all.' Ann

> 'The last time I went to the health visitor they weren't really happy that he was still breastfeeding. They thought that was what was stopping him eating - but I might be wrong but I felt it wasn't that at all - I felt he was just one of these children that doesn't eat much. The (health visitor) that I spoke to said that I should stop the night feeding. I didn't really co-operate - I mean I know she probably knows better than me really, but I just would talk to friends and things and I just didn't think that was what it was.' Liz

With subsequent children experienced mothers found ways to avoid discussing issues with the health visitor that they perceived would be a source of conflict or avoiding going to the child health clinic trusting that they would be able to monitor their infant's welfare without the sanction of the health professional.

> 'I had one health visitor who wasn't very supportive really of breastfeeding and I hadn't had a very good experience with her with

Mary....so I think I was quite choosy what I said to her next time. I don't think I allowed myself to get into that sort of debate with her, I just did my own thing and carried on really.' Jackie

'I'm kind of nervous of asking a health visitor now because I know they disapprove of me doing it anyway – I'm almost frightened to go.' Liz

'I've lost faith a bit in health visitors so now I tend not to say anything at all because they've got a completely different way of looking at things. The way that they are trained, it's just coming from a whole different perspective to the way that I feel that things should be....I've always felt like the health visitors don't....(they) see it as a process, and that's the way you do it and you don't do anything differently and if you have problems, what else can you expect really if you don't do it this way. And it's such a narrow way of looking at things.' Sophie

Regulating Breastfeeding by Myths

In the medical literature much is written about the benefits (primarily to physical health) of breastfeeding for both woman and infant. This literature is focussed on short-term breastfeeding activity. It becomes apparent that breastfeeding long-term can be seen by others as a risky activity. Women in this study gave many examples of how others would comment how they were endangering their own health, and that of their child by breastfeeding long-term. To promote regulation of breastfeeding others may use myths to influence the breastfeeding activity. Mothers who believed they had authoritative knowledge about appropriate child rearing might see long-term breastfeeding as 'ruining the daughter's health' and/or 'spoiling or harming the child's health'.

To persuade a woman to terminate breastfeeding myths were sometimes introduced as a strategy to change her behaviour.

Daughter's Health

As night time feeds can affect the sleep pattern of the parents too, comments about a child's persistent need to breastfeed at night may be couched in concerns over the woman's health.

> 'I mean I was very tired....but if I talked to mum....I got the impression that, well it's your own fault if you're tired.' Marie

> '.... "why don't you stop, you can't complain you're tired, it's your fault" - all that sort of thing.' Ann

Mothers may seem to be caring for their daughter's welfare but the women interpreted these comments as another means to cajole them into stopping breastfeeding.

> 'And then of course mother and her whole generation couldn't believe that I'd want to continue so long - mostly because, what about my time, what about - they seem to be so worried about where's my freedom and where's my independence and my free time - and it appears to be something that that generation is very hung up about – you've got to get your children in bed by 7 o'clock - then it's your time – I'd rather spend my time with my children.' Alex

Risk to the Unborn

Breastfeeding in pregnancy, and tandem breastfeeding[26] are unusual activities in the UK. Many women will give up breastfeeding when they want to conceive or as soon as they realise they are pregnant. Cross-culturally the cessation of breastfeeding due to pregnancy is common and there is little cross-cultural documentation of intentional breastfeeding in pregnancy or tandem breastfeeding. Considering the social conflicts long-term breastfeeding caused for some women it seems unusual that women in the UK would breastfeed in this way. Little research has been conducted on women's motivations to continue breastfeeding during pregnancy and thereafter tandem breastfeed a baby and toddler. Moscone and Moore (1993) conducted one such study in the US which identified the women as being in favour of child-led weaning which influenced the duration of breastfeeding.

In this study two women breastfed while pregnant. In the following extract a woman who is breastfeeding while pregnant consults her GP. She is made to believe that breastfeeding in pregnancy is a 'risky activity' as a comment was written in red by her GP on her notes and further comment made during a hospital visit. She uses her professional knowledge to interpret *their* actions as meaning she is undertaking a potentially harmful activity, which could increase her chance of miscarriage. However although she has 'expert' knowledge she clearly believes that point of view rests with others and is not shared by her so she does not modify her behaviour and continues to breastfeed her toddler.

[26] Tandem breastfeeding means that two (or more) children are breastfed, for example a baby and toddler.

'I was still nursing Steven when I became pregnant, so when I had my booking in visit with my GP he said "do you plan to breastfeed" - so I said "well seeing as I'm still feeding Steven now, yes I suppose I will" and he said "what? you're still breastfeeding?" I said "yes, I am"....and he put in red on my notes 'still breastfeeding' – in red. Then I went for my booking in visit to the hospital and said "I'm still breastfeeding my son, coming up 2 years old" – "oh, you're still breastfeeding?".... 'still breastfeeding' was written on my notes again. I thought – I'm a health professional myself and I knew why, with the risk of miscarriage *they* attribute to breastfeeding and I thought, that's interesting, but I could see for some mums who didn't understand it might be a bit worrying that they've put it in red.' Linda

Another woman, Sophie, who breastfed while pregnant gave accounts of how both her mother and a neighbour (an older woman) suggested she would damage her fetus if she continued to breastfeed during pregnancy. The mother was concerned that the fetus would not receive enough nutrients from its mother if she was breastfeeding another child. In this case the fetus had become public property and was being 'protected' by the older women who felt they had a right to inform the next generation of the correct way to behave. Sophie wanted to be seen to be a good mother so these comments about damaging her fetus weighed heavily on her mind. In conversations with both her mother and neighbour Sophie felt it necessary to demonstrate the lack of harm to the unborn baby by reading about the subject then reiterating the facts to these older women.

Risk to the Health of the Child

Women who were breastfeeding long-term would comment that they felt their mothers 'blamed' breastfeeding for physical or perceived behavioural difficulties in their children. A key theme that arose was the issue of independence of the child. Enabling a child to become independent is an important goal for many members of UK society. From babyhood parents encourage their child to reach the next stage of development e.g. weaning, sleeping through the night, sleeping alone. A child being able to do things for itself is seen to be progressing. If the child is seen to be dependant on a parent for 'too long' then others may believe this is unhealthy and encourage strategies to create independence. Long-term breastfeeding raises an interesting discord as the activity may be seen as belonging to a baby and not suitable for a toddler. Those who are uncomfortable about the role breastfeeding has to play for a toddler may believe it is marring the creation of independence from its mother.

> '[She would say] "he's too dependent on you, you're keeping him as a baby, you're doing everything for him - make him independent" and all the same kinds of things about sort of training your kids early, I guess, like feed them early and potty train them early and give them a bit of a smack if they are naughty - all that kind of thing - it always seems to go hand in hand really.' Marie

A child's ability to sleep through the night is another important step towards independence.

> 'And I had lot of negative stuff from my mum as well - she was one of these who's into sort of giving food you know really early and all of that kind of thing - and said "oh they don't sleep because you breastfeed them and if you give them more solids they'll be fine." ' Ann

To reinforce 'harm' that a woman may incur during breastfeeding the health professional may present information as a 'fact'. The women usually believed the health visitor was a knowledgeable expert who had access to credible information therefore these explanations could cause great consternation. The following accounts illustrate the myths used to by health visitors to encourage termination of breastfeeding.

> '....she (health visitor) is one of the ones who said that if the baby doesn't take solids between 8 and 9 months their speech doesn't develop properly.' Eve

> 'she (health visitor) was really telling me that *my* feeding, breastfeeding, is bad for children.' Liz

In this chapter it has been demonstrated that women use authoritative knowledge to help them manage their breastfeeding experiences. However women are not breastfeeding in isolation but draw upon, or are exposed to, others' opinions in their social world.

For both the early and long-term breastfeeders the act of breastfeeding exposed the women's feelings about their concept of mothering associated with this act. Both groups have demonstrated different foci on their notions of mothering. However, the importance of breastfeeding for the women either as a nutritive and/or nurturing act may be called into question when others do not share similar values or beliefs. All the women found conflicting opinions from others about their breastfeeding activity an area of concern and tension.

For most women, their social networks are important structures in their everyday lives therefore when conflict occurs this can challenge their beliefs about being a 'good' mother and disrupt the dynamics with those around them.

Chapter Seven
Discussion

This study has demonstrated that the process of breastfeeding is not only an enjoyable, satisfying experience for many women but is also one that can contribute to changes in self and social identity and generate conflicts which affect the social world of these women.

For each of the women in this study the breastfeeding act impacted on their life, in various ways, regardless of its duration. The method of collecting and analysing the data proved to be suitable for this type of study. The use of narratives enabled me to develop an appropriate insight into the social worlds of these women and provided an opportunity to explore the opinions of these women.

From this thesis four significant areas have been demonstrated:

- The construction of motherhood
- Management of conflict in the woman's social world
- Breastfeeding experiences and weaning decisions
- Significance of findings for health professionals

The Construction of Motherhood

Both the early and long-term groups of women viewed their breastfeeding activity as synonymous with being a good mother. For the early breastfeeders the embodiment of breastfeeding gave rise to an identity of motherhood. The letdown sensation clarified the woman's sense of identity of motherhood by its occurrence in response to the baby's cry; its presence when the baby was

feeding at the breast; the leaking of breastmilk confirming her ability to nourish her baby.

The long-term breastfeeding women, who might be breastfeeding into their child's fourth year, had different concerns – that of being able to continue being a 'good mother' against the hostilities of others. The women frequently found that those around them did not share their ideas of 'good mothering'. From the women's perspective, they were acting in the best interest of the child while the dominant viewpoint of those around them was that they were attending to their own needs rather than those of the child. These mothers held a more holistic approach believing that breastfeeding was attending to a range of their infants needs, not just nutrition. It is important to realise that breastfeeding is not only about an infant or child; the mother's fulfilment is important too and may contribute to her views of being a 'good' mother. The judgement the woman makes about her role as mother will be important to her sense of self identity (Weaver and Ussher 1997).

Responsibility for the health and well-being of the family is an important issue with regards to the definition of a good mother (Hays 1996, Tardy 2000). However, there is a confusing maze of information advising and instructing mothers about caring for their children. Mothers have to find ways of manoeuvring through the different forms of knowledge at their disposal. They must decide when to seek advice - from health professionals, friends and family, childcare books - or rely on their intuition. Furthermore concerns about when and what to divulge to others must also be considered. Those long-term

breastfeeders who received negative feedback from others when they voiced concerns about their child quickly learned who was sympathetic to their concerns, and who was not. It became apparent that the long-term breastfeeding mothers were sometimes caught in a struggle between following family practices, the advice of health professionals and their own intuitive notions. This dilemma has real consequences as not only does the woman hold herself responsible for the well-being of the child but others will hold her responsible too. For some women long-term breastfeeding was managed as a clandestine activity to avoid situations of conflict. It has become clear within this study that there is not a universal experience that binds breastfeeding to motherhood. The social and personal influences on the women's breastfeeding experiences are important factors.

Management of Conflict in the Woman's Social World

It is obvious that breastfeeding is not 'just' a nutritive act but also one bound up with feelings of motherhood, love and care. However to carry out this role the women have to negotiate their way through a social minefield of obstacles which result in them negotiating the right to do what they feel they should. Many of the women in this study found they had to manage a number of conflicts during their breastfeeding histories. These might occur between health professionals, family, friends or strangers. Breastfeeding in front of others, whether it be in domestic or public places, was often problematic. The women negotiated the time and place to breastfeed with, sometimes, military precision. Although the public health discourse focuses on the health benefits of breastfeeding to mother and child, there is little attention to the social

consequences of this act. For some women breastfeeding restricts opportunities to get out of the home and movements in public spaces. The generally negative attitude to breastfeeding in public coupled with the woman's views about exposing her body makes breastfeeding problematic.

The impact health professionals had on the experiences of women were conflicting. On the one hand the health professionals were seen as 'experts' who had access to knowledge and were seen as important sources of information. Yet, their credibility was brought in to question when their viewpoint did not correspond with the experiential knowledge of the woman. This was also true of the interactions between several of the women and their mothers. The women were content to listen to advice from their mothers providing it fitted into the value systems they held themselves. The women in the long-term group, particularly, developed the ability to avoid conflict with others by not discussing their breastfeeding practices with those who might criticise what they were doing or made them feel uncomfortable. These women were not dissuaded from their breastfeeding activity despite negative responses from others but might shroud the breastfeeding act in secrecy. This response is similar to how other aspects of childcare are managed when they arouse conflicts in opinion regarding appropriate behaviour, such as co-sleeping (Okami 1995, Byard 1994, Jackson 1992)

The conflicts that arose had an influence on the social world of each woman. It became obvious that the social influences of others ultimately affected the woman's belief in her body, the acceptance of this act and probably contributes

significantly to the continuance of short breastfeeding durations (Murphy 1999, Tarkka et al. 1999).

The media has a significant influence on the public's perception of breastfeeding. The media discourse of breastfeeding has commonly featured two aspects of breastfeeding that are found in this study; breastfeeding in public places and breastfeeding the older child. For both groups of women it was necessary for them to negotiate their breastfeeding activities within the gaze of others.

When individuals hold different values and beliefs about a social practice conflicting opinions might result. This often occurs when taken for granted notions are being challenged. For example, an experienced mother may perceive that her daughter regards her experiential knowledge as 'old fashioned'. Conflict is often a stimulus for social change. When a conflict in opinions occurs the opinions of others have to be considered. This might result in strategies being implemented to either resolve the conflict or avoid the situation that produces the conflict. This was evident within the accounts of the early breastfeeders when the women might explain to their mothers the current flexible approach to breastfeeding rather than the rigid feeding routine their mothers were encouraged to follow. Although the woman's mother might highly value her experiential knowledge she might embrace current opinion in order to offer breastfeeding support to her daughter. Conversely, for those long-term breastfeeding women who found themselves in conflict over whether their child should be breastfed

these women might confine breastfeeding to a clandestine activity in order to avoid the conflict.

Sometimes conflicts at one level, such as lack of understanding by kin, might lead to social cohesion in another group such as support groups. This was evident in both groups of women where postnatal support groups and lay organisations, such as the National Childbirth Trust and La Leche League, were often utilised to validate and support the women's breastfeeding decisions.

Influences on Weaning Decisions

Weaning the child from the breast can be mother-led or child-led. Those women who ceased to breastfeed their baby past the initial weeks of infancy undertook mother-led weaning. Those women in the long-term group were more child focused hoping their child would terminate breastfeeding when she/he was ready. For the early breastfeeding group the significance of weaning decisions was not a priority. The focus during the interviews was to talk about the women's struggles to breastfeed successfully rather than curtail to the activity. For the long-term group the women spoke of a long history of dialogue from different people about the concerns of their continued breastfeeding activity. Those people around the women (family, friends and health professionals) participated in the discourse to influence the cessation of breastfeeding. As breastfeeding is culturally embedded in the nourishment of babies many people found it difficult to understand the need to breastfeed a child who was walking, talking and partaking in adult food stuffs. However for the women breastfeeding had a different meaning. They did not see

it as a primarily nutritive act (except at times of illness in the child) but one associated with the provision of comfort and character forming.

Significance of Findings for Health Professionals

The health visitor was one health professional the women in this study had most contact with. Although several of the health visitors were reported to be helpful, the most criticism of health professionals was levied at health visitors. Hostilities are not surprising as the health visitor is seen by others (not necessarily themselves) as working with definitions of 'good' and 'bad' mothering and attempting to shape mothers in particular directions (Abbott and Sapsford 1991).

Traditionally, health professionals have been taught about lactation from a predominantly scientific basis. Consequently they draw on a base of knowledge informed by scientific, research-based information to explain the success and complications associated with breastfeeding. Health professionals then transmit this knowledge to women as reliable, scientific information. The power of the medical discourse is that it is clothed in an aura of science and thought to represent objective truth. It gains a privileged position in relation to other discourses about the body. The dominance of 'information giving' based on scientific knowledge treats the individual as existing in a social vacuum and fails to confront the complex social world in which subjectivity is constructed (Lupton 1995). Whilst there have been moves in medical practice towards greater recognition of the experience of the lay individual (Armstrong 1984, Kleinman 1988, Clark and Mishler 1992), these moves have been very partial and uneven, especially in relation to the recognition of female experience. The

medical/biological approach underpinning health education models treats women as a homogeneous group and breastfeeding as a biological process. This creates a gap in knowledge because it stops short of an understanding of collective, shared beliefs and values about the body, and of variations in individual experience.

The medical conceptualisation of the female body has been born out of the dominance of authoritative, scientific models. The language used to describe female bodily functions simulates industrial metaphors concerned with production and control (Corea 1985, Martin 1989). In contrast to the medicalization of childbirth, holistic discourses may influence the woman to listen to her body, to be guided by her own intuition and to have faith in her abilities as a woman.

Providing support, information and consistent advice has been shown to be effective in helping women to continue breastfeeding (Sikorski and Renfrew 1999). Those women who feel unsupported or receive conflicting advice are more likely to discontinue breastfeeding (Garcia et al 1998). It is essential that research findings be disseminated to health professionals to encourage changes in professional practice. My study offers a significant contribution to the research on breastfeeding. The initial focus of how letdown can affect a woman's experience of breastfeeding provides an opportunity for health professionals to gain a better understanding of the lived experience of breastfeeding. It has been demonstrated that women engaged in long-term breastfeeding often encounter difficulties in their social relations with others while engaged in this activity. If health professionals can gain a greater understanding about why women might breastfeed long-term then they would be in a better position to support women

who engage in this activity. The findings can contribute significantly to the advice and support health professionals provide for breastfeeding women.

In order to disseminate the findings of this research study it is necessary to make the information widely accessible to health professionals. It is my intention to use the findings of this study to encourage changes in breastfeeding advice and support given by health professionals. This can be achieved by;

- Involvement with the formation of local breastfeeding policies at a Health Trust level. These policies are formed by health professionals to encourage the use of research based findings in supporting breastfeeding women and reduce the incidence of conflicting advice.

- Attend local research seminars to share the findings and provide an opportunity for the information to cascade between health professionals.

- Attend national and international conferences to present papers on the findings.

- Publish further papers within academic and health professional journals.

Within this study it has been shown that health professionals often hold a biomedical viewpoint about breastfeeding which can ignore or minimise the experiential or intuitive knowledge of the breastfeeding women. In these circumstances women might turn to lay organisations in order to receive the support they require. Lay organisations such as the National Childbirth Trust and La Leche League are run by women who have personal experience of breastfeeding. The advice and support that a member of a lay organisation gives

will come from experiential knowledge which can be perceived as a shared 'knowing'. Historically there have been stormy relationships between health professionals and lay organisations associated with childbirth. Health professionals have assumed the role of 'expert' based on their medical knowledge whereas lay organisations have keenly expressed the views of women often by being critical of health care provision for women. Both health professionals and lay organisations have valuable knowledge and experience which can contribute to improving breastfeeding advice and support for women. In recent years progress has been made to encourage integration of these roles. Some effective partnerships have evolved such as the recommendation by health professionals of local breastfeeding counsellors, peer support networks and 'buddy' systems provided by lay organisations. However there are regional differences in the integration of lay and professional support services. Further development is needed by health professionals to form more effective partnerships and utilise the contribution lay organisations can make to provide effective health care.

Conclusion

This study has demonstrated that breastfeeding, for the women in this study, is embedded in a complex social context. Although the dominance of biomedical knowledge influences the breastfeeding discourse to a considerable extent, it is important to acknowledge what effect social influences have over this important event. Breastfeeding is not a solitary incident affecting one woman at one time; it is a social activity that a woman may engage in for many months in both a macro and micro social environment. The experience of these women

has revealed the complexities of their social worlds and illustrated how problematic breastfeeding can be.

Breastfeeding research has been primarily concerned with promoting the uptake of breastfeeding. Although this is important, it is clear that those women who start breastfeeding in the UK do so for relatively short periods of time. In this study the women's perceptions about their lactating bodies were important to their understanding about their bodies. Often what they constructed as 'failure' was actually normal (e.g. not leaking milk from the breast). The opinions of others were important too. The visibility of breastfeeding in the public arena is widely reported in the media as being a problematic activity needing social control. The emergence of private, secluded areas within which to undertake breastfeeding has reinforced the social aversion associated with breastfeeding as a public activity. This study has contributed to the understanding of why some women might engage in long-term breastfeeding however further study of this area might lead to a greater understanding of how breastfeeding women can be supported.

The term 'breastfeeding' is a misleading and ambiguous term. Breastfeeding is more about nurturing than nutrition and *feeding*. This study has demonstrated that the baby and child receive more than nutrition from this activity and there is a social significance for the mother too. In the conflicts women had with others about their breastfeeding activities the perceived inappropriateness of the child receiving nutrition from the breast was a major concern of many. A move towards a more holistic approach to breastfeeding should be encouraged.

However, although the results of research improve an understanding of the biological benefits of breastfeeding and strategies to improve the number of women initiating breastfeeding, the social context of breastfeeding has to be considered to gain an improved understanding of the conflicts and dominant forces which shape breastfeeding for many women.

Appendices

Appendix 1.

Age, occupation, parity and marital status of 35 early breastfeeding women.

Age in years	Number of women	Occupation	Parity P = primipara M = multipara	Marital status W= married C = co-habiting L = lone parent
20	1	Housewife	P	W
21	1	Student	P	C
22	0	-	-	-
23	3	Airport worker Clerical worker Housewife	P P M	C C W
24	1	Shop assistant	P	W
25	1	Airport worker	P	C
26	3	Secretary Nanny Housewife	P M M	C W W
27	2	Secretary Housewife	P P	W C
28	3	Manager Manager Housewife	P P P	W C C
29	3	Public Relations assistant Housewife Housewife	P M M	W C C
30	3	Retail Manager Retail Manager Project worker for the homeless	P P P	W W C
31	2	Nurse Clerical worker	P P	W W
32	4	Teacher Midwife Midwife Housewife	P P M M	W W W W
33	1	Lecturer	P	W
34	1	Teacher	M	W
35	3	Lecturer Teacher Health Visitor	P M M	L W W
36	1	Solicitor	P	W
37	1	Housewife	P	W
38	0	-	-	-
39	1	Health Visitor	M	W

Age range:- 20-39 years. Mean age = 29.3 years. Median age = 29 years.

Appendix 2.

Age, occupation, parity and marital status of 16 long-term breastfeeders.

Age in years	Number of women	Occupation	Parity P = primipara, M = multipara	Marital status W= married C = co-habiting L = lone parent
30	1	Secretary	M	W
31	0	-	-	-
32	1	Midwife	M	W
33	2	Teacher Nurse	M M	W W
34	2	Journalist Nurse	M P	W L
35	1	Nurse	M	W
36	2	Teacher Manager	M M	W W
37	1	Community activist	M	C
38	2	Manager Housewife	P P	W W
39	2	Chaplain Masseur	M M	W W
40	0	-	-	-
41	0	-	-	-
42	1	Health Visitor	M	W
43	1	Teacher	P	W

Age range:- 30-43 years. Mean age = 36.18 years. Median age = 36 years.

Appendix 3.

Age of children of the primiparous long-term breastfeeders and duration of breastfeeding.

Age of children at time of interview	Number of children in sample	Duration of breastfeeding
less than one year	0	-
1-2 years	1	2 years
2-3 years	3	2.5 years Ongoing at 2 years 2.5 years
3-4 years	2 (1 set of twins)	Ongoing at 3 years

Appendix 4.

A table indicating the length of breastfeeding by birth order in the families of the multiparous long-term breastfeeders (n=12).

Number of child in family	Birth order	Age of child now	Duration of breastfeeding
Two	First born Second born	8 years old 4 ½ years old	2 ½ years 3 ½ years
Two	First born Second born	6 years old 18 months old	3-4 days ongoing
Two	First born Second born	9 years old 6 years old	9 months 2 years
Two	First born Second born	3 years old 21 months old	11 months 16 months
Two	First born Second born	5 ½ years old 3 years old	Just over 2 years ongoing
Two	First born Second born	6 years old 4 years old	18 months 2 years
Two	First born Second born	2 ¼ year old 11 months	Ongoing Ongoing
Two	First born Second born	8 years old 3 years old	4 years Ongoing
Three	First born Second born Third born	6 years old 3 ½ years old 17 months old	8 weeks 20 months ongoing
Three	First born Second born Third born	8 years old 6 years old 3 ¼ years old	1 year Just under a year Ongoing
Three	First born Second born Third born	17 years old 14 years old 5 years old	3 years 10 weeks 2 ½ years
Four	First born Second born Third born Fourth born	14 years old 11 years old 8 years old 2 years old	4 years 2 ½ years 2 years Ongoing

Appendix 5.

Age ranges of the 29 children born to the multiparous long-term breastfeeders and the duration of breastfeeding.

Age range	Number of children	Feeding method	Duration of breastfeeding
less than one year	1	Breast fed	Ongoing at 11 months
1-2 years	2	Breast fed Breast fed	Ongoing at 17 months Ongoing at 18 months
2-3 years	3	Breast fed Breast fed Breast fed	Ongoing at 2 years Ongoing at 2 ¼ years 16 months
3-4 years	5	Breast fed Breast fed Breast fed Breast fed Breast fed	Ongoing at 3 years Ongoing at 3 years Ongoing at 3 ¼ years 11 months 20 months
4-5 years	2	Breast fed Breast fed	2 years 3 ½ years
5-6 years	2	Breast fed Breast fed	2 years 2 ½ years
6-7 years	5	Breastfed/Formula milk Breastfed/Formula milk Breast fed Breast fed Breast fed	3-4 days then formula milk 8 weeks then formula milk under 1 year 18 months 2 years
7-8 years	0	-	-
8-9 years	4	Breast fed Breast fed Breast fed Breast fed	1 year 2 years 2 ½ years 4 years
9-10 years	1	Breast fed	9 months
10-11 years	0	-	-
11-12 years	1	Breast fed	2 ½ years
12-13 years	0	-	-
13-14 years	0	-	-
14-15 years	2	Breast fed Breast fed	10 weeks 4 years
15-16 years	0	-	-
16-17 years	0	-	-
17-18 years	1	Breast fed	3 years

Appendix 6.

Pen-portraits of early breastfeeders quoted in the text.

Abigail is a 30 year old woman who is cohabiting with her partner. She is a project worker for the homeless. Abigail is primiparous[27]; breastfeeding her daughter who is 5 months old.

Ailsa is a 36 years old married woman who is a solicitor. She is primiparous; breastfeeding her daughter who is 4 ½ months old.

Amy is a 31 year old married woman who is a nurse . She is primiparous; breastfeeding her 11 week old daughter.

Andrea is a 35 year old married woman who is a teacher. She is multiparous[28]; breastfeeding her 5 ½ months old son.

Angela is a 25 year old woman cohabiting with her partner who has an administrative position at Heathrow airport. She was brought up in Sunderland, NE England. She is primiparous and breastfed her son for 4 months.

Charlotte is a 30 year old married woman who is a manager in the retail industry. She is primiparous; breastfeeding her son who is 4 months old.

Daphne is a 32 year old married teacher. She was brought up in Dundee, Scotland. She is primiparous; breastfeeding her daughter who 4 ½ months old.

Dympna is a 31 year old married women who is a clerical worker. She was brought up in Northern Ireland. She is primiparous and breastfed her daughter for 8 weeks.

Fiona is a 30 year old married woman who works as a retail manager. She is primiparous; she breastfed her daughter for 2 weeks.

Gillian is a 24 year old married woman who is a shop worker. She is primiparous; breastfeeding her 4 month old child.

Helen is a 35 year old lecturer who is a single parent. She is primiparous; breastfeeding her son who is 4 months old.

Jean is a 23 year old woman who is cohabiting with her partner. She has a manual job at Heathrow airport. Jean is primiparous; breastfeeding her 11 week old son.

Kate is a 28 year old woman from the Netherlands who is cohabiting with her partner. She has a managerial occupation. Kate is primiparous; she had difficulty with breastfeeding initially and changed to artificial formula milk after 5 days.

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[27] Primiparous is the term given to a woman who has given birth to her first child.
[28] Multiparous is the term given to a woman who has given birth to more than one child.

Maggie is a 29 year old married woman who is a public relations assistant. She is primiparous and she breastfed her son for 7 weeks.

Penny is a 27 year old married woman who is a secretary. She is primiparous; breastfeeding her 3 month old son.

Rebecca is a 37 year old married housewife from the United States of America. She is primiparous and gives her 4 ½ month old daughter both breastfeeds and artificial formula milk.

Sally is a 29 year old housewife who is cohabiting with her partner. She is multiparous; breastfeeding her 3 month old daughter.

Sarah is a 26 year old married housewife. She was brought up in Aberdeen, Scotland. Sarah is multiparous. She breastfed both her children, currently breastfeeding her 4 month old son.

Sharon is a 23 year old clerical worker who is cohabiting with her partner. She is primiparous; she breast fed her daughter for 3 ½ weeks.

Stephanie is a 28 year old married woman. She has a managerial occupation. Stephanie is primiparous; breastfeeding her 15 week old daughter.

Theresa is a 27 year old housewife who is cohabiting with her partner. She was brought up in Northern Ireland. Theresa is primiparous; breastfeeding her 3 month old child.

Tracey is a 21 year old student who is cohabiting with her partner. She is primiparous and breastfed her daughter for 3 ½ weeks.

Vanessa is a 26 year old woman who is cohabiting with her partner. She is a secretary. Vanessa was brought up in Leicester. She is primiparous; breastfeeding her 4 month old son.

Wendy is a 28 year old housewife who is cohabiting with her partner. She is primiparous; breastfeeding her 4 week old son.

Zosha is a 20 year old married housewife from Yugoslavia. She is primiparous; breastfeeding her 4 ½ month old son.

Appendix 7.

Pen-portraits of long-term breastfeeders quoted in the text.

Alex is a 38 year old housewife married to a man from Japan. She is breastfeeding 3 year old twins. As she is pregnant she is trying to restrict their breastfeeding activity to night-time only.

Ann is a 34 year old married journalist She has an 8 year old son who she breastfed until he was 2 ½ years old. She encouraged cessation of breastfeeding when she was pregnant with her second child. Her daughter is 4 ½ years old and she was breastfed until she was 3 ½ years old. Ann will give birth to her third child imminently.

Breda is a 30 year old married secretary. She has two sons. Her first son is 6 years old. He was breast initially but she gave up breastfeeding after 3-4 days while in hospital and continued to bottle feed him. Her second son is 18 months old and is still breastfeeding.

Eve is a 38 year old married manager. She has a 2 ½ year old daughter who stopped breastfeeding at 2 years of age. Eve purposively stopped breastfeeding prior to becoming pregnant. Her second child is expected imminently.

Gabby is a 43 year old married teacher from Germany. She has one son who is 3 years old. She breastfed until he was 2 ½ years old.

Jackie is a 42 year old married health visitor. She has a 9 year old daughter who was breastfed for 9 months and a 6 year old son who was breastfed for 2 years.

Karen is a 36 year old married manager. She has two daughters. One is 3 years old and was breastfed for 11 months. Her second child is 21 months old and was breastfed for 16 months. Karen is four months pregnant.

Linda is a 35 year old married nurse. She has three sons. Her first child is 6 years old and was breastfed for 8 weeks. Her second child is 3 ½ years old and was breastfed for 20 months. Linda encouraged him to stop breastfeeding during her third month of pregnancy. Her third child is 17 months old and still breastfeeding.

Liz is a 34 year old nurse. She is a single parent as her partner has recently left her. Her son is 22 months old and still breastfeeding.

Marie is a 33 year old married teacher . She has a 5 ½ year old son who was breastfed for just over 2 years. She was breastfeeding for the first six months of her second pregnancy. Her daughter is 3 years old and still breastfeeding.

Megan is a 36 year old married teacher . She has three sons. The first is 8 years old and was breastfed for a year. She second son is 6 years old and was breastfed for just under a year. Her third son is 3 ¼ years old and still breastfeeding.

Patricia is a 32 year old married midwife. She has two sons. The first is 6 years old and was breast fed for 18 months. Her second son is 4 years old and was breastfed for 2 years.

Selina is a 37 year old community activist whose mother comes from Pakistan. She cohabits with her partner. She has three children from her first marriage and one child with her current partner. Selina has a 14 year old daughter who was breastfed until she was 4 years old; an 11 year old son who was breastfed until he 2 ½ years old; an 8 year old son who was breastfed until he was 2 years old and a 2 year old daughter who is still breastfeeding.

Sophie is a 33 year old married nurse . She has a 2 ½ year old son and an 11 month old daughter who are both being breastfed.

Tina is a 39 year old married chaplain. She has an 8 year old daughter who was breastfed for almost 4 years and a 3 year old daughter who is still breastfeeding.

Victoria is a 39 year old married masseur. She has a 17 year old son who was breastfed until he was 3 years old; a 14 year old daughter who was breastfed for 10 weeks due to ill health of child and mother; and a 5 year old daughter who was breastfed until she was 2 ½ years old.

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