Socially sensitive lactation: Exploring the social context of breastfeeding

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Psychology & Health, 2013, 28(4):450-68. doi: 10.1080/08870446.2012.737465

Abstract

Many women report difficulties with breastfeeding and do not maintain the practice for as long as intended. Although psychologists and other researchers have explored some of the difficulties they experience, fuller exploration of the relational contexts in which breastfeeding takes place is warranted to enable more in-depth analysis of the challenges these pose for breastfeeding women. The present paper is based on qualitative data collected from 22 first-time breastfeeding mothers through two phases of interviews and audio-diaries which explored how the participants experienced their relationships with significant others and the wider social context of breastfeeding in the first five weeks postpartum. Using a thematic analysis informed by symbolic interactionism, we develop the overarching theme of '*Practising socially sensitive lactation*' which captures how participants felt the need to manage tensions between breastfeeding and their perceptions of the needs, expectations and comfort of others. We argue that breastfeeding remains a problematic social act, despite its agreed importance for child health. Whilst acknowledging the limitations of our sample and analytic approach, we suggest ways in which perinatal and public health interventions can take more effective account of the social challenges of breastfeeding in order to facilitate the health and psychological well-being of mothers and their infants.

Keywords

breastfeeding; qualitative research; breastfeeding support; public health; symbolic interactionism; United Kingdom

Introduction

Increasing the prevalence and particularly the duration of breastfeeding remain important child health goals in most developed nations. In the UK four out of five mothers initiate breastfeeding (IFF Research & Renfrew, 2011). However, fewer than 50% of infants receive any breast milk at six weeks of age and less than 1% are exclusively breastfed for the six months recommended by the World Health Organisation (2003), with even lower rates among younger mothers and those from less advantaged groups (Bolling, Grant, Hamlyn, & Thornton, 2007). This is despite widespread recognition among parents of the nutritional and immunological benefits of human milk and the initial intention of many women to breastfeed for longer than they do (Bolling et al., 2007). In trying to understand why more infants do not receive breast milk for the recommended time period, there is growing recognition of the importance of examining the context in which breastfeeding becomes established or breaks down (Hoddinott, Craig, Britten, & McInnes, 2012). Decisions about infant feeding take place within a family and social network against a backdrop of cultural ambivalence in Western societies about the symbolic meaning of breasts and the presence of social structures which make it challenging for mothers to combine breastfeeding with other roles (Carter, 1995; Kukla, 2006). However, there remains an emphasis in many public health messages on individual decisions and behaviour change (Hausman, Hall Smith, & Labbok, 2012), while studies examining the social context of breastfeeding are relatively rare. This article aims to extend understanding of this social context by reporting findings from a qualitative study of early infant feeding. The study explored women's experiences of breastfeeding broadly, though the analysis presented here focuses on the women's discussion of interpersonal and wider social issues.

The social context of breastfeeding

Women do not make sense of the meaning of breastfeeding and the transition to motherhood independently. Mutual negotiation and appraisal of changing family roles is informed by cultural and sub-cultural understandings, particularly related to gender roles, nutrition and what it means to be a 'thriving' infant and 'good' mother (Amir, 2011; Barclay & Lupton, 1999; Murphy, 1999). Breastfeeding, as a visible performance of one of these new roles (Stearns, 1999), not only invites comment by others about its perceived 'success' or otherwise but also places physical limits on the renegotiation of domestic labour. Hence, we can expect that women's experiences of breastfeeding might be influenced by their perceptions of the meanings ascribed to the practice by significant others, and their experiences of support.

Prior research suggests that key family members can indeed have an important influence on infant feeding. Approval and encouragement of breastfeeding by partners and significant others is particularly valued by breastfeeding women (Lavender, McFadden, & Baker, 2006; Scott & Mostyn, 2003), as is practical support with domestic activities (McInnes & Chambers, 2008). Decisions related to the initiation and maintenance of breastfeeding appear to be informed by the beliefs and expectations of partners and maternal mothers (Hauck & Irurita, 2003; Rempel & Rempel, 2004). Moreover, research with fathers of breastfed babies suggests that although some feel challenged by their exclusion from feeding, most see themselves as supporting and facilitating breastfeeding in a variety of ways, despite sometimes struggling with its practical implications (e.g. Barclay & Lupton, 1999; Rempel & Rempel, 2011).

Making sense of what is required to become a 'good' mother or father takes place not just within a familial network but also within the context of cultural discourses which have powerful moral implications and which, within Western cultures, are often contradictory in

relation to breastfeeding (McBride-Henry, 2010). Whilst the promotion of breast as 'best' can contribute to women feeling guilty and ashamed if they do not breastfeed (Mozingo, Davis, Droppelman, & Meredith, 2000; Taylor & Wallace, 2012), fathers can feel some discomfort where their partners do breastfeed and they are hence excluded from feeding whilst otherwise being exhorted to be 'involved fathers' (Barclay & Lupton, 1999). A further source of contradiction is the often perceived taboo on breastfeeding in public, due in part to the sexualisation of the breast in Western societies (Dowling, Naidoo, & Pontin, 2012; Stearns, 1999). Studies with breastfeeding women have indicated the discomfort many feel breastfeeding in public (e.g. Scott & Mostyn, 2003; Stearns, 1999).

Despite this research, our understanding of breastfeeding women's perspectives on the social context of feeding remains limited in a number of ways. First, much of the research on the impact of the father's role has been conducted from the father's perspective. Second, investigations of women's experiences of breastfeeding have often paid limited attention to social context. Two meta-syntheses of qualitative studies (Burns, Schmied, Sheehan, & Fenwick, 2010; Nelson, 2006) usefully included discussion of what was and was not experienced as supportive by breastfeeding women and the difficulties of feeding in public. However, although Burns and colleagues explore the relevance of wider cultural discourses to women's experiences, few conclusions were drawn in either paper about the *immediate* context of breastfeeding and how women experience breastfeeding as fitting (or not fitting) into family and social life. This seems to reflect a primary focus on women's personal meanings and the mother-infant relationship in several papers that contributed to these syntheses. Third, many of the studies that *have* explicitly focused on women's perceptions of the impact of others on breastfeeding have had the pragmatic aim of examining what kind of support is beneficial. Although this work has highlighted issues such as the importance of congruence between the mother's breastfeeding goals and the expectations of others (see

McInnes & Chambers, 2008 for a review), there has been limited concern with developing a social scientific understanding of breastfeeding and exploring how 'successful' breastfeeding is taken up and accommodated by the social network as a whole. There has also been limited exploration of the part that others may play in making sense of breastfeeding difficulties such as pain, problems attaching the baby to the breast and perception of insufficient milk supply, which have been identified in recent research (Berridge, McFadden, Abayomi, & Topping, 2005; Bins & Scott, 2002).

There are some notable exceptions to these general patterns in the literature, where breastfeeding has been examined in the context of interactions and relationships with key others, with the conclusion that breastfeeding meanings, expectations and practices are mutually negotiated (Dykes, 2006; Hauck & Irurita, 2002, 2003), in the context of the varied demands of daily living on mothers and their significant others (Hoddinott, et al., 2012; Lavender et al., 2006). Several studies, have also examined experiences of breastfeeding in the context of wider cultural discourses and norms, in particular relating to sexuality, autonomy and ideas about what is 'natural' (e.g. Larsen, Hall & Aargaard, 2008; Schmied & Lupton, 2001; Stearns, 1999). However, much of the breastfeeding literature has focused more narrowly on individual or dyadic experience.

The aim and theoretical focus of the study

The aim of the analysis reported in this paper was to explore breastfeeding first-time mothers' perspectives on the immediate and wider social context of their feeding experiences. We were interested in exploring how mothers saw breastfeeding as fitting into or challenging their relationships with others and their perceptions of the impact of their familial and social networks on infant feeding. We were also interested in how they experienced and negotiated feeding in public or semi-public (domestic but observed) settings.

An important theoretical lens for the study was symbolic interactionism which views individuals as creating meaning and subjectivity in interaction with others (e.g. Charon, 2004; Denzin 1985; Goffman, 1959). As such, self-identity (in this case as a breastfeeding mother) is intimately embedded in relationships with others and group memberships (Burr, 2002). Recently, symbolic interactionists have paid more attention to the place of the body in shared meaning-making and social life (Waskul & Vannini, 2006). This seems particularly important where changes in bodily processes and uses of the body, such as the onset of lactation, require new embodied understandings and performances. Hence our focus for data collection was the first few postnatal weeks when initial adjustments to both the breastfeeding body and parenthood are being made.

Method

Breastfeeding first-time mothers were asked to keep audio-diaries of their early feeding experiences and were subsequently invited to reflect on those experiences in semi-structured interviews. In phase one of the study, 22 mothers kept audio-diaries for seven days, beginning within one to three days of the birth. On completion of the diaries they were interviewed. In phase two, approximately three to four weeks later, all participants were asked to complete another seven day audio-diary followed by an interview. Thirteen of the participants agreed to be interviewed again, 11 of whom also kept a second audio-diary. Our transcripts and field notes suggest that younger participants and those experiencing feeding difficulties, and related emotional distress, were less likely to continue into phase two. It should be noted that an additional ten women were recruited to the study but completed brief interviews only, at one or both phases. The data obtained from these participants regarding social contexts were not judged to be of sufficient depth to warrant inclusion in the present analysis.

All 22 infants were singleton and born at or close to term, without significant illness or medical complications for either the mother or baby. All were living with a male partner at the time of data collection, though the two teenagers within the sample were also living with other family members. All participants described those living with them as largely supportive of breastfeeding. They indicated a range of occupational backgrounds, with two-thirds of these professional or managerial and 13 of the 22 women being educated to degree level or beyond. Information about the participants' age, ethnicity and method of delivery is included in table one below along with information about their feeding methods and participation in the various elements of the research. All names used are pseudonyms to protect the identities of the women themselves.

TABLE 1 HERE (see appendix)

Following university and NHS regional ethics approval, participants were recruited from the maternity unit of a hospital in the Midlands of England. The study, which took place in 2006-7, was advertised in local GP surgeries and antenatal clinics. Those over 16 years of age and intending to breastfeed were invited to register an interest. They were then approached shortly after the birth and invited to join the study. All were given a portable mini-disk player and asked to make audio-diary recordings twice daily for seven days if possible, either during feeding or shortly after. They were asked to talk about whatever they wanted related to feeding experiences, though were provided with prompts to use if they preferred. These prompts asked how the particular feed was going, likes and dislikes about feeding and what was going on in their lives relevant to feeding. The semi-structured interviews were conducted within 3-4 days of diary completion, after the interviewer had listened to the diary entries to enable probing of issues which had emerged. Additionally, the interviews included exploration of feeding decisions, challenges to feeding, positive aspects of feeding and, of particular relevance to the present analysis, reactions from others to feeding

or to changes in feeding patterns, any impact of breastfeeding on relationships, and experiences of advice and support. The diaries and interviews were then employed similarly at phase two. This enabled the capture of data close to the occurrence of events over the first five to six weeks and in a way which directly encouraged exploration of the social context of feeding within the interview, but also enabled participants to reflect relatively privately on their experiences using the audio-diary, employing their own frames of reference at a time of their convenience.

Our approach to the present analysis drew on Braun and Clark's (2006) thematic analysis. The participants' accounts were transcribed and, using NVivo software, coded for key points of interest regarding the participants' meaning-making about the impact of their social worlds on their feeding experiences and vice versa. Analysis proceeded in a largely inductive manner as codes were developed through detailed engagement with both the diary and interview data and then refined and developed to form a hierarchy of themes and overarching themes which were able to capture theoretically significant aspects of the data. This involved repeated reviewing of themes – moving back and forth between coded data extracts, individual participants' accounts and the developing themes. Interpretation was facilitated by methods drawn from grounded theory such as memo writing, focused coding and constant comparison (Henwood & Pidgeon, 2006). Written summaries of each participant's experiences were also produced, based on diaries and interviews across both phases where available, which aided the contextualisation of themes and minimised the fragmentation that can sometimes occur with thematic analysis (Joffe & Yardley, 2004). Once an initial list of themes and sub-themes had been produced for the 11 women with full data sets by the first author, this was audited and refined by the second author. The analysis was then extended by the first author to include all 22 women, revising themes and adding new themes where appropriate, and this was then audited by the other three authors. Although data

saturation appeared close to achievement before the final handful of participants' accounts were analysed, these accounts were still examined closely for possible novel material because of the tendency for normalising discourses in relation to breastfeeding (Wall, 2001), which can obscure and marginalise less common experiences. As Parker (2005) has argued, it was important not to close off useful theoretical vantage points prematurely. Reflexivity was fostered by discussion of differing perspectives on the data. Besides having varying professional backgrounds and views about breastfeeding advocacy, some of our research team are parents with differing experiences of breastfeeding and some are not parents. Therefore the team comprised a combination of 'insiders' and 'outsiders' regarding the topic being investigated (Langdridge, 2007), facilitating an analysis informed both by a hermeneutics of empathy and of suspicion (Ricoeur, 1976).

Findings

Two primary overarching themes were developed from the analysis: *Practising socially Sensitive Lactation* and *Making Use of Expertise.* The second of these, which concerns interactions with maternity-care practitioners, is presented elsewhere (Leeming, Williamson, Johnson & Lyttle, 2011). Below we discuss the first theme, referring to participants with pseudonyms.

Practising socially sensitive lactation

Despite all participants describing their partners and significant others as generally supportive of breastfeeding, they did not always experience breastfeeding as fitting easily into their social worlds, but often as requiring careful and sensitive management to enable synchrony between breastfeeding and relations with others. This was particularly, though not exclusively, where the physicality of lactation was more evident, for example, where there were difficulties with pain or attachment, where breasts were potentially exposed or leaking or where there was frequent and unpredictable suckling. This overarching theme of the

perceived requirement to practise socially sensitive lactation is developed through four themes which were evident across both the diary and interview data and are discussed below: (i) Making sense of the links between bonding, caring and feeding; (ii) Managing tensions between caring and feeding; (iii) Ambivalence and the public breast; and (iv) Observing the etiquette of breastfeeding. In presenting illustrative quotations from the participants' accounts we have used a few notations and symbols to facilitate clarity and fluency within their talk. Square brackets have been used to represent brief explanatory additions by the authors. Three ellipsis points within parentheses '(...)' has been used where speech has been omitted. Underlining of words signifies that these were emphasised by the speaker.

Making sense of the links between bonding, caring and feeding

Although there is a strong symbolic link between breastfeeding and nurturing, and the participants were all motivated to breastfeed, they did not necessarily experience breastfeeding as synonymous with caring for, or being cared for, by others. Sometimes they saw use of bottles as strongly symbolic of caring and bonding. Three particular sub-themes illustrated the varied ways that links were made between feeding, caring and bonding. These were: (i) family bonding through breastfeeding, (ii) others bonding with the infant through the bottle and (iii) caring for mothers via the bottle.

Family bonding through breastfeeding: Breastfeeding could enable a sense of connection with other women who had breastfed, and also with partners. Some participants talked about practising breastfeeding in the first few days as a triad, with fathers active in problem-solving and helping with attaching the baby to the breast. These fathers were perceived as not just 'involved' in breastfeeding (Rempel & Rempel, 2011), but were part of the embodied practices of feeding - holding the baby's head or arms and establishing breastfeeding as a 'two man [sic] team' (Amelia, phase 1 interview). Wendy valued the extra pair of eyes her husband provided and the resulting advice: '[He] could say, well, change this position, do

this, try that.... and you're so close to it...you can't stand back from it'. (Wendy, phase 1 interview). However, along with others, Wendy particularly valued the way breastfeeding enabled both her and her partner to 'develop that bond' with their baby and with each other:

> I really enjoy the opportunity that feeding is giving me baby and my husband time so that we, the three of us, are having time together and that's quite...personal...it's like our time that we spend together and it's really excellent *(phase 1 diary)*

Here the father's exclusion from the physical attachment between baby and mother was not seen as problematic because the meaning of feeding episodes was such that a sense of connection was enabled between mother, baby and father.

Others bonding with the infant through the bottle: At other times participants *were* concerned that fathers and other family members felt excluded from feeding, sharing Robin's sentiment that 'it makes partners perhaps feel like they miss out' (phase 2 interview). As Murphy (1999) noted in her interviews with mothers, several felt an obligation to facilitate some kind of 'bond' between others and the baby by enabling bottle feeding. Here Samantha, one of the youngest participants who lived with her extended family, talks about using bottles of expressed milk to encourage her baby's relationships with others:

> I like having the bottles because it gives her a chance to bond with...my partner and ...her grandma and her great granny...feeding her is one of the most beneficial ways of bonding with a baby because you are so close. *(Samantha, phase 1 diary)*

Physical attachment between baby and mother does not always fit with a social world organised according to contemporary notions of multiple 'bonds' between infants and other family members and contemporary constructions of involved fatherhood (Barclay & Lupton, 1999; Earle, 2000). Although some participants, similarly to the fathers in Gamble and Morse's (1993) study, saw partners as postponing a connection with the infant through

feeding, breastfeeding could still feel unfair or selfish. For example, when asked in the second interview whether she had yet tried expressing her milk as she had planned, Molly said:

> I haven't done that yet, no...I don't want to rock the boat introducing a bottle....I think in some ways he'd [father] like to be able to feed her, just you know every so often.... I don't know, I feel a bit mean saying that like, like I don't want to do it yet but I just don't.

This concern on the part of some of the participants that breastfeeding might constitute 'a dangerous form of possessiveness' (Earle, 2000) was exacerbated where partners and the women also had concerns about the effectiveness of breastfeeding and the baby receiving adequate nutrition.

Caring for mothers via the bottle: Several participants talked about others meeting *their* needs through bottle feeding. For example, Samantha felt reassured by her extended family's willingness to feed the baby her expressed milk:

> I'm really lucky...I've got a whole family ready and willing to...do feeds for me so I can get some rest....it makes me feel a lot better knowing that someone else can take over if I can't cope. *(Phase 1 diary)*

Similarly Nicole saw use of bottles by others as potentially a means of demonstrating care for her and described the difficult relationship dynamics which remained in phase one whilst she waited to try expressing milk:

> It's hard on me but it's hard on my partner as well because he can't help to do anything. He just has to sit there and look at me absolutely <u>shattered</u> and crying ... and there's nothing he can do to help. He can't....just grab a bottle....hopefully...I might be able to start expressing milk and then daddy can feed you as well. *(Nicole, phase 1 diary)*

Whether or not participants viewed others' offers to feed the baby via a bottle as an expression of care and concern appeared to depend on the prior relationship. Robin, who was mixed feeding using breast milk and formula milk, spoke about her mother giving her baby an occasional bottle of formula as an attempt to respond helpfully to Robin's painful struggle to establish breastfeeding:

> My mum is very pro breastfeeding, but she's also very pro me...she wants her baby, cos I'm her baby, to have, you know as much rest as possible and she thinks she's helping me by taking over *(Robin, phase 2 interview)*

However, Nicole interpreted her mother-in-law's interest in bottle-feeding as a form of intrusive and controlling 'care' and saw breastfeeding as a way to resist this:

> If I was bottle feeding I'd probably get coerced into leaving him with somebody. But because I'm breastfeeding I can't ...it's nice that I've got that kind of control aspect of it...if you've got kind of quite pushy in-laws like I have it's nice that nobody else can take control *(phase 2 interview)*

Accounts such as those above illustrate the impact of prior relationships and the general relational context on women's understandings of the symbolic meaning of different forms of feeding and feeding relationships. Relationships with partners also had an impact on whether women felt cared for while breastfeeding, or possibly taken advantage of. Some accounts suggested that participants viewed the allocation of feeding responsibilities as part of on-going negotiations with their partner about the fair distribution of workloads. As such the accounts echoed liberal feminist arguments in noting the burden of breastfeeding and the way in which this can undermine gender equality in childcare (see Carter, 1995 for a review). For example, in her second interview, Robin expressed some dissatisfaction with her husband's reluctance to look after the baby while she was still breastfeeding and referred to formula having become 'a bit of a freedom ship for women'. At the same time Robin, similarly to

others, was concerned to ensure that breastfeeding did not mean she was taking less than her fair share of the domestic workload. Evaluations such as this were sometimes made with reference to the views of others in the family. In her phase 2 diary Erica noted:

> We [Erica and her mother] were talking about the thing I find most difficult...with breastfeeding now is sitting all the time and not being able to get on with jobs and chores and things, and, erm she was talking about my sister in law, who did breast feed her two boys...and my mum sort of said in a derogatory fashion, 'Yes, but she's just happy to sit and be sort of Mother Earth', and, erm, and it was true that my brother did come back from work at five o'clock and then cook the meal and set about doing all the household chores.

Therefore, links between caring, feeding and bonding were complex, so that breastfeeding was sometimes associated with bonding, but was sometimes seen as a barrier to caring for other family members and being cared for by them. Alongside this, bottle-feeding was often viewed as enabling others to bond with the baby and to care for the mother. Therefore, as found by Hoddinott et al. (2012), general family well-being was sometimes prioritised over breastfeeding. However, this theme also illustrates the multi-layered process by which the participants made sense of the links between caring, feeding and bonding. The participants were not simply influenced directly by the cultural meaning of infant feeding. Instead, as Tiedje et al. (2002) argue, the meaning of infant feeding was mediated by relationships with others, being negotiated with partners, parents and significant others.

Managing tensions between caring and breastfeeding

There were two particular ways in which the participants who eschewed the use of bottles talked about managing some of the tensions where breastfeeding was potentially at odds with caring and mutually supportive relationships. First, many talked about multi-tasking, planning and being organised as ways to maintain care of others, and what they saw as domestic and social obligations, alongside breastfeeding. This was particularly apparent in

phase 2 when the participants often conveyed a sense of obligation to return to 'normal' activities and found it harder to accept lengthy periods of sitting and feeding. For example Erica, who was concerned that chores did not unnecessarily fall to her husband, said that she was thinking of trying a different way of tying her baby sling so that she could:

> ...see if I can breastfeed him at the same time as getting on with my chores, cos then I can just carry him around and do things *(Erica, phase 2 diary)*

Second, several of the participants talked about the need to protect their relationships with their partners - ensuring the continuation of a sexual relationship, spending time together and managing conflict related to feeding tensions. Gina, who had been forced to abandon a homebirth and transfer to hospital during a difficult labour, described both her and her husband as distressed by the further difficulties she experienced latching the baby to her breast and their perception that breastfeeding was failing. She did not talk about this shared concern as a form of bonding through breastfeeding, but felt pressured by her husband to resolve the problems. In her diary she was actively trying to manage her emotions:

> He's [husband] sort of is really worried and stressed and um, and it's hard not to feel that he's blaming me for not being able to do it, I know he's not, but it's just frustrating for him because he can't help me, and he's trying to help me *(Phase 1 diary)*

Others talked too about doing the kind of emotion work that has often been associated with women's traditional gender roles (Duncombe & Marsden, 1993) – trying to reduce the emotional atmosphere of the home by calming themselves, the baby and their partner and reducing conflict. For example Deanne, who felt that she was getting to know her baby much more quickly than her husband due to breastfeeding, talked about the need to guard against sounding critical of his parenting:

> Trying to be a bit more patient with him and just guiding him not telling him...it works better then he responds better and I respond better *(Phase 2 interview)*

For others, the issue was about balancing the need for proximity to the baby with being able to focus on their relationship with their partner. Nicole explained that this was an important part of her plan to finish breastfeeding after three months:

> At some point...you have...to balance it a bit more between being erm,…a partner and a mum as well...by then I think it's time that erm we got our life back a little bit and went out together as a couple...I want to be able to leave him [baby] and give John [partner] a bit more of my time...it's important not to just focus everything on being a mum cos I think that's when you can start to get cracks in your relationship *(Phase 2 interview)*

Therefore, synchrony between the breastfeeding relationship and the participants' other relationships was not taken for granted. Instead, many of the participants seemed to see the integration of breastfeeding into their relationships as something that required active emotion work.

Ambivalence and the public breast

Given the cultural debate around the appropriateness of public breastfeeding (Dowling et al., 2012), it was not surprising that ambivalence and uncertainty characterised many of the women's discussion of feeding in front of others. Although most thought that there was nothing wrong *per se* in feeding in front of others, some felt that social sensitivities required them to try and avoid this in certain situations. This presented the women with considerable difficulties, which their accounts suggested they resented:

> I found it again really difficult [breastfeeding] because there were a lot of men in there [a restaurant]...so I went down to the toilets...and found myself sitting on the loo giving him a top-up...and I was worried about the germs...I found myself sweating and rushing back to the

> car in the rain having got lost...trying to get back to the car, just desperate so that I can give him a feed *(Robin, phase 2 diary)*

Some women, such as Samantha, expressed uncertainty in defining the nature of the problem with public breastfeeding. She, and others, referred to the problem as her own lack of confidence but at the same time conveyed a sense that this was not simply a personal shortcoming as there were external rules that needed to be followed regarding the appropriateness of breastfeeding in public:

> I mean I think it's great for women that can do it and have the confidence to do it. But, erm I don't have the confidence to do it, no. With this stigma as well, it's just I keep going into a café thinking 'Can I? Can I do it in here?', getting someone to go up and ask for me if I can breastfeed *(Samantha, Phase 2 interview)*

However, it was perhaps some of the women who expressed the strongest views about their right to feed whose ambivalence was the most noticeable. For example, Uma said:

> If I'm in a pub, and she needs feeding I'm gonna feed her, and everybody else can just go to hell, because there's too many women that won't do it because of that, don't you think? It's not my problem, you know? *(Phase 1 interview)*

However, she also acknowledged that things were not quite so straightforward:

> I mean, don't get me wrong, I will probably sit there with a red face for the first few seconds, because yeah, you are getting your boob out in public, you know, but whose problem is it really?

Despite vigorously asserting her disagreement with the taboo on breastfeeding in public Uma (and others) found it difficult to ignore the possibility of what has been referred to as the 'male gaze' (e.g. Stearns, 1999), and the knowledge that she *could* be objectified by this and positioned as engaging in inappropriate sexual display. This ambivalence in hers and other

accounts seems not only to reflect contradictory views of the breast as nurturing or sexual but also to reflect a particularly Western dilemma about accommodating others' views of how we ought to behave. As Burr (2002) notes, '[w]e are at one and the same time drawn toward conformity with groups and obedience to authorities yet exhorted by the ideology of the individual to value independence from these' (p.54). We are not meant to care what people think and may, like Uma, vigorously assert that we do not care. However, at the same time we do care. As Goffman (1959) has argued, from a symbolic interactionist perspective, we need others to support our claim of a credible and morally acceptable social performance or we falter, particularly where our behaviour may be viewed as deviant, as Uma indicated:

> He [husband] wouldn't get embarrassed either, if I did it [breastfeeding] in public and I would die if he did, because I wouldn't want him to be ashamed or embarrassed of what I'm doing, I'd want him to support me *(Phase 1 interview)*

What made public breastfeeding possible for several of the women, after their initial uncertainty, was the acceptance shown by others:

> He [father-in-law] was absolutely great and didn't think anything of it [breastfeeding in front of him], even when they were leaving and I was feeding her he gave me a hug while I was there feeding her and it was a really, really positive feeling *(Louise, phase 1 interview)*

However, what also led to further ambivalence for many of the women was not just concern with others' evaluations of them but also a desire not to cause discomfort to others:

> If I was out to dinner with my in-laws, I wouldn't dream of sitting at the table, and feeding, because...I know that it would make, certainly my father-in-law, quite uncomfortable *(Hannah, phase 2 interview)*

Therefore, the women's accounts suggested that ambivalence about public breastfeeding arose because breastfeeding could be seen not only as socially inappropriate but also as insensitive

to others' feelings. As such, the participants' described their feelings about public breastfeeding and experiences of feeding as arising in interaction with others. When engaging in an act that they feared *might* be socially problematic, they seemed particularly oriented to others' reactions so that the acceptability and appropriateness of acts of breastfeeding was mutually negotiated, and many the participants appeared to feel a sense of responsibility for managing their newly lactating body in ways that reduced others' discomfort.

Observing the etiquette of breastfeeding

Some participants talked about resolving their concerns about public breastfeeding by withdrawing into a private space, though sometimes with a sense of injustice. Others used bottles of formula or expressed milk. (See Johnson, Williamson, Lyttle & Leeming, 2009 for further discussion of the accounts of milk expression). However, similarly to the breastfeeding mothers interviewed by Stearns (1999), many responded to their ambivalence about public feeding by adopting a discreet method of feeding, hoping that this could make public feeding acceptable:

> I think, so long as you're discreet, nobody's going to have a problem...I mean I have known people in the past who've sat there with kind of <u>all</u> their breast out kind of like 'it's my right to feed' *(Nicole, Phase 2 interview)*

Nicole seems to suggest that there is a 'correct' way to breastfeed that is discreet and that most reasonable people would accept. Other participants also implied that there were culturally agreed codes of behaviour around breastfeeding. For example, Emma referred to 'the etiquette of feeding'. This concept seems to have some currency, as suggested by several articles on websites providing advice about manners, health or parenting (e.g. Amato, 2011; Berch, 2010) which suggest that breastfeeding etiquette involves learning strategies for discreet breastfeeding in order not to discomfit others – for example using nursing covers which cover the breastfeeding baby as well as the breast. The notion of breastfeeding

etiquette seems to be about more than just modesty. It suggests that deviation from codes of etiquette can lead to being positioned as 'socially gauche', 'ill-mannered' or even 'exhibitionist' rather than being seen as in a hurry to feed a crying baby. On-line advice offered by La Leche League reflects such social norms by assuming the need for discretion is already understood:

> Rest assured that discreet breastfeeding becomes easier with practice - it is a learned skill. Before you first breastfeed in a social setting or in a public place, you may want to practice in front of a mirror so you'll be able to see what others would see and make adjustments (La Leche League International, 2008).

However, as La Leche League suggest, discretion was often difficult to achieve in this first month when our participants and their infants were still learning effective attachment:

> I think the, the hardest thing is when he's not feeding brilliantly, when he's off and on, erm, and then it's just trying to maintain a bit of dignity with my nipple, sort of exposed to the world *(Emma, phase 2 diary)*

Several of the women chose to postpone breastfeeding away from home until they felt more confident about being able to perform feeding in a socially accepted manner. This was not just a matter of keeping the nipple hidden. Etiquette also seemed to require that they were able to disguise any signs of milk production. Emma, who breastfed exclusively through both phases, added in her diary:

> I'm managing to spill a lot of milk all over him as well. If he comes off the breast, you'll [talking to baby] have milk all round your face, all on my tops...I just have to be careful to check that I haven't got dried milk everywhere, when I'm in public *(Emma, phase 1 diary)*

Drawing on Elias's historical study of general etiquette and advice manuals, Wouters (2004) notes the increased emphasis over the generations on keeping evidence of our animal or

mammalian nature (such as lactation) behind the scenes of social life. This may be a particularly sensitive issue for women, given that in various cultural and historical contexts they have been seen as unclean or inferior because of bodily functions and fluids (Schmied & Lupton, 1999). Breast milk can be seen as pure, but it can also be seen as a dirty and disgusting leaking of bodily fluid (Dowling et al., 2012).

As well as disguising evidence of lactation in public it also seemed important to disguise any struggle with breastfeeding. This was not just in order to keep the nipple concealed but also because this was viewed as socially problematic. Several participants saw struggling with breastfeeding as a worry to significant others who were concerned about their and the baby's well-being. Struggling also left some of the women feeling inadequate – as if unable to perform the 'good mother'. As Hannah said in her second interview: 'You sort of feel more, if people are sitting here watching me struggling, are they thinking that I'm failing him?' That women might feel a sense of shame in front of others for struggling to breastfeed has been suggested by feminist theorists who have noted the way in which ideologies of 'good mothering' can position women who struggle to breastfeed as unnatural or deficient as women (Taylor & Wallace, 2012; Wall, 2001). A few of the women outlined a more Goffmanesque understanding of the importance of a credible and confident performance of breastfeeding in order to assert the acceptability of breastfeeding in public spaces:

> And you don't want to struggle in front of other people because if they feel awkward and you're awkward then it...whereas now I can just latch him on straight away so then they don't have time to realise what I'm doing (Erica, phase 1 interview)

A confident performance often seemed to mean some kind of sleight of hand which made the breast, nipple and evidence of milk all disappear, which was difficult to achieve in the early weeks.

The etiquette around breastfeeding underscores the distinction between the social practices of breastfeeding and the physicality of lactation. Recent changes in legislation to protect women's right to breastfeed in public spaces in the UK, suggest that public 'nursing' may be increasingly acceptable. However, our participants generally spoke as if etiquette required them to be responsible for ensuring that the physicality of lactation and any difficulties related to this remained hidden.

Conclusions

In considering the implications of the findings, it is worth reflecting on the timing of our study and the nature of our sample. We were particularly interested in exploring women's views of how and whether their social networks adapted to and accommodated breastfeeding in the first few weeks, in order to extend understanding of some of the potential difficulties establishing breastfeeding. This is a time period when many mothers who originally intended to breastfeed give up the practice and when difficulties with pain and discomfort, latching the baby to the breast and concerns about the efficiency of lactation are most common among breastfeeding women (Bolling et al,, 2007). Our data highlight the way in which the perceived requirement to practice socially sensitive lactation can become an additional burden if women feel that the visibility of their early efforts to establish breastfeeding challenges social norms and harmonious relationships. Once breastfeeding is established its integration into social life may be less problematic, though other studies suggest that breastfeeding mothers continue to face challenges negotiating the meaning and hence acceptability of breastfeeding within both the immediate family and wider community (e.g. Hauck & Irurita, 2002; Stearns, 1999).

With regard to our sampling, it is worth noting that the participants in this study all expressed a desire to breastfeed, did not have other children to care for and indicated their partners were generally supportive of breastfeeding. Despite our aim to recruit a broad sample from a general hospital setting, many (though not all) who took part reported belonging to socio-economic groups associated with higher rates of breastfeeding. Therefore, our data offer only a limited perspective on the ways in which social or structural factors may pose challenges for breastfeeding women. However, it is noteworthy that participants from backgrounds that might be assumed to be relatively breastfeeding-friendly still found it difficult to integrate breastfeeding into their social worlds in the early days of feeding and felt that doing so required careful management of interpersonal relations. Their accounts suggested that acceptance of breastfeeding may not necessarily be experienced as acceptance of the reality of lactation and the way in which this reality can challenge aspects of familial and social processes.

The nature of our sample and our analysis of individual accounts through the lens of symbolic interactionism meant that we have not primarily focused on macro factors which can make breastfeeding less accessible for the infants of women who are less well educated, poorer, from certain ethnic groups and with multiple caring or economic responsibilities (Bolling et al., 2007; Hausman et al., 2012). What our analysis demonstrates is some of the complex and varied ways in which distal influences related to cultural norms and expectations can be mediated by women's immediate interactions and relationships with others. If we are to make sense of why so few infants are breastfed for the recommended time period in spite of many mothers' intentions to breastfeed for longer, we need to analyse the social context of breastfeeding at various levels to understand why the practice remains vulnerable. We also need to extend the present findings by closer examination of the social context of breastfeeding within subcultures where bottle feeding is the norm. It would be useful for

studies such as ours, which take the perspective of the mother, to be supplemented by studies which draw on multiple perspectives and studies which investigate social interaction around breastfeeding more directly and as this continues over time. In this way a fuller understanding will be developed of the place of breastfeeding in social life and some of the social barriers to breastfeeding.

Our findings have several implications for supporting new mothers and their families in the perinatal period and also for public health campaigns around breastfeeding. For example, the complexity of negotiations around feeding and caring suggests that it would not only be useful to prepare pregnant women and their significant others for the challenges of breastfeeding, but also to help them think about the likely impact of such challenges on relationships and consider strategies for managing these other than bottle feeding. Targeting breastfeeding education at partners and significant others can equip those who agree to take part with technical understanding about lactation and problem-solving strategies (Pisacane, G. Continiso, Aldinucci, D'Amora, & P. Continiso, 2005). Such education may result in greater tolerance of initial feeding problems and increase the chance of families bonding through tackling these challenges, rather than resorting to caring for mothers and babies via bottles.

In promoting breastfeeding, public health campaigns have often presented a rather idealised image of breastfeeding, emphasising the naturalness of breastfeeding and downplaying the possibility of difficulties (Kukla, 2006). More realistic health messages which also note the initial difficulties women can experience when establishing breastfeeding could mean greater awareness of the difficulty of discreet feeding in the early days and also of timing the feeds of a newborn to avoid feeding in front of others. Instead of making breastfeeding seem acceptable by promoting images of 'good' mothers who somehow manage to cover themselves modestly, we should be questioning why the nutritional needs of infants within the first month of their life should be secondary to the comfort of those around

the mother. Otherwise, societies like the United Kingdom will continue to prioritise propriety over child health.

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Table 1. Participants' age, ethnicity, method of delivery, participation in particular phases of the research and feeding methods at each phase

Pseudonym	**Self-Reported Age**	**Self-Reported Ethnicity**	**Method of Delivery**	**Participation**	**Feeding Status at the End of Phase 1**	**Feeding Status at the End of Phase 2**
Amelia	*38*	*White British*	*Vaginally*	*Phases 1 & 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Arabella	*29*	*White British*	*Caesarean*	*Phase 1 only*	*Mixed feeding of breast milk and formula*	
Belinda	*30*	*White British*	*Vaginally*	*Phases 1 and 2 (interview only at phase 2)*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Bianca	*31*	*Black-Caribbean*	*Vaginally*	*Phase 1 only*	*Exclusive breastfeeding*	
Caitlin	*34*	*Eurasian*	*Vaginally with ventouse*	*Phase 1 only*	*Bottle feeding of formula milk*	
Deanne	*36*	*White British*	*Vaginally (initially homebirth but transferred to hospital)*	*Phases 1 and 2 (interview only at phase 2)*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Emma	*31*	*White British*	*Vaginally*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Erica	*35*	*White British*	*Vaginally, Homebirth*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Georgina	*18*	*White British*	*Vaginally*	*Phase 1 only*	*Bottle feeding of formula milk*	
Gina	*30*	*White British*	*Vaginally with ventouse (initially homebirth but transferred to hospital.)*	*Phase 1 only*	*Mixed feeding of breast milk and formula*	
Hannah	*26*	*White British*	*Caesarean*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Imogen	*25*	*White British*	*Vaginally*	*Phases 1 and 2*	*Mixed feeding of breast milk and formula*	*Mixed feeding of breast milk and formula*
Louise	*35*	*White British*	*Vaginally with*	*Phase 1 only*	*Exclusive breastfeeding*	

			ventouse			
Molly	*29*	*White British*	*Vaginally*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Nicole	*33*	*White British*	*Caesarean*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Mixed feeding of breast milk and formula*
Queenie	*36*	*White British*	*Vaginally, Homebirth*	*Phase 1 only*	*Mixed feeding of breast milk and formula*	
Robin	*32*	*White British*	*Caesarean*	*Phases 1 and 2*	*Mixed feeding of breast milk and formula*	*Mixed feeding of breast milk and formula*
Samantha	*19*	*White British*	*Vaginally*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Bottle feeding of formula milk*
Uma	*27*	*White Irish*	*Vaginally with ventouse*	*Phase 1 only*	*Mixed feeding of breast milk and formula*	
Wendy	*30*	*White British*	*Vaginally with ventouse*	*Phases 1 and 2*	*Exclusive breastfeeding*	*Exclusive breastfeeding*
Yvonne	*31*	*Black-Caribbean*	*Vaginally Water birth*	*Phase 1 only*	*Exclusive breastfeeding*	
Zoe	*23*	*White British*	*Vaginally*	*Phase 1 only*	*Exclusive breastfeeding*	