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## **Making use of expertise: A qualitative analysis of the experience of breastfeeding support for first time mothers**

**Leeming, D., Williamson, I., Johnson, S. & Lyttle, S. (2013) *Maternal and Child Nutrition*<sup>i</sup>**

### **Abstract**

There is now a body of research evaluating breastfeeding interventions and exploring mothers' and health professionals' views on effective and ineffective breastfeeding support. However, this literature leaves relatively unexplored a number of questions about how breastfeeding women experience and make sense of their relationships with those trained to provide breastfeeding support. The present study collected qualitative data from 22 breastfeeding first-time mothers in the UK on their experiences of, and orientation towards, relationships with maternity care professionals and other breastfeeding advisors. The data were obtained from interviews and audio-diaries at two time points during the first five weeks post-partum. We discuss a key theme within the data of '*Making use of expertise*' and three subthemes which capture the way in which the women's orientation towards those assumed to have breastfeeding expertise varied according to whether the women (i) adopted a position of consulting experts versus one of deferring to feeding authorities (ii) experienced difficulty interpreting their own and their baby's bodies and (iii) experienced the expertise of health workers as empowering or disempowering. Although sometimes mothers felt empowered by aligning themselves with the scientific approach and 'normalising gaze' of healthcare professionals, at other times this gaze could be experienced as objectifying and diminishing. The merits and limitations of a person-centred approach to breastfeeding support are discussed in relation to using breastfeeding expertise in an empowering rather than disempowering way.

### **Keywords**

Breastfeeding; Infant Feeding; Breastfeeding Support; Qualitative Methods; Health Professional; Postnatal Care

# Making use of expertise: A qualitative analysis of the experience of breastfeeding support for first time mothers

## Introduction

Although there is now increasing attention to the need for effective professional support when establishing breastfeeding, there is limited research exploring how mothers experience the presence of healthcare practitioners and other breastfeeding supporters in their lives. This paper discusses one theme '*Making use of expertise*' which was developed from a qualitative analysis of the social context of breastfeeding and captured the sense that first-time mothers made of the role of maternity care practitioners during the first postnatal weeks. The term 'maternity care practitioner' is taken to include all those offering maternity care and support. In the present study these were mostly midwives and health visitors with some voluntary sector breastfeeding advisors. The analysis was conducted within the context of a larger study of experiences of breastfeeding (Johnson et al., 2009, 2012; Leeming et al., 2012; Williamson et al., 2012).

## Background literature

Despite increases in the number of women initiating breastfeeding in the developed world over the past 20 years, and widespread recognition amongst new parents that 'breast is best' (IFF Research & Renfrew, 2012), breastfeeding remains in many ways a marginal and precarious activity in Western societies. Many women experience difficulties establishing or continuing breastfeeding, including problems attaching the infant to the breast, nipple pain and concerns over the adequacy of milk production and consumption (Berridge et al., 2005; IFF Research & Renfrew, 2012). Although the UK *Infant Feeding Survey 2010* found modest increases in initiation and duration of breastfeeding with 81% of UK mothers initiating breastfeeding, only 42% of infants were receiving any breast milk at 4 months of age and only 1% were being exclusively breastfed for six months (IFF Research & Renfrew, 2012) as commonly recommended for optimum infant development (e.g. Kramer & Kakuma 2002).

One challenge that women face in maintaining breastfeeding is the discomfort many experience breastfeeding in public, partly related to the sexualisation of the female breast - hence the relative invisibility of breastfeeding in Western societies

(Dowling et al., 2012). This is compounded in communities where bottle feeding of formula milk has been the norm for previous generations (Scott & Mostyn, 2003). Many women who begin breastfeeding may have had very limited prior exposure to breastfeeding, increasing the likelihood they will turn to formula milk if they experience difficulties (Hoddinott & Pill, 1999). In recognition of such barriers to breastfeeding, the World Health Organisation *Global strategy for infant and young child feeding* (2003) recommends that health workers should be enabled to provide skilled breastfeeding support to all mothers.

A meta-analysis of studies examining the effectiveness of a range of interventions to support breastfeeding concluded that face-to-face interventions by health professionals and trained peer counsellors can extend the duration of breastfeeding (Britton et al., 2007), though not all interventions have been successful (Hoddinott et al., 2011). However, quantitative analyses, such as those reviewed by Britton et al., conducted within an objectivist framework which approach breastfeeding support interventions as a largely decontextualised phenomenon are unable to tell us much about how the different components of support are experienced and perceived in particular contexts. Given that breastfeeding is a culturally saturated yet highly personal activity (McBride-Henry, 2010), being a visible performance of a new and highly significant relationship (Stearns, 1999), attention to meaning and context seems particularly important. With a few exceptions (e.g. Memmott & Bonuck, 2006), trials of breastfeeding support have not usually sought the perspective of mothers (Britton et al., 2007) and hence have paid limited attention to the context and personal meaning of receiving such support.

A number of qualitative investigations of breastfeeding women's experiences and midwives' perspectives on providing breastfeeding support have attempted to address this gap and several important issues have emerged which have been highlighted by two meta-syntheses of this literature (McInnes & Chambers, 2008; Schmied et al., 2011). Drawing on overlapping sets of studies conducted between 1990 and 2007, both sets of authors argue that whilst the value of breastfeeding support is recognised by both mothers and healthcare workers, mothers are often disappointed with the nature and amount of support offered. Reaching largely similar conclusions, the authors note that dissatisfaction was particularly likely when healthcare professionals were perceived to have insufficient time for mothers, when

advice conflicted or was offered in an inflexible, standardised, and authoritarian manner and when professionals were perceived as blaming or judging women. Instead, they argue, most women preferred individualised advice which provided sufficient detail to enable them to develop specific skills and make choices, and which was offered in ways which respected their goals, encouraged and reassured them and acknowledged their experiences. As such, Schmied and colleagues characterise ideal support as 'facilitative' rather than 'reductionist' and describe preferred interactions with supporters as 'authentic' rather than 'disconnected'.

The importance of individualised breastfeeding support has been echoed in the findings of studies conducted since the two meta-syntheses (Bäkström et al., 2010; Furber & Thomson, 2008; Sheehan et al., 2009; Thomson & Dykes, 2011). Dykes and Hall Moran and colleagues have also highlighted the different facets of support and suggest, particularly from research with younger mothers, that emotional support and positive validation can be important for making more technical aspects of breastfeeding support acceptable (Dykes, 2005a; Dykes et al., 2003; Hall Moran et al., 2007). These findings have prompted calls, particularly within midwifery, for training for maternity care practitioners to pay greater attention to the psychosocial aspects of breastfeeding (Dykes 2006a; Entwistle et al., 2010) and led to concerns about the way in which the organisational context often limits possibilities for meaningful relationships with breastfeeding women (Dykes, 2005a, 2006b).

However, maternity care practitioners alone do not determine the relationship within which support is offered. Women differ in their expectations, their response to various forms of support, and their style of engagement with practitioners, according to culture, class, immediate concerns and personal history (Hunter, 2006). Yet, this area is not well researched. Interactions also take place in the context of medicalised health services. Several commentators have drawn on the work of Foucault and other social theorists to note the potential of the normalizing medical gaze to disempower and marginalise women who deviate from feeding practices which have the seal of professional approval (e.g. Dykes, 2006b; Murphy, 2003), adding a further dimension to women's relationships with providers of breastfeeding support.

Therefore, research to date has been useful in exploring breastfeeding women's perspectives on the helpfulness of the support they receive for breastfeeding and on the value of different styles of support. However, in order to inform the development of support services, it seems useful to broaden the research focus and to ask further questions about how breastfeeding women experience and make sense of interactions with practitioners and how this impacts on their experiences of breastfeeding.

### **The present study**

The present findings are drawn from an analysis that aimed to extend understanding of first time breastfeeding mothers' experiences of the social context of feeding. This included, but was not limited to, the presence of a range of healthcare practitioners and other trained breastfeeding supporters in their lives, which is the focus of the data discussed here. The analysis was undertaken as part of a larger study on early experiences of breastfeeding. We invited women to reflect on their recent experiences of breastfeeding and breastfeeding support via semi-structured interviews and solitary audio-diary recordings during or following day-to-day feeds. Data were collected during two time periods within the first five-six weeks postpartum, enabling accounts of both hospital-based and community maternity care to be captured at a time crucial for establishing breastfeeding. This is the period when mothers are most likely to experience breastfeeding difficulties (Sheehan et al., 2009) and hence require support.

### **Methods**

#### ***Participants***

First time mothers over 16 years of age and intending to breastfeed were invited to register an interest in a study of experiences of breastfeeding. They were approached via primary care teams and antenatal classes connected to a hospital in the Midlands of England. Twenty-two women, all of whom initially breastfed, kept a seven day audio-diary beginning one to three days following the birth and were interviewed shortly after this for phase one of the study. Thirteen agreed to be interviewed a second time five to six weeks postnatally, with 11 of these completing a second seven day audio-diary prior to the second interview for phase 2.

All births were singleton, at or close to term, and without significant maternal or infant illness. All mothers lived with a male partner, though the two youngest mothers also lived with extended family. The women indicated a range of occupational backgrounds, with approximately two-thirds of these being professional or managerial. Thirteen of the 22 women reported being educated to degree level or beyond. Further demographic data and information about method of delivery and feeding practices are provided in Table One below.

INSERT TABLE ONE ABOUT HERE

### ***The context of UK breastfeeding support***

Formal support with breastfeeding was provided mostly by National Health Service (NHS) midwives and health visitors. Within the UK all citizens are legally entitled to free health care via the NHS. Midwives provide this within both hospital and community maternity services and have a responsibility for care of both mother and baby during pregnancy, the intra-partum and post-partum periods. This includes breastfeeding advice and support, until at least 10 days following the birth (Nursing & Midwifery Council, 2010). NHS health visitors may also provide information and guidance on breastfeeding during pregnancy, but usually become a more significant source of support once care for the mother and baby is transferred from the community midwifery service. This typically occurs around ten days post-partum and support from health visitors may continue for a number of years (NHS Choices, 2011). Hence during our first phase of data collection the women were all receiving home visits from midwives and occasionally from health visitors. During the second phase, NHS support was mostly provided by health visitors, either in the home environment or through attendance at child health clinics. A few participants also sought feeding advice from voluntary sector breastfeeding advisors and a breastfeeding drop-in centre run weekly by health visitors and volunteers. Although most British hospitals with maternity services now employ specially trained staff with a particular remit to support breastfeeding (typically known as lactation consultants), this was not the case at the hospital where the women were recruited at the time of the study in 2006-7.

### ***Data collection procedures***

Following the birth, mothers who confirmed a continued wish to participate in the study were enrolled and consented. All were provided with a portable mini disk player and asked to keep an audio-diary for seven days, where possible making two or more recordings per day about their experiences of feeding and anything which seemed of relevance to feeding, either during feeds or shortly after. The set of disks was collected and reviewed before each woman took part in a semi-structured interview conducted by a research assistant approximately three to four days after the final diary entry. This arrangement enabled the interviewer to probe issues which had emerged during the audio-recordings as well as exploring other aspects of the participants' feeding experiences. Of particular relevance to the present analyses were questions about experiences and perceptions of those providing breastfeeding support. The diaries and interviews were employed similarly at phase two. The study was approved by the relevant university and NHS regional ethics committees.

### ***Analytical approach***

Data were analysed following Braun and Clarke's (2006) approach to thematic analysis with the additional theoretical framework of symbolic interactionism. This theoretical perspective emphasises the importance of meaning-making and views individuals as creating meaning and subjectivity in interaction with others (Charon, 2004). Following transcription, the participants' accounts were coded (using NVivo software) according to the participants' meaning-making about the impact of their social worlds on their feeding experiences. Analysis proceeded in an inductive manner with codes being developed through close engagement with the data, rather than pre-determined. Following Braun and Clarke's (2006) steps, the codes were refined and developed into themes and overarching themes. Interpretation was facilitated through the employment of grounded theory's methods of focused coding, memo writing and constant comparison (Henwood & Pidgeon, 2006). Data analysis was conducted and refined by the first and second authors and audited by the third and fourth authors.

## Analysis of Findings

### Making use of expertise

The theme discussed in this paper captures the various ways in which the participants orientated towards, and experienced, those they deemed to have expertise in breastfeeding (mainly professionals, but also from voluntary agencies), finding their assumed expertise both useful but also problematic at times. We use the term 'expertise' to signify that the women perceived certain others to hold specialist knowledge and skills in relation to breastfeeding, regardless of the nature of the particular knowledge or skills or whether these were viewed as arising from a particular training, professional role, experiential knowledge or familiarity with specialist literature. Sometimes the participants talked about actively seeking or deferring to the perceived expertise of those providing breastfeeding support. Many participants also seemed keen to gain, and hence be able to use, expert knowledge themselves. However at other times they indicated they were uncomfortable with and resisted what they saw as the normalising gaze of the expert. The implications of these variations are explored through three subthemes: *Consulting experts versus deferring to feeding authorities*; *Interpreting the body*; and *Being empowered or disempowered by expertise*.

Only two of the women talked explicitly about receiving support from trained voluntary sector breastfeeding supporters. Five used a breastfeeding drop-in centre but, as far as they were aware, had mostly spoken to health visitors there. As such, the theme of '*Making use of expertise*' mostly captured the participants' experiences of interacting with paid professional health workers. However, despite the limited data obtained on voluntary sector support, it was of note that in their accounts the participants did not particularly concern themselves with distinguishing between different kinds of supporters or different kinds of expertise (and were not always clear about the job title or role of advisors they had spoken to). As such the theme explores several issues that appeared to arise from engaging with someone deemed to have expertise in breastfeeding, regardless of the professional status or role of this person.

### *Consulting experts versus deferring to feeding authorities*

There were notable differences in the ways in which the women talked about their approach to those providing support for infant feeding. Some spoke at times as if they expected to take a rather passive role and were waiting to be guided in feeding decisions by those assumed to have expertise. However, others described a more active stance where they took a degree of initiative in seeking specific advice. As such, health professionals and others with expertise were treated by these women as a resource which could be accessed in order to address specific concerns about their baby's feeding (e.g. frequency, attachment difficulties and baby's apparent distress) and as consultants who could comment on the mother's plans for addressing these difficulties:

...<sup>ii</sup>so we've written that on our questions to the health visitor tomorrow. I've got a whole list of questions I'm gonna ask her, bless her, when she comes. (Yvonne<sup>iii</sup>, phase 2 diary)

That's one of the things I wanted to speak to the health visitor about when she came, sort of say, you know, this is what I'm doing [feeding expressed milk<sup>iv</sup>], how long do you think it's going to be able to carry on for? (Arabella, phase 1 interview)

As part of this more active approach, several women talked as if they were able to weigh up the advice offered and make their own choices. Although the advice of those deemed to have expertise was often accorded some value, it was not necessarily heeded:

The midwife was saying about...lots of fluid, so we'll try and encourage her to have a bit more perhaps. She was saying I could give her water as well, I'm not keen if we can manage, she was saying give it from a bottle, but it's quite early days for feeding...I don't want to stop her from breastfeeding, that's going to be important. (Molly, phase 1 diary)

No, even when it comes [weaning], I will wait to see, I'll read a little bit more, not just go with what the health visitor says. (Deanne, phase 1 interview)

This evaluative approach to practitioner advice where mothers appeared to see themselves retaining more control over decision-making was more often, though

not exclusively, noted in the accounts of the older, more educated, professional women. Erica commented explicitly that perhaps her age gave her a greater sense of control and power in the decision-making process:

I had to see a consultant because I had fibroids and they were all very sort of, 'ooh home births, ooh midwives who want home births', and it was quite funny how they all have prejudices but I don't really listen, I suppose because I am older, I feel quite able to go somewhere without feeling threatened and make my own choices (phase 1 interview)

An orientation to professionals and their expertise as a resource to be used at the women's discretion, rather than a source of authority, fits with Avishai's (2007) observations from her interview data. She argued that mothers who identify with middle-class mothering standards may approach breastfeeding as a project which necessitates expert knowledge, but over which the mother retains control. However, not all of the participants seemed to take such an active 'project manager' approach. Some mothers talked about the expertise of practitioners as if this was based on superior knowledge to their own and were less likely to evaluate or question advice given. Although there were exceptions, this was more noticeable among the younger, less educated mothers, who at times seemed to adopt a more passive and uncertain stance, as illustrated by Samantha, who was 19 years old:

Erm, I'm hoping that the health visitor will let me know what's going on today, so that I can, err, change the milk if I need to or, erm, get something to help her. (Samantha, phase 2 diary, talking about her baby's apparent constipation after switching to formula milk)

Although our data did not enable us to examine actual interactions with professionals, a symbolic interactionist perspective would suggest that reciprocal roles in interactions between mothers and maternity care workers are likely to be mutually negotiated. As such, younger mothers may find it more difficult to assert a 'project manager' identity and have this validated by professionals. Our sampling procedures do not enable generalisation about older and younger mothers, however, previous research suggests that adolescent mothers sometimes experience maternity health practitioners as doubting their mothering abilities (e.g. Dykes et al., 2003). Georgina, the youngest participant, also talked about her interactions with

health professionals as if she took a more passive role. She explained how she had stopped breastfeeding when her health visitor suggested that this might have transmitted an infection to her baby:

she [health visitor] did mention that it could be because of me being unwell that he's been unwell...she says...try and see if he'll have a bit of the bottle and see if that was making him bad as well. But he seemed to be OK  
(Georgina, phase 1 interview)

Therefore, because the baby seemed better after bottle feeding Georgina continued to bottle feed, feeling that this was what the health visitor had advised. However, her acceptance of the professional's advice was in spite of her stated preference for breastfeeding:

I was a bit disappointed [switching to bottles] cos I wanted to carry on feeding him (phase 1 interview)

Samantha and Georgina seemed to be orientating to healthcare professionals as if they offered a diagnostic opinion – as if women could present bodies that were not working and receive instructions for how to make these better. As Murphy (2003) noted from her interviews with new mothers, once abnormality in feeding processes is suspected, women can shift in their orientation to healthcare professionals so that they defer more to 'expert' medical or paramedical opinion. Although it was particularly the younger women who talked about less assertive interactions with health professionals, this shift to a 'health professional knows best' role whenever abnormality became a possibility was evident for other women. For example, Robin, an ex-lawyer in her mid-30s who said she did not always agree with all advice she was given still said:

I'll be able to have an MOT if you like of all the things I think are wrong with baby....so we're gonna make sure we've covered all that with the midwife tomorrow. (Robin, phase 1 diary)

Later she added in her phase 1 interview:

I had the midwife saying this is completely normal [initial soreness and attachment difficulties], plug away at it and keep going...But had I been at home, I'm sure that I would have faltered.

Confirmation of 'normality' by someone perceived as able to differentiate between normal and abnormal physiological processes could be tremendously reassuring for the participants. However, as argued previously (e.g. Dykes, 2002; Murphy, 2003), a medical framework for breastfeeding support with its connotations of privileged knowledge can position women more passively and undermine their confidence to manage the 'project' of breastfeeding. This may not be the case when support is offered by trained peer supporters (see Hall Moran et al., 2006 for a discussion of potential differences), though insufficient data were collected within the present study to enable conclusions to be drawn about this.

### ***Interpreting the body***

A recurrent theme throughout the data was the difficulty many of the participants said they experienced interpreting their own and their babies' bodies and their expectation that those advising about breastfeeding would be able to help with this. Uncertainty about the meaning of bodily changes, particularly in the first few days, considerably undermined confidence to make decisions and take charge of the feeding process. At these times many participants talked about midwives, health visitors and other breastfeeding advisors as having a better understanding of their and their baby's bodies than they did. They were seen not only as able to tell if the two bodies were connected 'correctly' when feeding but also as able to read signs, symptoms and behaviour in order to work out what had gone wrong and whether the participant's breastfeeding experience was 'normal' or 'abnormal':

Don't tell me you've got hiccups again...that's what I'm going to have to ask the health visitor. Why are you hiccupping all the time, hey, have you got trapped wind? But mummy's rubbing you. Am I doing it wrong? (Yvonne, phase 1 diary – talking to baby)

Several of the women talked almost as if all breastfeeding advisors possessed a special vision which enabled them to see beyond the surface of breastfeeding to what was *really* going on:

...she's [volunteer breastfeeding advisor] going to come tomorrow, to have a look and see what I'm doing,...I think that the reason why my nipples so sore is cos he's just not latching on properly....and so it'll be nice to see the lady who's coming tomorrow, cos she can say, you know, exactly what's happening (Erica, phase 1 diary)

Trying to make sense of the process of milk transfer and the baby's behaviour in relation to this was something all the women talked about struggling with to some extent, particularly during the first week postpartum. As other studies have indicated (e.g. Dykes 2002) some of this was a concern that they had no way of knowing whether the baby was receiving enough milk:

...and of course with breasts you can't see<sup>v</sup> anything. Is it coming through?  
Try and squeeze it - can't really see anything (Deanne, phase 1 diary)

This was not necessarily a worry that the baby *wasn't* getting sufficient milk, but was a realisation that they didn't know how to be sure of this. Several also talked about not being able to rely on embodied knowledge for evaluating and adjusting the attachment of the baby. Initially they were struck by the fact that they had little idea how a good attachment should feel and hence were reliant on expert interpretations of the attachment:

The midwife thought he'd had a good suckle, like one or two sucks, but I didn't really feel anything, I didn't really know what it would feel like (Gina, phase 1 interview)

In the absence of embodied and experiential knowledge, some women said they wished they had help to understand what was going on *inside* their and their babies' bodies. For several of the women this seemed the obvious way to make sense of the difficulties they were experiencing in establishing feeding. For example, Amelia talked about trying to work out why her baby had begun spluttering and choking:

...you don't have x-ray vision. It's really what you need, is...x-ray vision and or a dipstick...I don't know if, if the volume's just increased, the speed of it coming out of me has just increased (phase 2 Interview)

Similarly to Amelia and other women, Wendy indicated that she felt lost interpreting her son's requirements without some outside help in the form of an explanation or additional data:

This is my first experience of breastfeeding...I don't know when I'm doing it right, I don't know when I'm doing it wrong...am I reading the signs right?...there's no like self-help book, there's no-one here to say well you know, yes he does want feeding, but the reasons he's not feeding are x, y, z.  
(Wendy, phase 1 diary)

Others have noted how new mothers often feel an overwhelming sense of uncertainty when leaving hospital (Marshall et al 2007; Burns et al 2010). Many of our participants indicated that a key component of their uncertainty was the difficulty of making sense of bodily signs and processes and hence their reliance on professionals and other advisors for this. Such uncertainty is perhaps not surprising given that in modern industrial societies women have little access to family knowledge of, or vicarious learning about, breastfeeding (Britton, 1998; Hoddinott & Pill, 1999) and the breastfeeding body remains hidden. Instead women are socialised into a society which prioritises specialist, scientific understandings of physiology (Dykes, 2002), hence their sometimes unrealistic hopes that breastfeeding advisors would be able to use specialist or technical knowledge to say 'exactly what's happening' (Erica, above) inside their own and their baby's bodies. High expectations of maternity care workers also seemed to be fuelled by the sense of helplessness and powerless that some of the women said they felt about not having the exact knowledge they craved:

...you feel sort of powerless because you don't know, well she's just had 10 minutes, does that mean she's only had the, the bit that sends her to sleep at the beginning or has she had that and full milk...maybe I just like my life too regimented, but, it really would be nice to know. (Amelia, phase 2 interview)

However, although many of the women sought technical knowledge about their lactating body, and appeared to value abstract knowledge or 'headwork' (Bartlett, 2002) in learning to breastfeed, some of the women talked explicitly about the way in which they were gradually beginning to read their own bodily signs and develop a more embodied understanding of breastfeeding. Several saw this

knowledge as something to be used alongside advice from others. For example, Georgina who deferred to her health visitor's recommendations about trying bottle feeding while she was unwell, also made several diary-entries reflecting on how she was adjusting her feeding techniques in response to bodily feelings:

He didn't attach himself correctly straightaway on this feed but I took him off and started again. I knew that he wasn't on correctly as it didn't feel right but the second time it felt right. (Phase 1 diary)

A few participants talked about the helpfulness of being able to link theoretical knowledge, often gained from health professionals, to their own embodied experience. Bodily sensations confirmed and illuminated the explanations they had been given, whilst theoretical knowledge gave the women a new way of making sense of bodily feelings. For example, Deanne was focused throughout her first week's diary on making sense of her changing body and understanding her baby's response to this. After initial uncertainty, having read about the importance of a good attachment and following discussions with her midwife, she recorded towards the end of the first week:

I can tell which one [breast] to feed out of cos they get hard and engorged...and when they're hard that's when they leak...you can tell when she wants feeding now. She just (.) not so much with her tongue anymore it's just like [makes noise with mouth] open closed - I dunno, you can just tell really.

It is worth noting that Deanne talked explicitly within the interviews about her beliefs regarding a holistic approach to the mind and body and the importance of understanding one's own body. Amelia (above) who talked in more mechanistic ways about wanting a dipstick to understand her body and valued theoretical knowledge reflected on her 'analytical' approach to life. The differences in Amelia and Deanne's approaches are a reminder of how women can vary with regard to the kinds of knowledge and professional advice they find empowering.

### ***Being empowered or disempowered by expertise***

Contact with those deemed to have expertise in breastfeeding could be experienced as both empowering and disempowering. With regard to

empowerment, several women talked about expert support as crucial in establishing breastfeeding:

If I didn't have my midwife coming in to me every day, I, you know, I may have given up, just because it was so difficult in the first few days....she said, you know, you're doing really well (Zoe, phase 1 interview)

As suggested in other studies (e.g. McInnes & Chambers, 2008; Schmied et al., 2011), encouragement, empathy, praise and reassurance were valued as empowering. However, when examining accounts more closely, it seemed that often what was most empowering was the gaining of knowledge and skills to support new understandings and uses of the body. These often meant a transformation in the woman's experience of breastfeeding from being something difficult or puzzling to being an embodied experience that made sense. For example, Gina said her midwife helped her to move from passive uncertainty interpreting the breastfeeding attachment to an understanding of what was happening between herself and her baby:

So, that was great, she...got him feeding on both sides, um, the flat nipple was kind of brought out and she showed me what to do, assured me that I was producing colostrum and that the baby was swallowing, you could kind of hear, um, and that the baby really didn't know what to do initially. I sort of had imagined that babies would instinctively know, but he really needed to be sort of taught how to latch on, how to suckle, but we got him there and it was great. (Phase 1 interview)

Knowledge about physiological processes that enabled the participants to interpret and understand bodily signs, symptoms and processes meant that they could reassure themselves that they and their babies were 'normal', rather than relying on practitioners for this. It also appeared to enable them to identify causes of difficulties and develop problem-solving strategies. For example Yvonne said she could now make sense of the pain she'd felt as being a consequence of her baby's attachment to the breast:

He hasn't latched on perfectly, because they told me at the breast feeding clinic...when he comes on, off, your nipple,...should be kind of like nice and

round and not look like a lipstick and actually mine looks like a lipstick at the moment,...the nipple's like at an angle, so that means that he wasn't latched on a hundred percent properly...That's probably why it was hurting,...didn't have enough in his mouth. (Phase 2 diary)

Erica also saw herself as having been empowered by knowledge that enabled her to reassure herself about feeding:

And, so I think the thing that kept me going then was the fact that I'd been told by the midwife that when they're born, their stomach's only as big as a two-pence-piece, so that's so little, will fill them up, so actually even though I think they must be starving they're not actually. (Phase 2 interview)

Being able to conduct this kind of logical analysis of "cause and effect" with regard to feeding and feeding difficulties seemed to be experienced as particularly helpful by several of the participants. Experts were viewed as not having simply *used* their expertise but as having passed this on so that the participants were now able to monitor the feeding process themselves. Schmied et al. (2011) make a similar distinction between reductionist styles of support with standardised advice, and facilitative styles which enable women to learn for themselves. Several of our participants also indicated that they felt empowered by appropriate tuition in attachment positions and techniques:

I rang the hospital, and I got the midwife to come out to me cos I thought, if she doesn't come out to me today, I'm gonna pack this in. ...And within 20 seconds of her showing me what to do, the difference was unbelievable (Uma, phase 1 interview)

As Marshall et al. (2007) note, if women learn the technical skills of breastfeeding quickly then many of the emotional challenges disappear.

However, expertise was also portrayed as potentially *disempowering*. This was because at times practitioners were viewed as using their expert status in ways which pressured, confused or judged mothers. For example, a few of the mothers talked about feeling pressured by professionals' expectations of how they ought to feed their babies. Wendy compared her current positive experiences with ante-natal care in the town she had just moved from:

it was much more rigid...it was 'We deliver onto the body, we believe in skin to skin contact, we breastfeed, we do this, we do that'...rather than saying these are your choices,...I just felt that that was the wrong approach...you could be completely intimidated, it could make you feel, really sad if...that's not the way I want to do it. (Wendy, phase 2 interview)

Queenie talked more directly about her regrets at having felt unable to resist the midwife's argument that using formula was in her baby's interests:

I wish I had been strong enough at the beginning and said 'no' to the bottle...he hadn't eaten or suckled, ..but because he had swallowed so much fluid he kept being sick ....she was also concerned about dehydration and getting jaundiced so she said look, give him a bottle and that going into him will make him sick up all the amniotic fluid...to get an empty stomach and then hopefully latch onto the breast...I really wish she'd said to me, how determined are you to breastfeed and I could have said to her 100%...let's not do anything too hasty (Phase 1 interview)

Similarly to women in other studies (see McInnes & Chambers, 2008; Schmied et al., 2011), Queenie and other participants also appeared disempowered when those they saw as experts gave conflicting advice:

Within those 6 days I had 6 different midwives and the advice varied from each midwife....I said to [regular midwife] but one'll tell you to give boiled water and one'll tell you not to give boiled water...so she said, well just take the bits you want...but I said you don't know when you are a new mum, you don't know...one will tell you one thing and one another so I found that very difficult, when you don't know what's right (Queenie, phase 1 interview)

Where breastfeeding women in Western cultures are orientated to the value of theoretical and expert rather than familial and experiential knowledge, conflict between experts can be particularly disconcerting and undermining, especially if there is an assumption that 'experts' have access to a 'correct' answer. The presumed expertise of professionals also appeared to be experienced as disconcerting by some participants who talked about feeling uncomfortable under what they saw as the scrutinising and normalising gaze of professionals. The

participants who spoke about this issue of feeling judged were not the two who had sought help from voluntary sector advisors and therefore all were speaking about feeling judged by health professionals. Drawing on Foucault's work, several commentators (e.g. Dykes, 2006b; Murphy, 2003) have noted the power of moralising discourses around infant feeding when juxtaposed with the authority accorded to medical and associated professionals to judge what is and is not normal. Although it was highly reassuring for our participants to be told they and their babies were 'normal', the enactment of reciprocal roles where one person advised another on 'normality' left open the possibility of being judged 'abnormal':

I didn't want my baby screaming if nobody else's baby was screaming [on post-natal ward]...and didn't want the nurses coming in all the time or the midwives thinking what's wrong with her (.)<sup>vi</sup> she's not managing very well.  
(Robin, phase 1 diary)

Although some of the women also reported feeling self-conscious feeding in front of friends and family, professionals were seen as particularly able to judge the quality of their mothering:

...there was almost a pressure in hospital, because you just kind of, you knew that they were checking to see if he was feeding alright, and therefore there was a pressure...to prove that you were feeding ok. (Emma, phase 1 interview)

Other studies have also noted that some breastfeeding women can feel scrutinised and judged by professionals (e.g. McInnes & Chambers, 2008). The sense that breastfeeding is a test of mothering relates to the way in which successful breastfeeding has become linked to idealised views of 'good mothering' (Marshall et al., 2007; Murphy, 1999). Several of the participants who struggled with breastfeeding talked more explicitly about the way they felt that these difficulties implied failure as a woman and mother and hence were particularly vulnerable to others' potential judgements (see Williamson et al., 2012 for further discussion of this aspect of the data). Some felt some discomfort therefore in asking for expert help:

Interviewer: Not everybody will call and get help

Louise: No, they won't no, cos you feel like you're either a failure or you should be able to sort it out yourself if you're in a pickle (Phase 1 interview)

Therefore, although breastfeeding expertise could be a highly useful resource to draw on and a source of reassurance and empowerment, it could be a 'double-edged sword'. The very existence of experts in this physical aspect of mothering opened up not only the possibility of feeling judged as a mother, but also the possibility of being judged for being a mother who required expert help. In addition, women were further disempowered where 'expertise' was experienced as leading to more confusion than clarity or where claims of expertise were felt to be used to override their own choices and concerns.

## Discussion

Breastfeeding women and those who support them face something of a paradox. Successful breastfeeding has become linked to idealised views of 'natural' mothering (Wall, 2001) and yet many women, including the majority of our participants, feel they need the input of breastfeeding experts to help them achieve what they expected would come naturally. Given this paradoxical situation it is perhaps not surprising that, from our participants' perspective, making use of breastfeeding expertise was not necessarily a straightforward process. Whilst many talked about access to expertise as crucial for enabling them to make sense of their own and their babies' bodies, it seemed that this expert status could also be experienced as undermining. At times participants talked of being able to draw on professional expertise in a way that supported their autonomy and empowered them. However, they also spoke about professional expertise as if it were a source of authority, informed by privileged knowledge, which enabled professionals to undermine the mothers' autonomy or pass judgement on them.

The relatively high proportion of degree educated, professional women within our sample suggests a need for caution in extrapolating from our findings. However, the suggestion that breastfeeding support, whilst often useful, can undermine breastfeeding mothers is not new. Historical analyses of infant feeding have linked medical supervision with practices which can inhibit lactation such as scheduled and

supplemental feeding (e.g. Apple, 1994; Dykes, 2006b). Contemporary 'expert-led' approaches to breastfeeding have also been criticised where they undermine women's confidence in their own embodied knowledge. For example, Dykes (2005b) cautions against mechanistic approaches to breastfeeding which draw on a techno-medical discourse of measurement and monitoring of milk supply, arguing that this reinforces women's mistrust in their bodies. Similarly Bartlett (2002) notes the tendency for breastfeeding education to be approached as 'headwork' in a way that potentially disrupts the 'corporeal logic' of women's embodied subjectivity, while McCaughey (2010) suggests that new mothers can become over-exposed to and hence over-reliant on expert knowledge. Such analyses seem to mirror the distinction made in the knowledge management literature between abstract or explicit codified ('know-what') knowledge and tacit or embodied ('know-how') knowledge gained through experience (e.g. Brown & Duguid, 1998), with embodied knowledge typically being more highly regarded because of its perception as appropriately women-centred. Although it is worth noting that such distinctions are not necessarily clear cut and healthcare expertise can include tacit, embodied knowledge as well as more abstract and evidence-based forms of knowledge (Paley, 2006), concerns have been raised about the way in which use of an objectivist, scientific paradigm to develop knowledge about breastfeeding can lead to a universalising and overly prescriptive approach (e.g. Burns et al. 2010). This can ignore women's individual lactational responses and prioritise a particular kind of professional expertise (Bartlett, 2002). However, our data suggest that although there is the *potential* for women to become disempowered by the implied message that breastfeeding requires expert technical supervision, many of our participants appreciated gaining technical and abstract knowledge (e.g. about the physiology of breastfeeding) where this enabled rather than limited their own decision-making and hence autonomy, as Nelson (2006) also reports. Unlike the participants in Murphy's (2003) study, who either resisted or deferred to medically-informed expertise, several of our participants wanted this expertise for themselves. Rather than being disempowered by becoming objects of the professional gaze, they aligned themselves with the gazing subject in order to acquire the abstract, scientific knowledge which they saw as validating normalising judgements. From their perspective such knowledge enabled the logical analysis of "cause and effect".

Although we may lament the loss of familial transmission of tacit and embodied knowledge about breastfeeding (Britton, 1998; Eden, 2012) it seems important not to lose sight of, and to value, other abstract or technical forms of knowledge that are available to women in contemporary western societies which can enhance their understanding of infant feeding. However, it is also worth noting that not all of our participants appeared interested in seeking or using technical knowledge about breastfeeding. Some indicated that they were more focused on developing awareness of bodily feelings. Just as women differ in their expectations of, and relationships with, midwives (Hunter, 2006), so they are also likely to have different approaches to learning a new use of part of the body. Our data suggest therefore that maternity practitioners need to 'tune-in' to possible variations. Useful breastfeeding support needs to employ different forms of language and metaphor (e.g. mechanical, experiential or relational) for different women with varied relationships to, and understandings of, their bodies and varying levels of prior access to technical or scientific forms of discourse. That differences between women were apparent from our relatively small and fairly homogenous sample suggests the value of research with more diverse groups.

A strong theme throughout our data was the difficulty many of the participants experienced initially in interpreting their and their babies' bodies in order to breastfeed successfully, and the value of knowledge and skills transmitted by practitioners for enabling them to make sense of the feeding process. Other qualitative studies (e.g. Dykes et al., 2003; Entwistle et al., 2010) and a meta-synthesis of both qualitative and quantitative studies (Hall Moran et al., 2007) have focused on esteem building and emotional support as key to many breastfeeding women, rather than informational or instrumental support. As Dykes and colleagues (2003) note, these forms of support are not separate. Many of our participants described their feeling of empowerment and confidence to breastfeed as a direct consequence of the information and practical advice they had received. However, they did not appear to look towards the practitioners primarily for emotional support or esteem building. Although many talked about the supportive nature of contact with practitioners, this was often said in passing, in a taken for granted manner. Instead, they were more likely to talk about emotional support from partners or other friends and family.

In synthesising our findings with those of others, it is worth noting that studies which have emphasised the value of emotional and esteem support from those supporting breastfeeding rather than technical or instrumental support (though not negating the value of the latter) have focused on social groups for whom breastfeeding is less common and where there may be additional support needs, for example low-income women (Entwistle et al., 2010), adolescents (Hall Moran et al., 2007), or hospital settings where women do not have access to their usual support networks (Dykes, 2005a). All our participants stated that significant others in their lives were generally supportive of their wish to breastfeed. In this situation, women may primarily look towards professionals for technical advice and information. However, the manner in which practitioners offer this advice remains important if contact is to empower women by increasing their own knowledge and skills rather than disempowering them by leaving them feeling pressured or judged.

Recent discussions of ways to ensure that breastfeeding support empowers mothers have looked towards Rogers' (1961) person-centred approach to counselling for a way of ensuring that control over the process of change is located with mothers and that those who support them do not become inappropriately directive (e.g. Dykes, 2006a; Hall Moran et al., 2006). Person-centred approaches position counsellors as facilitators of personal growth, rather than advisors or educators, and argue for the importance of a genuine, empathic and accepting relationship between helper and client. Hall Moran et al.'s (2006) research on volunteer breastfeeding supporters trained using a person-centred approach, suggests that the approach may encourage helpers to offer breastfeeding advice in a flexible and open-minded manner and to make better use of active listening skills in order to understand and empathise with the perspective of the mother. However, the person-centred approach as used in a counselling context may need to be adapted for use with breastfeeding support. There are times when health professionals with a responsibility for the well-being of the baby as well as the mother cannot remain non-directive (Hall Moran et al., 2006). In addition, a person-centred approach generally eschews the notion of knowledge or skills transmission from counsellor to client, seeing this as possibly inhibiting the client's self-direction and self-management (Thorne, 2007). However our data (though from a limited sample) suggest that what some breastfeeding women want from their interactions with

professionals is precisely the transmission of knowledge and skills. Therefore the challenge for practitioners is to find ways of transmitting their expertise in a spirit of tentative collaboration rather than direction. As Dykes says, “the ultimate aim should be to place authoritative knowledge in the hands of the mothers” (2002, p.500). However, to do this in a truly empowering and collaborative manner is a time-intensive process, requiring sufficient sustained contact with women to understand more exactly what their informational and other needs are and respond to these appropriately. In the UK context it remains to be seen whether, following changing roles such as those within health visiting services (Lowe & Department of Health, 2007), post-natal services will be able to provide the necessary individualised, collaborative and sensitive support. If not, there is a risk that women’s contact with breastfeeding expertise may not empower them to breastfeed, and may even leave them feeling disempowered and reluctant to engage with both the support available and with the practice of breastfeeding.

## **7989 words**

### **Key messages**

Breastfeeding women may particularly value assistance in interpreting their and their baby’s bodily signs and changes.

Those supporting breastfeeding need to ensure that their expertise is not used in ways which disempower breastfeeding women, for example by leaving women feeling confused, pressured or judged as failing.

Breastfeeding women differ in their informational needs. Therefore support is more likely to be effective where such needs are identified on an individual basis.

Person-centred approaches to breastfeeding support are likely to be useful so long as their non-directive nature does not mean the absence of clear information and guidance where women want this.

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Table one

Pseudonym	Self-reported Age	Self-reported Ethnicity	Method of Delivery	Participation	Feeding Status At End of Phase 1	Feeding Status At 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 (initially homebirth but transferred to hospital with ventouse.)	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 ventouse	Phase 1 only	Exclusive breastfeeding	
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	

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<sup>ii</sup> '...' indicates quotation beginning mid-sentence or speech omitted

<sup>iii</sup> Pseudonyms are used for all participants

<sup>iv</sup> Material within square brackets has been added by authors for clarification

<sup>v</sup> Underlining indicates emphasis in participant's speech

<sup>vi</sup> '(.)' indicates noticeable pause in participant's speech