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The Experience of Infant Feeding for Women Diagnosed with
an Eating Disorder: An Interpretative Phenomenological
Analysis

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A thesis submitted to the University of Huddersfield in fulfilment of the
requirements for the degree of Master of Science by Research (Human and
Health)

The University of Huddersfield

October 2017

Acknowledgments

I would like to thank my family, in particular my mother and my sister, Maalia, for their love and continuous support throughout the completion of this research.

I would also like to thank my supervisors Dr Dawn Leeming and Dr Joyce Marshall for their instructive feedback, words of encouragement and confidence in my ability, which has been invaluable in my development as a researcher. Finally a special thanks to all of the participants who took part in this study, for sharing your stories and insightful experiences, without which this research would not have been possible.

Thank you.

Abstract

Feeding a baby has varied meanings for mothers, related to both images of mothering and ideas about bodily control and connection. For mothers with eating disorders these meanings may be shaped by additional concerns about body image, nutrition, weight and identity. The research available places particular importance on the difficulties during pregnancy, when adjusting to a changed body and conflicts between preferred eating patterns and the demands of pregnancy arise. However, there is very little research focusing specifically on the post-partum period in relation to the experiences of infant feeding for those with eating disorders which might usefully inform support for these women and their babies. Using Interpretative Phenomenological Analysis (IPA) the current research aimed to explore the lived experience of infant feeding for women who had a current or previous diagnosis of either anorexia or bulimia and who still experienced challenges related to eating during early motherhood. Six women aged between 31-39 years were interviewed using a semi-structured telephone interview. Interpretive engagement with the data led to the identification of four master themes. These highlighted challenges faced by participants, such as feeling overwhelmed by nutritional advice for breastfeeding, as this conflicted with the requirements of disordered practices. This was however, a motivation for some to 'give up' anorexia or bulimia. Therefore, the findings provide an insight into infant feeding for women with eating disorders as potentially both challenging and rewarding. These findings suggest that, despite challenges, breastfeeding helped participants in shifting their identity given their sense of purpose, as well as a new found appreciation of a body that, though somewhat damaged by an eating disorder, was now able to breastfeed. Support for mothers who experience difficulties with eating and weight needs to address issues unique to this group, such as the challenges of nutritional intake and bodily changes, whilst recognising the resilience of many women and the positive meanings provided by motherhood and breastfeeding.

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Word Count: 25,917

Chapter 1: Introduction

Infant feeding may present a challenge to women with eating disorders because of the demands this has in addition to issues of identity, weight and eating concerns. However there is currently little research on and awareness of this matter, therefore this thesis aims to address this gap. This chapter will detail contemporary issues surrounding the use of breast milk and formula milk, with reference to women's experiences of both. An outline of some of the psychosocial issues involved in eating disorders and infant feeding will be given, with reference to psychological and some feminist theory. The purpose of this chapter is to provide some background and context for the later review in Chapter 2 of the academic literature on the experiences of breastfeeding and how eating disorders might relate to this.

The transition to motherhood is considered to be a significant experience in a woman's life and can often be overwhelming for new mothers. Research has indicated that women may face a number of difficulties and challenges from the onset of pregnancy to after birth (Darvill, Skirton and Farrand, 2008). A loss of control and self-concept can occur for some women during this transition and the need for support is essential (Bollen, 2015). Therefore ensuring maternal psychological health and well-being is generally a key component in the care of this group of women where the presence of mental health problems would perhaps mean additional challenges might be experienced. Eating disorders are amongst a variety of psychological problems which women might face in their lifetime; these have been given little attention in relation to the postpartum period. With breastfeeding being an aspect of motherhood some women see as a key area requiring support (Coates, Ayers and de Visser, 2014) it is important for research to develop a psychological understanding of the subjective experience of infant feeding in the context of an eating disorder.

Currently there is an extensive body of research highlighting the benefits of breastfeeding for both maternal and infant health and well-being. For instance, breastmilk contains live components such as antibodies, proteins and various other immunological factors, protecting the infant from illness and infection in a way in which infant formula, made up of processed cow's milk, vitamins and prebiotics, is unable to (Oddy, 2001). Furthermore, some research suggests that breastfeeding can reduced the risk of postpartum stress (Groer, Davis and Hemphill, 2002; Hale, 2007) while other research argues that the challenges breastfeeding can cause are stress inducing in themselves (Schmied and Lupton, 2001; Shaw-Flach, 2002). Research has demonstrated the benefits to children's early development as well as resilience to certain health problems and generally better long-term health outcomes when they have been breastfed as infants. This is apparent in a number of domains such as obesity, cardiovascular disease and Type-2 diabetes, where breastfeeding is shown to have protective properties (Liamputtong, 2011; WHO, 2013; Williams, Davies, Boyd, David and Ware, 2014). Breastfeeding is also recognised as having a dual role, as it not only reduces the risk of non-communicable diseases in infants but also reduces the risk of ovarian cancer and breast cancer for the mother (Victora et al., 2016). In the shorter term, breastfeeding is associated with lower incidence of health problems such as respiratory infection and mortality from diarrhoea (Victora et al., 2016). However, it is noteworthy that some of the studies included from the meta-analysis reporting these findings only show association, therefore cause and effect cannot be confirmed.

The World Health Organisation recommends exclusive breastfeeding for the first six months of the infant's life and suggests that in order to sustain breastfeeding, initiation should occur within the first hour after birth (WHO, 2003). According to the most recent Infant Feeding Survey [IFS] (McAndrew et al., 2012), based on data from 2010, the rate of breastfeeding initiation amongst women in the UK was 81% with only around 34% of women still

breastfeeding at 6 months, and less than 1% exclusively breastfeeding (McAndrew et al., 2012). Therefore it has been suggested that attempts to encourage and support breastfeeding should be put forward in the first two weeks following birth to help improve these rates (Hoddinott et al., 2009). The Infant Feeding Survey (2010) supports this finding as it found that breastfeeding initiation rates across the UK (81%) decreased from birth to 69% at one week post-partum, to only 34% of mother breastfeeding at six months. Additionally, there are a number of factors which contribute to cessation of breastfeeding within two weeks postpartum, despite the widespread knowledge of the health problems associated with formula feeding and efforts of various government initiatives. The UNICEF Baby Friendly Initiative has been introduced in the UK (UNICEF UK Baby Friendly Initiative Standards, 2012) and implemented in other countries too, in order to value, support and inform mothers' decisions around infant feeding among other things. This was a publication which expanded on previous initiatives such as the Ten Steps to Successful Breastfeeding (WHO, 1998) after consultations with academics, professionals and importantly, mothers. This initiative helped to inform and encourage new mothers to breastfeed and reduce the use of infant formula milk, whilst respecting those who choose the latter method of feeding. Importantly, there is a difficult balance required by maternity services where on the one hand breastfeeding needs to be promoted. However, on the other hand women who chose not to breastfeed need support and information so that they can use formula milk as safely as possible.

Dykes (2006) provides a historical analysis of infant feeding, and writes that political interest in this began during the Enlightenment period due to high mortality rates for infants becoming apparent. Prior to this infant feeding was considered to be a woman's concern only. By the twentieth century, when science and medicine were becoming even more influential, there was an even greater emphasis on monitoring of mothers' feeding of their infants, as part of the increased medical supervision of childbirth which, Dykes argues, led to greater use of

dried formula milk. She suggests that formula milk fitted better with medical supervision as it was possible to measure and monitor formula intake more easily than intake of breastmilk.

Dykes is one of many commentators to have also noted that the rise of formula milk was further fuelled by commercial interests during the twentieth century, as well as the expanding role of women within the workplace where accommodation was rarely made for breastfeeding. This meant that by the mid twentieth century women in industrialised countries were predominantly formula feeding (Dykes, 2006). This then led to more recent initiatives such as the UNICEF/WHO initiatives described above and the introduction of the International Code of Marketing of Breast-Milk Substitutes (1981) which have aimed to promote breastfeeding and discourage the promotion of formula milk.

Feminist literature in relation to infant feeding argues that shame and guilt can be associated with a woman's chosen method of feeding her infant, due to a number of social constructions making either breastfeeding or formula feeding a challenge which serves as an undermining force for women (Taylor and Wallace, 2012). Therefore women's decisions not to breastfeed and the lower than desired rates of breastfeeding need to be understood in the context of a male dominated society which often places constraints on women's reproductive behaviours. Feminist scholar Young (2005) argues that in a patriarchal society women's perceptions of their body can be defined by men's sexualised perceptions of breasts, thus preventing women from experiencing breasts as something to attach alternative non-sexualised meanings to. For example, it then becomes difficult for mothers to view breastfeeding as part of an emotional relationship with their child.

However some feminists advocate breastfeeding as an empowering force for women which allows for the positive expression of motherhood and the female body (Schmied and Lupton, 2001). In a qualitative study on the role of motherhood drawn from a number of interviews internationally, Smith (2008) found that many women challenged the idea of breastfeeding as

an alienating practice. Instead they saw it as a part of the reproductive cycle which was a right of women and argued that in fact some aspects of breastfeeding practice were made more difficult for women given the defensive nature of liberal feminists. From this perspective breastfeeding ought to be defined as a 'labour of love' and a powerful means of honouring and valuing women through embracing the whole of womanhood (Smith, 2008). Studies like this show that the meanings of infant feeding are often contested amongst theorists therefore it is important to understand different views to consider how women come to personal decisions around feeding.

Despite figures showing that breastfeeding patterns vary globally (Victora et al., 2016), in the UK exclusive breastfeeding rates increased slightly from 2005 to 2010 (McAndrew et al., 2012) with the highest rate at six weeks being in England (24%). There are also important differences between high-income and low-income countries worldwide, with the highest rates of exclusive breastfeeding prevalent in low and middle income countries (Victora et al., 2016). As such, exclusive breastfeeding is affected by socio-economic and various other issues, however it would seem that even prolonged breastfeeding can be an issue for many mothers. In a UK study, Fox, McMullen and Newburn (2015) found that low rates of prolonged breastfeeding were a result of being given unrealistic expectations and problems with breastfeeding such as pain. Other research within the UK has suggested that embarrassment is a key issue in discontinuation of breastfeeding (Morris, Zarate de la Fuente, Williams and Hirst, 2016). In summary, despite slight increases in breastfeeding rates between 2005 and 2010, rates in high income and western countries such as the UK are lower than for low and middle income countries, particularly with regards to exclusive and prolonged breastfeeding. This could be partly attributed to western cultures and ideas around embarrassment and breastfeeding in public, among others, which will be discussed further within this chapter.

Although breastfeeding can clearly be challenging for some women, it is important to recognise that some of these challenges arise from cultures, such as that of the UK, which can be hostile towards breastfeeding, meaning that breastfeeding mothers experience stigma or difficulties accessing support. Dowling and Brown (2013) found in a sample of women from the UK that many perceive prolonged breastfeeding as eliciting negative attitudes from others, with mothers suggesting that the restrictive timeframes put forward by health promotion agencies for breastfeeding are unhelpful in making it a norm to breastfeed for longer. As mentioned in earlier studies, support for prolonged breastfeeding is perceived as significant for many women in their decision to breastfeed for longer than the considered norm (Dowling and Pontin, 2017; Scott and Mostyn, 2003).

Infant feeding practices also vary cross-culturally and across socio-economic and demographic groups. Although patterns vary globally, in the UK the Infant Feeding Survey (2010) found that breastfeeding was most common in mothers over 30, from minority ethnic backgrounds and in professional occupations (McAndrew et al., 2012). Although breastfeeding overall is a rising trend, this is not necessarily the case in other countries (Victora et al., 2016). These disparities could be partially explained by looking at the experiences of infant feeding for women, which will be discussed in the following chapter. However it seems that women feel the potential to be judged for either formula feeding or breastfeeding, with the global concern with both formula and breastfeeding methods posing strains on mothering (Thomson, Esbich-Burton and Flacking, 2015). Consequently it is important for the promotion of breastfeeding to be done without prompting feelings of blame amongst women (Benoit, Goldberg and Campbell-Yeo, 2015), which initiatives such as the BFI strive to do. As a result of the issues discussed above breastfeeding promotion has become a rather controversial topic meaning there is increasing discussion about how promotion can be more sensitive (Fox et al., 2015).

In a review of the reciprocal effects of eating disorders and the postpartum period, it was suggested that breastfeeding is particularly important in sustaining a healthy and mutual bond between infant and mother (Astrachan-Fletcher, Veldhuis, Lively, Fowler and Marcks, 2008). Breastfeeding is not only a means of feeding and providing nutrition for an infant, it is widely considered to be the basis for a mutual and strong mother-infant bond (Britton, Britton and Gronwaldt, 2006). However, Jansen, Weerth and Riksen-Walraven (2008) found in a review of breastfeeding and maternal-infant attachment studies that while breastfeeding is theoretically underpinned by mechanisms which may enhance the mother-infant relationship, there is a lack of empirical studies providing substantial support for this claim. It was therefore advised that instead studies should look to provide evidence on breastfeeding having a positive effect on maternal and infant health (Jansen et al., 2008). Alternatively, many women report that breastfeeding is a beneficial experience for both themselves and their child, and advocate breastfeeding as a symbol of motherhood (Afoakwah, Smyth and Lavender, 2013; Else-Quest, Hyde and Clark, 2003; Smith, 2008). This suggests that social and cultural norms around breastfeeding and the notion of ‘breast is best’ seems to have more value and meaning to mothers than evidence suggests. However, these findings also recognise that many women’s experience of breastfeeding do not come without alternate problems and dilemmas.

As discussed above, it can be difficult to navigate the contradictory meanings of breastfeeding for women, which has the potential to create personal, psychological and social problems when making decisions around infant feeding. These conflicting feelings may be particularly significant for women with eating disorders for whom meanings of infant feeding and the use of one’s body might differ. Eating disorders are more common in women of childbearing age (Smink, Van Hoeken and Hoek, 2012) therefore some of these women are likely to face dilemmas in regards to feeding their infant, and may be tentative about

breastfeeding and how this might affect body shape and size (Patel, Wheatcroft, Park and Stein, 2002). The concern around food for these women has even more psychological significance compared to the general population, therefore decisions concerning eating are not made primarily in relation to hunger or nutritional needs but instead eating or not eating serves powerful psychological needs.

Eating disorders can be especially problematic when considering the psychological impact on an individual. Anorexia nervosa (AN) is characterised by the severe preoccupation with achieving a low body weight which is sought by food restrictions, excessive exercise and self-induced vomiting (Eminson, 2001; Halmi et al., 2003; Obadina, 2014). Although fertility is often compromised there is no clear evidence that the infant's nutrition is at risk if women with eating difficulties become pregnant. However, given that eating disorders can have adverse effects on family and relationships with others (Stitt and Reupert, 2013) it is feasible that the postpartum period, which is already a time of profound change, can cause additional challenges. For example some women with an eating disorder go onto having problematic feeding interactions with their child, as well as an increased likelihood of having difficulties with breastfeeding (Sadeh-Sharvit, Levy-Shiff, Arnow and Lock, 2016; Squires et al., 2014). In the case of bulimia nervosa (BN), it is distinguished by bouts of over-eating followed by purging, dietary restrictions or excessive exercising in order to avoid weight gain (Obadina, 2014).

According to a report done by BEAT, a leading UK Eating Disorder charity, an estimated 750,000 people in the UK suffer from an eating disorder (BEAT, 2015), of which 90% are female (National Institute of Health and Care Excellence, 2017). Furthermore, eating disorders affect up to 8% of women during pregnancy (Easter et al., 2013). Indeed medical advances have been able to address issues of infertility among women with eating disorders, and other research suggests that fertility problems are not more common in women with

bulimia nervosa (Crow, Thuras and Mitchell, 2002). In addition to this, evidence suggests that the chance of being able to conceive is not necessarily effected by having suffered from an eating disorder (Ward, 2008). However, this means that when the time comes infant feeding is something which has the potential to become an issue of concern for women who suffer from issues around eating, weight and the control of these factors.

Eating disorders are often life-threatening conditions and are associated with a number of short-term and long-term effects on an individuals' health and well-being (Obadina, 2014) with anorexia nervosa, bulimia and binge eating disorder being the most common eating disorders. They are characterised by abnormal attitudes towards food causing the individual to change their eating habits and behaviour, with aspects of their weight and shape often being focused on as a point of concern (Fairburn and Harrison, 2003). This can lead to unhealthy choices being made and affect an individual on a physical, psychological and social level. BEAT (2015) estimates that 1 in 250 women will experience anorexia nervosa, and bulimia is two to three times more common than anorexia with around 90% of sufferers being women. Despite these figures it is important to note that the medicalisation of eating disorders is contested from a qualitative approach, as the categorisation of a subjective experience undermines the significance of this for the individual experiencing it. Additionally feminist literature has argued that eating disorders are a culturally embedded issue and therefore disagree with the medicalisation of such disorders (Conrad, 2007).

Research has shown that mothers with a history of eating disorders or an active eating disorder report having problems feeding their infants (Micali, Simonoff & Treasure, 2009). Whether these problems are associated with having a diagnosis or not, choosing to breastfeed means that the infant's health and well-being is closely tied to the mother's. Therefore breastfeeding might be experienced as problematic for women in this group if they are likely to anticipate problems because of their diagnosis. Furthermore, this can lead to many women

feeling guilty and reporting feeling a sense of failure for attributing these feelings to the experience of breastfeeding, which is so widely considered to be the ideal for nourishing an infant (Schmied and Lupton, 2001). These problems could account for the increased incidence of postnatal depression in women with an eating disorder (Astrachan-Fletcher et al., 2008). Other research suggests that there is a higher risk of discontinuing breastfeeding in the first 6 months postpartum in women generally, with or without an eating disorder (Torgersen et al., 2010). This evidence therefore provides a basis for the assumption that an eating disorder might have an adverse effect on infant feeding (Squires, Lalanne, Murday, Simoglou and Vaivre-Douret, 2014), with the literature having established that around two thirds of women in the UK stop breastfeeding at 6 months post-partum (IFS, 2012).

Women might expect an eating disorder to impact on infant feeding, particularly when breastfeeding. One of the practical issues they might expect to face are nutritional guidelines for breastfeeding, which they might expect to find difficult to adhere to, given that breastfeeding advice calls for a healthy and balanced diet. Khan (2004) provided a summary for maternal nutrition when breastfeeding and argued that there are a number of common misconceptions in this area. Many women assume that their diet is directly linked to their milk supply, which can be expected to be a particular concern for women with eating concerns, however a breastfeeding woman will be able to produce enough milk when feeding on cue regardless of her food intake. Therefore education of this should be given to mothers who might be concerned about breastfeeding who also have an eating disorder. Furthermore, women are weighed down by cultural notions, superstition and taboos regarding breastfeeding, being led to believe that they need to consume 500 extra calories a day compared to pre-pregnancy, despite this being a rough estimate (Khan, 2004). Nonetheless this idea may become somewhat concerning for women who have experience of an eating disorder, thus creating even more barriers to breastfeeding. Women's anxieties about their

own food intake might lead to anxieties about the baby's nutritional intake. It has been noted in the literature that mothers with eating disorders may become particularly controlling, critical or restrictive in regards to their child's diet (Hoffman et al., 2012) particularly during meal times (Ward, 2008) therefore infant feeding might be expected to pose a challenge.

Another issue women with eating disorders often struggle with is control, and how this notion fits with the idea of scheduled versus demand feeding in relation to breastfeeding. As breastfeeding is often more time consuming than formula feeding, many women experience it as draining even without having severe eating or bodily concerns (Schmied and Lupton, 2001). A Dutch study done by Hipple Walters, Adams, Broer and Bal (2016) analysed online illness narratives of women suffering from various eating disorders, and found that women discussed control as a independence tool, in which disordered eating would aid in controlling an unruly life. This study demonstrates the persistence of a psychological need for control in some women. The demands of breastfeeding have been shown to trigger or intensify feelings of loss of control and even undermine confidence in women's bodies and induce a sense of violation (Schmied and Lupton, 2001). Additionally, breastfeeding may be associated with an increase in breast size (Riordan and Wambach, 2010) which may become problematic for women with body image concerns. Despite possible problems as indicated above, becoming a mother might be helpful to some women with eating disorders in giving them an additional sense of meaning and purpose. While motherhood can be an overwhelming experience it is also important to recognise that it can be a time of elation for many (Darvill et al., 2008). Chapter 2 will review what the literature adds to our understanding of the combination of these issues.

The qualitative exploration of experiences of infant feeding for women with a history of eating disorders is important. The literature suggests that the prevalence of eating disorders in women generally affects those of childbearing age with eating disorder symptomology

reoccurring post-partum (BEAT, 2015; Micali, 2008; Ward, 2008). Research taking an interpretative phenomenological approach has the potential to develop a more nuanced understanding of why women may develop psychological difficulties post-partum, how women attach meaning to experiences that coincide with motherhood, and the role infant feeding plays in this. Therefore the consideration of research on women's perspectives and experiences is of importance and will be addressed further in the following chapter.

Chapter 2: Literature Review

This chapter will review and evaluate the existing literature on women's experiences of infant feeding. This will be followed by reviewing the literature on eating disorders, in order to develop an understanding of how this might impact on infant feeding, with reference to the role of eating disorders during pregnancy and the post-partum period. This literature will help provide an overview of the current understandings of some issues women may have leading up to breastfeeding decisions, from which gaps in our present understanding of the experience of eating disorders and infant feeding may become apparent. The chapter will conclude with an account of the issues that present themselves to women with an eating disorder in the postpartum period, thus providing a context for why the present study is required.

2.1 Women's experience of infant feeding: breastfeeding and formula feeding

This section will introduce the existing literature on the experiences of infant feeding and the various ideologies of infant feeding in different societal and cultural backgrounds. In order to gain an understanding of women's experience of infant feeding, an insight into this in the context of the broader understandings of motherhood and feeding is required.

According to Nelson's (2006) review of 15 qualitative breastfeeding studies, the experience of breastfeeding was generally viewed as an engrossing, personal journey for women and as an act that requires much physical as well as maternal commitment and adaptation. This level of commitment also means that breastfeeding comes to play a profound role in a mother's life so much so that breastfeeding cessation can trigger various emotions and many women require time to come to terms with discontinuing (Nelson, 2006). The findings of this review

also showed that breastfeeding means constant adaptation for the mother, as well as the importance many mothers placed on support from others whilst breastfeeding. Nelson (2006) concluded that clinical practice needs to recognise this in order to adapt to facilitate the individual needs of the mother, whilst being responsive to the opinions and desires of women in regards to their infant feeding decisions. This review demonstrates the complexity of infant feeding and how women's experiences can differ based on various social and emotional factors from the level of support they receive to how well a mother can prepare for and adapt to the needs of a baby.

Despite the benefits of breastfeeding presented in the literature, the experience of infant feeding seems to be mixed, and can be both a positive or negative phenomena for women. As discussed in Chapter 1 there are disparities among socio-cultural and demographic groups in terms of breastfeeding which imply that the breastfeeding experience goes beyond the simple notion of providing a baby with a source of nutrition. Breastfeeding is widely recognised as a symbol of motherhood with biological, social and cultural aspects influencing the experience (Afoakwah et al., 2013; Kelly, Watt and Nazroo, 2006). However quantitative research suggests women with weight concerns who are diagnosed with an eating disorder are less likely to breastfeed (Larsson and Andersson-Ellstrom, 2003) meaning these concerns might create anxiety around breastfeeding. It is therefore important to look at real-accounts of women who struggle with psychological issues in order to understand why infant feeding might be problematic, or else, how infant feeding might have a positive influence on their experience. In a narrative review of qualitative studies about the experience of breastfeeding for women, it was found that for some women the physical connectedness between mother and child developed the emotional bond creating a mutual sense of security (Afoakwah et al., 2013). However, for others this closeness meant an invasion of privacy and the demands of breastfeeding became a burden , despite acknowledging breastfeeding as being 'natural' and

best for the health of their baby (Schmied and Lupton, 2001). Therefore perhaps for women with additional issues related to their bodies, such as with an eating disorder, this sense of closeness and intrusion from breastfeeding may be experienced as problematic.

There is an issue of stigma surrounding formula feeding found particularly within the UK, according to a review of studies (Lakshman, Ogilvie and Ong, 2009), which seems to be one of the consequences of the broader 'breast is best' discourse. Lakshman et al. (2009) suggested that women often feel judged for formula feeding and in turn experience negative emotions such as anger and guilt. In a UK sample of 63 women who took part in semi-structured interviews (Thomson et al., 2015) found that women experienced shame and guilt about breastfeeding as well as formula feeding, each having their own constraints on mothers. Many perceived judgement from others with regards to breastfeeding in public whether this was due to fear of judgement or negative responses from others. Additionally those who formula fed felt they were under similar scrutiny, particularly from health professionals. However, the BFI now places more emphasis on supporting safe formula feeding which aims to reduce women's concerns and experience of negative feelings of guilt, anger and discouragement when deciding to formula feed (UNICEF, 2012). These guidelines also emphasise the importance of health professionals and mothers forming good relationships and encouraging women to bond with their babies from birth, with support in this regardless of whether or not they choose to breastfeed. In an interview-based study of breastfeeding cessation, Larsen and Kronborg (2013) found that some women felt that help from health professionals was inconsistent. While some felt supported during the transition from breastfeeding to formula feeding, others experienced reluctance from staff to discuss formula feeding options. This suggests that women's experience of infant feeding can be conflicting and decisions made as a result of social pressures and access to support. It is also important to avoid placing blame on health professionals, as their adherence to government standards may

not be easily transferred into practice. Alternatively, women might also face a number of challenges in relation to breastfeeding. In the western culture where women's sense of autonomy is highly valued, many mothers may become reluctant to adhere to the guidelines set by public health agendas on how best to feed their child (Smith, 2008). In an Australian qualitative study on the experience of breastfeeding in relation to embodiment and selfhood, notions of identity which value autonomy and control meant that some women felt a disconnect from their child when breastfeeding (Schmied and Lupton, 2001). This study suggests that regardless of the presence of an eating disorder some women find breastfeeding to be an intrusive practice, which further provides evidence of the ambiguity of the breastfeeding experience. Furthermore, having a negative experience of breastfeeding can motivate women to disregard the social norms and expectations which associate breastfeeding with good motherhood (Shaw, 2003). In a systematic review of global studies relating to breastfeeding Rollins et al. (2016) concluded that there may be wider societal barriers to breastfeeding. Breastmilk substitutes (formula milk) were found to have an influence of breastfeeding rates with women suggesting that formula advertisements and industries providing free samples meant that breastfeeding was negatively impacted on. However it was also found that the presence of health systems, including interventions and breastfeeding promotion, alongside supporting policies, increased breastfeeding rates in women globally (Rollins et al., 2016). These findings do not disregard the often conflicting messages regarding infant feeding, as a culture which promotes breastmilk as being the "best" for babies is not always considered in social settings where breastfeeding women feel "vulnerable" and judged for doing so (Thomson et al., 2015). Women can also fear this judgement when breastfeeding in public, whether it be real or perceived, there is a notion of shame as breastfeeding can be viewed as a violation of modesty (Taylor and Wallace, 2012). In an interview-based study Thomson et al. (2015) found that infant feeding can be shame-

inducing for both breastfeeding and non-breastfeeding mothers, with regards to exposure of breasts and infant feeding methods. Insufficient support was recognised among these participants and was sometimes experienced as undermining when provided, which made women feel inadequate in terms of their mothering. Although not all women experienced feelings of shame, those that did felt added pressures at an already disorienting time with similar feelings of failure and vulnerability between both breastfeeding and formula feeding mothers. This may be because some women feel breastfeeding is a defining aspect of their motherhood (Marshall, Godfrey and Renfrew, 2007) whilst others resist this notion.

Some research also suggests that despite breastfeeding, women experience challenges when they prolong breastfeeding for longer than the socially accepted norm where increasingly less support was felt by women (Dowling, 2013). Another study found that women perceive less approval the longer they breastfeed which has shown to be a mediator in breastfeeding duration (Rempel, 2004). It is important to consider that decision making around the method of infant feeding is not a linear process and often mothers may arrive at a decision to either breastfeed or formula feed having tried the other either from subsequent babies or from trying both methods within the first few days after birth, and either not working for their particular circumstance. Therefore additional issues may arise for women when contemplating when to stop providing breastmilk for their baby. Larsen and Kronborg (2013) studied mothers' experiences after giving up breastfeeding and found that some women were reluctant to do so and did not expect to encounter problems with breastfeeding. Although they eventually reported preferring formula feeding because they were not as exhausted from breastfeeding, they were also concerned about others' judgements of formula feeding. This study shows that many women attach significant meaning to the ability to breastfeed and social constructions around stopping. Thompson et al. (2015) found that a number of women experienced dejection and devaluation in their role as a mother when they discontinued breastfeeding and

felt they had damaged the bond they had with their child when formula feeding instead. From studies like this it is clear that breastfeeding has different meanings for women depending on their social and cultural context. These meanings create the basis for the lived experience of breastfeeding, and perhaps within the context of an eating disorder might present more of a dilemma if women felt cessation was a result of their own weight or eating issues.

There has been much research into women's experiences of different forms of support for infant feeding. A recent example is a study of the experience of UK users of community breastfeeding support services (Fox et al., 2015) which found that the combination of support from breastfeeding specialists and peers in a group setting was able to enhance breastfeeding attitudes and behaviour as well as encouraging women to achieve their personal feeding goals. Many women felt they had been given unrealistic expectations for breastfeeding from health professionals in the current climate of breastfeeding promotion which led to feelings of unpreparedness and disappointment in their feeding decisions when postnatal issues such as pain occurred. Despite the heavily promoted discourse of 'breast is best' there seems to be a lack of support in practice where often women report feeling overlooked in infant feeding decisions (Nelson, 2006; Thomson et al., 2015). The professional advice often given to mothers regarding how to breastfeed has been shown to not always transfer well in practice in that it fails to consider each individual woman and the potential barriers she may face (Marshall et al., 2007). Other research has found that some women experience a lack of attention and support from health professionals when deciding to breastfeed, with them reporting the advice they receive for breastfeeding as routine and rushed (Afoakwah et al., 2013; Andrew and Harvey, 2011). In a qualitative synthesis exploring experiences of support for breastfeeding, McInnes and Chambers (2008) found that health service support was described as unhelpful across many of the studies, with issues relating to lack of availability and conflicting advice, which meant that social support was rated as more important by

mothers. Thulier and Mercer (2009) supported the former review of research in the finding that amongst other variables, professional support was one of the issues associated with breastfeeding duration, which suggests that women rely on support from health care professionals and feel at a loss when this is not received.

The research explained above shows a wide range of experiences of infant feeding both within and outside of the UK, showing a range of meanings surrounding eating, food and weight in relation to feeding behaviours and how these may differ in women who suffer from or have experience of an eating disorder. In a Norwegian cohort study on eating disorder diagnosis and breastfeeding, it was found that compared with mothers without an eating disorder, mothers under all eating disorder subgroups were at risk of early cessation before 6 months post-partum (Torgersen et al., 2010). However, a UK based longitudinal study on infant feeding in the first year for women with eating disorders found that women with eating disorders were more likely to breastfeed (Micali et al., 2008). However, those with anorexia had a higher risk of their infants experiencing feeding difficulties from birth to 6 months. Given that the majority of women in the UK stop breastfeeding by six months (IFS, 2012), a further understanding of this experience for women with eating and weight difficulties could be of value to theory and practice. There has been little research on the infant feeding experiences in this group of women, therefore the following section will explore research on the experience of living with an eating disorder during early motherhood in order to examine what the broader literature suggests.

2.2 Research on the experience of living with an eating disorder during early motherhood

The research literature on experiences of eating disorders in women of childbearing age has been focused primarily on pregnancy rather than the postpartum period. The findings from

these studies will be presented below followed by the research on eating disorders in the postpartum period.

2.2.1 Experiences of eating disorders during pregnancy

According to Ward (2008) women with eating disorders are more likely to feel concerned about weight gain during pregnancy, given the major weight changes, which can lead to increasing bulimic and anorexic behaviours in order to control weight gain. Psychological symptoms of eating disorders may become particularly pertinent for some women during this time of profound change both physically and hormonally. In a review of qualitative studies on the experience of eating disorders in pregnancy, Tierney, McGlone and Furber (2013) found a number of recurring themes within women's experiences which were summarised as being an inner turmoil. Many women felt a strong desire to be 'a good mother' and be responsible in taking care of themselves for their child, however this was often counteracted by anxieties around a changing body shape. Little and Lowkes (2000) found, in an analysis of three mothers case reports, that the presence of an eating disorder had adverse effects on both mother and child, and recommended that the eating behaviours of these women should be carefully monitored. These findings demonstrate that dealing with an eating disorder during pregnancy can be a dangerous and often conflicting time for women.

Generally, the literature suggests that women feel positively about their weight during pregnancy (Micali, 2008) however whether this is true for women with eating disorders is quite unclear. In another review of studies on pregnancy experiences among women with eating disorders it was concluded that women faced a dilemma between wanting to maintain a healthy weight for the sake of their baby, and the need to control their body for self-preservation purposes (Tierney et al., 2013). Differences such as the stage in recovery may play a role in how pregnancy is experienced in this group of women (Micali, 2008). Another

qualitative study found a more complex account of experiences in that some women felt 'cured' of their eating disorder through experiencing motherhood and were able to put their eating disorder on hold during pregnancy, whilst others found this to be conflicting and could not give up disordered behaviours (Stringer, Tierney, Fox, Butterfield, and Furber, 2010). Similarly it was suggested that women who suffer from anorexia or bulimia nervosa during pregnancy show a decrease or even absence of symptoms, though these often returned during the postpartum period (Blais et al., 2000). Therefore, Coker, Mitchell-Wong and Abraham (2013) argued that women should not be told that pregnancy can be a time for recovery of an eating disorder, given the potential for relapse postpartum.

Contrary to research on the negative experience of eating disorders in pregnancy, a qualitative study of mothers with an eating disorder transitioning to motherhood, found that during pregnancy some women began to question their disordered identity, and felt pregnancy was incompatible with an eating disorder (Taborelli et al., 2015). This suggests that perhaps pregnancy provides protective features against some symptoms of an eating disorder, which was found to be more apparent in first time mothers. Similar findings from Squires et al. (2014) showed pregnancy as having a positive impact on eating disorder development in this time. However, others contradict this and argue that although symptoms of an eating disorder may decline during pregnancy, the issue is more complex than this in that once pregnancy is over and the post-partum period begins, the profound changes following a pregnant body may become a problem for new mothers having the potential to exacerbate feelings of body dissatisfaction (Crow, Keel, Thuras and Mitchell, 2004). Despite the negative impact and experiences of women who have eating difficulties in pregnancy being emphasised in research, the positive aspects of this also need to be recognised.

Much of the literature surrounding eating disorders during pregnancy demonstrates an inconsistent experience for women. For some, pregnancy means that the eating disorder is no

longer a priority given that there is a new life growing within them which requires nourishment, whilst for others this time is preoccupied with concern over weight gain and the physical changes occurring in pregnancy which play a role in exacerbating the symptoms of an eating disorder. In an exploration of the association between maternal body image issues during pregnancy and intended versus actual breastfeeding duration, it was found that mothers with higher body image concerns had shorter intended and actual breastfeeding duration (Brown, Rance and Warren, 2015). This was due to worries relating to changes in breast shape due to breastfeeding. This research shows that women's anxieties around body image in general are a cause for concern in regards to breastfeeding initiation and duration, however with these concerns being higher in women with a history of disordered eating (Conrad, Schablewski, Schilling and Liedtke, 2003), it may be expected that infant feeding will be an even more problematic experience. Contrastingly, one study found that there were no significant differences in breastfeeding between women with eating disorders and those without (Torgersen et al., 2010). This suggests that perhaps women's decision to breastfeed may not be influenced by an eating disorder.

Skouteris, Rallis, Werthiem and Paxton (2009) found that women felt a greater sense of body dissatisfaction in the early post-partum period as compared to during pregnancy. Given that this finding was in a group of women without an eating disorder it would be expected that the sense of dissatisfaction for women with eating and weight difficulties would be experienced to a greater extent. Research regarding women's experiences of eating disorders during pregnancy would suggest that this is the most challenging period in the transition to motherhood. However an insight into the postpartum period is required to reveal the extent of difficulties faced during this time.

2.2.2 Postpartum issues for women with eating disorders

There are few qualitative studies of general postnatal experiences for women with eating disorders, however there are fewer qualitative studies explicitly exploring breastfeeding experiences in the context of eating disorders. A systematic review of the Summon database, a combined search tool, was carried out. I used a structured search between the months of January to May 2016, searching using the keywords “eating disorders and motherhood”, “infant feeding and eating disorders”, “breastfeeding and eating disorders”, “anorexia and motherhood”, “bulimia and motherhood”, “postpartum issues with eating disorders”. Most previous studies have relied on quantitative methodologies to research breastfeeding rates, and the epidemiology of this in relation to eating disorders. For example, Torgersen et al. (2010) found that women with eating disorders are more likely to stop breastfeeding at six months postpartum compared to women without an eating disorder, in particular anorexia nervosa sufferers have an increased risk for cessation of breastfeeding. Women who are diagnosed with an eating disorder are also at an increased risk of postnatal depression and various other obstetric and gynaecological problems (Franko et al., 2001; Kimmel, Ferguson, Zerwas, Bulik and Meltzer-Brody, 2015; Mazzeo et al., 2006). While quantitative studies might provide some context for the issues at play in this experience, inferences must be made with caution.

Stringer et al. (2010) found that disordered eating behaviours are likely to be exacerbated during the postpartum period due to women feeling they have the freedom to engage in purging/restricting food as they no longer have a baby growing inside them hence the regain of control. Alternatively this period could trigger attempts to lose pregnancy weight (Ward, 2008) as well as a way to deal with the changing routine and irregular eating patterns which develop because of having an infant. It might be the case that a number of these psychological factors associated with breastfeeding become particularly pertinent for women with an eating disorder, given that eating disorders are associated with ideas of body image

distortion, preoccupation with weight and the control of this (Tierney et al., 2013). As a result breastfeeding has the potential to be something of concern for women who are struggling to cope with body image, weight issues and eating behaviours, as this can impede on breastfeeding and infant feeding in general (Brown, Rance & Warren, 2015).

Women with an eating disorder might face additional challenges postpartum in regards to maternal-child bonding, adapting to motherhood, the return of disordered eating and behaviours, and infant feeding. This might be expected because pregnancy and the postpartum period prompt a number of body-related changes which, along with positive feelings, can create negative feelings for women, potentially triggering disordered thinking and behaviours as a result. Contrary to the findings of quantitative research, Carwell and Spatz (2011) who advocate breastfeeding as a potential means of recovery from an eating disorder, suggest that breastfeeding can have a positive influence on women's recovery from an eating disorder given it provides a mother with the motivation to re-establish healthy eating patterns for her infant. A key study done by Stapleton, Fielder and Kirkham (2008) explored the subjective experience of women with eating disorders and their motivations for infant feeding. The findings showed that while some women opted to formula feed so that they could resume disordered behaviours as a means to lose weight, most participants were eager to breastfeed as this implied 'good' mothering and allowed them to indulge more in terms of eating, something they were not accustomed to. The latter portion of women also expected breastfeeding to aid in weight loss, however others did not want to delay restrictive eating and purging in order to lose weight. This study demonstrated that infant feeding is understood by women as an important feature of motherhood and these decisions are likely to be made in relation to the practices underpinning an eating disorder. The authors noted a limitation of this study was that participants were from a clinical sample therefore their views

might have been shaped by their exposure to various medical practices and therapies they were involved in.

A number of studies show that some women with an active eating disorder or a history of an eating disorder may feel concerned that their issues around eating and weight will interfere with their parenting (Mazzeo, Zucker, Gerke, Mitchell and Bulick, 2005; Tuval-Mashiach, Ram, Shapiro, Shenhav and Gur, 2013) which could include concerns about their chosen method of feeding. Other research has found that women with eating disorders express feelings of dissatisfaction and uneasiness during feeding (Squires et al., 2014). In interviews with three groups of women with various level of eating disorder psychopathology, Patel et al. (2002) found that women with eating disorders were particularly vulnerable to weight and shape changes during pregnancy and postpartum. Although this study did not aim to explore breastfeeding issues, participants with an eating disorder spontaneously talked about experiencing their baby's dependence on them for milk as uncomfortable. Importantly, this study recommended more research to be conducted in relation to the experience of breastfeeding and the impact of an eating disorder on this.

2.3 Research aims and rationale

While many studies have examined general experiences of breastfeeding for women, there have not been many open-ended exploratory studies looking into the experience of infant feeding for women with existing or previous eating disorders and the meaning making process involved in this experience. The existing literature, as discussed in the above sections, have presented findings which would suggest that women face difficulties in the postpartum period which lead on from pregnancy for women with eating disorders. However with the majority of these findings coming from quantitative studies aiming to establish causal links between eating disorders and the effects of this on mothering, the meaning of the

experience for women is not captured. Some qualitative studies suggest that women face dilemmas about infant feeding and despite wanting to provide the best for their child, this does not always seem attuned with the demands of an eating disorder. However many of these studies have been focused on a fuller experience of motherhood as opposed to a detailed understanding of infant feeding. Breastfeeding may have preventative properties for post-partum disorders in women with an eating disorder (Carwell and Spatz, 2011) and Stapleton et al. (2008) provided an insight into infant feeding decision making processes for women with an ED, which helped towards an understanding of the various meanings attached to this experience. Therefore it is understood that women face conflict when making decisions regarding infant feeding. However further research on first person accounts of infant feeding would enable an understanding of the experience beyond decision making processes and allow the emergence of meaning in the everyday lived experience. Therefore exploring the perspective of women's embodied experience is important in order to understand why challenges may occur and to develop support for mothers with eating disorders.

Much of the findings from the existing literature reviewed in this chapter are limited, in that there is no clear message giving a voice to women in this group in relation to what infant feeding and an eating disorder means to them and how they interpret their experience of the two in conjunction. Feminist literature on infant feeding argues for an approach which listens to women's voices and understanding lived experience in order to allow for appropriate and sensitive means of support (Benoit, Goldberg and Campbell-Yeo, 2016). Given that there have been very few qualitative studies done previously which are similar to the current study, in relation to eating disorders and infant feeding, a greater understanding of the meanings of this experience is necessary, and a phenomenological approach would allow for aspects on personal significance for a participant to emerge.

The aim of the following study is to explore the lived experience of infant feeding for women who had been diagnosed with either anorexia or bulimia prior to their pregnancy and who self-identified as still experiencing some challenges relating to eating and weight. In doing so the study will pose the research question: What does it mean for women to breastfeed/formula feed an infant whilst managing concerns relating to their own weight and eating? To address this aim the study will adopt an interpretative phenomenological stance and attempt to capture how individuals make sense of their lived experience. Indeed, Pringle, Drummond, McLafferty and Hendry (2011) suggest that it is only by gaining an understanding of meanings that health care professionals can influence behaviour and theory.

Chapter 3: Methodology

This chapter focuses on the philosophical influences for this phenomenological study and aims to clarify the reasons for the chosen methodology. The nature of phenomenology, how this informed the current research aims, and its relevance in addressing a somewhat novel area of research will be discussed. Finally, this chapter will describe the interview design, the interview schedule, and the process of analysis and issues of reflexivity.

3.1 Philosophical Underpinnings

The aim of the present research was to explore and gain an in-depth understanding of the lived experience of infant feeding for a group of women who have/had a diagnosis of an eating disorder. Therefore it was crucial for the chosen methodology to facilitate an understanding of the lived experience of this phenomenon. Phenomenology is a method underpinned by philosophy which aims to understand the nature of lived experience and discover the meaning of this from the perspective of the individual (Quay, 2015). This focus on the individual's perception of the world allows for more subtle emotions and affects to be accessed. This is particularly important for the current research given that there is little existing literature on the way in which women with eating disorders make sense of infant feeding and how their experience has an impact on their interpretations of themselves, as well as the world around them. Interpretive phenomenology concerns itself with the life-world of the person, which is an attempt to understand "what is this experience like?" to unfold meanings which often uncover taken for granted notions (Lavery, 2003). This theoretical viewpoint places individuals as active in their response to surrounding stimuli in the external world, where reality is socially constructed, therefore individuals are engaged in extracting meaning from their interpretations of phenomena as it is experienced.

There are a number of schools within phenomenology, with two main approaches: descriptive and interpretive, the latter which I have considered to be a great influence on this study.

Husserl's descriptive phenomenology preceded Heidegger's interpretive phenomenology and focused on ontology, contemplating what it means to '*be*', and studies what it means to exist within this world (Connelly, 2010; Lavery, 2003). Husserl proposed that the phenomena is best understood as it happens to the individual and pre-reflectively, meaning that it would be free from the context surrounding it and before the individual consciously interprets it (Caelli, 2000). Therefore, the Husserlian descriptive approach aimed to express the experience of an individual in written language, leaving the resulting data in its raw form prior to critical reflection, after which an explanation can be given (Van Manen, 1990).

On the other hand, Heidegger (1962) believed that the study of hermeneutics was essential for phenomenological research, which is the study of interpretation of intention and meaning behind an experience. Hermeneutic phenomenology is focused on epistemology, which is concerned with the discovery of '*how*' we gain knowledge of the world. Accordingly, Heidegger suggested that we should not only aim to describe what it is to be, as Husserl proposed, but we ought to interpret this concept and in doing so we understand what it means to live in this world and so the experiential life-world of the individual is given a voice. He argues that experience involves interpretation in the first place, it is perceived in a particular way to an individual depending on various things such as context, previous experience, and novelty of the experience. That is to say that the interpretivist and hermeneutic school does not claim to capture the very nature or essence of an experience, instead we try to get as close as the data allows to knowing what the phenomena is like to experience. This process describes the hermeneutic circle, which is a key feature in hermeneutics. It describes moving back and forth within the analysis of data in order to make interpretations of the participant making interpretations on their own experience (Smith, Flowers and Larkin, 2009). To put it

simply, the researcher is aiming to interpret the interpretations of the individual making sense of their personal experience, which is referred to as the 'double hermeneutic' in IPA (Smith and Osborn, 2003).

Therefore this approach is considered the most appropriate method when taking into account the idiographic nature of the data whilst allowing for shared aspects of the experience to be acknowledged. This method is particularly appropriate for the current research aim exploring the complexities of the breastfeeding experience (Spencer, 2008). In terms of the analytical process the researcher engages with the data and moves within a 'hermeneutic circle', by immersing oneself into individual parts of a text to gain an understanding of the text as a whole and vice versa. Ultimately an understanding is reached through this circular manner of interpretation (Dowling, 2007; Langdrige, 2007). This method allows reciprocity between the participant and the researcher which acknowledges the individual's experience of a phenomena as a whole in addition to the role of the researcher within the process of extracting meaning from this experience (Sloan and Bowe, 2014).

Interpretative Phenomenological Analysis (IPA) (Smith and Osborn, 2008) is one type of phenomenological research method as it is concerned with understanding the lived experience of a phenomena. It is also interpretative as the role of the analyst is considered to be crucial in the process of making sense of the participants meaning making (Smith, 2004).

An interpretative approach was chosen for the present study as opposed to a descriptive approach as it allows for the inductive analytical process to provide explanation where relevant. Additionally, an interpretive approach proved to be more useful for the current research aim in that an identification of 'what' and 'how' something is experienced, which is the aim of descriptive approaches, would mean little practical knowledge could be gained to find ways in which aspects of an experience can be improved or prevented for women with experience of an eating disorder contemplating methods of infant feeding. Instead, by

engaging with the data and analyses to find meaning within an experience allowed interpretation of how experiences had arisen in particular contexts, as well as other emerging factors to help women with eating disorders to infant feed. Additionally, infant feeding experiences seem to be profoundly shaped by the meaning they have for women, further demonstrating the appropriateness for using an interpretative approach.

Epistemologically rooted within phenomenology, hermeneutics and ideography, IPA focuses on the exploration of experiences and events which are significant and personal to an individual (Smith and Osborn, 2003). In accordance with this, the goal of this method is to reveal a representation, through the interpretation of individual accounts, of what the experience of a phenomena is like, without drawing from pre-existing knowledge of the phenomena or arriving at overgeneralised conclusions about the experience to fit a specific theory or model of behaviour (Creswell, Hanson, Plano and Morales, 2007). Despite this, Smith (1996) notes that IPA assumes that the sense made of phenomena is often shared among the individuals experiencing it, therefore allowing for themes to be generated during the analytic process. These very ideas are what constitute interpretive phenomenological analysis, in that here lies a method which recognises itself for being dualistic, with its data gathered from the thoughts and experiences of the participant which are then reflected on and analysed by the researcher (Brocki and Wearden, 2006).

IPA is a commonly used method in qualitative studies, with its roots in health psychology as well as a method often implemented within healthcare for use by practitioners (Biggerstaff and Thompson, 2008; Smith, 2004). Phenomenology is particularly relevant for studies relating to sensitive topics and difficult life situations (Heinonen, 2015) such as the current study in regards to both infant feeding and eating disorders. Reid, Flowers and Larkin (2005) noted the use of IPA in research concerning eating disorders. There are few qualitative studies looking at the meaning individuals attach to an eating disorder, with research on this

topic predominantly quantitative in nature, therefore it is necessary to allow for the emergence of unanticipated findings to elucidate the lived experience of this. Although the interpretive phenomenological approach is largely idiographic in nature, with a focus on the reality created by the individual, IPA has scope for the identification of shared experiences. There are a number of characteristic features within phenomenological research, including description of phenomena, reduction, and intentionality of consciousness (Kafle, 2011). A distinguishing feature which is common to many phenomenological approaches is the concept of phenomenological reduction, which Husserl described as *epoché*, meaning free from prejudice and judgement (Dowling, 2007). This refers to the idea of the researcher 'bracketing' and putting aside, though not abandoning, their pre-existing thoughts and perceptions of a phenomena while immersing themselves into the data to gain a better understanding of the experience. It is a concept which has caused debate among phenomenologists in that interpretive phenomenologists such as Heidegger believed that one cannot accurately interpret and 'meaning-make' while attempting to detach themselves from their own perception of the experience itself (Sloan and Bowe, 2014). That is to say that my interpretations of the data are just as significant to the analysis of the phenomena as is the interpretation of experience from the participants themselves, therefore the meaning drawn from the topic under investigation is co-created by both participant and researcher (Langdrige, 2007). With this in mind, my view is fundamentally supportive of Heidegger and hermeneutic phenomenology.

This theoretical stance therefore was the most suitable method for capturing the meaning of experiencing infant feeding for women with eating disorders. IPA enabled interpretation as well as description which facilitated a deeper understanding of the significance and meaning of the women's experiences. This is especially relevant for the present research given that the issue is two-fold, encompassing both infant feeding and eating disorders which have the

potential to pose various connected and unconnected issues for women, therefore a description is not only required but further depth through the use of interpretation is beneficial for any further phenomenological research in related scenarios. Additionally, my intention was not to assume that the topic in question was something of concern and perhaps a burden on individuals, rather it was an attempt to better understand life experience, exploring this flexibly where the researcher serves as a bridge between the individual and an insight into authentic meanings found from this experience (Lien, Pauleen, Kuo & Wang, 2012).

In addition to understanding through interpretation, the acknowledgement of symbolic interactionism within IPA is also considered during the analytical process, therefore a concern for how meaning is constructed by individuals in both their personal and social world is taken into account (Smith, 2008). In order to inform healthcare services for the support and potential treatment of issues surrounding infant feeding and eating disorders, first an in-depth explanation and extraction of common elements of this experience is required. Therefore I followed the methods of IPA which allows the researcher to delve into the meaning attached to the life world of the participant in order to establish the extent of a problem, that is, if there is one at all, which can then inform the development and implementation of strategies for support.

3.1.2 Reflexivity

The process of reflection was facilitated by logging my thoughts in a journal throughout the data collection process. This included aspects of shared experiences amongst the participants as well as areas of disparity. Reflexivity refers to the influence of personal values, experience and beliefs on research (Sullivan, 2002) and is often emphasised as being essential for the recognition, evaluation and effectiveness of research (Lien, Pauleen, Kuo and Wang, 2014).

Reflectivity in research is connected with bracketing in qualitative psychology (Smith et al., 2009) which refers to one's ability to set aside existing ideas on a phenomenon. However it is important to recognise that with IPA complete bracketing is unlikely given the visceral role of the researcher. Reflexivity is also a way in which researchers can provide some insight for readers on their thought process, which ultimately adds to the scope of analysis, particularly when considering the interpretative aspect of IPA. In keeping with hermeneutic phenomenological values I believe that research which is undertaken by psychologists has some meaning or personal relevance to the researcher otherwise they would seldom take part in or conduct specific research. Hence if one's personal interests and views drive their research it would be questionable as to whether or not the researcher would be able to bracket their own beliefs and knowledge regarding a particular phenomenon, and I consider self-reflection within an interpretation of a participant's view to be a pivotal stage in meaning being uncovered. My personal motivations behind undertaking this research came from my knowledge of a family member who struggled with bulimia for years and recently had a baby. I was interested to hear upon talking to her about her infant feeding experience that it was something she felt insecure about. After looking into how she could access support or advice I was surprised to find that there was not much available for women everywhere. Therefore I was keen to do research in this area as I am passionate about child and maternal health and well-being. This resonated in an interview with one of my participants who said that her midwife also struggled to find support for her.

Through taking a reflexive approach I recognised that I might have been making assumptions that experiences of women would be negative. However as I interviewed the participants I noticed the relative normality of the women's intentions towards breastfeeding and mothering. That is, although they had experience of an eating disorder which is often stigmatised within society as well as the research literature as negatively impacting one's

competence, the participants made clear that their role as a mother was important to them. The research which I was continually coming across portrayed mothers in this group as a risk to themselves and their children. As a result I was able to set aside any notions suggesting that the experience of infant feeding may be completely negative for women with eating disorders and aimed to instead develop an understanding of this experience which is viewed as a gift from a mother to her child. Throughout my literature review I became increasingly aware of the fact that studies on eating disorders in the post-partum period were not easily found. I was interested to discover that government documents such as the Infant Feeding Survey (IFS, 2012), did not touch upon the presence of an eating disorder and its effect on feeding. It seems that the focus was on physiological factors relating to breastfeeding and the mother, such as the effects of smoking and drinking on breastfeeding prevalence. Upon considering my reflective notes I came to the conclusion that these kind of guidelines if read by a woman with anorexia or bulimia, could have been disheartening, as though mental health issues are not something considered in practice regarding motherhood. Furthermore, the Lancet Series on breastfeeding (Victora et al., 2016; Rollins et al., 2016) did not explicitly comment on eating disorders in relation to infant feeding, despite referring to various epidemiological variations in breastfeeding. From the interviews I gathered this was not only my perception as many participants shared experiences of their diagnosis being overlooked (see page 76).

3.2 Design

This section outlines the design adopted by the present research and provides a rationale for the choices made. Firstly, a brief introduction to the participants who took part in this study will be given followed by issues pertaining to recruitment, the use of interview methods, ethics and the analytical process.

3.2.1 Recruitment

This study used purposive sampling, for a fairly small and homogenous sample in accordance with Smith and Osborn's (2003) suggestions for studies employing IPA. Participants were recruited using an online advertisement via the BEAT (beating eating disorders) website, a UK based charity which supports individuals affected by eating disorders or those who have difficulties with food, weight or shape. I gained permission from BEAT to advertise my study as the organisation offers this platform for postgraduate research projects concerning eating disorders. This process consisted of sending in my research proposal for approval followed by an advertisement calling for participants being launched on the website for service users to view. This sampling method allowed for a broad range of eating disorders to be included and enabled recruitment for the criteria of having either a previous or current diagnosis for an eating disorder, therefore allowing for a wider range of perspectives to be explored. This method also meant that participants were aware of the services available at BEAT had they wished to get further support for any reason. Although only women with a previous or current diagnosis for an eating disorder were recruited, it is important to understand that this does not mean I endorse a medicalised understanding of eating disorders. Rather I wanted to ensure that the problem was severe enough to be recognised as a disorder, though again diagnosis was self-reported by participants meaning severity of the eating disorder could have varied. Additionally, flyers advertising my research were distributed to a local Sure Start centre, after gaining permission from a manager, which were targeted towards breastfeeding support service users, however no participants were recruited from this. Perhaps as women were in a community setting at a place where they may be around friends and family, they felt reluctant to show an interest in this research, particularly if their eating disorder was not of common knowledge to others. This meant that the sample of participants in my study were all recruited

from the online advertisement, which suggests a preference to maintaining as much anonymity as possible.

In line with the present study aims of understanding the experience of infant feeding for women with weight and eating difficulties, the selection criteria specifies mothers with a previous or current diagnosis of an eating disorder (i.e. Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or EDNOS) who have a child of up to 3 years of age. This was seen as an appropriate age range which did not put age-related constraints on infant feeding and included women who might have decided to breast or formula feed up to this age. This also allowed some women's experience of weaning, to be reflected within the data and how this might have added to their experience as a whole. An option was given for either telephone or Skype interviews to take place if the conventional face-to-face interview was inconvenient for mothers, which also addressed potential geographical limitations. The participants remained anonymous from each other as well as throughout the study and were given pseudonyms to ensure their identities were unknown. There is a possibility that participants could have recognised women's quotes or experiences from the BEAT organisation had they known them, however given the number of service users accessing the website I would assume that this was unlikely to be the case.

Once participants had volunteered to take part in the study I provided them with the opportunity to address any queries they had about the research and further information about the study was emailed to them. Following this correspondence an information sheet (appendix A) and consent form (appendix B) was sent to the participant via email which the participant was asked to read and email back to myself in order for fully informed consent to be obtained. This also ensured that both the participant and I had copies of the consent form. Following the interview I emailed participants a debriefing letter (appendix C) which restated the aims of the research and thanked them for their participation.

3.2.2 Participants

Six individuals volunteered to take part in this study after responding to advertisements calling for participants on the BEAT website. All diagnoses mentioned below were self-reported by participants.

Elle, a 37 year old, white British, breastfeeding peer support worker was still breastfeeding her 6 month old daughter at the time of the interview. She also has a 6 year old daughter who she did not initiate breastfeeding with. She had a previous diagnosis of anorexia nervosa and depicted herself as being in recovery.

Emma was 39 years old, white British, and worked as a staff nurse. She had a current diagnosis of anorexia nervosa but like Elle considered herself to be in recovery. She breastfed her 18 month old son up until 11 months and was pregnant with her second child at the time of the interview.

Jess, 36, was of Eastern European origin and worked as a land surveyor. She breastfed her first child until 10 months and he was 3 years old at the time of the interview. She had a current diagnosis of bulimia.

Sofia, was a 35 year old, white British peer support worker. She had a current diagnosis of anorexia nervosa (purging type), she was still breastfeeding her third child who was 1 years old at the time of the interview.

Katy, was a 31 year old, white British, self-employed teacher. She had a previous diagnosis of anorexia nervosa, and was breastfeeding her second child who was 21 months old at the time of the interview.

Sarah, 33, was a small business owner and the only participant to not breastfeed her child. Her youngest daughter was 3 years old at the time of the interview and she is her second

child. She had a previous diagnosis of bulimia nervosa and considered herself to be in recovery for almost a year after being in therapy, which included cognitive behavioural therapy (CBT).

Sarah did not provide information on her ethnicity therefore it cannot be assumed that this group was made up of all white women. Therefore the current sample was a predominantly middle class group of older mothers who either had a current or previous diagnosis of anorexia nervosa or bulimia nervosa.

It is noteworthy that a few of my participants worked as peer support workers. Unfortunately I did not ask at the time the explicit nature of this role, whether they were breastfeeding support workers or not. However this profession could have meant that these women were practised at discussing experiences and therefore more open to discussing their own.

3.2.3 Ethical issues

This research was conducted in accordance with the ethical guidelines of the British Psychological Society (Ethics Committee of the BPS, 2010) and approved by the School Research and Ethics Panel of the University of Huddersfield. Informed consent was obtained from all participants prior to taking part in the research. The consent form covered issues regarding consent, withdrawal, and anonymity as well as participant wellbeing. It was made explicit within the consent form and information sheet that participation was voluntary and that participants were free to withdraw from the study or terminate the interview at any stage and without having to give reason for this. The information sheet included details on what the interview would entail as well as confidentiality and its limits, that is, that the transcript would remain anonymous unless I believed that somebody was at risk of harm, in which case the appropriate services would be contacted. All participants were made aware prior to and at

the onset of the interview that sensitive topics might be discussed and that they were not under any obligation to discuss anything which made them feel uncomfortable.

3.2.4 Data collection: Semi-structured interviews

Given that the existing research in regards to the lived experience of infant feeding for women with experience of an eating disorder requires development, it seems that in depth interviews were essential to allow for a better understanding of this phenomena and the meaning attached to it. Semi-structured interviews are considered to be the norm for studies qualitative in nature (Howitt, 2010) which follow a loose agenda allowing flexibility and divergence from a topic, meaning the interview is participant-led with the focus being on their lived experience and what they felt was important (Smith et al., 2009). Semi-structured interviews are particularly relevant for research of a sensitive nature given that they create an opening for a narrative to unravel without being overly obtrusive, albeit with the inclusion of questions which may lead to further meaning making for the participant (Galletta, 2013).

From the three choices given to participants for the interviews to take place all 6 participants chose to be interviewed via telephone interview. Although this is not a well-established method of data collection for qualitative research, Cachia and Millward (2011) endorse the use of telephone interviews to gather in depth data, particularly for IPA, by placing importance on its methodological strengths. These include that telephone interviews follow a similar structure to that of semi-structured interviews, which is the recommended method for IPA studies. Additionally, this method allows for a sense of autonomy and privacy which face-to-face interviews don't allow particularly if participants feel uncomfortable speaking about a sensitive issue. Telephone interviews also allow for the interviewee to have control over their environment, so they are most likely to choose somewhere they are comfortable with such as their home. This therefore encourages the participant to vocalise any parts of

their experience they may have otherwise hesitated to speak about in an unfamiliar setting, particularly with a topic of a sensitive nature. Women with body image issues might have chosen this as their preferred method of interview for a number of reasons. A telephone interview may have heightened their sense of anonymity given that I was unable to view them physically (Holt, 2010). This could have also meant, to them, that it was therefore impossible for me to grasp any physical indication of their eating disorder, meaning they did not perceive any judgement. I believe that it would have been somewhat easier to talk about their experience without an interviewer's presence, and not being able to see me either. This could have served to strengthen the data I collected given that participants might have felt more comfortable to open up to me given their sense of anonymity. I think telephone interviews also enabled me to ask more questions and delve further into the women's experiences because I felt that they were secure in their environment (they were all at home at the time of the interview often with babies sleeping or being cared for by a family member) and given this there were less distractions at the time of the interviews. In my view, as a student seeking out participants, when I encountered women who were willing to take part in my research I was keen to get across that I valued their experiences, which is a practice that can greatly impact the mood of the interview from the beginning. I also believe that many of the women understood that I was a student considerably younger than them which could have led to them feeling more confident and with an added sense of maturity.

The interviews ranged from 43 minutes to an hour long, and were audio-recorded and transcribed verbatim by myself with any identifying information removed. Demographic information was collected via email with regards to age, eating disorder diagnosis, ethnic origin and occupation.

3.2.5 Interview schedule

The interviews followed the guidelines for a semi-structured interview recommended by Smith et al. (2009) which adheres to the methodological aims of IPA. An interview schedule is a set of questions or topics for discussion which the researcher uses as a guideline for gathering data in a semi-structured interview. The interview schedule (appendix D) was therefore used to prompt for potential areas of relevance whilst allowing the participant to recall their account freely and follow their own trajectory. The interviews began with questions which generated a descriptive level of detail around which method of infant feeding they chose and whether or not they were still engaged in this particular method. This was followed by questions which produced a more narrative account. This sequence of loose questions to begin with were followed by questions which probed slightly more in an attempt to gain more detail. For instance, the use of evaluative questions within semi-structured interviews mean that participants are able to reflect on their own experience and this facilitated in capturing the meanings attached to particular events or emotions which were emerging from the individual accounts. The use of open-ended questions within the interview schedule meant that a range of topics could be discussed without presuming particular emotions or feelings that might have been experienced (Smith et al., 2009), with the interviewer merely looking in on this. The subsequent stages of analysis are where the researcher takes the role of interpreting the interpretations of the participant in regards to their experience, thus the double hermeneutic of IPA. Overall the interview for the current study explored feeding experiences during the first 12 months postpartum, feelings about becoming a mother, interactions with others related to infant feeding (including health professionals), and the sense the women made of the relationship between their eating issues, infant feeding and mothering.

3.2.6 Stages of analysis

Following transcription of the interview, data was analysed using IPA (Smith et al., 2009; Smith and Osborn, 2003). Adhering to this process of phenomenological inquiry ensures that the researcher does not go beyond the data to explain it using theoretical assumptions, but the meaning of an experience is captured by the researcher through the repeated decontextualisation and contextualisation of data, as is explained below when engaging in the process of analysis (Larkin, Watts and Clifton, 2006).

In line with IPA all parts of the transcripts were coded using a 'bottom up' approach given that the current research aims sought to explore what was significant for the participant and to follow their meaning making processes.

The initial stage of analysis consisted of reading and re-reading the transcripts, as recommended by Smith (2004), and beginning to make descriptive notes on the data on anything of interest and significance to the participants' experience. The purpose of this was to get to know each participants' perspective with an empathetic understanding which involved carefully looking at the use of language and beginning to develop a conceptual understanding of the issues discussed (Smith et al, 2009). In accordance with this, low level codes were generated for each transcript. Primarily some areas of concern seemed to emerge across the participants accounts in relation to motherhood in general and the demands of it. During this stage I became quite aware of some of the areas of shared experiences amongst women and began to see the duality of infant feeding whilst dealing with body image concerns.

The second phase of analysis following initial coding was identifying emergent themes from each individual transcript and looking for commonalities in these themes across all the transcripts. I was able to do this by using a Word document to create tables for each

participant, in which emergent themes were supported by quotes and my personal reflections on these (appendix E). This stage involved a higher level of interpretation in that the initial descriptive comments which were explicitly discussed by participants were then interpreted by myself to produce a theme which was collaborative in that meaning is derived from both the participant and myself in a double hermeneutic. At this stage I also shared my ideas with my research supervisors in order to get their opinions of the suggested themes. From this I was able to get another perspective which helped in deciding on which themes seemed most prominent. What was also important was to recognise variation between the different participants' experiences, which helped illuminate the phenomena from a different perspective which was also meaningful. This stage of analysis revealed the often conflicting nature of the women's experience, with them facing various dilemmas and positioning themselves as making active choices along their journeys. It was becoming evident that this was not always a negative experience or one that induced guilt and shame, which on reflection I realised I was somewhat surprised by. It would seem that my initial thoughts were that breastfeeding might contradict with disordered thoughts and behaviours. However perhaps I underestimated the dedication of mothers to their children, which could be because I am not a mother. Despite this, as a woman I also appreciated this bond and had some understanding of motherhood from years of taking care of younger siblings.

This formed the basis for the third stage of analysis which involved the organisation of super-ordinate and sub-ordinate themes which incorporate the primary themes (Smith et al., 2009). This stage was reiterative in that various codes became themes and these were often moved around or re-examined and placed within another super-ordinate theme upon closer inspection of the data whilst considering the many commonalities and differences. The fourth and final phase of analysis consisted of clustering any common super-ordinate themes

together under an overarching theme while ensuring the sub-ordinate themes still fit under these respectively.

The themes extracted from the data will be illustrated using verbatim extracts from the participant accounts, though some minor changes were made to the transcripts in order to improve readability, for instance missing parts of the conversation are indicated by dotted lines within brackets (...). Any additional explanatory comments made by myself within the extract will be presented in square brackets, this may be to explain what the participant is referring to if it was not made particularly clear. It is also important to recognise that the following themes provide a possibly singular account of the participants' experience of managing infant feeding and an eating disorder and provide a subjective interpretation, however each theme has been carefully selected for its relevance in addressing the current research aims. While areas of similarity have been found in the data it is also important to recognise that there were areas of divergence between the participant experiences, which were addressed where appropriate to the analysis. Given that IPA aims to capture the essential features of a lived experience (Smith et al., 2009) the focus of the analysis was on aspects of the participants' experience which were relevant to this aim, though without discarding possible meaning attached to the experience as a whole.

Chapter 4: Findings

Following Interpretative Phenomenological Analysis (IPA) of six semi-structured interviews this chapter presents features of the participants' experiences and the themes identified from this. The emerging themes from the data are presented in Table 1 below. The significance of the findings will be discussed in relation to the existing literature in Chapter 5.

Table 1. Master themes and subthemes identified from the participants transcripts.

Overarching theme Two incompatible worlds: Breastfeeding/motherhood vs. Eating disorder	Master theme	Sub-ordinate theme
	Master theme 1: Giving up an eating disorder to breastfeed	<ul style="list-style-type: none"> • Eating concerns
	Master theme 2: Breastfeeding/motherhood saving me from an eating disorder	<ul style="list-style-type: none"> • Satisfaction with body for providing nourishment • Shift in identity from sufferer to mother • Breastfeeding as temporary shelter from eating disorder
	Master theme 3: Challenges of combining breastfeeding and an eating disorder	<ul style="list-style-type: none"> • Loss of control • Weight concerns

	<p>Master theme 4: The influence of others on infant feeding</p>	<ul style="list-style-type: none"> • Surveillance • Seeking advice and an understanding
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An overarching theme of incompatibility between two aspects of the participants' lifeworld was identified with three subthemes within this: 'giving up an eating disorder to breastfeed', 'breastfeeding/motherhood saving me from an eating disorder and 'the challenges of combining breastfeeding and an eating disorder'. The final theme of the influence of others on infant feeding was not included in the overarching theme given that it does not demonstrate conflict between infant feeding and an eating disorder. Rather it focused on the participant's perceptions of others in regards to their decisions around infant feeding and the impact their diagnosis had on these perceptions. The notion of incompatibility refers to the idea that breastfeeding and an eating disorder were two conflicting paths for the participants, given that the practices of an eating disorder seemed to contradict the role of motherhood, leading to a sense of feeling they could not 'do' both easily. As demonstrated by the following quotation:

Elle: ...you know if you're struggling quite a lot [with an eating disorder] then it would be very difficult to have this person need you so much for their nutrition, and also invading that space and kind of interfering in your ability to actually be anorexic.

This meant that the women made active decisions to no longer engage in bulimic or anorexic behaviours once becoming a mother, given the sense of responsibility and selflessness they felt was required from motherhood and in turn breastfeeding. They were therefore faced with a dilemma between the value they had for an eating disorder in their lives and the value they placed on motherhood and in turn the choice to breastfeed. The majority of women expressed

that an eating disorder would affect their ability to produce milk and therefore made decisions to give up either anorexia or bulimia, though some women found this more challenging than others. However, others felt as though this sense of incompatibility gave them a physical purpose as well as a distraction from an eating disorder and saved them from it. Despite this, there was also some contradiction and uncertainty around the idea of incompatibility at times. For example breastfeeding was seen as being highly compatible with an eating disorder when its potential to help with post-partum weight loss was recognised:

Jess: ...maybe this is why I was so hell bent on breastfeeding, because I was told that if I did this I would lose weight quickly, maybe that's why I was so desperate to breastfeed because I so much wanted it to get that weight off me...

However, there were also many ways in which the two (an eating disorder and breastfeeding) seemed to be incompatible throughout the women's narratives. There seemed to be a transition for participants moving from something of value in their lives (an eating disorder) to another thing which perhaps held more value to them (nurturing a child through breastfeeding).

4.1 Giving up an eating disorder to breastfeed

This theme refers to the participants feeling as though they had, to a certain extent, given up something which was, in some cases, a valued aspect of their lives. This included giving up various eating concerns associated with the eating disorder as well as giving up their perceived importance of body image and their body ideals. Participants' often emphasised that they had done this in order to breastfeed which they felt came hand in hand with being a good mother. This sacrifice and change of priority is seen by the women as demonstrating their willingness to adapt their diets and change their attitudes towards their body, food and eating in order to be able to breastfeed and provide for their children. This theme contributes

to the overarching theme of incompatibility between breastfeeding and an eating disorder as the participants expressed feeling torn between choosing to focus on one or the other, though remained consistent once they made a decision. Though this theme uses the phrase ‘giving up’ it is considered to be a fluid term representing the shift in priority from disordered thinking and behaviours to a focus on the baby. It is recognised that the notion of giving up an eating disorder was not a linear process for participants. The following quotation is illustrative of this:

Elle:...I was thinking, god I have no choice now, there’s no way I can starve myself and have a baby and be a mum, and it’s like by having a baby I very much, had definitely lost any opportunity to go back to having anorexia...

Elle seems to come to a realisation that she could no longer ‘be anorexic’ whilst being a mother. Her words imply that the two cannot coexist and the possibility of anorexia remaining a part of her life was diminishing. She suggested that it was a lost opportunity for anorexia which shows she was giving up something valued to her. Often participants described feeling that they had to give up anorexia or bulimia because of breastfeeding, it was this notion of a shared body which meant they felt they would be harming their child if they were to continue or go back to having an eating disorder. For instance:

Sofia: are they feeding enough...is it more or less and is that because I’m not eating enough or because of the anorexia.

Some participants felt guilt at not being able to breastfeed a previous child meaning they were determined to sacrifice their concern over eating and weight in their current experience. For some the start of breastfeeding triggered the cessation of disordered behaviours such as purging and restricting food. The following quotes are illustrative:

Elle: I think the first weeks are just a bit of a blur, and I didn't have time or energy to think about what I was eating but after that I became quite conscious of it, even though I would think about cutting back I never actually did it.

Emma: After having a baby I haven't been able to do any of that [over-exercise]...it [breastfeeding] made me realise that gosh I do need to keep eating otherwise I'm going to lose too much and not produce enough milk for my baby...

Participants were faced with the choice to resume engaging in these behaviours and seemed to come to a crossroads. They acknowledge their thoughts to resume restrictive eating or over-exercise, however both Elle and Emma expressed that it would be contradictory to maintaining their health and perhaps breastfeeding. Other participants implied that the focus on self that is required by an eating disorder is incompatible with other aspects of life. For instance:

Emma: ...it's a very egotistic disease as well, you're very self-centred with it and very selfish in a way although you can't help that at the time, but there are reasons for that but sometimes you have to be harsh on yourself, step out of that circle and say right, hello I'm going to take control of this, there is more to life and I'm going to do something about it.

Emma describes a bigger picture to life which was brought about by becoming a mother and having this sense of responsibility. There is also a sense of sacrifice in that she is making the decision to come away from an eating disorder given that it is 'selfish' for the sake of her role as a mother. The very nature of an eating disorder, for Emma, means to focus on one person, whereas motherhood requires selflessness. Jess emphasised the practical elements of breastfeeding and motherhood which made having an eating disorder all the more difficult. She explains:

Jess: There are many reasons to why I can't go back [to bulimia] some are very silly [laughs]. An eating disorder takes lots of energy and lots of planning, you eat, you need to then find time to get rid of it, so throw it up or burn it, but other things become more important and there's just no time for it.

Jess seems quite rational in her explanation as to why the eating disorder was not fitting with her lifestyle any more. However throughout Jess' reflection she comes to a realisation that she has given up something of importance to her which was the control she had over her body. This sacrifice seems to have been felt as too much for Jess as is evident in the following quotation:

Jess: ...I don't think I can have another baby and go through these changes in my body, it took me nearly 3 years to go back to what I was before and I'm still not there...

Breastfeeding was experienced as a safety net for some participants in that it provided a distraction from their worries about weight or eating, and helped overcome feelings of guilt associated with having an eating disorder, as Katy described:

Katy: I suppose it [breastfeeding] takes me away from it all really [thoughts of anorexia], I sort of go into a little bubble I suppose and forget all the things that are going on around me while I'm feeding her. I'd say it's sort of like a little protective bubble that's a distraction or a comfort I'd say, to know that I'm still doing something right.

4.1.1 Eating concerns

This theme refers to how the participants' decision to breastfeed meant they felt they had to compromise their concerns around eating and nutrition. Participants described feeling

overwhelmed with dietary advice but maintained their food intake so they could breastfeed their infants. This not only demonstrates the sacrifice made in terms of giving up a preoccupation with eating, but also highlights participants' perceived sense of incompatibility between an eating disorder and breastfeeding. Despite formula feeding, Sarah was also conscious of her eating as she wanted to model a positive relationship with food for her children. For example:

Sarah: I'm actually looking at one of the certificates my daughter got from her school and it says 'healthy lunch box', so yeah I think my changes have made a big difference because children learn from you don't they, they can pick up some of your bad habits, and I'm not saying I'm the best parent in the world...I'm hoping that by boycotting that [bulimia] early on I have made a better example...

Sarah talks about setting a better example for her daughter, which means eating healthy foods and not allowing her to pick up on any behaviours associated with bulimia.

All women expressed that once becoming a mother their nutrition was not just for themselves but for their child, and that their own diet was inextricably linked with the wellbeing of their baby. Katy spoke about a dual struggle between motherhood and having an eating disorder which highlights the contribution of this theme to the overarching theme of incompatibility. She explains:

Katy: ...you have those issues with feeding, nursing and being tired but you also have those other issues of how you feel about your body or what you should really be eating to help your milk supply or to sort of be better, to be able to hack it all I suppose because if you're not really eating you get more tired and if you're not looking after yourself you get even more run down which will affect your milk supply, and it's just a vicious circle.

Here Katy conveyed an image of balancing motherhood which includes issues around feeding alongside the issues with an eating disorder, which both have a great deal of personal meaning to her. There is a sense of struggle to deal with both these issues simultaneously which is suggested by her attempts to “hack it all”. There was a strong feeling of being overwhelmed with the dietary recommendations for breastfeeding women, for example:

Katy: I just ignored it all, I couldn't face it, I remember the baby magazines and all the leaflets saying you should be having this and you should be eating this and consuming so many portions of fruit and veg a day, and so many portions of dairy or protein it's just really overwhelming, and I know it's there to be sort of nice and helpful for people but for somebody with an eating disorder or any issues with food it's horrible...

Katy indicates that breastfeeding may become an overwhelming experience as a result of these guidelines. The challenges she faces are portrayed as a vicious circle implying feeling trapped, which links to the theme of feeling a loss of control. Emma, who had a history of anorexia, spoke about how breastfeeding changed her perspective on her diet:

Emma: I think it [breastfeeding] made me realise that gosh I do need to keep eating otherwise I'm going to lose too much and not produce enough milk for my baby, whereas before I would have thought oh I'm losing all this weight let me just carry on like this, but not now when I've got a little one relying on me to feed.

There is a sense of urgency in continuing to eat for the sake of keeping up her milk supply, and a shift in her thinking from previously where the idea of losing weight would be a goal to achieve. The prospect of eating more in order to breastfeed was experienced as concerning for some:

Elle: ...although the thing I was concerned about and I spoke to my midwife about was you know, how much you have to eat to breastfeed, I was worried that I might have to eat a lot more.

Emma: ... I think you need to have an extra 500 calories a day is it, I was finding that I was thinking gosh how was I going to eat that as well as well as feed a baby and look after a baby, and eat my normal meals on top of that

Both women experienced the idea of eating more as problematic and resisted others' suggestions to eat more. There was a sense of alarm at the thought of eating more in order to breastfeed as this conflicted with the nature of an eating disorder. Some of the women's concerns were additionally affected by concerns about the baby's allergies. Jess, Katy and Sofia, were therefore even more aware of their eating and diet, as illustrated in the following quotes:

Jess: ... there was also concerns around what I eat, because if he had any reactions to what I eat, I mean the doctors were always saying it doesn't matter what you eat, but it does, from my experience. My son turned out to be an allergic child, and I know it happens often but it's a big strain on the feeding...

Katy: ...I had to stop having anything that was dairy based in my diet because it would go through my milk and it affects her... I mean you just want to eat the things that you feel comfortable with eating but then you get those guilty voices in your head saying well maybe...maybe I'm harming my baby...

Additionally, Katy indicates feeling as though she had to give up restrictive eating and step out of her comfort zone in order to avoid harming her baby, and although she feels uncomfortable in doing so there is a sense of guilt if she continues with her previous eating routine, or lack of one. Jess reports giving up her bulimic episodes whilst breastfeeding and

only continued once she had stopped, which suggests that she felt this was a time of incompatibility. She explains:

Jess: when I tried it [purging] after the pregnancy, after I was breastfeeding it wasn't the same effect, maybe because I wanted to do it to lose weight and not to relieve stress and I just didn't like that feeling...I think maybe this is just part of being a mum, it's a big sacrifice.

Therefore there is a real sense of shifting priorities and responsibility amongst the women, especially in terms of their relationship with food and eating, in that the effects of their eating or not eating have a perceived influence on their breastmilk supply and in turn the well-being of their infant.

However, Katy suggested that perhaps breastfeeding did not have to be restricting in terms of her own eating, as she says:

Katy: ...it didn't really necessarily matter what I did to myself with regards to my relationship with food, because my body will still do what it needs to do for my daughter to produce milk if that makes sense.

Unlike the other participants Katy shows a somewhat confident attitude towards the idea of perhaps an eating disorder not being completely incompatible with breastfeeding, which is a contrast to other participants who were rooted in the idea that harming themselves would impact on their ability to breastfeed, thus damaging the health of the baby. It seems as though Katy does not necessarily think it would matter if she was to restrict her eating in terms of this affecting her milk supply.

Though there was some divergence in the participants accounts in relation to how they managed their eating when initiating breastfeeding, participants held the view that the symptoms of an eating disorder had to be controlled in the early post-partum period.

As demonstrated within this master theme the reasons for giving up an eating disorder varied among women with some feeling more inclined to give it up for nutritional value, ensuring a healthy diet to breastfeed and model good eating, and others to simply maintain sufficient supplies of breastmilk.

4.2 Breastfeeding/motherhood saving from an eating disorder

This theme explores the participants felt sense of being saved from their eating disorder because of breastfeeding and motherhood or for one of the participants' motherhood alone. The themes in this section are based on the finding that for many women a significant part of mothering is to breastfeed and some participants saw it as a second chance and almost as an absolution for what they had done to their bodies because of an eating disorder. This master theme contributed to the overarching theme of incompatibility as the desire to be a good mother and be responsible for a baby contradicted the focus on self that is required from an eating disorder. Having children for most the women meant that an eating disorder was less of a problem. Breastfeeding allowed participants to feel a sense of accomplishment and new found love for themselves and their bodies in being able to provide nourishment for their babies. However there is also some ambiguity in the participant accounts, in that once the infant feeding journey is over many women pondered on what this would mean for them in terms of an eating disorder. The following quotes summarise how the experience of motherhood was felt as a positive change in the lives of these participants and regarded as incompatible with anorexia:

Elle: So in some ways, probably having babies has saved my life, it's given me something to live for, you know rather than living and having anorexia.

Emma: ...my life is now my little boy and my husband and this other little one that's about to arrive, and why would I want to jeopardise that by having anorexia back it's just a no brainer for me.

4.2.1 Satisfaction with body for providing nourishment

This subordinate theme was a core feature of Elle, Emma, Sofia and Katy's experience. They expressed having a change in attitude in themselves and the ability of their body to be able to have a child and to breastfeed, something which is not always possible for women with eating disorders. The women's talk suggested a sense of feeling grateful that they were able to breastfeed despite their current or previous diagnosis of an eating disorder, which in turn helped them accept their body for what it is and what it has been able to do for them, for instance:

Sofia: ...since his birth the breastfeeding has helped with me trusting my own body and seeing that it can provide nutrition for my baby, seeing what it can do can actually be a positive thing rather than something to battle with . I see it as I've got a child now who needs to be nurtured and I don't see my body the same anymore...

Sofia explains transitioning from a previously negative perception of her body, such as in her experience during pregnancy, to a positive perception from her experience of breastfeeding. There is a sense of pride at the idea of being able to breastfeed and the capability of her body. Similarly, Katy felt a sense of accomplishment in being able to take care of her child through breastfeeding, when asked about how she felt about breastfeeding she says:

Katy: ...what I might not be able to do for myself I might be able to do with somebody else, I can look after them, I can make them well I can help them grow [by breastfeeding]...I might not be brilliant at doing it with myself obviously in terms of looking after myself but I can do it for them.

There is almost a sense of making up for the past in that the experience of motherhood and breastfeeding has given her a sense of purpose. There is a theme running through the women's accounts of almost being given a second chance at life and how there is a sense of hope for them now. For example:

Emma: ...you think how horrible you've been to your body over the years and how badly you've treated it and yet it can still do this wonderful thing and give another person life, and you think about that and think that's the most amazing thing ever.... we have only got the one body, and if you've damaged it beyond that line you miss out on all of this in a way and seeing what it can do it's amazing.

Emma reflects on the thought of what anorexia could have cost her in terms of having a baby or not being able to breastfeed, and a shift in attitude towards her body is expressed.

Participants viewed motherhood as a role of responsibility which means to put the needs of the infant first. There is also a sense of appreciation expressed from a few participants towards their body and what it can do for them in terms of breastfeeding:

Katy: It's [breastfeeding] helped me see my body in a different way, that actually my body is good for what it does and it's brilliant and actually I should cut it some slack every now and again [laughs] it's done a very good job and I shouldn't be so mean to it sometimes. It's helped me produce two beautiful children and it's helped me look after them and feed them and nurture them and I've sort of grown to love my body in a different way.

Breastfeeding for Katy seems to have made her grateful for the capabilities of her body.

Perhaps what the breastfeeding experience means to her is that it helped her realise that there is more to looking a particular way on the outside, whether the ideal for her was being thin or not, Katy seems to appreciate the fact that her body can have a purpose other than that of

satisfying her own body image concerns. Similarly Emma felt a sense of pride from breastfeeding and seeing the effects of doing so on her child:

Emma: ...knowing that each week he was putting on weight and that was me that was doing that it was quite a good feeling [laughs] it's like he's growing and putting weight on and it's down to me.

Here Emma captures the structure towards a path of acceptance of herself, in that every week the physical reminder of her son's weight seems to give her more confidence in herself and the fact that she is central to his weight gain.

Generally all the participants, despite often finding breastfeeding a challenge, spoke about how it had protective features against their respective eating disorders and the negative feelings associated with this. The women talk about their bodies as something they now feel happy with as opposed to having a body damaged by an eating disorder even if it did serve their desire to look a certain way.

4.2.2 Shift in identity from sufferer to mother

The shift in identity from being someone with a diagnosis of an eating disorder to being a mother was consistent amongst the participants. This theme explores the participants trajectory in terms of their identity since becoming a mother and how an identity of having an eating disorder conflicted with motherhood. This meant that the women were instrumental in expressing their motivations to let go of their past identity in order to engage with their new role as a mother. This contributes to the overarching theme of incompatibility given that participants often explained why a dual identity would not work for them and the following participant explained how she felt a sense of changing identities:

Sofia: I think it's definitely helped gain some perspective and kind of, detach myself from the eating disorder so I see the eating disorder as something separate to me rather than intrinsic to my personality, because when I'm with my children and feeding them I'm not, it might not make sense, but I'm not anorexic, I have an illness. That isn't me, so it doesn't define my motherhood and therefore my personality. Whereas before the children I kind of thought we were one and the same thing...

There is a sense of motherhood and all it encompasses as overriding the issues of an eating disorder, which no longer hold as much importance in her life. It seems that the physical act of breastfeeding helps separate her illness identity with that of a mother as she is now responsible for the well-being of her child. Although she accepts that the eating disorder is still there she makes clear that this is no longer her dominating identity. Sofia talks about her detachment from an eating disorder in terms of motherhood saving her from it and helping her dissociate from anorexia. She explains:

Sofia: ...kind of my own sense of identity and who I am has changed and there's kind of not the same room for anorexia as there was before, it's not disappeared but it doesn't have the same dominance in my life.

The experience of motherhood has meant that something else has become of more value in her life and she has made the conscious decision to not let her identity of having an eating disorder dominate this. Her comparison to how she felt about anorexia before becoming a mother denotes this shift in identity and gave her a sense of hope that it is not part of her personality. Similarly, Sarah felt that motherhood in general made her question her eating disorder identity and her children seemed to be a motivator for this, for example:

Sarah: I can't do that [purging] no more. I think that it's [motherhood] made me stronger to think no I've got to get through this for them, it's [bulimia] not going to go completely because I've done it for so long but no that made me stronger...

There is a strong sense of motivation to leave an eating disorder behind in order to be a good mother. Katy expresses how her role as a mother means that she let go of her existing mentality towards eating, and she now had another person to think about:

Katy: I wouldn't want to put that risk of my own sort of feelings or my own selfishness out there, when you become a parent they become your number one, everything you do is because of them. So my issues with the eating don't play that big of a role anymore, well I don't have the time to think about it because I am busy with two children, a job, a family, so you don't get as much time to think about it.

Some participants referred to the idea of a joint identity at times where their disordered eating was somewhat of an asset to their motherhood. The following quotation demonstrate a shift in identity without disregarding the value an eating disorder had to their experience:

Elle: I think most people who suffer from anorexia have quite strong wills and they're determined and they focus on goals and things like that, and because breastfeeding has always been, you know, I want to have children and I want to breastfeed, I want to...achieve my goals and that makes me feel really positive.

It seems that aspects of her identity as suffering from an eating disorder have played a role in her identity as a mother. There is an attempt at drawing a parallel between life with an eating disorder and life as a mother, with the latter at times benefiting from an eating disorder.

Therefore perhaps this indicates that motherhood wasn't always completely incompatible with an eating disorder.

The demands of motherhood seemed to take over the lives of the participants which meant their identities as eating disorder sufferers were dominated, though it is important to note that all participants demonstrated a sense of agency in this as they felt that the change was not only necessary but worth it.

4.2.3 Breastfeeding as temporary shelter from an eating disorder

Despite many participants feeling as though breastfeeding and motherhood helped them resist disordered thoughts and behaviours, a few of the participants felt that this notion of 'saving' them from an eating disorder was temporary given that the breastfeeding journey is not a lasting one. Therefore some ambiguity was expressed in terms of how permanent this feeling of salvation from an eating disorder through breastfeeding is. For example:

Katy: But it makes me wonder what it'll be like when she decides she doesn't want the milk anymore, whether I will still be having that same relationship with food or if it'll change again, which undoubtedly it probably will do... Your priorities change, not to say that once they're a bit older I wonder whether I'll have issues then or not, who knows because obviously your time starts to free up a bit when they get older but things could be very different down the line.

There is some ambiguity around what the end of the breastfeeding journey will mean for her eating disorder, and whether or not her positive attitude from the postpartum period whilst breastfeeding will continue. Similarly Emma looks towards the future as she explains:

Emma: ...I'd think oh what was going to happen...when I got that freedom back but because I'm now pregnant again I've not really had the opportunity to let that creep in, and to be honest thinking about it when I finish my next feeding journey I'm going to have two little boys running around who I need to be healthy for.

Emma suggests that breastfeeding meant that she doesn't have the opportunity to allow an eating disorder back in her life. Her reference to coming to the end of her breastfeeding as giving her 'freedom' implies the constraints of breastfeeding as being limiting in terms of the eating disorder. There is often ambivalence as to whether breastfeeding providing a shelter for mothers is a positive aspect of their experience or not. For some participants, the sense of temporary shelter being provided by breastfeeding meant they could not revert back to their usual coping strategies as long as they breastfed.

Jess: ... I did have some episodes after pregnancy especially after breastfeeding, so not during but when I'd stopped, when we were separate entities and what I did, did not impact on my child...

Jess reports engaging in bulimic episodes after she had stopped breastfeeding, given that she felt what she did to herself in terms of her eating disorder would at this point not affect her child.

Indeed all of the participants reported the lasting nature of an eating disorder, in that they felt it was something which would always affect them, but experiences such as breastfeeding and motherhood seemed to delay their disorder from returning. The following quotations are illustrative:

Katy: ...at the moment things are just getting a little bit on top of me or I've got a few things going on just niggling away at me that reminds me that it's always there [anorexia] that it's never going to be gone as such it's just something I've got to try and manage for my sake, but also for theirs...

Jess: I feel like you are a bulimic all your life, you always worry about eating, and when am I going to put on weight, it's a bit like being an alcoholic...

Despite the realisation that an eating disorder will remain with them throughout their lives, the women were optimistic in terms of not allowing it to affect their relationship with their child at present. Breastfeeding was viewed as a motivation for participants to look after themselves, however they felt that there was the possibility of encountering difficulty once their breastfeeding journey was over.

4.3 Challenges of combining breastfeeding and an eating disorder

The themes within this section explore the difficulties reported by participants with regards to the everyday practices of mothering when dealing with an eating disorder. These issues contribute to and highlight the sense of incompatibility felt between the two life worlds of the participants and how they make sense of this. Often participants conveyed struggling to deal with bulimia or anorexia given that this was an integral part of their lives for a long time, and breastfeeding had the potential to be equally as demanding as managing an eating disorder. Women often faced dilemmas in regards to issues of control and weight concerns, however they were also active in resolving these issues through the construction of their identities as a mother.

4.3.1 Loss of control

A loss of control and sense of intrusion was felt by a number of participants not only when they breastfed but in relation to motherhood more generally. This loss of control was felt in relation to the various changes they made, which meant there was often conflict between the very nature of breastfeeding as being demanding, and the desire to have control over one's body, which was experienced as problematic for some women. Elle describes having a need for space which breastfeeding can undermine:

Elle: I did wonder if I might feel a bit, kind of invaded by someone always having to be next to me... because when my other daughter was born I couldn't bear for her to

be near me you know. So I wondered now how it would affect breastfeeding...you know breastfeeding is quite an invasion of your personal space.

However, participants also made attempts to overcome their dilemmas regarding the issue of control, for instance:

Emma: I mean I don't think it [anorexia] ever goes away no matter how long you've been in recovery, I don't think that control element will ever really leave you, it's just something you've got to learn to live with and recognise it's there and manage it.

Sofia expressed feeling limited by the demands of breastfeeding:

Sofia: there were times probably around 6 months when I'd expressed and he wouldn't take the expressed milk in a bottle and it meant that I'd not be able to go and do things and not be apart from him, so there were times where it felt quite limiting...

There is an underlying sense of experiencing a lack of freedom and they express finding this difficult to deal with. With regards to breastfeeding Elle goes on to explain:

Elle: ...it's very much feeding on demand and especially at the beginning I found it difficult, I'm the sort of person who likes to do certain things at certain times, I like to be in charge when I do things, so that was a concern for me as well.

She makes reference to the 'sort of person' she is and almost how breastfeeding contradicts this identity, so there is a sense of compromising an identity which values control in order to comply with the demands of infant feeding.

Managing the eating disorder was a powerful concept among the participants in that they felt it was something that they had to deal with as opposed to something that would simply go away. As a result some participants took on a dynamic role in construing this as a new way of gaining control. Emma's account is particularly illustrative:

Emma: There's only you that's in control of it, it's not the eating disorder it's not anorexia, that's the anorexia talking, you've just got to find a way of getting that control back, finding somebody or something that gives you that purpose. It takes a long long time but it can be done.

Jess expressed concern over her loss of control in relation to her physical appearance as a result of breastfeeding. She explains:

Jess: ...during pregnancy your body doesn't belong to you, it's on display everyone is looking, people are touching your belly and after when breastfeeding I just felt that everything was on display. I stopped caring about it, the baby was the most important, so breastfeeding in public, well that was a stressful thing, but when you breastfeed you just have to do it [laughs] but yeah I felt like my body wasn't my own like I had no control over it.

Jess expressed discomfort over her body and other in relation to this which indicates her conflicting emotions, given that the decision to breastfeed, which was something she had wanted to do, meant sacrificing her own tolerance for accepting the changes in her body. Therefore she is giving up something which was important to her which is her identity and self-image of a thinner self. She captures this through the discourse of her body not belonging to her and therefore not having control over it. There is a sense of her letting go of her desire for control in that she felt she just "had to do it", which again ties in with the theme of sacrificing the eating disorder to breastfeed her baby.

4.3.2 Weight concerns

Another theme which emerged from the interviews was how the participants' felt in regards to their post-partum weight and the perceived effects of breastfeeding on this. All participants had longstanding concerns about their weight and body shape as part of their ED, therefore

some women felt a sense of disappointment from breastfeeding not leading to postpartum weight loss. For others the concern was about accepting the lasting effects of having a child on the body, which for a few came as a powerful shock. For example Elle felt unhappy with her body after birth:

Elle: I would say there has been a bit of a struggle but I haven't actively tried to sort of lose weight, but I felt very conscious of my post-baby body. So when you're breastfeeding obviously...your body changes a lot quite a lot more after the baby as well not just during [pregnancy] and it's kind of, yeah some of that has been quite difficult.

Elle expresses concern over her changing body which she attributes to breastfeeding, however she resists any attempts to actively losing weight. Jess felt the most strongly about breastfeeding as she explained that it was meant to help her lose the weight from pregnancy:

Jess: I think breastfeeding for me it was meant to help me lose weight, that was my thought in my mind all the time, that I need to breastfeed so I can lose weight, the baby weight... I expected a more profound effect, probably I don't know, how I would be if I didn't breastfeed, would it have any impact, but I expected better results, especially that I'd put so much effort into it, and to keep it up, I expected more.

Jess's account demonstrates that for her breastfeeding was meant to serve as a method to lose weight. This was a challenge as perhaps satisfaction with breastfeeding was not solely based on being able to feed her baby, she also wanted to achieve weight loss from breastfeeding therefore set herself a much more challenging criterion for 'success'.

Contrary to this was Emma lost weight as a result of breastfeeding, however this still caused concern as she felt breastfeeding would be affected, as she explains:

Emma: ...especially with breastfeeding I found that the weight fell off really quickly within sort of a couple of weeks I was back to my pre pregnancy weight, and possible a little bit less, so there was that 'oh ok I need to keep a check on this' so I'd know when I needed to put on weight so I'd had enough milk.

This shows that despite anorexia Emma recognises that she no longer has the freedom to allow weight loss to occur. Throughout her account she refers to her weight as being a central factor in her ability to breastfeed. For Jess, breastfeeding meant that she felt worse about her body as a result of the physical changes caused by it. She describes a loss of her sense of self:

Jess: Also the way I looked was stressful, big breasts, very round, I wanted to be myself and that wasn't me, that wasn't how I looked before. I think image and how you perceive yourself when you have an eating disorder is very important to me, and I just didn't like it, didn't like the clothes, didn't like myself back then.

There was an expectation for breastfeeding to solve the problem of weight gain for Jess which made her determined to breastfeed. Although this may be something many women would like to achieve from breastfeeding, the emphasis shown by Jess in that she was "so desperate" to breastfeed for the sole purpose of weight loss suggests that breastfeeding was seen as a means to an end. Katy also described her disappointment at her postpartum body which she compares to her body during pregnancy:

Katy: I found it really challenging after I'd had both my children actually because I'd found I'd put on weight, I didn't put on much weight when I was pregnant I actually lost weight with both of them, they grew so much and I probably wasn't consuming enough and so I ended up losing weight in both my pregnancies, but then because of the tiredness and I think my body's way of trying to produce milk I ended up putting

on weight after both my pregnancies and I found that quite hard to cope with and that definitely affect my relationship with food.

She attributes the additional weight as being down to breastfeeding which she seems to experience as problematic, as it affected her eating. What's more is that breastfeeding for Katy seemed to be related to her weight and whether or not she was restrictive in her eating, she explains:

Katy: I remember there was one point when my son was just over a year old and he wasn't feeding very well and I did lose quite a bit of weight then just because I suppose I use food as a coping mechanism again I didn't really eat, I did a lot of walking and took him on walks to burn off more than I was eating...

Notice how the episodes seemed to be a result of feeding difficulties, which suggests that aspects of infant feeding may be an added pressure, for Katy this was overwhelming leading to her using a familiar coping mechanisms. Unlike Katy, Sofia's concern was in relation to her being underweight, as she felt this would diminish her milk supply, she also felt that the wider societal focus on weight was unhelpful:

Sofia: I find it really triggering hearing people talk about how much weight they've lost or need to lose because I'm trying not to lose weight and look after myself for the children, so it's really hard when that's what everyone seems to be talking about

There was a divergence in the participants concern regarding weight as some had difficulty maintaining a healthy weight in order to breastfeed, whilst others were disappointment in breastfeeding not resulting in weight loss. Nonetheless the issue of weight seemed to be closely linked to the relative experiences of breastfeeding amongst the participants with dilemmas around how to deal with weight gain or weight loss inextricably linked to the act of breastfeeding.

4.4 The influence of others on infant feeding

The final theme refers to the perceptions and expectations of others such as family members, significant others, and healthcare professionals in relation to the women's infant feeding practices and their eating disorder. Many women felt a strong sense of judgment from others and often felt undermined when making feeding decisions. Support from others was highly valued among participants and Jess described it to be a "lifeline" for her. Participants also expressed feeling that their own issues were forgotten or pushed aside once their babies were born. For instance:

Jess: When the baby came everyone forgot about it [the eating disorder]...

Katy: ...you get people that might mean well but just have no comprehension of how your brain is feeling and say 'oh stop being silly you've got to think of your child now it's not about you', because I know that, you know it's not about you anymore but because those voices are already in your head they're there forever.

All of the participants felt as though there was a lack of understanding for their situation, despite there being support whether it be from health professionals or family and friends, there was a sense of loneliness in the participant accounts, which was summarised by one participant in particular.

Sarah:... it is a dark place to be in, it's a secretive place, people think you're alright and you're not really, and to just have that bit of moral support from people who actually know what they're talking about, I think that can make all the difference.

This sense of loneliness was also felt by other participants, as they expressed a need for support in regards to breastfeeding for mothers with anorexia or bulimia. For example:

Katy: I would have liked for there to have been something about...I didn't know of anywhere to go to or anyone to talk to, yeah there wasn't anywhere...

Sofia: It would be nice if I suppose, people believe in you rather than them thinking you can't do it [breastfeed] it would have been useful...

4.4.1 Surveillance

Most participants felt concern over what others would expect from their eating given that they were breastfeeding. Sarah did not disclose this to be a particular issue for her regarding formula feeding, rather she emphasised that women should not be judged for formula feeding. However the women included within this subtheme felt they were being perceived as a group of risky mothers and therefore not trusted to breastfeed. There was a felt sense of surveillance from others in some of the participant accounts, such as the following:

Sofia: ...initially I was a bit worried because of my own eating difficulties, and I was worried about what other people would think and worries they would have about my calorie intake...

Jess: ...my husband became very stressed about what I ate and started to, insist that I shouldn't eat certain foods that could cause allergy, we're talking about milk, nuts, things like that. He put a lot of stress on it and when my son started getting eczema my husband was I think blaming me...

Jess felt at blame for her son's allergies and feeling of a loss of choice over her eating. She felt that there was too much pressure for her to regulate her diet on top of having her own concerns around food. Similarly Sofia worried that breastfeeding would lead to others surveillance on how much she was consuming. She implied that she was now reluctant to

seek help for her eating disorder due to the potential of her role as a mother being undermined. As she describes:

Sofia: ...it's kind of hard to focus on trying to be a mother, because mothers are meant to look after their children, and get well and be healthy, so I felt like I needed support for me but I was quite confident in my mothering. But if I asked for support for me people would then think I was not looking after my children properly, so it kind of made things difficult...

There is a sense of feeling judged by others which made her unlikely to discuss her problems with health professionals. Similarly a few of the other participants felt that family members as well as health professionals were not trusting of them to breastfeed due to the eating disorder. Sofia's account was particularly illustrative of her felt sense of judgement from healthcare professionals. The following quotation demonstrates this:

Sofia: I really had to fight to breastfeed him not because he couldn't but because of people not wanting me to, so I had to express a lot more...I felt like they [midwives] didn't trust me...I suppose they thought breastfeeding wouldn't provide the best nutrition, whereas I could see that I was doing well with the feeding and they were healthy so I knew I could continue.... my family were kind of saying that I didn't have to [breastfeed] and you know you can just use a bottle, so yeah a bit of mixed messages from family, I suppose they wondered if I'd get enough sleep and it'd be difficult and might make me depressed or lose weight...

Sofia suggests some reasons for the surveillance she felt, in that she wasn't trusted to make her own decisions because of her diagnosis which meant others were not confident in her ability to breastfeed.

4.4.2 Seeking advice and an understanding

Participants struggled with the advice which was offered by health professionals in regards to nutrition whilst breastfeeding, for example:

Katy: so I don't know just a little bit of support or advice or guidance or somewhere you could go to talk to just to help you manage those thoughts and feelings and process it all a bit when you're pregnant and when you've got a baby too.

Later she described her attempts of doing so but felt there was a lack of understanding:

Katy: I tried to discuss it with my doctor but he didn't understand, he was a male doctor and yeah he just didn't understand. Even my husband didn't quite sort of understand it...

The perceptions of the male perspective was often concerning for women which was similarly experienced for Jess (page 79), meaning participants often felt reluctant to talk about their issues with men, regardless of whether the men were also health professionals. Other women were reluctant to talk about issues because they were concerned that others would think they should not be struggling or feeling down. For example:

Katy: I think people probably don't assume that there are these issues, and it'll be the same for everybody regardless of the eating disorder or not...

Sofia: so it would just be nicer to talk about the reality of how things are without judgement afterwards...

Some participants express a need for more support and an understanding for the difficulties they face in regards to breastfeeding and managing an eating disorder. Sofia in particular addressed this concern:

Sofia: I'd like for there to be an understanding of the fears of whether I am eating enough, if this could actually be bad for me and if it's going to affect my child's

future bone growth, like if they're getting enough calcium and vitamin D. Or if my supplies are good enough, would there be any long term consequences of my nutritional intake on their long term health, whether things are normal in terms of feeding patterns, like are they feeding enough...is it more of less? And is that because I'm not eating enough or because of the anorexia...

Despite this many of the participants recognised the availability of support in the form of mother and baby groups as well as breastfeeding support groups. Jess explains how these were crucial to her management of the challenges she was facing when breastfeeding:

Jess: ...especially the breastfeeding support group, they were like a lifeline, I was waiting for that day, I couldn't wait to go there and speak to the midwife about my concerns, just seeing the other women and their problems too, all of a sudden my issues were becoming insignificant because someone else had a bigger problem...

Likewise, Elle had a sense of appreciation for her perinatal mental health team and the support they provided:

Elle: ...last time I was on antidepressants but no one ever suggested something that I could take and breastfeed with, whereas this time it was very much planned and they were like yeah you can have this and you can breastfeed. So I had a lot more options this time sort of presented to me as well, which was nice, you know a lot more choice I felt...

Generally participants felt others underestimated the difficulties they had with breastfeeding, which led to them feeling alone and misunderstood. Sarah talked directly about her experience with a midwife who assumed breastfeeding was her chosen method of feeding:

Sarah: ...like that midwife coming to me and being like breastfeed, breastfeed, breastfeed! She didn't sit down and ask me what do you want to do, I think they should approach it instead of making you feel like you have to breastfeed...

However for those with support systems around them the overall experience of breastfeeding seemed to be much more positive in that they appreciated health care professionals' attempts to provide individualised support for them during the postpartum period as well as partners and family members helping with keeping an eye on their meals. For instance, Emma explained that her mum preparing food for her made eating more manageable, therefore the idea of surveillance was not always seen as intrusive or negative. Though what was usually unhelpful about others' responses to women's decisions around infant feeding was the sense of not being trusted in doing what was best for their child. As a result the two subthemes were more or less relevant for different women.

Chapter 5: Discussion

This chapter will discuss the findings of the current research with reference to the existing literature base and relevant psychological theory. Implications for practice will also be discussed alongside the methodological issues and suggestions for future research. The aim of this research was to explore and understand the lived experience of infant feeding for women diagnosed with an eating disorder. The study identified a number of significant findings in regards to this aim in that the relationship between an eating disorder and breastfeeding was not a straightforward one at the least, revealing ambivalence, dilemmas and conflict between two equally demanding aspects of the individual participants' lifeworld. Breastfeeding was identified as producing a sense of pride and satisfaction for some mothers in relation to their bodies as having a purpose in motherhood. For some however the changing breastfeeding body came as a concern and caused discomfort for participants who were accustomed to being in control of the physical appearance of their body shape and size. Therefore breastfeeding was both considered as an empowering experience as well as a daunting one at times. It was found that the participants felt that an eating disorder and motherhood, particularly whilst breastfeeding, were, generally, incompatible. Therefore this was a powerful factor in preventing an eating disorder to manifest in the early post-partum period. There was a perceived sense of judgement felt by the women from others in relation to their infant feeding choice and their competency as mothers as a result of their diagnosis. For Sarah in particular, who was the only formula feeding participant this was something she struggled with given that she acknowledged that she had more of an opportunity to purge as she was not breastfeeding. However Sarah also felt that her actions were damaging her relationship with her child, despite not experiencing the physical connection from breastfeeding, therefore she was motivated to give up these behaviours. As a result many women were motivated in constructing an identity of a 'good mother' as a means of proving

themselves as competent, though they also indicated a desire for more support and an understanding from others of the impact their concerns had on them.

The following sections will provide a discussion focusing on the themes set out in Chapter 4 and will make reference to issues relating to identity, conflict and dilemmas faced by the women in this study.

5.1 Giving up an eating disorder to breastfeed

The findings were that participants viewed breastfeeding to be an act which could not easily exist with an eating disorder. This supports previous research on infant feeding decisions for women with eating disorders, which suggested that women make conscious decisions to not re-establish disordered behaviour whilst breastfeeding for fear of this affecting the quality and supply of milk (Stapleton et al., 2008). However the current findings also demonstrate the often persistent nature of an eating disorder through the participants' continuation of disordered thoughts. Within their accounts all participants in the current study discussed both negative and positive aspects of infant feeding as well as the difficulties an eating disorder posed on this and therefore showed a strong sense of agency in the construction of their lived experience. The experience of participants in the present study shows a trajectory from living with an eating disorder and this dominating their lives to a realisation that motherhood was actually more meaningful to them, meaning they were active in making changes in relation to their eating disorder. For many the decision to breastfeed served as a motivation to focus on maintaining a somewhat healthy regime and helped them to see a bigger picture. Sarah, who formula fed also expressed eventually coming to a realisation that bulimia was no longer compatible with motherhood more generally.

An eating disorder was seen as being incompatible with motherhood because of the focus it requires on self. Emma made explicit what other participants would only imply: that an

eating disorder was “selfish”, and thus contradicted the meaning of motherhood. The participants’ ideas around giving up an eating disorder seem consistent with the notion of intensive mothering. Hays (1998) suggests that women feel a need to omit any ‘selfish’ practices in their lives once becoming a mother, which then become child-centred. It seems the participants in this study understood motherhood as an intensive role which required their full attention, therefore an eating disorder was often set aside, put on hold or questioned. Taborelli et al. (2015) found that women reconsidered their eating disorder identity during the first year post-partum, in particular with their first child. The current findings provide support for this, as well as adding to the findings of Taborelli et al. (2015) as most of the participants in the present study were not first time mothers. This could mean that perhaps intervention for mothers with an eating disorder could go beyond that of the first year post-partum and include multigravida mothers. However it is also important to recognise that some participants spoke about their eating disorder “always” being with them, therefore breastfeeding and motherhood might not necessarily be something which ‘saves’ them or is as easy to ‘give up’ as suggested.

The present research revealed contradictory findings to previous quantitative studies regarding infant feeding in women with eating disorders. These were specific in suggesting that women with eating disorders are more likely to impose restrictive diets on their infants at the weaning stage (Hoffman et al., 2012; Ward, 2008). However the theme of giving up an eating disorder in order to breastfeed demonstrated the keen will of mothers to breastfeed which they valued above their respective eating disorders. Furthermore, most participants were conscious of not imposing any restrictions on their child’s eating and Sarah expressed her excitement at watching her child’s first attempts at eating food. This is consistent with Stapleton et al.’s (2008) findings that participants tended to allow themselves to eat unrestrictedly whilst breastfeeding and fits with previous research indicating that motherhood

has a positive effect on eating problems (Soest and Wichstrom, 2008). However, a few of the participants described imposing restrictions on their own diet due to the baby's allergies. It is unknown for two out of the three participants as to whether these allergies were confirmed by health professionals or if this was a reflection of their general anxieties around food being a problem.

The current findings suggest that breastfeeding for the women in this study was a barrier to purging and restricting food. What is more, previous research has also found that women with eating disorders were more likely to breastfeed compared to women with other psychiatric disorders (Micali et al., 2008). This is consistent with the current findings in that participants showed determination in breastfeeding if they felt that this was a fundamental feature in good mothering, which supports the notion of breastfeeding as a socially influenced practice (Marshall, Godfrey and Renfrew, 2007).

Breastfeeding for women in general is often experienced as a challenge as it can be both conflicting and rewarding for mothers (Afoakwah et al., 2013) however five of the six participants interviewed in this study were keen to breastfeed. This may have been a result of anorexia in particular being characterised by perfectionism and a strong will (Obadina, 2014) which Elle believed was a key feature in her continuation of breastfeeding. The women who breastfed showed resilience in their accounts and remained determined to breastfeed despite their challenges. Positive self-talk and goal setting have been recognised as powerful tools in the continuation of breastfeeding for women who experience difficulties (Brodrigg, Hegney, Fallon and O'Brian, 2007). It seems that this was something which, to some extent, helped the participants overcome the desire to return to disordered behaviour. Despite Sarah's initial difficulty in limiting disordered behaviours post-partum she expressed concern over the effect her eating disorder might have on her child. The concern of providing bad modelling for a child is common amongst mothers with an eating disorder (Tuval-Mashiach et al., 2013)

and was something many women in the current study commented on in passing. The idea of becoming a role model specifically for food and eating, which many mothers spoke of as it followed or coexisted with breastfeeding, could be an explanation for them giving up an eating disorder.

5.2 Breastfeeding/motherhood saving me from an eating disorder

The lived experience of breastfeeding for the women in the current study showed a distinct shift from a preoccupation with the adherence to the 'thin' ideal, as the literature would suggest (Hogan and Strasberg, 2008), to feeling as though they had a rejuvenated sense of being and finding a purpose in motherhood. Breastfeeding for some was a form of empowerment as it reminded them they were adhering to the moral ideal of the 'good mother'. As with any life transition, motherhood had a profound effect on the participants' sense of identity and this conflicted with their previous identity of having a diagnosis of an eating disorder. The goals of one identity were incompatible with that of the other. Some theorists suggest that the construction of an eating-disordered self is based on continuity of its practices and is therefore not easily disrupted, given that a sense of control and agency in disordered behaviours are key features of this identity (Moulding, 2003). Perhaps a barrier to participants' feeling of successful breastfeeding was that it might have meant replacing a disordered identity for one of a breastfeeding mother. This again is evident from the participant accounts which describe greater difficulties in giving up disordered thinking than disordered behaviours. Interventions and therapies could therefore aim to tackle these thoughts in mothers early on, perhaps during pregnancy, in order to facilitate the prevention of disordered behaviour post-partum.

The current findings suggest that motherhood and breastfeeding were a powerful influence on the road to recovery from an eating disorder, although for some participants breastfeeding

was only seen as a temporary shelter from returning to the coping mechanisms of an eating disorder. Carwell and Spatz (2011) suggested that there was a reciprocity between an eating disorder and breastfeeding as the latter would help with recovery from both the pregnancy and with a return to a potential pre-pregnancy weight. This would in turn ease women's concern with disordered thinking, which is in line with the current findings of some participants feeling motivated to continue breastfeeding for both the baby as well as the benefit of weight loss. Though complementary to this finding, the current findings emphasise the emotional and psychological benefits breastfeeding had for the participants. For instance despite acknowledging her weight loss due to breastfeeding, Emma was still concerned that this would in turn impact her milk supply. Therefore the reciprocity between breastfeeding and recovery from an eating disorder seems to be more complex than suggested.

Previous research has found that a key feature in women with an eating disorders' decision to breastfeed has been the desire to lose weight (Stapleton et al., 2008). However most participants in the current study emphasised that they wanted to breastfeed primarily for the well-being of the baby. This is an aspect of the current findings which I was able to reflect on as demonstrating the shared concern of mothers about the care of their children, regardless of mental health issues. One reason why the findings from the present study may differ from those of Stapleton et al., and be more in keeping with data from mothers without eating disorders, is that the majority of the current sample considered themselves to be in recovery. This suggestion is supported by research on a sample of women with eating disorders which found that those mothers who were still more preoccupied with weight loss (unlike the present sample) had greater difficulties breastfeeding their infant, both emotionally and physically (Squires et al., 2008). In relation to the theme of a shift in identity from sufferer to mother the current findings show that the women placed importance and value on the embodied experience of breastfeeding as a means of establishing motherhood, thus giving

them a sense of pride. This finding reflects feminist views of women breastfeeding as embracing the unique qualities of the female body and finding meaning in motherhood (Smith, 2008). The participants seem to be shifting from an identity which required them to place the demands of their eating disorder first, to one of being a good mother. It can be suggested that the reinforcement felt from breastfeeding and adhering to the construction of a 'good mother' perhaps dominated the value placed on an eating disorder, which served to uphold the 'thin' ideal (Thompson and Stice, 2001) and therefore breastfeeding participants were keen to let go of this identity. According to Smith (1999) motherhood is a defining aspect of identity and for the participants in this study it meant this role had to be made their priority.

Perhaps for many breastfeeding was a way of normalising their identities, as eating disorders are not part of a wider paradigm of 'goodness', whereas breastfeeding might have served as a method of re-establishing a previously stigmatised identity to one that is better regarded in society. This finding is in accordance with Tuval-Mashiach et al. (2013) who suggested that because eating disordered individuals belong to a stigmatised and socially deviant group, the role of a mother somewhat normalises this deviancy with an acceptable and conventional female role. Smith's (1999) study on identity development in the transition to motherhood demonstrates a shift within the self during and after pregnancy which impacts on women's long-term priorities and life choices. This theoretical model of transitioning identity in motherhood seems to apply to the participants in this study as well as women in general. Therefore it seems certain parts of the experience of infant feeding for the participants in this study was very similar to that of mothers without an eating disorder. In a qualitative paper from Taborelli et al. (2015) it was suggested that the shift to motherhood for women with an eating disorder was experienced as a conflict and led to participants questioning their eating disorder identities, therefore they proposed that pregnancy was a window for intervention in

this group. The current finding of incompatibility between an eating disorder and motherhood is consistent with this research, however what the current findings add is that the postpartum period also seems to be a unique opportunity for intervention as women are in a period of transition and often question their loyalty to an eating disorder.

Schmied and Lupton's (2001) research on women's breastfeeding experiences is particularly relevant to the current findings, as some participants in the current study embraced the intimate and mutual relationship provided by breastfeeding while for others there were issues of control and invasion. For example, Elle and Emma talked about the difficulties they felt early on with relinquishing control and feeling invaded by the bodily closeness required by breastfeeding. The participants in this study also make striking comparisons in their experience and shifted during the conversation from the difficulties of feeding to its rewards, showing the ambivalent nature of this phenomena.

In some ways Sarah seems to be an exception to the theme of breastfeeding saving participants from an eating disorder, rather it was motherhood more generally that, in some ways, saved her from bulimia.. Given that she was the only one to exclusively formula feed, she did not suggest this as being a comfort or saviour for her and with regards to her issues with bulimia. While the other participants explain breastfeeding as a defining aspect of motherhood Sarah rebels against the notion of 'breast is best' and argues that the choice of infant feeding should not be a debating factor for others. In doing so she is forming her own identity with formula feeding and emphasises her bond with her children to demonstrate this. Unlike the other participants Sarah had episodes of purging during the post-partum period which provides some support for the idea of breastfeeding potentially having protective features for disordered behaviours. However the influence of breastfeeding on purging and various other disordered behaviours post-partum would require further research to indicate possible protective properties.

5.3 Challenges of combining breastfeeding and an eating disorder

It was found that weight concerns and issues of control were two of the particular challenges participants in this study faced. Eating disorders are characterised by a desire for control among various other methods of emotion regulation (Obadina, 2014) and the perception of control is considered to be an important theoretical contrast within psychology. Breastfeeding has been documented as a process which some women find compromises their sense of self in that autonomy is lost through a shared body as a result of the demands of breastfeeding (Schmied and Lupton, 2001). The findings of the current study support this notion as the participants, particularly Jess, Elle and Sofia found breastfeeding to take away the element of control they had over their body as well as their nutrition, given that they were eating more for the sake of keeping up their milk supply. What is more, some research has implied that there is a sense of incompatibility between women's expectations for motherhood and the reality of this in the post-partum period (Darvill, Skirton and Farrand, 2008), which demonstrates an inherent need for control, regardless of mental health issues. Similarly, the women in the current study were faced with dilemmas of wanting to breastfeed while at the same time maintaining an element of control. Therefore these issues seem to be more pertinent to women with eating disorders and need to be recognised as a potential area of concern particularly when breastfeeding.

Jess' motivations to delay disordered behaviour were driven by a desire to lose weight through the act of breastfeeding which has been indicated as motivation to breastfeed in previous research (Stapleton et al., 2008). However the extent of her weight concerns, both in pregnancy and the post-partum period, seemed to overwhelm her, and meant that she was reluctant to have another child. Evidently her fear of not getting back to a desired weight postpartum made her question becoming pregnant again, and this negative attitude towards pregnancy for women with bulimia has been documented in existing literature (Easter,

Treasure and Micali, 2011). Again this finding suggests that despite mothers 'giving up' purging or food restriction, the thought process behind disordered behaviours is not as easily ignored. Patel et al. (2002) argued that women with weight and shape concerns need to be educated about the bodily changes in the postpartum period following their findings of participants with an ED becoming preoccupied with weight and feeling anxiety around feeding. Consistent with this, participants in the current study such as Jess and Katy had unrealistic expectations about breastfeeding and weight loss.

Skouteris et al. (2008) suggest that body dissatisfaction is higher in women with eating disorders postpartum as compared to during pregnancy, because many felt that changes in their body during pregnancy were expected and therefore weight gain was not overly problematic. This may account for the participants in this study's concern about their weight and the regulation of this post-partum. Some participants were worried about gaining weight and made sense of this by either blaming breastfeeding for not causing weight loss or for having to eat more in order to maintain their milk supply. Despite weight during the postpartum period differing more between women with an eating disorder than for women generally (Zerwas et al., 2014) often their expectations for weight loss were not met.

5.4 The influence of others on infant feeding

This theme was a focus on participants' perceptions of how others viewed their decisions around infant feeding in relation to their diagnosis of an eating disorder. An issue of concern for participants was feeling a sense of surveillance and a lack of understanding for the difficulties they might have been facing. However it is important to note that the experience of professional and social support was mixed among participants, while some women felt there was a lack of understanding others were reliant on the support they received in managing their eating disorder in the context of motherhood and breastfeeding.

The sense of surveillance experienced by some participants in relation to their decision to breastfeed and their diet seemed to be interpreted as judgement for having an eating disorder, despite many women without an eating disorder also experiencing a sense of judgment from health professionals (McInnes and Chambers, 2008) as well as family members (Thomson et al., 2015) when breastfeeding. While some of the women felt the surveillance from others was helpful and something they relied on, others perceived it as a lack of confidence in their mothering. However this finding has also been established in research on women's experiences of infant feeding who do not have eating disorders. Thomson et al. (2015) found that women within the UK perceived support to be inadequate or even undermining towards their choice of feeding. The study concluded that strategies for support should aim to target social, cultural and structural constraints among public and professional discourses in order to diminish shame felt by mothers in their choice of infant feeding.

Contemporary medical and public health discourses as well as mothering ideologies regarding intensive mothering (Turck et al., 2013; WHO, 1998) and the notion of putting the child's needs first somewhat overlook the difficulties and challenges which may be faced by a new mother. Stringer et al. (2010) found that a lack of understanding and awareness of health care professionals, in relation to eating disorders, impacted on the care women received. They suggested that service users as well as health professionals must cooperate in order to facilitate an understanding of the difficulties women might face during pregnancy and the postpartum period. Similarly the current finding of a lack of understanding perceived by participants indicate that women want the professionals to have knowledge of the issues they face. Additionally, perhaps health professionals do have an understanding of the issues women face with breastfeeding, regardless of the presence of an eating disorder or not, but time constraints and a lack of resources to help women may be the issue (Brown, Raynor and Lee, 2011).

Jess's account is illustrative of the importance of both peer and professional support during the postpartum period. It seems this was an essential element for Jess continuing breastfeeding despite her describing her difficulties with it, and indeed support from others is widely acknowledged within the literature (Graffy and Taylor, 2005; McInnes, Hoddinott, Britton, Darwent and Craig, 2013) as having positive effects on the experience of breastfeeding and Bodribb et al. (2007) highlighted that women turn to trusted health care professionals and peer support when experiencing breastfeeding difficulties.

The role of stigma in relation to eating disorders needs to be considered, given that a number of research findings suggest that individuals with eating disorders are often perceived as responsible for their disorder (Stewart, Keel and Schiavo, 2006). This idea seems to have informed some participants' views of themselves which perhaps contributed to the idea that they might be 'bad' mothers, which many mothers then strived to resist. Therefore the current findings, to some extent, counter the idea of mothers with eating disorders as problematic, and many participants described resistance of this perception through their commitment to their child, which for some was achieved through breastfeeding.

What was particularly helpful for women was the reinforcement from their midwives and other health professionals of their performance of breastfeeding, which was often in relation to the infants weight gain. In Stapleton et al.'s (2008) findings participants' valued positive feedback, especially when their feelings towards their own bodies were inconsistent and negative. Despite health professionals' attempts to provide support for women, Katy explained that her midwife found it difficult to find appropriate support for her in terms of dealing with anorexia and breastfeeding simultaneously, which might have intensified feelings of loneliness. What seemed to hinder discussion of breastfeeding concerns with health professionals was the feeling of being perceived as inadequate in their mothering.

Sofia was hesitant to ask for support due to this which meant that she kept her concerns and desire for eating disorder support to herself.

5.5 Methodological considerations

The current findings do not attempt to suggest that all women with eating disorders experience the issues discussed above, rather that the experience can be one of ambivalence and conflict around the various themes which were of particular importance for the participants interviewed in this study. The current sample cannot be seen as representative of all women with eating disorders, as eating disorder psychopathology varies among women and the participants did not disclose their diagnosis as being severe or for those who had current diagnosis, if they were part of any outpatient treatment.

It is also important to recognise some of the demographic features of the current sample. All women were aged between 31-39 years, which could have meant they were more confident in discussing their experience as opposed to younger women or adolescents. I noted this characteristic of the participants within my reflective journal as, in contrast to my previous encounter with this issue with a younger woman, the participants in this study were very open about their experience. I also found that many mentioned a desire to talk to their peers or professionals about their difficulties and concerns. Despite this I am not making an attempt to generalise these findings to all women in this demographic, rather the findings can be used to develop a greater understanding of this experience for women in similar situations. Another limitation of the current study was the limited number of formula feeding women with eating disorders, as there was only one, meaning an aim of exploring the experience of infant feeding in general in fact produced more data in relation to breastfeeding.

While this is a useful consideration to make, Popay, Rogers and Williams (1998) noted that “the aim [of the qualitative research enterprise] is to make logical generalisations to a

theoretical understanding of a similar class of phenomena rather than probabilistic generalisations to a population.” (p. 348). A strength of the methodology is the approach used to analyse the data, which allowed an in-depth and rigorous exploration of the participants’ experiences. The commitment to ideography allowed for each of the participant accounts to be considered in its unique place before finding similarities and differences between the accounts (Smith et al., 2009). IPA has been criticised on grounds that it is not easily refutable given its inductive nature meaning the author can simply chose a theory to account for and give meaning to the findings of their research (Starks & Trinidad, 2007). However hermeneutic phenomenology aims to learn something about the psychological world of the individuals in a purely interpretive manner in order to capture meaning (Smith, 2008) instead of attempting to explain the very nature of meaning attached to a phenomenon by using psychological theories. I found this approach was particularly useful in the interpretation of the data, because as I reflected on the women’s experiences throughout my analysis I was able to empathise with their personal accounts. I believe my data was able to capture how women make sense of stages within their life in the context of an eating disorder, which many of them believed to play a significant role.

5.6 Areas for future research

The findings of the current study have captured the lived experience of infant feeding for the six individuals interviewed in the context of managing an eating disorder, which has illuminated the experience as one of ambivalence, identity shifts and conflict. Despite this, future research could attempt to gain further insight into this experience through the use of a more homogenous sample of women with similar diagnoses as well as having children of similar ages, as there was some disparity between the current ages of the infants. Therefore in order to prevent overly retrospective data future studies would benefit from interviewing women whilst they are in the early post-partum period. The current findings did not seem to

demonstrate any explicit experiential disparities as a result of eating disorder. However, as the literature suggests anorexia nervosa might pose more difficulty for women breastfeeding during this period (Micali et al., 2008) perhaps this sample should be targeted in future work

The current research has highlighted the need for more qualitative and phenomenological inquiry into the exploration of this lived experience. For example Micali et al. (2008) investigated feeding patterns in infants of women with eating disorder using quantitative methodology. Although this study found that women with eating disorder were more likely to breastfeed, the current study has been able to give a voice to the reasons behind this.

Finally future research could explore specific themes emerging from this study, for example regarding a key finding of women having eating concerns. In-depth study of this notion could aim to capture the role of nutritional guidelines accompanying breastfeeding practice and how women make sense of this in the context of disordered practices.

5.7 Implications for practice

The current findings suggest that the experience of infant feeding, particularly breastfeeding, and motherhood in general can be beneficial for women with an eating disorder in helping them to appreciate the capabilities of their body. However this experience did not come without conflict and ambivalence, especially in relation to the nutritional demands motherhood can be associated with. Women require education on the nutritional requirements for breastfeeding which do not exacerbate eating disorder psychopathology, in terms of making drastic changes to their diet and eating. In accordance to this the reconsideration of breastfeeding guidelines for women with eating disorders could be helpful. Many women were concerned and felt an added pressure to eat more, and while one participant had to do this due to being underweight, many found nutritional advice difficult to adhere to. However

reassurance about dietary changes was offered by some health professionals when participants expressed their concern which placated them.

In terms of support some participants felt a sense of judgement and surveillance from family members and health professionals. Many mothers expressed a desire for health professionals to know about their diagnosis in order to support their decisions around infant feeding though without feeling undermined. Therefore these findings would emphasise the need for women to feel listened to so they are more open to discussing issues of concern in relation to an eating disorder with a midwife or someone trusted. It is also crucial for sensitive communication within this setting in order to prevent women feeling judged and under scrutiny, as is important for all women perhaps even more so for those younger than the current sample (Noble-Carr and Bell, 2012).

There is a need for health care professionals to recognise that breastfeeding can play a positive role in the lives of some women with an eating disorder. They should therefore offer their support and advice when women with eating disorder diagnoses want to breastfeed. The participants in this study found community based support and breastfeeding peer support groups particularly helpful and often relied on these visits where midwives would be present to address any queries. Therefore it would be useful for midwives to emphasise the use of these support groups prenatally.

Some participants were keen for information on how disordered behaviours during pregnancy or postnatally would affect their infant whilst breastfeeding, and if this would have any lasting implications on their child. Therefore education on these effects, if any, is essential for women in order to help relieve anxieties. Although many of the concerns they expressed were in line with general concerns of mothers, it is important for health care professionals and family members to understand the additional issues an eating disorder might present.

While the current findings cannot be used to make statements for therapy of eating disorders for mothers, perhaps the early post-partum period should be considered as a window for intervention, given the unique features of this experience in which the women in this study considered giving up their eating disorders to be able to experience all aspects of motherhood more fully.

5.8 Key conclusions

This study has shown that infant feeding for women with a diagnosis of either anorexia or bulimia is a multifaceted phenomenon. The overall experience for mothers was shaped by the various challenges and rewards of motherhood and infant feeding. Breastfeeding for some participants provided motivation to ‘give up’ an eating disorder, and helped them with body satisfaction. However, at times they felt a concern around making dietary changes and the impact they believed this to have on their body shape and weight. The perceptions of others were important for the women and while some felt a lack of understanding for their problems, other valued and relied on various means of support. Contrary to some of the existing literature around the challenges of managing an eating disorder in early motherhood, these findings suggest that, despite challenges, breastfeeding as well as motherhood generally helped towards women constructing an identity for themselves as a mother which was more meaningful to them than a disordered identity.

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Appendices

Appendix 1: Participant Information Sheet

Study Information Sheet

Title of Project:	The experience of infant feeding for women who have been diagnosed with an eating disorder.
Researcher email:	Rumaanah.Shabir@hud.ac.uk

You are being invited to take part in this study..... Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

Aims of the Study: The purpose of this phenomenological study is to explore and understand the lived experience of infant feeding, with a particular focus on managing breastfeeding, in a group of women who have/had a diagnosis for an eating disorder (ED).

Eligibility Requirements: Participants are required to be female, with a previous or current diagnosis for an eating disorder and have a child of up to 3 years old.

What does the study involve?

If you decide to take part in the current research you will be asked to read and sign a consent form, however please note you are free to decide not to participate or withdraw your data from the study at any time after this if you wish to and there would not be any negative consequences in doing so. Additionally you do not have to discuss anything or answer any questions which you do not feel comfortable talking about. The study involves you being interviewed by myself via telephone or Skype. Alternatively, if it is more convenient for you, a visit to your home can be arranged or at the University of Huddersfield if you live nearby. There will be one, single interview in which I will ask you open ended questions from an interview schedule. The interview is expected to last no longer than an hour and will be recorded for analysis later on. Once I have completed the study I will produce a summary of findings which I would be more than happy to send to you if you are interested.

Confidentiality of your data:

If you agree to take part, all data collected from the interview, and any other details including your name will remain anonymous and will not be disclosed to other parties. All your responses to questions will be used for the sole purpose of this project and will remain fully confidential, unless in the case that the researcher has reason to believe that you or a member of your family are at serious risk of harm, in which case a local authority/council may have to be notified.

What are the advantages of taking part in this study?

This study is an opportunity for women who may feel as though there is little help out there for mothers who are considering breastfeeding and have been diagnosed with an eating disorder. You may find that by talking to a researcher about your experience you are able to better understand any issues you face. On completion of this study I hope to develop a better understanding of the meaning of this experience which may inform healthcare professionals.

Remember that participation in this research study is completely voluntary. Even after you agree to participate and begin the study, you are still free to withdraw at any time and for any reason. Again there will not be any negative consequences of you deciding not to take part or withdrawing your data from the study.

If you have any complaints or concerns about this research, please do not hesitate to contact me or my supervisor at: d.leeming@hud.ac.uk. Alternatively you can contact the School Research and Ethics Panel at hhs_srep@hud.ac.uk.

Thank you for your time and consideration.

Appendix B: Participant Consent Form



CONSENT FORM

Title of Research Project: The experience of infant feeding up to 12 months postpartum for women who have been diagnosed with an eating disorder.

It is important that you read, understand and agree to the statements on the consent form. Your contribution to this research is entirely voluntary, if you require any further details please contact the researcher.

I have been fully informed of the nature and aims of this research

I consent to taking part in it

I understand that I have the right to withdraw from the research at any time without giving any reason

I give permission for my words to be quoted (by use of pseudonym)

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield

I understand that no person other than the researcher/s and facilitator/s will have access to the information provided. It will remain confidential unless they have reason to believe that I or a member of my family are at serious risk of harm, in which case a local authority/council may be notified.

I agree to have the interview recorded

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report.

If you are satisfied that you understand the information and are happy to take

part in this project please send this form back to the researcher via email at Rumaanah.Shabir@hud.ac.uk

By sending this document back to the researcher I confirm that I agree with all the points mentioned above.

Remember that participation in this research study is completely voluntary. Even after you agree to participate and begin the study, you are not obliged to answer any questions or talk about anything you do not feel comfortable discussing. You are also free to withdraw your data at any time and for any reason.

If you have any complaints or concerns about this research, you can direct these to myself at: Rumaanah.Shabir@hud.ac.uk or my supervisor at: d.leeming@hud.ac.uk.

Alternatively you can contact the Research Ethics Panel for the School of Human and Health Sciences at the University of Huddersfield at hhs_srep@hud.ac.uk, who have approved this project.

Thank you for your time and consideration.

Appendix C: Debriefing Letter

Participant Debriefing Letter

Thank you for taking part in the present study concerning your experience of infant feeding, and managing breastfeeding. The study aimed to explore and understand the lived experience of infant feeding for women with a previous or current diagnosis for an eating disorder and the implications of this on the meaning making process during this experience. It is recognised that breastfeeding is in itself challenging for many women, and more so with the added difficulties of having issues around diet and weight, therefore we aimed to reflect on your accounts in order to facilitate a better understanding of this experience and provide more support for affected women.

Previous research in the area has discovered that body image concerns have the potential to shorten breastfeeding duration and increase breastfeeding cessation in women with a diagnosis for an eating disorder. However a fuller understanding of this experience was yet to be studied from a phenomenological perspective, whereby a greater understanding can allow for greater support provisions.

In the event that you feel psychologically distressed by participation in this study, please contact the BEAT helpline: 0345 634 1414 or BEAT youthline: 0345 634 7650, which are open 1pm – 4pm Monday to Wednesday. Beat provides helplines for adults and young people offering support and information about eating disorders and difficulties with food, weight and shape. Alternatively you can contact the University of Huddersfield Counselling Service at 01484 472227.

Please do not hesitate to contact myself (Rumaanah.Shabir@hud.ac.uk) or my supervisor(s) (d.leeming@hud.ac.uk) and (Joyce.Marshall@hud.ac.uk) if you have any further questions regarding this study.

Thanks again for your participation.

Appendix D: Interview Schedule

Interview Schedule

Main focus	Probe for
How have you been feeding your baby since birth?	Bottle or breastfed? Expressing? When you began weaning?
How have you found feeding?	Are there any particular challenges? Pain, difficulties latching, concerns about insufficient milk/weight?
Are there any aspects of feeding that have gone well?	
How did you initially make a decision about feeding?	Did your original plan change for your chosen method of feeding?
How is your own eating at the moment?	Do you have a routine for yourself and baby?
I wonder if you feel that having issues around eating has been/is relevant to your experience of feeding.	
Have you had any experiences which have been difficult to deal with?	In terms of eating difficulties posing a challenge for managing breastfeeding or feeding in general.
Did you expect to have these difficulties?	What are your thoughts on your baby's weight?
How do you tend to cope with these challenges?	Seek professional support and family/friends support?
What did your family/friends think about the various methods of feeding?	
Are there any aspects that you actually find enjoyable/positive?	What did you think it might have been like prior to this?
Would you like to discuss anything else that you feel might be relevant or that we haven't discussed?	

Appendix E: Stage of Analysis: Emergent themes and Reflection

Participant 1 – Elle

Emergent themes	Original transcript	Exploratory comments
<ul style="list-style-type: none"> • Attribution of mother-child bond to breastfeeding 	<p>I felt like I had a much stronger bond with my daughter straight away because I was able to breastfeed her</p>	<p>Breastfeeding means a stronger bond/attachment with baby</p>
<ul style="list-style-type: none"> • Breastfeeding vs. anorexia/eating disorder 	<p>You know if you're struggling quite a lot then it would be very difficult to have this person need you so much for their nutrition, and also invading that space and interring in your ability to actually be anorexic</p> <p>I think if you're well enough to think about the positives of breastfeeding over the feelings of anorexia then yeah those feelings wouldn't take over</p>	<p>Breastfeeding can be a particular challenge when issues (emotional) associated with an ED are apparent</p> <ul style="list-style-type: none"> - Loss of personal space from issues around proximity - Stage of recovery is therefore an important factor <p>Shift from focus on self to focus on baby</p>
<ul style="list-style-type: none"> • Motherhood saving life from ED 	<p>So in some ways probably having babies has saved my life, it's given me something to live for, you know rather than living and having anorexia</p> <p>I think the main thing is that bond with my baby and I haven't felt depressed and have had a really positive experience and that's really helped me so I don't think about going back to anorexia</p>	<p>Motherhood changes perspective on life</p> <p>Life meaning more with children and breastfeeding is a big part of this</p> <p>Breastfeeding = stronger bond = barrier against ED</p>
<ul style="list-style-type: none"> • Support crucial for initiating and continuing with bf 	<p>So I had a lot more options this time, sort of presented to me, which was nice you know, a lot more choice I felt</p>	<p>Value of both practical and emotional support during feeding decision making</p>

<ul style="list-style-type: none"> Breastfeeding as being in the public – makes it harder 	<p>you just think I'm never going to be able to do this, it just sounds really difficult, you know, and there's so much in the media about breastfeeding I think as well. I felt very much, when I went to the breastfeeding workshop, I went there to learn about breastfeeding but it made me feel like I would be a bad person if I gave my baby formula milk</p>	
<ul style="list-style-type: none"> Conflicting emotions 		<p>Positive aspects of breastfeeding can help with recovery from ED</p> <p>Challenging aspects of breastfeeding can trigger negative emotions and ED</p>