



University of HUDDERSFIELD

University of Huddersfield Repository

Marshall, Joyce and Godfrey, Mary

Shifting identities: social and cultural factors that shape decision making around sustaining breastfeeding

Original Citation

Marshall, Joyce and Godfrey, Mary (2011) Shifting identities: social and cultural factors that shape decision making around sustaining breastfeeding. In: *Infant Feeding Practices: A Cross-Cultural Perspective*. Springer, New York, USA, pp. 95-108. ISBN 9781441968722

This version is available at <http://eprints.hud.ac.uk/id/eprint/8215/>

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: E.mailbox@hud.ac.uk.

<http://eprints.hud.ac.uk/>

Chapter ...**Shifting identities: social and cultural factors that shape decision making around sustaining breastfeeding****Author(s) Joyce L Marshall & Mary Godfrey**

Joyce L Marshall

Senior Lecturer

Department of Human and Health Sciences

University of Huddersfield

Harold Wilson Building

Queensgate

Huddersfield

HD1 3DH

United Kingdom

Email: joyce.marshall@hud.ac.uk

Mary Godfrey

Senior Research Fellow

Leeds Institute of Health Sciences

University of Leeds

Charles Thackrah Building

101 Clarendon Road, Leeds

LS2 9LJ

United Kingdom

Email: m.godfrey@leeds.ac.uk

Abstract

In the UK, women's beliefs, attitudes and behaviours around breastfeeding are shaped by myriad influences and by changing social and structural factors and cultural mores. Whilst public health discourse equates breastfeeding with 'good mothering' and health professionals emphasise 'breast as best', these normative values compete with other standards or criteria of 'good mothering' held by others within women's social networks that exert influence on them. Moreover, cultural and structural factors affecting the pattern of women's labour market participation, specifically public policy emphasis on return to paid work aligned with policies directed at reconciling work and family act as constraints on sustaining optimal breastfeeding i.e. exclusive breastfeeding for six months as advised by the World Health Organisation (2003).

For women in this study, initiating and sustaining breastfeeding was subject of a complex process that contributed to multiple valued outcomes: nurturing thriving and healthy babies, experiencing themselves as 'competent' mothers, successfully managing shifting identities and negotiating competing pressures in the real life context of their daily lives and relationships with 'significant others'. Even as women struggled to present and see themselves as 'good mothers', they were active agents and not just acted upon. They sought to reconcile the value they placed on breastfeeding with seeing themselves and being seen by others as 'good mothers'. Thus, they sought out situations where breastfeeding was highly valued (such as support groups), and developed strategies to counter or avoid threats to their sense of themselves as nurturing and competent mothers that was related to, but not synonymous with sustaining breastfeeding.

Midwives and health visitors in this study encouraged women to breastfeed but not in the way that this is generally portrayed in much of the current literature. Analysis of observed interactions between women who had chosen to breastfeed and midwives and health visitors suggests more of a negotiated encounter in which these health professional considered the whole situation of the woman and her struggle to be a ‘good mother’.

Keywords

Breastfeeding, infant feeding, identity, motherhood, decisions, social, cultural, England

Table of Contents

1. Introduction
2. Infant feeding in England: the social and political context
3. Study methods and introducing women
4. Moral dilemmas in the decision to breastfeed
5. Women’s experiences of breastfeeding
6. Pressure or support? Interactions with health professionals
7. Conclusion

References

1. Introduction

Childbirth and breastfeeding are at once both very personal and public, social phenomena. Having a baby impacts upon daily living, social relationships and women's sense of themselves, including their embodied selves. Infant feeding, and in particular the act of breastfeeding, is not just about meeting the nutritional needs of babies, it is imbued with cultural and social meaning with significance for women's successful transition to motherhood. A major life change, motherhood profoundly affects women's assumptive worlds and disrupts the 'normal' pattern of life 'before baby'. Motherhood is a source of joy, of anxiety relating to its successful accomplishment and concerns about loss of freedom and self identity (Miller, 2005; Oakley, 1979; 1993).

At the same time, women are located within webs of relationships comprising partners, family members and friends. Focus on women's 'social networks' - the structure and composition of these relational ties (Wellman et al, 1988; 1997) - directs attention at how women's emotions, attitudes and behaviour relating to motherhood and infant feeding are shaped by the reactions of these 'significant' others (Blum, 1999; Carter, 1995). Women also draw on support and resources from within their social networks to manage the transition to motherhood. Even so, the weight and intensity of influence of network members will vary with the perceived significance of, and support derived from, particular relationships within the network.

Although generally women subscribe to the dominant scientific and health discourse that 'breast is best' they encounter contradictory views among 'significant others' within their social networks (Blum, 1999; Marshall et al 2007) and have to make sense of their experience of motherhood and infant feeding in light of the practical realities of their lives. This includes managing an acceptable self/work/family balance. Consequently it is important in any discussion about breastfeeding to

consider influences at a variety of levels – individual, immediate social networks and broader societal and structural factors. In this chapter, our primary focus is on the relational or social network level. We explore how women's sense of themselves as 'good mothers through their infant feeding practices takes account of the perceptions of significant members of their social networks, including health professionals, and facilitates negotiation through the conflicting expectations of these others with whom they interact.

2. Infant feeding in England: the social and political context

The social and political context within which women make the transition to motherhood at least in part shapes the development of cultural knowledge, beliefs, meanings and practice of infant feeding (Maher, 1992; Palmer, 1993; Van Esterik, 1989). This can be appreciated by the considerable variation in breastfeeding rates evident within Europe (Cattaneo et al, 2005). In the UK around 70 percent of women start to breastfeed but only a quarter are doing so six weeks later (Bolling et al, 2007). These rates are among the lowest in Europe, a stark contrast to Scandinavian countries (Norway, Sweden, Denmark) and Switzerland where initiation rates are over 90% and more than 80% of women are still breastfeeding between three and four months later (Cattaneo et al, 2005).

In light of expert guidance (World Health Organisation, 2003) and to increase UK breastfeeding rates, breastfeeding has become a prominent feature of recent public health policies. Thus, *Choosing Health* (Department of Health, 2004a), *Every Child Matters* (Department for Education and Skills, 2004), the *National Framework for Children and Maternity Services* (Department of Health, 2004b) and the *High Quality Care for All: Next Stage Review* (Darzi 2008) emphasise the health benefits of breastfeeding initiation and continuance. However, the reasons women who start to breastfeed but do not persist are multidimensional and interactive, and such policies to date appear to have had little impact on breastfeeding rates.

At the structural and broader societal level the changing patterns of women's participation in the labour market and differing maternity leave policies provide some explanation. In a review of the literature, Galtry and Callister (2005) found an association between time off work and duration of breastfeeding, with return to work in the UK being among the factors predictive of early breastfeeding cessation. In Sweden, which has a high breastfeeding initiation rate and a high maintenance rate at six months (97% and 73% respectively), supportive family policies mean that although a large proportion of mothers continue in paid employment, few return to work in the early months of their baby's life taking on average eleven months parental leave and tending to work on a part time basis (Galtry 2003).

Since 1997, successive Labour governments have introduced policies aimed at reconciling work and family through extended maternity leave, introducing a right to request flexible working and increasing availability of childcare (Lewis and Campbell 2007). Thus, paid maternity leave was extended to 18 weeks in 1999 and to 26 weeks in 2003, with a commitment to increase it to 40 weeks in 2010. These changes mainly post-date data collection in our study (between 2000 and 2002). Further, the primary focus of policy was on maternal not parental leave with minimal provision for fathers; and protection of women to return to work if they took more than six months leave was restricted to the right of return to a similar (and not the same) job (Department of Trade and Industry 2006). This contrasts with more extensive and flexible maternity and paternity leave in Sweden.

In the past medicalisation has been suggested as an explanation for the decline in duration of breastfeeding. It has been argued that rather than being viewed as a natural event childbirth and related practices such as infant feeding were seen as pathological (Miller 2005). Increased dependence on technology and professional expertise (Illich, 1976; Oakley, 1979) was seen as

displacing traditional knowledge acquired from family and friends (Arnup et al, 1990). Midwives and health visitors, the main health professionals who support breastfeeding women in England, have often been linked to the medicalisation of breastfeeding (Carter 1995, Murphy 2000, 2003). It is likely that some practices previously encouraged by health professionals have been detrimental to breastfeeding success, for example separation of mothers and babies, restriction of breastfeeding and supplementation with formula. Yet, this line of argument does not explain the wide variation in breastfeeding rates between high income countries also subject to medicalisation.

Breastfeeding initiation rates have increased in recent decades, particularly among higher income groups. There is a strong 'natural' discourse around breastfeeding that has been attributed to feminism, linked with the attempt to demedicalise pregnancy and birth and to increase women's empowerment (Oakley 1979, Saha 2002, Crossley 2009). Teaching curricula and professional practice among midwives and health visitors emphasise the health benefits of breastfeeding and these health professionals generally work with an ideology that places women at the centre of care. Although most women still give birth in hospital, length of in-patient stay is steadily decreasing with more care being provided by community midwives in the woman's home – an environment more likely to be conducive to smoother transition to motherhood and greater maternal control of infant feeding.

Murphy (2003) argues that although mothers are ultimately in control of how babies are fed, expert opinion sets the moral context within which women negotiate their changing identity. One consequence is that women may experience a sense of 'failure' and 'guilt' when they do not continue to breastfeed (Lee 2007; Crossley 2009). Our thesis in this chapter, however, is that the situation is considerably more complex and that the moral context of infant feeding is not only set by the influence of 'experts' but women encounter considerable dissonance from within their social

networks regarding constructions of ‘good mothering’ and feelings of responsibility (Murphy, 1999; Wall, 2001). For women, making sense of, and managing these tensions as they embark on the journey into motherhood, involving their changing self identity, building a relationship with their baby, and simultaneously maintaining a positive image of themselves as mothers present a considerable challenge. We now turn to discuss the study that investigated not only how women manage these changes and contradictions, but also the part played by midwives and health visitors in supporting them.

3. Study methods and introducing women

The qualitative study reported here adds to the small but expanding literature exploring women’s baby feeding practices from their perspectives. It is unique in that in addition to in-depth interviews with women, some encounters with midwives and/or health visitors were observed. This enables exploration of women’s experiences and practices of breastfeeding; including the meanings constructed through interaction with others in their social networks, as well as with health professionals.

Health professionals were accompanied by a researcher (JM) during their daily work. A total of 158 interactions between women who had chosen to breastfeed and midwives or health visitors were observed in the community setting. Interactions with women from a range of socio-economic and ethnic groups were sought, and to achieve this fieldwork was carried out in a geographical location comprising inner city, suburban and rural areas. Although many women took part in the research and were very willing to invite a researcher into their home, 22 women provided their own detailed breastfeeding stories, including their views and experiences in the early weeks. A full account of the research methodology has previously been reported (Marshall, Godfrey, & Renfrew, 2007). Here we introduce these women to provide the reader with some contextual information about their lives.

The study was conducted in the North of England and included women who had chosen to initiate breastfeeding. They ranged in age from 19 to 34 with a mean of 28 years. They were interviewed at different times in the childbirth trajectory: the earliest interview was 10 days after the baby's birth and the latest when the baby was 6 months old, although most women were interviewed between 6 and 16 weeks following the birth. For all but six women, it was their first experience of motherhood. The majority were still breastfeeding when they were interviewed, although many not exclusively; two women never really established breastfeeding and both had expressed breastmilk to feed to their baby.

Sally had given up her job in a newsagent and moved to another town to live with her boyfriend. Before the birth Sally and her partner returned to stay with Sally's mother in an average sized semidetached house in an inner city area. Sally wanted to have her baby at home as she hated hospitals but was transferred to hospital during labour. After her baby's birth, Sally was distraught because she was not given the opportunity to breastfeed within the first hour (she had read that this was important) but described the 'special moment' when she finally breastfed. After the first couple of feeds Sally found she was unable to breastfeed and asked for help from the midwives. This resulted in a myriad of suggestions from various midwives that left Sally very confused and upset. She eventually took her own discharge from hospital and at home with help from her mother (who had breastfed her three children) Sally continued to exclusively breastfeed. Sally described her partner as emotionally supportive but said he kept encouraging her to give the baby a bottle. Sally had a good relationship with the community midwife who she trusted implicitly.

Emily was working in a temporary job when she became pregnant. She lived with her partner in a terraced house on the outskirts of the city. Emily did not like hospitals but had given birth there. Although she felt exhausted after the birth she said her baby had fed easily from the first feed and described feeling a 'connection' with him. Although several of her family had breastfed including her mother, Emily said she could not remember seeing anyone except her sister breastfeeding. She said she believed her partner felt 'left out' through not being able to feed the baby but never the less breastfed exclusively for ten weeks, and was feeding alternate breast and formula at twelve weeks. Emily described a wide social network of people close to her who she could talk to and whilst she found this helpful she also pointed out that 'everyone's opinions are different about everything aren't they, whether it's breast-feeding or changing a nappy?' She 'tried not to take on board everyone's opinions' but to 'figure it out' herself.

Amelia was a solicitor but had changed her job because she did not want to continue working the long hours the job required as she felt this was not compatible with family life. Although planning a family she was surprised to find she became pregnant very quickly after getting married. She experienced few problems during pregnancy apart from some sickness in the early weeks and continued to work. She did not have strong views about breastfeeding saying: 'if I can do it great, if I can't I'm not too worried'. Amelia described two contrasting embodied experiences of breastfeeding prior to becoming pregnant, the first, on a train journey was a woman breastfeeding an older child that she described as 'revolting'. The second, a very good friend, a glamorous, beautiful girl who breastfed discretely she described as 'really natural'. Her baby breastfed soon after birth and suckled straight away Amelia said she enjoyed feeling close and that it felt 'natural'. After some initial help to learn the skill of breastfeeding in hospital she experienced few difficulties. She

decided to introduce a formula feed in the evening to involve her husband more as he had made comments like 'It's only your mum can help'. Amelia intended to breastfeed for four months when she planned to return to work.

We now turn to explore how women made sense of and managed complex contradictory notions related to breastfeeding within the broader context of motherhood. Women's experiences are presented chronologically to build up a picture of the way they manage breastfeeding as part of early motherhood.

4. Moral dilemmas in the decision to breastfeed

During pregnancy the moral nature of the infant feeding decision was clearly demonstrated in discourses equating breastfeeding with health of the baby, such as: 'improving the baby's immunity' and 'reducing allergies', decreasing the chance of the child getting diabetes, 'not having to worry about diarrhoea' and improving the child's IQ. Although such ideas about infant feeding were garnered from a range of sources including books and magazines, midwives played a significant role in this when delivering parent education classes. Several women spoke of feeling 'pressure' to breastfeed; such messages were not always explicit but could result from simply more time spent discussing breastfeeding than formula feeding. Health professionals were clear that promoting breastfeeding was part of their role and Alison (a community midwife) spoke of this during fieldwork:

She said that during the class one of the mothers had said to her "you really promote breastfeeding don't you?" and replied "well I'm a health professional and I have to promote healthy rather than unhealthy things, like I have to discourage people from smoking". She described how she had said to this woman "it's a shame it has to be that way because it's a natural thing that should not have to be promoted. It's natural, like getting pregnant, and

none of you needed my help for that!" This made them laugh and the woman said "well when you put it like that..." (Fieldwork with MW4)

Not all health professionals believed in framing breastfeeding as 'best' but rather focussed on the need to convey breastfeeding as normal – perhaps an impossible goal as many women had little or no embodied knowledge of it. Molly a health visitor said:

It needs to be that health professionals as a whole send the message that breastfeeding is the norm, not even the best, it's just the norm. (HV6 interview)

Women generally expected health professionals to promote breastfeeding but some expressed concerns about not feeling free to choose: For example Deborah, who breastfed for 10 weeks said:

...it [breastfeeding] is encouraged sometimes I think without, how can I put it? That certain people can't breastfeed, certain people don't want to breastfeed. I think sometimes there's a negative vibe that comes out perhaps from the midwife or perhaps in general that if those people aren't prepared to give it a try. I think that's unfair sometimes. It is not something for everybody. (Deborah aged 29, rural area)

Although these examples concur with the idea of a moral imperative to breastfeed, women's narratives also revealed many conflicting aspects important to their changing identity during pregnancy such as their sexuality. For example Sally said:

I just think that breasts kind of aren't viewed, as means of feeding a baby anymore you know what I mean. They are for sex, they're for men, more than anything else...and then, it, that all changes when you meet your little baby. (Sally aged 21, inner city)

Women generally involved their partner in the initial decision to breastfeed and most were supportive; for example, Paula said her husband wanted her ‘to try breastfeeding’. Unusually Natasha described how her partner had encouraged her to change her mind when she intended to bottle feed, she said ‘he persuaded me to give it a go’. Some partners were supportive but ambivalent about how to feed the baby. Uniquely Laura said her partner ‘wasn’t particularly supportive’ and related how she had returned from a ‘talk’ on breastfeeding given by her midwife and wanted to discuss feeding with him:

I said, you know “Do we want to bottle or breastfeed him?” ... “Personally”, I said “I’d like to breastfeed him ‘cause I think it’s natural, it’s the best thing” ... and he kind of said “Whatever you wanna do, I’ll leave it to you because you know”. So fair enough I breastfed him. But then from the word go I think he felt quite pushed out (Laura aged 27, rural area)

So whilst the moral nature of the breastfeeding enterprise was apparent during pregnancy – the emphasis clearly on ‘breast is best’, there also existed ambivalence among ‘significant others’ in women’s social networks that they had simultaneously to negotiate. We now consider women’s experiences of breastfeeding and the factors that impinge on it as they embraced motherhood.

5. Women’s experiences of breastfeeding

In the early days acquiring the physical skills of breastfeeding was of paramount importance to women. Accounts of breastfeeding at this time revealed feelings of uncertainty and vulnerability both in their selves as mothers and in their ability to breastfeed. For many, the sense of not knowing what to do was overwhelming in the first days after leaving hospital. A consistent theme within women’s narratives during this period was the need to know they were ‘doing it right’, partly

because women recognised breastfeeding as a skill that had to be learnt but also because they felt they were being tested out as ‘competent’ new mothers.

It’s important for me to have someone to kind of say, you know “What am I doing? Am I doing this right?” Because you know ... you can read as much as you want but, you know it’s nice to know that you’re doing the right thing. (Laura)

Partners played a supportive role, albeit as observers, through the sometimes difficult period of acquiring practise skills, primarily through reinforcing the women’s own decision to breastfeed, as exemplified in Holly’s account:

Well he was just really going along with anything that I said, you know, he couldn’t really do much. He watched, he knew what the midwives were saying and if I was having trouble on my own then he would say “Oh have you remembered to do this” and “are you doing this?” ... Basically just reminding me what the midwives had said. So he was supportive, but he couldn’t really do a lot. (Holly aged 32, rural area)

Some women encountered a degree of ambivalence from partners between wanting to be involved in all aspects of baby work, yet feeling excluded from feeding. Sally who experienced difficulties in the beginning described her partner as supportive although:

I mean, he doesn’t really know what to do...he has he’s been an absolute star as far every thing else, looking after the baby goes..., but... he sits there and he kind of puts his arms around me: “there, there, I know your nipples hurt, poor you”, you know what I mean. He is kind of emotionally supportive, but he hasn’t got the foggiest idea ...where to begin helping somebody to breastfeed... He was ... a lot more keen than me to just give her a bottle, I think... it was really upsetting him that she was crying and hungry and I was crying

and in pain,... and as far as he could see the easiest solution was to give her a bottle and then we both shut up. So I mean he was sort of like “are you sure you don’t want to give her a bottle why don’t we just like feed her with a bottle it’ll be fine”. And it was me who was just like she can’t have a bottle it’s not fair she needs breast milk. (Sally)

Confronted with difficulties in breastfeeding and ambivalence from partners, women actively sought and relied upon help to continue from ‘knowledgeable and reinforcing’ others within their social networks (as well as from health professionals). Holly maintained telephone contact with a friend experiencing similar problems and Emily received support from her friends with babies. Lisa regularly attended social and breastfeeding support groups with the mothers she had met at the child health clinic. Sally turned to her mother who had breastfed.

Whilst, women’s mothers were often a source of support and advice, they could also be seen as unhelpful in the practice of breastfeeding. Thus, Jenny kept her mother at a distance when the baby was feeding frequently but not gaining weight and turned to the midwife for help:

Because she never breastfeed, cause I was a month early, in an incubator, so she never breastfed me and then when my sister came along she just didn’t think about it. So I think because she hasn’t breastfed she can’t understand. There’s like, they need to feed more regularly don’t they than bottle fed babies ...and she was thinking “I’m not giving him enough milk”. (Jenny aged 30, rural area)

Over time, having mastered the technique of breastfeeding, women’s priorities shifted to focus on the need to know the baby was receiving adequate nutrition – the underlying problem being their inability to directly observe the quantity of breastmilk the baby was taking. In the absence of unequivocal observable evidence, women drew upon indirect cues such as: the way their breasts felt

in relation to feeds and the baby having wet and dirty nappies. These ways of making the invisible visible worked to increase women's confidence in their ability to provide sufficient milk for their baby and to counter criticisms that they were not performing adequately. Paula, who was happily breastfeeding her second baby, described what happened at a family gathering when her baby became unsettled, cried and needed feeding more frequently than usual:

They were saying: "oh you need to talk to your health visitor or your midwife, because it doesn't look as if you have got enough milk there or it might not be strong enough". So I was tired anyway so I was getting really upset. But I knew he was putting weight on, so I thought well there is nothing wrong with him. (Paula, aged 22, second baby, rural area)

Paula was able to draw on her previous experience and the empirical knowledge that her baby was gaining weight to reassure herself.

Such cues were not foolproof as an unsettled baby could easily undermine women's confidence in their milk supply. Deborah was confronted with multiple and conflicting expectations that affected her perception of breastfeeding as equating to good mothering:

The hardest thing for me was the fact that when Abigail was awake she was never content and that I found really, really difficult... used to tear me up inside really, because I couldn't understand why when she was awake she was always crying... And that towards the end was one of the major factors in coming off and going on to the bottle ...And it was difficult because on the one hand my mum was really trying to encourage me to keep going. [Partner's] mum was the opposite; her answer to everything was the bottle...And it nearly came to the stage where we had words...In the end I had to say "Look I'll make the decision as to when and where and how this baby is fed". (Deborah)

Sarah also was a first time mother and felt upset that her mother-in-law judged that she was not 'coming up to scratch' as a mother:

I think she [mother-in-law] was horrified to see Simon didn't sleep (pause) at all... and she was you know, 'ooh he's not very settled...I felt pretty bad...he was at his worst really...and they also made a big deal every time he was grouchy like: 'ooh babies don't cry for no reason there must be something wrong with him'. And passing him round saying to me: 'have you fed him...he's hungry; have you fed him. (Sarah aged 31, suburban area).

For Sarah, the fact that she viewed her baby's behaviour as atypical and that her relationship with her mother-in-law was not very close meant that she could put aside her mother-in-law's negativity, albeit taking an immediate knock in confidence. Women's status as 'good mothers' then was not universally equated with breastfeeding by key members of their social networks. Where women attributed high value to breastfeeding, they actively sought out positive reinforcers from within their networks. Negativity – either in the context of periods of particular vulnerability or from network members whose influence was particularly salient – could threaten continuance.

6. Pressure or support? Interactions with health professionals

Commentaries in the literature suggest that medicalized discourses around motherhood and breastfeeding simultaneously position mothers as responsible for the well-being of their children and reliant upon experts (Arnup et al, 1990; Apple, 1995; 2006; Murphy, 2000; 2003). Here, as discussed earlier, the discourse of 'breast is best' was pre-eminent in the antenatal period and this was clearly reflected in women's accounts linking breastfeeding with improved health of their babies. However, although it could be argued this may set a moral imperative for breastfeeding (Murphy, 2000), our findings suggest that in the postnatal period a much more complex picture

emerged. Whilst for women, breastfeeding was generally equated with good mothering to the extent that the baby was seen as healthy, happy and thriving, where observable indicators did not support this (the baby was feeding often but unsettled and not gaining weight), the link between breastfeeding and good mothering was open to doubt. Within this context health professionals did not simply continue to promote infant feeding and help women with the technical aspects of infant feeding but carried out extensive emotional work (Nettleton 1995) supporting women in their struggle to see themselves and be seen as ‘good mothers’.

Women referred to different elements of support from health professionals that they found helpful and this varied over time. In the early days, practical help with the physical aspects of breastfeeding was paramount. As feeding became established suggestions about how to manage the life-baby balance became more important as was the knowledge that the baby was growing and developing well. Support at this stage was usually offered with attention to how women felt – their emotional well-being. Women spoke of being encouraged by health professionals telling them they were ‘doing well’ and being reassured that their baby’s behaviour was ‘normal’. Even women who knew their baby was healthy and happy liked this to be reiterated by health professionals, as illustrated by Amelia:

I could feel her feeding quite regularly and getting quite a lot and then going to sleep. So I thought it, but you still want somebody to tell you it’s all right ... even though you feel its right, it’s still nice to have that reassurance... (Amelia, aged 31, rural area)

Most women believed there was a ‘right way’ to do things and that health professionals would be able to give them this information. For example Sally said ‘...you just need someone who knows’. Women valued timely and relevant information from health professionals not simply to ensure

continued breastfeeding but to help them to maintain their identity as ‘good mothers’, ensure a happy healthy baby and manage the life/baby balance.

Women frequently talked about need for input from health professionals to resolve a particular issue of relevance to them – general or abstract advice or help was rarely perceived to be useful. Observational data revealed that health professionals made considerable efforts to encourage women to express their concerns. This was done in a variety of ways, such as, asking open questions: ‘how is the feeding going?’; or ‘how are you getting on?’ Their body language often conveyed interest (e.g. sitting close to women on the same level and maintaining good eye contact) and they listening attentively to women’s stories and offered suggestions that specifically responded to these. Women usually described their concerns as a series of events that had occurred – as a narrative of the baby’s feeding pattern. Such stories did not merely recount events but also conveyed messages to health professionals about the way the woman *felt* about those events, enabling them to provide relevant and useful information and/or emotional support in response to the uniqueness of their individual situations. The following excerpts from field work with one health professional illustrate this variation:

(Khalda – an Asian woman, a paediatrician, having her second baby. Her first child had lost a large amount of weight after birth)

MW5: How’s the feeding going?

Khalda: She’s going 4 hours... [More talk about times of feeds]... I got [another midwife] to watch me feed her because she was making gulping noises.

Weighed baby – baby had lost weight. Further discussion about feeding pattern in more detail...

Khalda: I don't know if she is using me as a dummy...

MW5: Just go with that...'

(Lisa's baby was 14 days old and her first baby)

MW5: I presume she's been doing fine since I saw you last?

Lisa: Yes she fed ever so often yesterday. (Further discussion)

MW5: Are you drinking?

Lisa: Yes I'm drinking loads.

MW5: She's putting on weight?

Lisa: Yes she is. The health visitor popped in this morning. (talks to the baby)

MW5: 'They do this at times when they are feeding all the time to boost the milk supply, you have to go with the flow. It's about 6 weeks when they have a big growth spurt.'

These data illustrate that whilst dialogue was specifically relevant to each woman there was a common theme of encouraging women to breastfeed more – 'to go with the flow'.

Health professionals said they tried to present information in a meaningful way and this sometimes meant altering the language they used to explain things taking account of what they knew about women:

HV5: I thought this was basic simple communication skills? (Laughs) If I said to you that I had, I don't know, a 16 or 17 year old here, who may not have attended school very much, if

I said 'research has shown', I sound like a sales person off the telly, selling bras or something. But you've got to make it meaningful for them.

Health professionals assessed many factors with potential to impact women's ability to breastfeed their baby and modified what they said in the light of these, for example some health professionals suggested middle class women should view breastfeeding like a job to encourage full commitment to it.

The relationship with health professionals was also important. Women in this study described health professionals using words such as 'nice and supportive', 'interested', 'patient with me', identified openness and honesty as important characteristics and needed to feel that health professionals listened to and had time for them but at the same time wanted to remain in control, as the following quote illustrates:

I mean Beverley [MW5] was brilliant because she was really open about everythingwith the pregnancy and the birth and everything Really sort of laid back and doesn't push things on you and make you feel she's taken charge of your life or anything. (Emily, 22 years old, suburban area)

Health professionals also recognised the need not to attempt to direct women's lives, for example:

I am not here to shape anybody's culture yes, ...I'm not about to tell them they mustn't do this, I will say 'well try this' or 'I don't think it is a good idea to that', or 'see what you think about it', 'if you try it the first time and it doesn't work then you will know', you know. That way you gain their confidence of the women you don't go in and try to direct people's lives.... (MW8)

Interactions between breastfeeding women and health professionals after the birth of their baby were more of a negotiated encounter than has been previously suggested. Although it was apparent that health professionals did generally encourage women to breastfeed they did this in a way that was sensitive to the context within which women were operating – with an understanding of the multiple pressures affecting women as they breastfed and at the same time tried to maintain a their view of themselves as ‘good mothers’.

8. Conclusion

Women aspired to become and be ‘good mothers’ and although all of them in this study had made the decision to start breastfeeding, continuing with it and for how long was contingent upon a range of factors. Not only was there the challenge of ‘doing it right’ but of balancing the growth and health of their babies with the demands of their daily lives. Within their social networks women’s status as ‘good mothers’ was not universally equated with breastfeeding. Where women attributed high value to breastfeeding, they actively drew on salient sources of support from their social networks and sought to minimise their exposure to challenges to their identity as ‘good mothers’. Whilst health professionals encouraged women to sustain breastfeeding they also recognised their struggle to maintain a positive self identity in the face of varying conceptions of ‘good’, ‘bad’ and ‘adequate’ mothering.

References

- Apple, R. (2006). *Perfect motherhood: science and childrearing in America*. New Brunswick: Rutgers University Press.
- Apple, R. D. (1995). Constructing mothers: Scientific motherhood in the nineteenth and twentieth centuries. *Social History of Medicine*, 8(2), 161.
- Arnup, K., Lévesque, A., & Pierson, R. R. (1990). *Delivering motherhood: maternal ideologies and*

- practices in the 19th and 20th centuries*. London: Routledge.
- Bolling, K., Grant, C., Hamlyn, B., & Thornton, A. (2007). *Infant Feeding Survey 2005*. London: The Information Centre for Health and Social Care.
- Blum, L. M. (1999). *At the breast: ideologies of breastfeeding and motherhood in the contemporary United States*. Boston: Beacon Press.
- Carter, P. (1995). *Feminism, breasts and breastfeeding*. New York: St Martins Press.
- Cattaneo, A., Yngve, A., Koletzko, B., & Guzman, L. R. (2005). Protection, promotion and support of breast-feeding in Europe: current situation. *Public Health Nutrition*, 8(01), 39-46.
- Crossley, M.L. (2009), Breastfeeding as a moral imperative: an autoethnographic study, *Feminism and Psychology* 19: 71-87.
- Darzi, A. (2008). *High quality care for all: NHS next stage review final report*. London: Department of Health.
- Department for Education and Skills. (2004). *Every child matters: change for children*. London: The Stationary Office.
- Department of Health. (2004a). *Choosing health: making healthier choices easier*. London: The Stationary Office.
- Department of Health. (2004b). *National service framework for young people and maternity services*. London: The Stationary Office.
- Department of Trade and Industry (2006), *Work and families: choice and flexibility: additional paternity leave and pay: Government response to consultation*, London: Department of Trade and Industry.

Dykes, F. (2006). *Breastfeeding in hospital: mothers, midwives and the production line*. London: Routledge.

Galtry, J. (2003), The impact on breastfeeding of labour market policy and practice in Ireland, Sweden and the USA, *Social Science and Medicine* 57: 167-177.

Galtry, J., & Callister, P. (2005). Assessing the Optimal Length of Parental Leave for Child and Parental Well-being: How can research inform policy? *Journal of Family Issues* 26(2), 219.

Illich, I. (1976). *Limits to medicine*. London: Marion Boyers.

Lee, E. (2007). Health, morality, and infant feeding: British mother's experiences of formula milk use in the early weeks, *Sociology of Health and Illness* 29 (7), 1075-1090.

Lewis, J. and Campbell, M. (2007), UK work/family balance: policies and gender equality, 1997-2005, *Social Politics: International Studies in Gender, State and Society*, 14 (1): 4-30.

Maher, V. (1992). *Anthropology of breastfeeding*. Oxford: Berg Publishers.

Marshall, J. L., Godfrey, M., & Renfrew, M. J. (2007). Being a 'good mother': Managing breastfeeding and merging identities. *Social Science & Medicine*, 65(10), 2147-2159.

Miller, T. (2005). *Making sense of motherhood: a narrative approach*. Cambridge: Cambridge University Press.

Murphy, E. (1999). 'Breast is best': infant feeding decisions and maternal deviance. *Sociology of Health and Illness*, 21, 187-208.

Murphy, E. (2000). Risk, responsibility, and rhetoric in infant feeding. *Journal of Contemporary Ethnography*, 29(3), 291-325.

- Murphy, E. (2003). Expertise and forms of knowledge in the government of families. *Sociological Review*, 51(4), 433-462.
- Nettleton, S. (2006). *The sociology of health and illness*. Cambridge: Polity Press.
- Oakley, A. (1979). *From here to maternity: Becoming a mother*. Oxford: Martin Robinson.
- Oakley, A. (1993). *Essays on women, medicine and health*. Edinburgh: Edinburgh University Press.
- Palmer, G. (2009). *The politics of breastfeeding: when breasts are bad for business*. London: Pinter and Martin.
- Saha, P. (2002), Breastfeeding and sexuality: professional advice literature from the 1970s to the present, *Health Education and Behaviour* 29 (1):61-72.
- Van Esterik, P. (1989). *Motherpower and infant feeding*. London: Zed Books.
- Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender and Society*, 15(4), 592-610.
- Wellman B, Carrington P and Hall A (1988) Networks as personal communities, In I Sarason and B Sarason (eds.), *Social structures: a network approach*. The Hague: Martinus Nijhoff.
- Wellman B, Wong RY, Tindall D, and Nazer N (1997) A decade of network change: turnover, persistence and stability in personal communities. *Social Networks* 19: 27-50.
- World Health Organisation (2003), *Global strategy for infant and young child feeding*, Geneva: WHO.