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**AN EXPLORATION OF YOUNG MOTHERS' EXPERIENCES OF
BREASTFEEDING WHILST LIVING WITH THEIR FAMILY OF ORIGIN**

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A thesis submitted to the University of Huddersfield in fulfilment of the requirements for the degree of
Masters by Research in Psychology

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Abstract

There is a wealth of research exploring the breastfeeding experiences of women. However, the majority of this research focuses on older women or women of all ages, and few focus on breastfeeding experiences of young mothers aged 21 and under. Like this, there are very few studies exploring how living with family affects and influences a mother's choice to breastfeed, and even less so exploring this amongst young mothers specifically. Using online qualitative interviews and an open-ended qualitative questionnaire, this research aimed to explore young mothers' experiences of breastfeeding whilst living with family (other than just partner and/or child/ren) and the impact others around them had on these experiences. Using thematic analysis, five overarching themes were identified: (1) breastfeeding as deviant vs normalised; (2) respecting others; (3) a process of overcoming difficulties; (4) impact of support and absence of support; and (5) baby comes first. The findings of this study showed that others around these women (either people close to them or strangers), found breastfeeding to either be a normal or deviant behaviour and there was a link between how others perceived breastfeeding and the level and kind of support these mothers received. If others perceived breastfeeding as deviant, young mothers would usually experience a lack of support, whereas if others perceived breastfeeding as normal, young mothers would usually experience high levels of support. Also found was the respect that these young mothers had for the comfort, views, space and authority of those around them, even if these people had different opinions of breastfeeding to these young mothers. This study also found that these women experienced a large number of difficulties over their time breastfeeding, as well as exploring how these mothers overcome these difficulties by a process of learning, adapting and adjusting. Lastly, this study found that despite their young age and living in someone else's home, that some of these mothers took control of their autonomy as mothers and made decisions regarding their babies, regardless of the opinions and views of others around them. These findings indicate that these young mothers' experiences of those around them had a substantial impact on their overall breastfeeding experience, either positively or negatively. Overall, the present study illustrates the need for realistic prenatal support and care when mothers are making their infant feeding decisions, as well as postnatally in order for these women to be able to overcome any difficulties they have with the assistance and encouragement of others and become confident in their ability as breastfeeding mothers.

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Literature review

Breastfeeding is a normal way of providing infants with the vital nutrients needed for healthy growth and development, which is why the World Health Organisation [WHO] recommends that women exclusively breastfeed for the first 6 months postpartum and continue to beyond this time, along with appropriate foods (World Health Organisation, 2011). However, in a context where there is strong promotion of breastfeeding and its health benefits in the United Kingdom [UK], the number of new mothers who breastfeed exclusively or at all, is still low, despite the increase in breastfeeding campaigns and support now provided to any mother interested in breastfeeding. Like this, the number of teen mothers breastfeeding is even lower than older mothers (Condon, Rhodes, Warren, Withall & Tapp, 2012; Feldman-Winter & Shaikh, 2007; Smith, Avery & Gizlice, 2004). Even though research has shown that adolescent mothers can be aware of the health benefits of breastfeeding (Nesbitt et al., 2012; Wambach & Koehn, 2004), many issues can be attributed to why breastfeeding rates are much lower for teen mothers, and these will be discussed further on.

It is important to explore why a mother does not or does not want to breastfeed, but it is also very important to look at the context in which she breastfeeds. Despite research on the contrary, there are still people in society that hold negative views of all teenage mothers being irresponsible, promiscuous and even incompetent parents, amongst other things (Ellis-Sloan, 2014; SmithBattle, 2013) which causes a stigma associated with teen mothers. Depending on how much this affects a mother can affect her breastfeeding. When a teen mother breastfeeds, especially in public, it cements the idea that she is a teen mother and allows society to judge her accordingly. This could be positive or negative, depending on people's views of breastfeeding. For some teen mothers, the thought of feeling judged and stigmatised can be enough to influence her infant feeding choices.

Most new mothers will have some family influencing them on how to parent their child, including how to feed their baby, however, this is even more so for young mothers who will more than likely still live with their family of origin and be deeply enmeshed in family networks. There has been a wealth of research on mothers' experiences of breastfeeding, less so for young mothers but research in this subject area is increasing. However, during my research, I found little being conducted on mothers living with family and how this impacts on their infant feeding intentions and choices and found no research specifically exploring the influences of living with family as a breastfeeding young mother.

When I was 17, I became a mother myself and often felt judged by people when in public. I felt as though people thought it was wrong to be a mother at that age and when people ask how old I was when I had my daughter, even now I fear judgement. Although I was only able to breastfeed my daughter for a short time and therefore did not feed in public, I would have struggled with breastfeeding in front of others, despite knowing how beneficial it was. Because of my experiences and views on breastfeeding, I am very interested in researching this area in an attempt to explore why and how new mothers breastfeed and if not, why not. This is paired with a particular focus on whether living with their family of origin could affect or influence a young

mother's decision to breastfeed or the duration of which she breastfeeds. The research in this chapter will focus predominantly on teen mothers, as generally, research is either carried out on teen mothers or older mothers and there is usually no distinction between teen mothers and young mothers.

Before the literature on the subjects mentioned above, the composition of breastmilk will be discussed in order to understand why it is so beneficial for a baby.

The biological composition of breast milk

There are three distinct stages of human milk; colostrum, transitional milk, and mature milk. Colostrum is a concentrated, nutrient-rich milk that is present in the first few days after birth and can be seen as a 'first vaccine' due to its wealth of immunoglobulins and white blood cells, which protect against disease (NHS, n.d.a; UNICEF, WHO, 2018; Wszolek, 2015). Transitional milk occurs at approximately day 6-14 postpartum and consists of a decrease in immunoglobulins and an increase in lactose, fat and water-soluble vitamins (Morera Pons, Castellote Bargalló, Campoy Folgado & López Sabater, 2000). Lastly, mature milk is produced from approximately day 15 after birth until the cessation of breastfeeding and this is made up of 90% water to ensure hydration, as well as carbohydrates, proteins, and fats for growth and energy (Kaingade, et al., 2017). However, not only does breast milk composition change depending on the age of baby, but it also changes during and between feeds as it is individually tailored to reflect what the baby needs (Andreas, Kampmann & Mehring Le-Doare, 2015). This individual tailoring means the baby receives the perfect composition of nutrients needed at the time of lactation. This tailoring, along with the multitude of antimicrobial, anti-inflammatory, immunomodulating and bioactive molecules and compounds (Oddy, 2002) in breast milk makes it superior to formula milk which cannot provide the ever-changing, individualised composition of breast milk.

Benefits of breastfeeding

The individualised composition of the milk is beneficial in itself but breastfeeding also has many other benefits for both mother and baby.

Infant benefits

One benefit for the baby includes protection from certain infections. Howie, Forsyth, Ogston, Clark & du V Florey (1990) found that breastfeeding for 13 weeks or more resulted in significantly less gastro-intestinal illnesses in those infants than infants bottle-fed from birth and this continued even after cessation of breastfeeding. Like this, Dewey, Heinig & Nommsen-Rivers (1995) found the incidence of diarrheal illness was 50% lower in breastfed babies than in formula-fed babies. With regard to respiratory infections, Quigley, Kelly & Sacker (2007) found a protective effect against lower respiratory tract infections for both exclusive and partially breastfed babies. Similar to this, Beaudry, Dufour & Marcoux (1995) found that breastfeeding had a protective effect against respiratory illnesses. A study by Kull, Wickman, Lilja, Nordvall & Pershagen (2002)

found that breastfeeding had a preventive effect on the early development of asthma, atopic dermatitis and suspected allergic rhinitis, up to 2 years of age.

Gómez-Sanchiz, Cañete, Rodero, Baeza & González (2004) conducted a study to analyse the effects of breastfeeding and formula feeding on infant's mental development using the Bayley Infant Development Tests. Breastfed infants scored significantly higher than formula-fed infants, and those breastfed for more than four months, scored higher than those fed for less. A cohort study by Victora et al. (2015) found that breastfeeding was positively associated with IQ, educational attainment and income and that duration of breastfeeding also played a part in this as those who were breastfed for more than 12 months had higher IQ scores, more years of education and higher monthly incomes than those who were breastfed for less time. However, it should be noted that IQ is a very subjective term and most research will 'calculate' IQ using different methods.

Another positive outcome of breastfeeding is that it can reduce the mortality rate in infants with research finding that scaling up of breastfeeding to a near-universal level, could prevent the deaths of 823,000 children annually (Victora et al., 2016). A study by Chen & Rogan (2005) studied overall and cause-specific odds ratios and found that those infants who had been breastfed had a lower risk of postneonatal death. Those who had been breastfed for longer durations had an even lower risk of death. Other studies have found a reduced risk of SIDS in breastfed babies (Alm et al., 2002; McVea, Turner & Peppler, 2000; Thompson et al., 2017). Most studies examining the link between mortality rate and breastfeeding, like the ones mentioned, are conducted in developed countries such as Germany, Scandinavia and United States. However, it is important to discuss developing countries where risk factors of infant mortality are a lot more common (Ndu, 2016). Over the years, the risk of SIDS in developed countries has declined dramatically due to the introduction of campaigns such as Safe to Sleep, created to educate parents on the risk factors of SIDS. This has had a significant effect, with SIDS levels in the UK reducing by 81% (The Lullaby Trust, 2016). However, for developing countries such as Africa, with its poor socioeconomic conditions and ignorance of SIDS risk factors (see Ndu, 2016), the rate of SIDS has not reduced at the same rate as developed countries. Certain African countries such as Nigeria for example, do not keep case registries for SIDS. Therefore, it is difficult to estimate how many babies die in this country from SIDS specifically, however, the infant mortality rate in developing countries is substantially higher compared to developed countries. The UK infant mortality rate is just 4 deaths in every 1000 live births, with only 0.26 of these being caused by SIDS (The Lullaby Trust, 2019). Whereas in developing countries, some of the mortality rates per 1000 live births are as follows: Central African Republic (88), Somalia (80), Nigeria (65) and Pakistan (61) (The World Bank, n.d.). Therefore, it is extremely important that education is provided, even more so for parents in developing countries on how to reduce the risk of SIDS, with breastfeeding for at least 6 months being recommended.

Other health outcomes include infants' reduced risk of certain cancers such as Lymphoma (Mathur, 1993), Leukemia (Amitay & Keinan-Boker, 2015; Shu et al., 1999) and Hodgkin's disease (Bener, Hoffman, Afify, Rasul & Tewfik, 2008; Davis, 1998). Many studies have found a reduced risk of childhood obesity in breastfed

children (Arenz, Rückerl, Koletzko & von Kries, 2004; Gibson, Hernández Alava, Kelly & Campbell, 2017). Like this, research has also found breastfeeding to have a protective effect on child diabetes with research showing that a longer duration of breastfeeding reduces the risk of type 1 diabetes (Alves, Figueiroa, Meneses & Alves, 2012; Pérez-Bravo et al., 1996) and type 2 diabetes (Halipchuk, Temple, Dart, Martin & Sellers, 2018; Pettitt, Forman, Hanson, Knowler & Bennett, 1997).

Maternal benefits

Maternal health benefits include a decreased risk of certain cancers. Victora et al. (2016) estimated that breastfeeding could prevent the deaths of 20,000 women from breast cancer. This is because breastfeeding has a protective effect on specific types of breast cancer (Anstey et al., 2016; Lee, Chen & Wang, 2015; Gajalakshmi et al., 2009). Luan et al. (2013) found that breastfeeding reduces the risk of ovarian cancer and even more so for those who breastfed for longer durations. Other research found results in keeping with this (Gaitskell, Green, Pirie, Reeves & Beral, 2015; Jordan, Siskind, Green, Whiteman & Webb, 2009).

Another benefit is reduced weight retention. To exclusively breastfeed a baby, mothers need 500kcal to produce enough milk (Stuebe & Rich-Edwards, 2008) therefore, this metabolic load helps to reduce the weight gained in pregnancy (Baker et al., 2008; Dewey, Cohen, Brown & Rivera, 2001; Dewey, Heinig, Nommsen, 1993). Research also shows that women who have breastfed are less likely to develop diabetes than those who have never breastfed (Schwarz et al., 2009; Villegas et al., 2007). Research by Schwarz et al. (2009) when studying postmenopausal women, as well as a reduced risk for diabetes, also found that those who breastfed for 12 months plus, were significantly less likely to have hypertension, hyperlipidaemia and cardiovascular disease. However, it should be noted that this decreased likelihood of certain conditions stated above, could be due to weight loss in general and not specifically due to breastfeeding, with healthy weight loss being known to decrease blood pressure (U.S Department of Health and Human Services, 2003), reduce the risk of diabetes, hyperlipidaemia (Sniderman & Durrington, 2010) and cardiovascular disease (Brown, Buscemi, Milsom, Malcolm & O'Neil (2016).

Breastfeeding also necessitates skin-to-skin contact, which has benefits itself, including regulating a newborn's body temperature and allowing bacteria from the mother's skin to populate their skin, helping the baby's immune system and providing protection from certain infectious diseases (Rollins et al., 2016). Both breastfeeding and skin-to-skin contact have been found to promote bonding between mother and baby (Daly, Pollard, Phillips & Binns, 2014; UNICEF, n.d.a).

Rates of breastfeeding in the UK

According to the NHS (n.d.b), almost all women can physically breastfeed their baby and apart from in a few select circumstances (see Lawrence & Lawrence, 2010), this is the best way to provide a baby with the best start in life. With this information and a wealth of research into the benefits of breastfeeding, it is important to discover why UK breastfeeding rates are so low, especially when compared to other countries. Whilst the

breastfeeding rate in the UK starts out quite high, with the most recent (2010) Infant Feeding Survey showing 81% of mothers initiate breastfeeding, this quickly falls to 17% exclusively breastfeeding at 3 months and just 1% exclusively breastfeeding at 6 months, as recommended (McAndrew et al., 2010). There is a notable contrast between the UK's exclusive breastfeeding rates at 6 months and other westernised countries' breastfeeding rates. Data collected in 2010 showed the percentage of women exclusively breastfeeding their child at 6 months in the USA, Canada and Slovakia were 17.2% (Centres for Disease Control and Prevention, n.d.) 25.9% (Government of Canada, n.d.) and 49.3% (Bagci Bosi et al., 2015) respectively. Overall, although the percentage of UK mothers initiating breastfeeding has been steadily increasing, up from 76% in 2005, the duration that mothers breastfeed could be improved and would bring about many benefits if it was. However, the rate of young mothers breastfeeding is still extremely low, with research showing that for a variety of reasons individual to that age group, young mothers are much less likely to breastfeed than older mothers (Condon et al., 2012; Feldman-Winter & Shaikh, 2007; Smith, Avery & Gizlice, 2004). The reasons for this will be discussed later on.

The Innocenti Declaration and Baby-Friendly Hospital Initiative (WHO and UNICEF)

In 1990, the Innocenti Declaration was made by the WHO/UNICEF, recognising that breast milk is the ideal nutrition for infants and that, as stated above, breastfeeding has a wealth of benefits. With this information, it was declared that breastfeeding rates should be increased and to do this, the reinforcement of a "breastfeeding culture" needs to come about. For this to happen, efforts should be made to support women with breastfeeding. This includes increasing women's confidence in their ability to breastfeed by removing constraints and influences that could shape perceptions and behaviours towards breastfeeding. This declaration included recommendations that all governments should develop national policies that should be integrated into overall health and development policies and set national targets for the 1990s (UNICEF, 2005). With this, the Baby-Friendly Hospital Initiative (BFHI) was launched, based on the Ten Steps to Successful Breastfeeding. This initiative was introduced to motivate facilities that provide maternity and newborn services to implement these steps in an attempt to increase breastfeeding rates. Some of these steps include ensuring that staff has sufficient knowledge, skills and competence to support breastfeeding, support mothers to recognise their infants feeding cues, facilitate immediate and uninterrupted skin-to-skin contact and initiate breastfeeding as soon as possible after birth (WHO, 2018). This initiative has increased breastfeeding rates by helping maternity and newborn services to provide improved support. However, there is still a large number of babies who are being born in a non-Baby Friendly environment due to a number of reasons, one being the misconception that formula milk is a close second best to breast milk. The UK has been a great success story with regard to being Baby Friendly with all babies in Scotland and Northern Ireland now being born in a Baby Friendly environment. As well as this, the UK standard has expanded beyond the original Ten Steps and now integrates its own independent standards with regard to neonatal care, children's centres, community services and universities (UNICEF, 2018).

With this success in the UK in mind, it is very important to question and understand why then that UK exclusive breastfeeding rates at 6 months, are one of the lowest in the world. Some of the reasons found in pre-existing research and my own ideas for this are discussed below.

Reasons for not initiating breastfeeding and early cessation of breastfeeding

Although breastfeeding could be especially beneficial to babies of young mothers, due to increased risk of adverse outcomes (these will be discussed further on) (Chen et al., 2007), the rates of these mothers breastfeeding is low, especially compared to older mothers.

There are many reasons mothers of all ages do not initiate or continue to breastfeed for the recommended time. Pre-existing research into what influences a young mother's decision on whether to initiate breastfeeding includes sexualisation of the breast (Dyson, Green, Renfrew, McMillan & Woolridge, 2010), breastfeeding in public (Condon et al., 2012; Dyson et al., 2010), going back to school or work, pain, difficulty establishing a latch (Tucker, Wilson & Samandari, 2011), lack of social support (Clark, 2016), physical exhaustion, perception of breastfeeding 'ruining breasts' (Morrison, Reza, Cardines, Foutch-Chew & Severance, 2008) and their family's views on breastfeeding (Nesbitt et al., 2012). These will be discussed in more detail below.

Reasons for young mothers not initiating breastfeeding and early cessation of breastfeeding

One issue featuring frequently in pre-existing research on young mothers was the worry they had with exposing their breasts. This is most likely linked to the breast becoming more sexualised rather than being seen as a way to provide breast milk to infants. This, however, is highly unsurprising with how hypersexualised the western world has become, with visual examples of sexual objectification of women prominent in advertising, as well as female nudity and erotic content becoming commonplace (Papadopoulos, 2010). Seeing breasts as a sexual part of the body is a highly westernised construct and research has shown that this is not the case in non-westernised countries such as Africa, where other parts of the body such as the face, hips, and buttocks are more important with regard to sexual appeal (Dettwyler, 1995, cited in Groleau, Sigouin & D'souza, 2013).

Objectification theory (Fredrickson & Roberts, 1997) is the idea that, in a culture where the female body is highly sexualised, women are socialised to view their bodies from that of an outside observer perspective. How women internalise this is called self-objectification, and this can involve the prioritisation of physical traits (e.g. sex appeal) over other traits. When a woman becomes pregnant, her body changes both internally and externally and how she looks during this stage and sometimes after may not conform to society's very select views of what is beautiful. Therefore, causing young mothers to view their breasts from an outsider perspective and not one of their own. Over time, these negative views of their breasts and what breasts should look like could become ingrained within them and become their new norm, therefore, themselves conforming to society's select views of what is attractive.

All parents' circumstances are individual, however, for teen parents, their health, education and economic outcomes remain disproportionately poor (Public Health England, 2016). Often teen mothers lack financial capital (Williams & Makwikila, 2018), with research finding that 36.1% of teen mothers are in receipt of benefits (Robling et al., 2015), as well as other research finding that children of teenage mothers are 63% more likely to be born into poverty than children with mothers in their 20's (Meyhew & Bradshaw, 2005, cited in, Department for Education, 2014). Research has shown that teen mothers are also more likely to have lower education levels than older mothers. One study (Robling et al., 2015) evaluating the Family Nurse Partnership (FNP) found that of all participants, 45.8% of mothers had been excluded or expelled from education at some point and 47.9% of mothers were not in education, employment or training [NEET].

Keeping these poorer outcomes, objectification theory and factors such as age and education level meaning mothers can be less critical of hypersexualisation (Groleau, 2015) in mind, it is clear to see how some young mothers, lacking other capital, may see their body as one of their best 'assets'. The changes a woman's body goes through during pregnancy and in the postnatal period can be enough to bear. If the 'function' of a mother's breasts is then changed during breastfeeding from sexual to non-sexual, this could be difficult for any new mother and something which may put a mother off of the idea of breastfeeding, in order to 'preserve' her body. This is, even so, more for teen mums who as stated above, can lack other forms of capital and therefore, more than the average mother, want to keep their sexual capital intact (Groleau, 2015).

Another reason is the issue of breastfeeding in public, which could be linked to the sexualisation of the breast. To establish and successfully breastfeed, all mothers need to feel comfortable and confident breastfeeding in front of others. This is because breastfed babies need to nurse on demand (recommended eight times per day in the early postpartum period) to produce a sufficient milk supply (Institute of Medicine, 1991), therefore breastfeeding mothers need to be able to breastfeed whenever and wherever the baby needs. Despite the limited research with young mothers, there is a growing body of research on the experiences of mothers of all ages regarding public feeding. This has found that some mothers breastfeed entirely at home until they feel more comfortable and confident (see Brouwer, Drummond & Willis, 2012; Dyson et al., 2010; Leeming, Williamson, Lyttle & Johnson, 2013). However, research defines public and private breastfeeding differently. Some research simply describes private as in the home and public as outside the home, for example, Owens, Carter, Nordham & Ford (2016) whereas, in pre-existing research, mothers, depending on who is there, have considered their own home to be public. For example, in Nesbitt et al. (2012) one teen mother describes how at home "so many people were living here" and how she had no privacy as people would just "walk right in my room" (p. 9). This could be especially difficult with young mothers who are more than likely to live at home with their family, unlike older mothers in the UK, who usually live with solely their partners and/or children and may not feel they need as much privacy around these people.

Research has outlined many more reasons why women choose not to or find it difficult to breastfeed around others. Boyer (2012) found that mothers thought about the comfort of others when making infant feeding decisions. She suggests that mothers feel they are expected to act in a way that maintains people's comfort or

else they risk censure. With some people still holding the view that the breast is sexual, when mothers use breasts for anything else, it can be met with disapproval from the public for 'disrupting their comfort'. Similar to this, Goffman's (1956) Self-Preservation Theory could explain why some women choose not to breastfeed in front of others. He explains that we are 'actors' on a social stage and that we perform behaviours to benefit the 'audience'. In this, we put on a 'front' to project a certain image of ourselves depending on what 'stage' we are on. We fulfil the basic roles of what is expected of us in that situation to fit into society. This is even more so for teen mothers as research focusing on teen mothers has shown that breastfeeding can be associated with negative moral judgement and this has created a 'culture of resistance' (Dyson et al., 2010) against mothers interested in breastfeeding. Other research has found similar, showing some teen mothers not wanting to disrupt dominant social norms by breastfeeding in public as this was not the 'usual behaviour for young mothers' (Condon et al., 2012). Therefore, those mothers may choose not to breastfeed to fulfil the expectation that breastfeeding in front of people is deviant and this, therefore, protects them so that they fit into society. However, this then also creates a cycle and enhances the bottle-feeding culture in the UK. This will be discussed more later.

Similar to this is Erikson's theory of identity development (1968), in which he discusses identity development tasks an individual goes through at different developmental stages. In adolescence, an individual experiences identity versus role confusion, in which an adolescent is faced with the question of "who am I?" and "what is my place in the world?". If an adolescent is able to assess their personal attributes and match these with outlets of expression, they will be successful in the formation of their identity. However, if they cannot do this, this results in role confusion (Dunkel & Harbke, 2017). However, Erikson (1959) claims: "Individual and society are intricately woven, dynamically related in continual change" (p. 114). This shows that an individual does not simply develop an identity, but that this identity is affected by the social context surrounding an individual. With regards to young mothers breastfeeding decisions and the social context, they could experience a crisis in which they will have to find a balance between developing their own unique identity, but at the same time, still be accepted in society. If a mother is able to successfully navigate this crisis, they will have a clear sense of self, that they can share with others. However, if they are not able to do this, these mothers will be 'stuck' at a stage where they are not confident in their identity and ability as mothers to negotiate their identity, and views that come with this, within a social context.

The transition to motherhood at a young age

Some of the issues mentioned above were issues all mothers faced. However, to understand the decision-making process that young mothers go through when making their infant feeding decisions, we need to recognise other age unique challenges they may experience. These relate to their transition to motherhood. This transition to motherhood at any age can be difficult, with research finding that this is often a highly stressful event that brings about great change (Deave, Johnson & Ingram, 2008) for any aged mother. Young mothers may not be physically, psychologically, socially and cognitively prepared to become a mother, especially with an unplanned pregnancy like a large number of teen pregnancies are, with a cohort study

showing that 85% of teen pregnancies are unplanned (Dex & Joshi, 2006; cited in Bradshaw, 2006), not accounting for abortions and miscarriages. The responsibilities that come with teen pregnancy and parenthood can be highly consuming to the mother, which leaves little time for her to go through the normal process of adolescent development and because of this, they must adapt to adult roles, sometimes before they are really ready to, without time to gradually adapt to these changes. A study by Mangeli, Rayyani, Cheraghi & Tirgari (2017) found that young mothers lacked the knowledge of how to effectively or correctly look after their baby and therefore depended on others to help with the maternal role. A baby being looked after by someone other than its mother can have implications. Although this support can be helpful to the mother, the more the baby is looked after by someone else, the more the chances of exclusive breastfeeding decrease. Therefore, as most young mothers are likely to be dependent on others for help, especially those living with family, this could make them less likely to breastfeed for the recommended time.

However, the findings of teen mothers lacking the knowledge to look after their baby cannot be generalised to all young mothers. This is because most mothers, regardless of age, have the ability to effectively look after and breastfeed their child. This will be discussed below.

The influence of others on a young mothers' decision to breastfeed

The younger the mother, the more likely they will be to live with their family. Because of this, it is important to understand how family members' influence a young mother on how to parent or breastfeed their child. However, despite the large numbers of young (especially teen) mothers living with family, there is little pre-existing research into how this can affect or influence a young mother's infant feeding choice.

As the current study is exploring young mothers' experiences of breastfeeding whilst living with family, it is important to explore the issue of how family and living within a family home can affect a mother's ability to make her own decisions about parenting. Parents have a duty to guide and protect their children and because of this, most decisions are made for the child by their parent/s, depending on age. Some children and adolescents can find they have little control over certain aspects of their lives and therefore, can lack the autonomy to make their own decisions. As we age, our autonomy continues to develop and we can make decisions without the input of others (Russell & Bakken, 2002), but it is hard to pinpoint an age when a person is completely autonomous. When a young woman becomes a parent, she must learn to make adult decisions and be responsible for the care and safety of another human being. Parents of these mothers may feel that she is not fully capable of making sensible decisions regarding her child due to her age and may try to influence or make decisions for her. Research has shown that adolescents, when making choices they perceive their parents have expertise in (for example, parenting decisions), choose to follow their parents' advice and opinions (Wilks, 1986). Therefore, with the potential of these mothers being as young as 13 years of age, these mothers may follow the decisions of their parents. As well as this, as they are young, these mothers may feel 'childlike' in the family home and therefore feel they cannot 'stand up' to their parents or negotiate their

choices well. This could affect their infant feeding because they think their parents know best, they may go against their own decisions.

Studies into the influence of women's familial network have shown that participants' mothers and other female relatives have been a large influence on infant feeding decisions. One study by Bentley et al. (1999) exploring mothers of all ages' experiences, found that participants' mothers' opinions were strongly associated with intention, with 37% of women intending to breastfeed stating their mothers thought they should breastfeed. The influence of other female relatives' opinions was the same. A similar finding was found for those who intended to formula feed, with a high percentage of their female family members having the opinion that they should formula feed. Other studies support these findings with Morrison et al. (2008) finding that for teen mothers, their mothers and grandmothers and female relatives were influential in their infant feeding decisions. Other research by Ross & Goulet (2002) found that before the age of 20 years old, family was extremely influential to young mothers making their infant feeding decisions, however, after 20, participants started to make their own decisions, more so involving their partner and less of their family (cited in Morrison et al., 2008). This shows a clear influence of female relatives when making infant feeding decisions, which could be even more so for young mother living with family including female relatives. Therefore, this familial influence should not be overlooked in breastfeeding promotion.

Being a young mother (the positives, negatives, and outcomes of children)

Overall, society seems to have a negative view of young mothers. Although the rate of teen pregnancy in the UK is declining, with teen pregnancies in England and Wales declining by 60% since 1998 (Local Government Association & Public Health England, 2018) the UK still has one of the highest teen pregnancy and birth rates in Europe (Family Planning Association, 2016). However, not all aspects of teen motherhood are negative, with pre-existing research showing a wealth of positive experiences. Research with both positive and negative findings will be discussed below.

Research has shown that for some mothers, a sense of maturity develops from pregnancy and having a child young. Research by Ngum Chi Watts, Liamputtong & Mcmichael (2015) showed that some mothers felt a sense of maturity, responsibility, and purpose after having their baby. Other research has shown that being a young mother can be something that makes them 'grow up quickly' (Anwar & Stanistreet, 2015; Chohan & Langa, 2011; David, Van Dyk & Ashipala, 2017; Seamark & Lings, 2004). For other mothers, having a baby young had been a corrective experience (SmithBattle, 1995, cited in Smith, Skinner & Fenwick, 2012) in which they got the 'push' they needed to sort their lives out (Seamark & Lings, 2004), with one study finding that 39.8% of their participants were ex illegal drug users that had stopped using drugs immediately before or during early pregnancy (Quinlivan & Evans, 2002). Research has also shown that having a baby young can encourage mothers to look towards the future and see what is important (Chohan & Langa, 2011). In Seamark & Lings' (2004) research, mothers were aware that being young mothers meant they had a lot of time left to be able to do and achieve what they want in their lives. Many planned to finish their education or continue onto higher

education, whilst some mothers were already working or in education at the same time as bringing up their children. Other research showing positive effects of young motherhood include some mothers being happier, calmer and more patient (Aparicio, Gioia & Pecukonis, 2016), becoming more autonomous and independent, having feelings of positive self-worth and pride (Shea, Bryant & Wendt, 2016) and for some improvements in their mental health (Jenkins, 2013).

However, there can also be negative aspects and effects of having a baby young and this is what the majority of the literature portrays. As briefly discussed above, some mothers lacked the knowledge of how to look after a baby (Mangeli et al., 2017). Other research has found similar, with some teen mothers lacking parental skills and being unable to cope with the baby alone (Gyesaw & Ankomah, 2013). Other research has shown that adolescent mothers are more likely to suffer from postpartum depression than older mothers (Jenkins, 2013). Many mothers felt a sense of loneliness and isolation with some feeling restricted and unable to see their friends when they wanted (Bah, 2016; Cater & Coleman, 2006; Ellis-Sloan & Tamplin, 2019). There has been a wealth of research exploring the stigma attached to being a teen mother and many young mothers have experienced this, along with feelings of judgement. Ellis-Sloan (2014) examined teen mothers 'paths' to motherhood and found that these mother often felt that people judged them as bad mothers simply because they were young. Many of the mothers reported people communicating how they felt about young mothers by giving them certain 'looks', for example, a sneering face. Research by Cater & Coleman (2006) has shown that even when pregnancies are planned and thought out, some young mothers still experience negatives such as financial struggles, poor housing conditions after moving out of the family home, regret, and the large contrast between expectation and reality of motherhood, with regards to hard work and tiredness.

Young mothers can be very vulnerable to negative social evaluation by non-young mothers and research shows there were similar responses to the negative experiences above when non-mothers were asked about their perceptions and opinions of what being a young mother would be like or is like. In one study, many responses showed endorsements of stereotypes (Eshbaugh, 2011), whilst other research showed that non-mothers assumed that teen mothers would be restricted, lack knowledge to care for a child, and the need to push their goals and dreams to one side (Smith et al., 2012).

Overall, a mother of any age can have positive or negative experiences of motherhood. However young mothers can also face issues relating to the developmental stage she is currently in. There becomes a conflict between being a mother and meeting the physical, social and emotional needs of her baby, but at the same time, knowing how different life would be if they were not a mother. Young mothers can miss out on a lot including education and socialisation and can also have negative experiences, with some research finding that some young mothers want to take back the role of 'child' and want to be nurtured and cared for by their own mothers (DeVito, 2010). However, as shown in the research, having a baby young can also be a very positive experience for some mothers who felt that their decision to go through with the pregnancy and have a child young, was the best decision.

It is important to remember that a teenage mother of 13 years of age will more than likely have a completely different experience to a young mother of 21 years of age as there is a significant developmental difference between these ages. However, it is difficult to comment on this as there is a lack of research that compares or even includes such young teen mothers. Like this, there may also be a difference in more positive or negative experiences of young motherhood depending on whether the pregnancy was planned. One may expect the mothers of planned pregnancies to have better experiences as mothers than those without, however, some studies have shown this is not always the case. One study by Clarke (2013), found that even though all participants' pregnancies were unplanned, many adapted and experienced positive outcomes. On the other hand, some research by shows even in planned pregnancy, teenage mothers can feel regret and experience a range of negative outcomes (Cater & Coleman, 2006). However, research into this subject is lacking and more research needs to be conducted before concluding whether planned versus non-planned pregnancy can have an effect on experiences as a young mother.

Looking at the pre-existing literature, a significant amount of research has been conducted into the outcomes of teen mothers' children. Most of the literature portrays adverse outcomes for these children, both short term and long term, which will be discussed briefly. Firstly, the risk of infant mortality is higher for adolescent mothers, with the younger the mother, the greater the risk (Phipps, Sowers & DeMonner, 2002). Research has also shown these children to have lower birth weights (Aras, 2013; Khatun et al., 2017), worse APGAR score (a measure of the physical condition of a newborn) than those with older mothers (Chen et al., 2007), higher risk of developmental vulnerability at age five, including physical health and well-being, emotional maturity, social competence, language and cognitive skills, communication skills and general knowledge (Falster et al., 2018). Other outcomes include leaving school early with fewer qualifications, more frequent juvenile offending, more substance use and more mental health issues (Fergusson & Woodward, 1999; Mok, Antonson, Pedersen & Webb, 2017). Female children of teen mothers are also much more likely to be teen mothers themselves (Francesconi, 2008; Hoffman, 2006). After researching, there were only a small number of papers that specifically examined or found positive outcomes or explored positive experiences from having a teenage parent. For example, Geronimus & Korenman (1993) found no negative effects and a few positive effects (cited in Levine, Pollack & Comfort, 2004). However, this does not necessarily mean that there are less positives for these children, but that more research in this subject area is needed. This lack of previous research could be due to society having the misconstrued view of teenage parenting having only negative consequences and associations (Ellis-Sloan, 2014; SmithBattle, 2013).

Is teen pregnancy and teen motherhood a public health issue?

There are many debates about what the most appropriate age is for someone to have a child and this will be different for everyone depending on certain things including culture, ethnicity, and religious background, amongst other things. However, within the last 30 years, having a child young has been seen as a public health problem in the UK, alongside other problems such as mental health issues and cancer (Lawlor & Shaw, 2002). However, this is constantly changing and is becoming seen as less of a problem than was first thought.

It used to be that marital status was more important than maternal age, however, in the 1970s onwards, countries such as the USA and the UK's concern shifted from marital status to age and thus, teenage pregnancy became seen as a problem. Then in 1999, the new Labour government published a policy document that immediately discussed Britain as having the worst record of teen pregnancy (Arai, 2009), immediately ingraining the idea that teenage pregnancy was a problem of magnitude. However, by the time this document was released, teenage pregnancy levels in the UK had almost halved. Over the next decade, more research was being conducted around the area of teen pregnancy and there was found to be biased and contradictory research (Arai, 2009).

There is contradicting information on adverse health outcomes of having a baby as a teenager. As discussed briefly above, some research suggests that the younger the maternal age the higher increased risk of adverse outcomes such as low birth weight, higher incidence of fetal death and preterm birth, amongst many others (Fraser, Brockert & Ward, 1995; Gortzak-Uzan, Hallak, Press, Katz & Shoham-Vardi, 2001; Olausson, Cnattingius & Haglund, 1999). However, other studies have shown this is not the case (Roth, Hendrickson, Schilling & Stowell, 1998), with some studies (Demirci et al., 2015; de Vienne, Creveuil & Dreyfus, 2009) finding a significant link before controlling for confounding variables, but not after. With reference to confounding variables, one study found that these adverse outcomes were more likely to happen to black mothers in their 20's than black teenage mothers (Reichman & Pagnini, 1997) and another showed no increased risk for young mothers (Makinson, 1985).

There are many reasons why teenage pregnancy and young motherhood is not seen as so much of a public health problem anymore. This is to do with new research finding that maternal age alone is not usually an indicator of adverse outcomes. As well as this, media coverage has hugely declined and now focuses on other present increasing issues such as knife crime and suicide (Arai, 2009). Research being conducted into the consequences of delayed childbearing (and the possibility of involuntary childlessness) have also played a part in young motherhood being seen as less of an issue.

Social context and breastfeeding

Many things shape a woman's breastfeeding experience, including cultural norms. For many generations, the UK has had a strong bottle-feeding culture with over half of all babies being given formula milk by just one week after birth, and many breastfed babies receiving breast milk through a bottle (UNICEF, 2016). In 1981, The International Code of Marketing of Breastmilk Substitutes [the WHO code] was published. This regulated the marketing of breastmilk substitutes in an effort to protect breastfeeding and soon the UK created legislation based on the WHO code stating that (from birth) breastmilk substitutes could not be promoted or advertised. However, many formula milk brands are still doing this, despite legislation (Baby Milk Action, n.d.). Advertising influences our behaviour and the formula milk industry is spending millions of pounds every year on marketing these products which could encourage mothers to decide against initiating breastfeeding or to stop breastfeeding prematurely (UNICEF, n.d.b). Research has shown evidence that the media is influencing

social norms (Ward, 1995, cited in, Fischhoff, Crowell & Kipke (1999), therefore, if you pair this with an adolescent's impressionable brain, it is likely that adolescent mothers are being influenced by formula milk advertisements. As well as this, due to this bottle-feeding culture, it is the norm in the UK, when any sort of breastfeeding issue arises, for mothers to feel they have no other option but to start formula and/or bottle-feeding (Ashmore, 2018). However, in a country with a breastfeeding culture, there would be much more done to overcome these difficulties and enable mothers to breastfeed. Because of all this, for many women in the UK, it is extremely normal for bottle feeding to be their first thought when it comes to infant feeding decisions, and for those wanting to breastfeed, any difficulties make this cycle of formula and bottle feeding, used for so many generations, hard to break.

Social support

Having support when breastfeeding is extremely important, especially with young mothers who may lack the knowledge or skills to breastfeed effectively. With a key barrier to breastfeeding being poor social support, this support from friends and family could be the difference between a young mother continuing breastfeeding or stopping breastfeeding before 6 months. Research has shown that family have been the main form of support for many young mothers when breastfeeding. One study by Palupi & Devy (2018) found for many women, their own mothers taught them how to breastfeed and for others many of their female relatives would give them tips and reminders on how and when to breastfeed. However, on the other hand, some mothers experienced their family members thinking they were being helpful when in fact they were not. Lavender, McFadden & Baker (2006) found that some women's mothers and female relatives 'left the room' and 'kept busy and out of the way'. Giving this privacy may have seemed helpful to family, however, these women often felt unsupported, alone and isolated. For this reason, it is important for mothers and their family members to communicate with each other about how they feel and what is the best way to provide effective support.

A young mother's partner can have a significant impact on her decision to breastfeed and the duration of breastfeeding. Research has shown that as well as female relatives, a woman's partner was the most supportive, generally supporting them to breastfeed by encouraging and reminding them to breastfeed (Palupi & Devy, 2018). This study also found that in nuclear families, the partner played the dominant role in breastfeeding support. A study by Nesbitt et al. (2012) also found that some young mothers' partners were extremely supportive, with some even identifying ways to assist with the process of breastfeeding. One mother talked about how her partner would bring the baby to her and make her snacks and drinks. Overall, those mothers who were encouraged and supported by their partners and family members were more positive about their breastfeeding experiences than those that were not supported (Nesbitt et al., 2012). This shows that if the rate of young mothers breastfeeding is to increase, then partners and family members must be more supportive or else this could influence a young mother's choice to either not breastfeed or to stop breastfeeding early.

Support from friends with breastfeeding is also very important with one study finding that after the baby's father and maternal grandmother, friends were the next most important support for mothers (Cox, Giglia & Binns, 2017). In one study, a mother spoke about how her friend also breastfed and this influenced her, giving her the attitude of 'if she can do it, I can do it' (Nesbitt et al., 2012). Another study by Wiemann, DuBois & Berenson (1998), showed similar results, finding that after controlling for other factors, having friends who breastfed increased the likelihood of that mother breastfeeding herself. However, other studies have shown that friends can be unsupportive and that young mothers would like more support from them (Reeves et al., 2006). As above, the study by Lavender et al. (2006) found that friends, like family, also stayed away from visiting the breastfeeding mother, making her feel unsupported and alone.

Overall, research has shown that having good social support is important when it comes to a mother successfully breastfeeding. As discussed earlier, mothers can experience several barriers that may affect the initiation and duration of breastfeeding. However, with good social support, family and friends can have a positive effect on a mother's breastfeeding experience. For many mothers, female relatives are number one in a new mother's support network, therefore this support is even more important to a young mother living at home.

Formal support with breastfeeding

All mothers should have access to professionally skilled support to help them successfully initiate and continue breastfeeding. Formal support is there to provide emotional and educational support which will aid mothers on how to breastfeed and how to prevent and overcome difficulties. There are many different types of professionals that can help with breastfeeding in addition to or instead of social support from friends and family. These include doctors, midwives, health visitors and many more. There is a wealth of research around the area of formal support with breastfeeding and this has shown both positive and negative experiences. One study by Nesbitt et al. (2012) found that adolescent mothers often had positive experiences of formal support stating that nurses encouraged them to breastfeed, as well as increased their knowledge, skill, and confidence. Another study by Leeming et al. (2013), showed both positive and negative experiences of formal support. One mother spoke about how she would have given up if it was not for seeing her midwife every day, another spoke about how her midwife offered information about what was happening during breastfeeding. However, for some mothers, it was felt that health professional's expertise was used in a way that made mothers feel pressured, confused, judged and disempowered. Research by Cross-Barnet, Augustyn, Gross, Resnik & Paige (2012) found lots of negative experiences, with 27% of participants experiencing no mention of breastfeeding or breastfeeding support at all, including some professionals even assuming the mother would be bottle feeding. One mother, after her caesarean-section, was even told she could not breastfeed due to her condition and without her permission, her baby was given formula. Other research by Hunter, Magill-Cuerden & McCourt (2014) found that some teenage mothers felt 'manhandled' with breastfeeding. One mother spoke about how the midwife, not taking care or time, just 'rammed' her baby to her breast. Other mothers were unhappy with their care yet felt they could not challenge the situation or tell the carer what they wanted.

Much more research shows adolescent mothers experiencing positive and negative experiences (see Edwards, Peterson, Noel-Weiss & Shearer Fortier, 2017; Nankunda, Tumwine, Nankabirwa & Tylleskär, 2010; Tucker et al., 2011).

Despite these positive experiences of formal support experienced by some mothers, research has shown that there is a lack of investment in resources such as time, adequate training for healthcare professionals and even lack of enough personnel to provide support. This is evident in a report by The Royal College of Midwives [RCM] (2014) which found that only 27% of mothers feel they had enough support and encouragement with breastfeeding and 21% of mothers stated they had no support at all. From the point of view of healthcare professionals providing this support, many also felt they lacked the time, knowledge or ability to provide breastfeeding support and felt like they were providing a 'conveyor belt' of postnatal care (RCM, 2014). Of course, to combat this issue of inadequate breastfeeding support experienced by mothers, there is a need for more resources being put into providing more healthcare professionals as well as providing frequent, updated training to those providing the support. By increasing the number of healthcare professionals and providing more training, there would be more time to provide breastfeeding support and therefore, a possibility to increase the effectiveness of this support and therefore, maybe increase breastfeeding initiation and duration.

Social media

As mentioned above, lack of breastfeeding support can be detrimental to a breastfeeding mother. Research has shown that mothers are starting to use social media in the form of parenting/breastfeeding groups in order to access different supports. One study by Wagg, Callanan & Hassett (2019), analysis posts on Facebook found that 65.3% of the posts were asking for informational support, suggesting that breastfeeding mothers lacked knowledge and information about breastfeeding. Other posts related to needing emotional support and support with self-esteem. Other research by Alianmoghaddam, Phibbs & Ben (2019) found that most mothers in the study used parenting websites, as well as parenting/support groups on Facebook to access breastfeeding support. This study also found that those who lived in a different geographical location to their friends and family relied a lot on social media platforms to access breastfeeding support from these people. Other research has also found similar, in that many mothers, in their respective studies, used social media and the internet for breastfeeding support, resources and advice (Bridges, Howell & Schmied, 2018; Skelton et al., 2018; Tomfohrde & Reinke, 2016).

As the subject of social media and breastfeeding support is an emerging one, there is little research specifically looking at how young mothers use social media to access breastfeeding support. Unlike any generation before them, today's generation of teen mothers (generation Z) has grown up having always had access to the internet. Studies have found that a large percentage of generation Z use the internet and social media, with one study by Curtis, Ashford, Magnuson & Ryan-Pettes (2019) finding that 94.3% of this generation own social media accounts and almost 80% use them daily. Support groups that exist within these social media platforms create a community of likeminded people who can provide support in any topic area, regardless of

geographical boundaries. If you pair the use of social media together with the subject of breastfeeding, it can create a very useful tool for young mothers who may need to access support online or who, for whatever reason, may not be able to talk to people in close proximity.

Rational and aims

Overall, the rate of UK women initiating breastfeeding is substantial, however, as time goes on, these numbers drop dramatically (McAndrew et al., 2010). The number of young mothers who initiate breastfeeding is considerably lower and they usually breastfeed for less time (Condon et al., 2012; Feldman-Winter & Shaikh, 2007; Smith et al., 2004). As discussed above, there are many reasons for mothers not initiating breastfeeding such as sexualisation of the breast (Dyson et al., 2010), breastfeeding in public (Condon et al., 2012; Dyson et al., 2010), and mothers' family's views on breastfeeding influencing her choices (Nesbitt et al., 2012).

However, for young mothers living with their family of origin, these issues may be even more sizeable due to their lack of private space within the home, their 'child-like' status within the family and the influence of the family living with them. As previous research has shown that infant feeding decisions are made, not individually, but in a social context, it is imperative that research is conducted to explore how the social context of a young women's breastfeeding journey can affect or influence her choice to and experience of breastfeeding. To do this, the present study will explore how others, with a particular emphasis on how living with family of origin, affects or influences a young mothers' decision to breastfeed as well as their breastfeeding experience. Therefore, the main aim and objectives of this study is as follows: To explore how others (both inside and outside of the young mothers' family environment) shape their infant feeding choices and practices. To do this, the objectives of the study are as follows:

- Explore how mothers felt about breastfeeding in front of others and their practices in relation to this
- Understand how mothers negotiated feeding choices within their family network

Method and methodology

As this research looked to explore the experiences of breastfeeding young mothers, qualitative methods were chosen for this study. Qualitative research attempts to explore the social world in which we live and stresses the way that people make sense of and interpret their experience of a phenomenon to understand the social reality of these individuals (Mohajan, 2018). A qualitative researcher acknowledges that reality is viewed through different lenses and is always obstructed in some way and because of this, we only get a glimpse of true reality. Depending on the lenses, there will be different views of reality and there is no way to know how distorted this view is (Howitt, 2016). Therefore, because they are viewing it through their own lenses, people's experiences of the same phenomena could be completely different from each other. It is important to take this into account when conducting qualitative social research.

Therefore, the current study adopts a critical realist perspective. Critical realism is a philosophy of science that believes that the world operates as a complex multidimensional open system (Benton & Craib, 2001, cited in, Parlour & McCormack, 2011). A critical realist researcher, therefore, retains an ontological realism (that is that there is a real-world that exists independent of what we perceive), whilst also accepting a form of epistemological constructivism and relativism (that is that our understanding of the world is a constructed from what we perceive) (Maxwell, 2012). Critical realists believe that something is real as long as it has a causal effect (Howitt, 2016). As well as this, they believe that knowledge is fallible to the extent that the complexity of the real world has the potential to be wrong and therefore it is extremely important for social researchers to study the causal mechanisms within different research contexts (Benton and Craib, 2001, cited in, Roberts, 2014). This qualitative theory of causality is relevant in this research. This is because, not only am I interested in how young mothers make sense of their relationships with others, but I also intend to shed light on the 'real' social processes that they are part of in an attempt to understand causality by taking into account how these interactions shape their experiences of infant feeding.

Critical realism perspective informed my aims as I did not take how the participants experienced breastfeeding or what they said as a fact of the real world, I instead took the empirical data of how these participants experienced and interpreted their breastfeeding journey's through their own lenses. Just like this, when completing the analysis, the data was analysed through my interpretations of their interpretations of their breastfeeding experiences.

This study used qualitative methods to explore young mothers' perspectives and experiences of breastfeeding whilst living with family. Using these methods, participants were recruited to, by choice, take part in either an online text-based interview or to complete an open-ended questionnaire.

Participants

The interview sample consisted of 8 young mothers aged between 19 and 24 and were of white (6) and (2) mixed ethnicity. The questionnaire sample consisted of 6 young mothers aged between 21 and 28 and were of white (4) and mixed (2) ethnicity. All mothers had breastfed between the ages of 16 and 21 years old.

For the purpose of this write-up, all participants have been given a pseudonym by the researcher to further protect their identities.

Table 1: Data showing Interview participants' demographics and breastfeeding information

| Name (pseudonym) | Age at the time of the interview | Ethnicity | Marital status at the time of the interview | Age/s when breastfed | Length of breastfeeding | Family members lived with |
|------------------|----------------------------------|-----------|---|----------------------|-------------------------|--|
| Emily | 20 | White* | Living with partner | 19, 20 | 12 months+ | Mother, Father |
| Danielle | 19 | Mixed** | Living with partner | 17, 18 | 13 months | Mother, father, grandmother |
| Louise | 24 | White* | Single | 20 | 6 weeks | Mother, brother |
| Alex | 24 | White* | Living with partner | 18, 19 | 5 weeks | Mother, father |
| Faye | 21 | White* | Living with partner | 19, 20, 21 | 19 months | Grandmother, grandfather, partner, son |
| Gracie | 22 | White* | Living with partner | 18, 19 | 19 months | Mother, father, sister |
| Harriet | 23 | White* | Living with partner | 20, 21 | 12 months | Mother, father, brother |
| Jess | 19 | Mixed** | Married | 18, 19 | 15 months+ | Mother, father, brother, aunt |

Refers to: - Participants who self-identified as * White (British, English, Welsh, Scottish, Northern Irish, Irish, Gypsy or Irish Traveller, any other white background) ** Mixed / Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, any other Mixed/Multiple ethnic background)

- Still breastfeeding at the time of interview/questionnaire +

- Breastfeeding refers to any breastfeeding including exclusive breastfeeding, mixed feeding (breastmilk and formula) and expressing of breast milk

Table 2: Data showing questionnaire participants' demographics and breastfeeding information

| Name (pseudonym) | Age at the time of the questionnaire | Ethnicity | Marital status at the time of the questionnaire | Age/s when breastfed | Length of breastfeeding | Family members lived with |
|---------------------|---|-----------|---|-------------------------|--------------------------------|-----------------------------------|
| Sophia | 23 | White* | Living with partner | 17, 19, 20, 21 | 10 weeks | Mother, father |
| Sara | 21 | Mixed** | Living with partner | 21 | 3 months+ | Mother, sister, partner |
| Ruby | 28 | White* | Single | 19, 20, 21 | 3 years, 6 months | Mother |
| Emilia | 22 | White* | Living with partner | 20 | 10 months | Mother, sister, partner |
| Lacey | 25 | Mixed** | Married | 19 | 23 months (1) 13 months (2) | Mother, stepfather |
| Kate | Unknown | White* | Single | 17, 18 | 16 months+ | Mother, father, sister, sister |

Refers to: - Participants who self-identified as * White (British, English, Welsh, Scottish, Northern Irish, Irish, Gypsy or Irish Traveller, any other white background) ** Mixed / Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, any other Mixed/Multiple ethnic background)

- Child number (number)

- Still breastfeeding at the time of questionnaire +

-- Breastfeeding refers to any breastfeeding including exclusive breastfeeding, mixed feeding (breastmilk and formula) and expressing of breast milk

Inclusion criteria

The inclusion criteria for participants included: (1) being a young mother aged between 16 and 21 years of age at the time of breastfeeding, (2) whilst breastfeeding, lived with family other than solely partner and/or own child/ren, (3) residing in the UK. All participants who fit these criteria were accepted regardless of other demographics. Any participants that did not fit these criteria, were excluded from taking part in the study. The reasons for not including younger teen mothers related to the ethical complications with gaining parental consent for those under 16 years old.

Participant recruitment

Following ethical approval, all participants were recruited by volunteer sampling. Volunteer sampling is where participants self-select themselves to take part in a research study after, for example, seeing an advertisement by the researcher (Sanders, 2010).

Recruitment of participants was carried out through both online and offline means. One way was via an advertisement flyer posted on multiple online platforms such as social media and webpages. These included pages such as Netmums, Mumsnet and teen parenting groups within Facebook. Permission to post on webpages and Facebook was granted by admins of these pages.

An email advertisement was also sent to students at the University of Huddersfield by my research supervisors. No permission was needed for this.

Physical copies of flyers (see appendix A) were also displayed in parenting and breastfeeding groups around the local area. Permission for this was sought from management within these groups.

Data collection

The data was collected through two means. The first through 1-to-1 text-based interviews via the use of the instant messaging app Wire. The second through an online qualitative questionnaire on the website Qualtrics.

Looking at the kind of participants this study wanted to recruit, online interviews and online questionnaires were seen as advantageous as I presumed that it would be easier to reach young mothers, who may struggle to travel with children, find time to travel or may not have the financial means to do so.

Similarly to this, there has been a huge increase in households with internet access, with this rising from 9% in 1998, to 90% in 2018 (Office for National Statistics, 2018), with the same survey finding 92% of young adults (aged 16-24) had “on the go” devices with internet access. Also found in a recent survey, 92% of teenagers reported going online daily, this included 24% who stated they go online “almost constantly” throughout the day (Lenhart, 2015). With this being said, the researcher felt it made logistical sense to collect data via means that were similar to what participants were using daily regardless of the study taking place.

Using these online means makes it possible to facilitate greater geographic diversity by enrolling participants from a greater number of locations (Rupert, Poehlman, Hayes, Ray & Moultrie, 2017).

Other reasons for using online data collection methods centred around overcoming the logistical difficulties surrounding other face-to-face data collection methods which included researcher costs associated with travel and accommodation renting, sometimes needed in traditional interviews. It is also easier as I was able to write the data up onto a secure word document, reducing my time spent recording and transcribing verbal data.

Originally, I planned to use virtual focus groups to collect all of the data, however, due to difficulties with recruitment, I offered the choice of individual interviews and supplemented this with questionnaire data, which was a lot more successful. The choice of completing a questionnaire was added fairly late during data collection as there were difficulties with getting enough interview data due to time constraints. Using a qualitative questionnaire allowed me to distribute the questionnaire quickly and easily and receive responses within a small time frame (Braun & Clarke, 2013). Not having to transcribe the data also made it possible for

me to quickly start coding the data as soon as I received responses by simply copying and pasting the data to a secure word document.

Procedure

Interview

For the interview data collection method, participants first got in contact with the researcher via email or Facebook private message to show their interest in the study or to ask further questions. After this, the information sheet (see Appendix B) was sent via email or Facebook private message. Once this was read and all questions participants had were answered, participants were asked to complete an online consent form on the website Qualtrics. To see this consent form follow the link https://huddersfieldbss.eu.qualtrics.com/jfe/form/SV_a3s5CapBo9QSL7 or see Appendix C. The consent form asked them to read several statements and if they agreed to them, they were asked to electronically consent to the interview. They were then asked to complete a small number of demographic questions as well as stating their Wire username and this data was then sent electronically to me, ready to conduct the interviews. After I had checked this form, those who had consented were added on Wire using their usernames. After this, all further communication was conducted via Wire. The interview dates and times were then organised between myself and participants. If possible, 24 hours before the interview was set to take place, participants were asked if they were still willing to take part at the set time. Around 5 minutes before the interview started, a small paragraph (for example see appendix D) would be sent explaining what will happen during and after the interview and explaining the participant's right to withdraw, amongst other things. This paragraph would also ask participants to set their Wire messages to a 'timed message' of four weeks, this meant that after this, all data in the conversation would be deleted for both the participant and me, making the data more secure.

The interview contained three different topic areas, named: 'the decision to breastfeed your baby', 'living and negotiating with family' and 'public breastfeeding', all of which included questions relating to its topic area. Participants would answer a set list of questions, however, if a participant said something that seemed relevant/interesting to the study, I would probe more into this area. I would also comment on participant responses to the questions to make it more conversation-like. Once all questions were completed, I asked if the participant had anything else to add around the broad topic area of young parenting or breastfeeding. I then thanked participants for their time and again stated their right to withdraw and more about what will happen with their data. Participants were asked to email me or message via wire if they had any further questions.

Questionnaire

The questionnaire advertisement was posted in the same places as the interview advertisement. The link to the anonymous questionnaire was posted within the advertisement and therefore to take part, all participants had to do was click the link and then follow the steps. The questionnaire started out with a shortened information sheet (much like the one sent to participants taking part in the online interviews). After this came

certain demographics such as age now, age when breastfeeding, followed by a unique ID code given to each participant (used as an anonymous way of tracking the data to the participant in case they wanted to withdraw their data). The open-ended questionnaire followed this, consisting of 16 questions much like the ones on the interview schedule for the online interviews. Just as at the end of the interview, questionnaire participants were given the opportunity via an open text box to add information regarding young parenting and breastfeeding. Once the questionnaire was completed, there was a debriefing page giving the same information such as the right to withdraw, contact information and helplines. To see the questionnaire please follow the link https://huddersfieldbss.eu.qualtrics.com/jfe/form/SV_71yg0SAd7YxUrqd or see appendix E.

Development of the interview topic guide and questionnaire

The interview topic guide was developed after examining relevant literature to establish the aims and objectives of this research. This guide intended to meet the aims set out by this study by using questions that the researcher felt would successfully explore each part of a breastfeeding mother's experience of breastfeeding around others.

The questions were split into 3 different topic areas. The first topic was named: 'the decision to breastfeed your baby' and included questions designed to explore how and when the decision to breastfeed was made, as well as if participants were always going to breastfeed or not, and finally, if anyone had any influences on their decision to breastfeed.

The second topic was named: 'living and negotiating with family'. This included questions exploring how living with their family affected breastfeeding, support from family, participants' family's reactions to their decision to breastfeed, whether family help or hinder breastfeeding and how much input family was allowed in participants' decision to breastfeed their baby.

The third topic was named: 'public breastfeeding' and looked at whether participants breastfed away from home, whether there were anywhere participants did not feel comfortable breastfeeding and finally, participants experiences of breastfeeding in public.

Pilot

A pilot refers to mini versions of a full-scale study that pre-tests a particular research instrument such as a questionnaire or interview schedule (van Teijlingen & Hundley, 2002).

I conducted a small pilot of the interview data collection method to ensure the ease and usability of the Wire app. Firstly, I produced a step-by-step guide (Appendix F), which was sent via email to two, young adult volunteers who were approached by the researcher to take part. They were asked to follow the steps on creating a Wire account. This was to make sure that the guide was adequate before it was sent to real participants. They were also asked to check for spelling or grammatical errors within the guide. Once this was done, a small pilot conversation was carried out where the two volunteers communicated separately with me. One volunteer was asked to communicate through the app using a Samsung phone (via the Android Play

store), the other was asked to use a computer (via the website) and I used an iPhone (via the Apple App store). This was to make sure that all versions of the Wire app worked well and would be suitable for use in the study. I deemed this to be a suitable data collection method as both volunteers found following the guide, setting up a Wire account, and using the account easy and without issue.

Data analysis

I typed all data up verbatim onto a word document within 4 weeks of the interview or questionnaire. This was stored on the university system securely and was then analysed using Braun and Clarke's (2006) six-stage method of thematic analysis. Thematic analysis is described as "a method for identifying, analyzing and reporting patterns within data" (Braun & Clarke, 2006, p.6). I chose this method of analysis as it is flexible as it is not linked to a specific theoretical or epistemological approach, unlike other more rigid analytic strategies. Thematic analysis is beneficial for use by researchers early in their qualitative research career as it does not require the researcher to have detailed theoretical or technical knowledge (Braun & Clarke, 2006). It is particularly advantageous when a researcher wants to summarise the key features of a large data set into a clear and organised final report (King, 2004). A mostly inductive or "bottom-up" approach was selected, this meaning that most of the analysis was data-driven instead of trying to fit a pre-existing theoretical framework or my analytic preconceptions (Braun & Clarke, 2006). However, it is important to note that data is not coded in an 'epistemological vacuum' (Braun & Clarke, 2006) and therefore, research is rarely bottom-up or top-down but often somewhere in the middle. Because of this, some of my coding was informed by broad theoretical considerations such as symbolic interactionism.

Braun & Clarke (2006) emphasise how integral it is to be writing thoughts and ideas down throughout the whole process of analysis, from phase 1, all the way through to phase 6: writing up the report. Therefore, I kept a small journal of ideas that I would add to each time I found a potentially interesting feature from the data set.

There are six phases within Braun and Clarke's (2006) method of thematic analysis and these should be followed in order to analyse a data set well.

With most qualitative data, transcription is usually needed as some data can be verbal. However, as all data collected for this study was written, for transcription, it was a simple case of typing up verbatim onto a Microsoft Word Document. For examples of the transcript data see Appendix G. This is a good way of starting phase 1: familiarising yourself with the data (Riessman, 1993), of Braun & Clarke's (2006) thematic analysis.

During phase 1, I achieved familiarisation with the data through rereading the transcripts and questionnaire data multiple times until I felt like I was familiar with the data. As my topic guide was split into 3 sections, I first read each participant's response to each topic, then read each participant's response to all topic sections as a whole, one after the other. I did this to make sure I did not miss anything and so that I could get a feel of what the whole data set was about. This was time-consuming, however, I felt it was important as phase 1 provides the base for the rest of the stages in Braun & Clarke's (2006) method of thematic analysis.

Phase 2 is when the researcher starts to generate initial codes. Codes identify a feature within a data set, allowing a piece of the data to be assessed in a meaningful way regarding the phenomena (Boyatzis, 1998). In order to generate codes, I looked through the data and manually wrote codes on the right-hand side of the documents (printed earlier). I read through the data in a similar fashion as I did in phase 1 when I was familiarising myself with the data. Firstly, I read each individual response to each topic section, I then read the transcript and questionnaire as a whole, in an attempt to gain a sense of each participant's experience and of what they were trying to tell me. To make this a bit neater, I then typed this up on a word document which I stored on the university's secure network. For examples of this coding, see Appendix H.

Phase 3 is referred to as: 'searching for themes'. This section of the process is concerned with how each different code may connect with another, combining to form an overarching theme. I started by colour coding codes that seemed to fit into the same category. I then manually wrote these up on to a piece of paper using the same colours as on the word document. As this phase involves re-focusing of the analysis to a broader level of themes, rather than codes. I did this by cutting up the piece of paper so that all codes were on a separate piece and I then. This helped me to organise the themes into overarching themes and subordinate themes. To make it easier to visualise each theme, I then copied these into a Microsoft PowerPoint document, (for an example see appendix I), with each slide a new theme, followed by sub-themes and quotes relevant to that theme. When this was completed, I drew a rough thematic map so that I could visualise it all together. Any codes that were on their own or did not seem to fit anywhere on the thematic map were put to one side for the time being.

During phase 4, I reviewed the themes from phase 3 against the data set. This stage involves reviewing each overarching theme and subordinate theme to ensure that they are actually themes and that they are not too diverse, as well as making sure that each theme has enough evidence from the data set to support them (Braun & Clarke, 2006). These themes were discussed with my supervisors and then changes were made as some themes were a bit too diverse and were therefore made into their own theme, while others were collapsed into each other.

Phase 5, is referred to as 'defining and naming themes'. In this, I looked at each theme and tried to capture the meaning behind the themes. I named the themes, however, after discussing this with my supervisors, some theme names were changed. This is because, instead of finding what was interesting about the theme, I instead paraphrased the context. For example, the themes used to be called 'perceptions of others' and 'bottle-feeding culture', but these were collapsed into each other to make the theme now called 'breastfeeding as deviant vs normalised'. I then made a final thematic map (Appendix J).

Phase 6: producing the report, was completed once I had fully and completely worked out my themes and involved completing the final analysis and write up of the report. The write up is concerned with producing a report that tells the story of the data set and convinces the reader of the merit and validity of the analysis

(Braun & Clarke, 2006). This is completed by providing sufficient evidence in the form of data that is embedded in convincing analytic narrative that tells the true story of the data set.

Ethical considerations

Before the research was conducted an ethics form was submitted (Appendix K) to the School of Human and Health Sciences School Research Ethics Panel and approval was gained (Appendix L) after making amendments (Appendix M) recommended by the panel. The original amendments were in regard to the focus groups that were going to be used via the app wire. I applied for revisions for the interviews (Appendix N) and questionnaire (Appendix O) to be used as data collection methods. Ethical approval was gained for interview revisions (Appendix P) and questionnaire revisions (Appendix Q).

All interview participants were sent an information sheet to read before starting the study which explained several things, including the purpose of the project, their participation, what is involved in the study and ethical considerations. These included making participants aware that they were able to withdraw from the study at any point, without reason or consequence, as well as explaining how anonymity and confidentiality will be maintained during their participation. At the end, mine and my supervisors' contact details were included in case participants had any questions or simply wanted more information. As well as this, the information sheet included helpline contacts of breastfeeding support and parenting support. After this, a consent form was sent to participants in which participants had to, on the Qualtrics website, choose the 'I consent' drop down box. This was to ensure informed consent was gained before their participation in the study. As it would be unethical to collect data without the knowledge and willingness of the participant, gaining valid informed consent is extremely important. This is because it ensures a participant 'voluntarily confirms his or her willingness to participate in a particular trial, after having been informed of all aspects of the trial that are relevant to the subject's decision to participate' (Hardicre, 2014, p. 564). Participants were also advised that they do not have to answer or discuss any questions they do not want to.

In addition to this, to protect participants anonymity, I sought no identifiable information and further to this, all participants and any identifiable participant information given freely in interviews/questionnaires, were given pseudonyms in the write-up report. On the Wire app, the only information visible to anyone but the participants themselves is their username which should not have included any identifiable information as the information sheet discouraged this.

I originally intended to use Facebook discussion groups for data collected, however, the ethics panel had concerns about several things including difficulty with maintaining confidentiality and anonymity with regards to details on their Facebook pages and the possibility of a breach of this data by another participant. In order to overcome this, I found the Wire app and decided this was a much more suitable method of data collection with regards to ethics.

The Wire app uses end-to-end encryption which involves the scrambling of text into unreadable code that can only be deciphered by those who have the secret key. In this case, the receiving device. This means that those messages are technically impossible to access unless you are either the sender or receiver of those messages (Endeley, 2018). Even if myself or the participant was to log into their account on a different device, the chat data would not show. It would only show on the device it was sent and received to, meaning the data was very secure.

As well as this, all data from interviews/questionnaires were transcribed within 4 weeks of the interview/questionnaire and kept secured on the university system and further, in a password-protected document. After 4 weeks, all data on the Wire app self-deleted from mine and the participants' device. I deleted all questionnaire data manually after transcription from Qualtrics.

At the end of the study, all participants in the interview were sent a debriefing paragraph via Wire which explained again, why the study was conducted, their right to withdraw their data up until a specific date, what happens with their data now and a reiteration of the helplines available to them should they need support with anything. If any participants gave any information that made me question whether they needed more support, I had information about helplines ready that I could send if needed, however, I felt no participant needed this extra support during or after the interviews. Everything in this study was conducted in line with The British Psychological Society's Code of Ethics and Conduct (2018). Regarding the questionnaires, at the end, this information was also stated. However, as the questionnaires were completely anonymous, I could not give specific support via this means, however, contact information for myself and my supervisors was given to both questionnaire and interview participants.

Reflexivity

It is important when conducting research that researchers acknowledge that as both researchers and the researched are both living, experiencing human beings, it is necessary to reflect on how these experiences, emotions, and attitudes will affect engagement with participants and subsequently, analysis of data (Shaw, 2010). Therefore, through introspective reflexivity; an integral, continuous process (Shaw, 2010;), a researcher attempts to maintain research focus by bracketing attitudes and biases of the researcher, in order to minimise their influence on the research process (Patnaik, 2013). However, it is imperative to remain aware that, as data is being interpreted through the eyes of the researcher and the participants, that, to some degree, there will ultimately be some subjectivity. However, acknowledging this as a researcher by being reflexive allows for the reader to draw their own conclusions on the presented findings of the research (Lambert, Jomeen & McSherry, 2010).

With regards to personal reflexivity, something to recognise when attempting to learn about young mothers' experiences of breastfeeding is that I was also a young mother who also had her own breastfeeding experiences. It could be argued that I have first-hand personal experience of what it is like to be a young breastfeeding mother. However, this study aimed to explore mothers breastfeeding around others, namely

family other than partner and/or child/ren, and as I have little experience with this specifically, I feel, to an extent, this reduced my own personal preconception of what it is like to breastfeed around others as a young mother. In the short time I did breastfeed both my children, I personally had a positive experience of breastfeeding around others, despite this, I cannot assume that all young mothers would have the same positive experience as me, nor can I assume that they had a negative experience either. However, despite all of this, there is value to having insider-status and therefore having some understanding of the context. Research has shown that if a researcher is part of the group, they are more likely to have a level of trust and openness with the researcher, compared with an outsider (Dwyer & Buckle, 2009). As well as this, it has been shown that participants are a lot happier to discuss their experiences with someone who they perceive understands them and their experiences (Bell, 2005, cited in Greene, 2014). This improves data quality as research has shown that when participants feel at ease, they answer more honestly and remember more accurately (Ghosh, Laxmi & Chattarji, 2013, cited in Bell, Fahmy & Gordon, 2014).

As most of my interview participants were recruited through an advertisement in a teen mothers Facebook group I am part of, I can assume that they were aware of my status as a teen mother. However, I did not go into this much more unless the interview responses warranted it. If I did discuss this, it was very brief as I wanted participants to feel comfortable sharing information with me, however, I did not want them to be excessively open to me in particular as this can lead to greater vulnerability of the participant, who may feel 'seduced' by the comfort of familiarity with the researcher (Watts, 2006). Another reason for decentering myself was that I did not want participants to tell me what they thought I expected them to say about their experiences. As in the literature review, teen mothers have felt they are judged for being a young mother and breastfeeding as a teen mother and therefore, it was even more important that I took a neutral stance. Those recruited via email and parenting web pages were not told about me being a breastfeeding teen mother, however, as before, if this came up in the interview, I would briefly discuss it. As the participants in the questionnaire were completely anonymous, I cannot be sure where they saw the recruitment advertisement and therefore, I am unaware of whether they knew I was a teen mother when they were completing the questionnaire.

As mentioned above, the data collection method was originally going to be virtual focus groups within Facebook but instead, due to concerns with ethics, moved to the Wire app. This could have discouraged people from taking part in the study as people may have not had or wanted to make a wire account. As well as this, it could have affected participant engagement as all interview participants did not have a Wire account before the study already and therefore, Wire, was not part of their everyday use of instant messaging/social media. Therefore, it is assumed that participants may have engaged or interacted more if data collection had been strictly done via a page they were already engaging with, for example, Facebook.

Lastly, it is important to note how my struggles with social anxiety have shaped my methodological choices. Although there are a number of advantages to online data collection as discussed above (particularly with a subject that young mothers may feel judged for), I recognise that my choice to use online methods was partly

due to my anticipated difficulties with face-to-face interviewing. Whilst the importance of reflexivity and researcher characteristics is widely recognised in qualitative research, the research into how the emotional life of the researcher shapes, and sometimes constrains the choice of methods, is sparse.

Findings

From the interview and questionnaire data, five overarching themes, amongst women who had breastfed around others as young mothers, were identified. These themes were (1) breastfeeding as deviant vs normalised; (2) respecting others; (3) a process of overcoming difficulties; (4) impact of support and absence of support; and (5) baby comes first. All participant quotations are written verbatim in this report.

Breastfeeding as deviant vs normalised

The mothers within this study were well aware of the normalisation of bottle-feeding in their local community and this being the accepted way by most, to feed a baby. For the majority of these mothers, their family members either normalised breastfeeding or saw it as a deviant behaviour. Whether or not family members agreed with their decision to breastfeed was representative of the level and kind of support these mothers received. In this, there was also a sense that these mothers, for choosing to breastfeed, felt doubly judged in the sense that people judged them for being teen mothers and also for breastfeeding.

Bottle-feeding culture

Throughout the data, there was a real sense of a bottle-feeding culture, in which some young mothers and their families were aware that the majority of women, especially younger women, bottle-fed instead of breastfed. This had an impact on these young mothers, with some making the initial decision to bottle-feed their baby and with some whose family members made assumptions of bottle-feeding without discussing it with the young mother as this was seen as the 'normal' thing to do. Danielle decided to bottle-feed her baby up until she gave birth, she said:

"I probably just assumed I would bottle feed because that's what my sister did and everyone else I knew. I'd never really seen anyone physically breastfeed around my age at that point so I suppose if I didn't have a family nurse, I probably ... would have just bottle fed like every other teenager" (Danielle)

Louise had a similar mindset when it came to feeding her baby before the birth and had made all the preparations she needed to feed her baby via bottle. She said:

"It [breastfeeding] wasn't something anyone else had done within my friends so it just felt a norm a baby comes out you have bottles and milk ready for them to drink ... I wanted to be prepared I wanted to know id got everything ready for when baby arrived this includes baby and making sure the baby has a stock of eating"
(Louise)

Gracie bottle-fed for the first week of her baby's life. She said:

"I bottle fed for the first week because ... its kinda what everyone does around here" (Gracie)

Some of the mothers felt they stood out when breastfeeding and even considered bottle-feeding to fit in and be more accepted. Emily said:

"I felt a bit out of place since my brothers partner ... was bottle feeding ... I felt like I had to hide away in order for me to feel like they'll accept how I choose to feed my child so some times I did think about going to formula so I'd feel more accepted" (Emily)

Jess had a similar experience, she said:

"Even though I did have a positive attitude and experience of breastfeeding, I did at one point just think, should I just do the normal thing ... just so that I don't stand out?" (Jess)

Overall, these young mothers were exposed to others, especially mothers around their age, bottle-feeding and this became the norm for them. This led to questions about whether breastfeeding is the normal thing to do. For mothers such as Emily and Jess, this norm of bottle-feeding being the 'normal' way to feed a baby even went as far as to influence them into thinking about changing to bottle-feeding just to not stand out.

Breastfeeding seen as deviant by others

For some mothers, their decision to breastfeed was seen as a deviant, abnormal behaviour and some family members did make their opinions heard when these mothers breastfed. For a small number of these mothers, there seemed to be a link between the level of support they received when their family members had a history of bottle-feeding or believed breastfeeding to be an abnormal way to feed a baby. Gracie spoke about discussing her decision to breastfeed with her parents, she said:

"My mum said pretty much it was not normal and my dad said dont think im getting my boobs out around him" (Gracie)

Emily also spoke about discussing her decision to breastfeed with family, she said:

"I'm the first to breastfeed on my side of the family. They all thought it was wierd having a baby sucking on your nipple, they wasn't that supportive and said I would last a few weeks" (Emily)

These mothers not only received negative comments when they were discussing their decision to breastfeed but were also made to feel aberrant when they actually breastfed their baby. Gracie said:

"First few times I did it in the living room my dad used to walk out and say shit like cant even be in my own living room and id be called selfish" (Gracie)

Emily spoke about her baby needing feeding at her uncle's funeral. She said:

"My grandma did infect tell me that I was disrespectful if I fed in the church where we went for my uncles funeral. Obviously I fed him but she announced it to everyone but me so I felt very uncomfortable" (Emily)

For one mother, her own mother made negative remarks throughout her breastfeeding journey. Ruby said:

"She did also interfere negatively ... making jibes and pushing breast milk alternatives" (Ruby)

These mothers, by deciding to breastfeed their babies were made to feel like they were feeding abnormally. This may have been partly due to their decision to breastfeed being different from their family's history of infant feeding choice and their opinions around this decision. Some mothers were made to feel not belonging and disgusting for choosing to breastfeed not bottle-feed. Some negative comments from members of the family revolved around not wanting to see these young mothers' breasts when breastfeeding and this could be due to people still seeing breasts as a sexual part of the body and not as a food source for a baby.

Doubly judged

A few mothers in this study experienced judgement or perceived judgement from family members and strangers. This judgement related to being judged as a young mother and as a breastfeeding mother, which was not the norm in their local community. Therefore, these mothers were going against the cultural norms of where they lived and were consequently seen as doubly deviant by society and in turn, judged for this. Alex spoke about the stigma of being a teen mother when she had her baby. She said:

"The stigma there was against teenage mums at the time. When I was 18 there were a lot of bad views on being a teenage mum" (Alex)

Gracie similarly spoke about her anxiety regarding people knowing she was a teen mother. She said:

"I didn't go out in the first few months cause I was scared I would get negative reactions with been a teen mum" (Gracie)

Danielle spoke of her worries regarding discussing breastfeeding with her family out of fear of judgement. She said:

"I felt like I couldn't talk about it with family and I was a bit nervous to talk about breastfeeding as I know everyone sees boobs as like a sex thing don't they so I didn't want to get laughed at or judged" (Danielle)

Alex also feared judgement of people in public believing she did not know how to parent her child due to her being a young mother. She said:

"I felt that if I latched him on wrong people could tell I was a teenage mum and that I didn't know what I was doing" (Alex)

A few mothers felt judged and had negative experiences when they breastfed in public. Emily spoke about how she had to be thick-skinned when breastfeeding in public as a young mother. She said:

"Everyone staring or even people coming up to you telling you to hide away ... you have to have a thick skin" (Emily)

Danielle spoke of the abuse she received from one member of the public who made comments insinuating she was sexually promiscuous for breastfeeding. She said:

"I had one man start kinda abusing me asking me why im getting them [her breasts] out in public ... that I must like everyone seeing my boobs" (Danielle)

Alex also had a negative experience of breastfeeding in public and explained how she already felt judged for being a teen mother and did not need the judgement of breastfeeding on top of that. She said:

“I was in a cafe, baby needed feeding and I got so many dirty looks. An older man asked me to cover up. It was bad enough being a teenage mum but that on top just made that experience horrendous. I ended up going home and feeding my baby there” (Alex)

Overall, these mothers received judgement for both being young mothers and for being breastfeeding mothers. This extra judgement reflects society's view of teen motherhood being a negative thing. Different types of judgement from people in public consisted of views of these mothers being incompetent mothers, sexually promiscuous and attention-seeking. However, in a society where bottle-feeding is the norm and where people are judged for breastfeeding, these mothers also felt judged in many ways simply because of the way they chose to breastfeed their baby. This may be because as breastfeeding mothers, they stood out in public and therefore this made them being young mothers more visible and therefore opened up to more judgement. Being judged for being a young mother seemed to exacerbate the judgement of being a breastfeeding mother and vice versa.

The importance of families normalising breastfeeding

For some mothers, it was extremely important for their families to normalise breastfeeding. It seemed to be that for many participants their female family members' infant feeding choice affected the kind of support they received after their decision to breastfeed. In this study, it was found that those who mentioned their female family members breastfeeding, usually had a more positive experience with regards to support from family than those who had a family history of bottle-feeding. This support included family helping with latching and positioning of the baby, normalising the unpleasant aspects of breastfeeding that some women face, and instrumental support. Danielle spoke of her grandmother's support and her perceived reasoning behind this. She said:

“She used to help me with the latch cos my baby struggled cos of tongue tie and she fed her 2 babies (my dad and aunty) so she knew what she was doing ... she's the one that kind of supported me both physically and emotionally ... But I suppose it would probably be easier for her with her having been through it herself twice”
(Danielle)

Louise also had a similar experience with her mother. She said:

“My mother breastfed both me and my brother and she was more attentive want to help and be there. Maybe instinctively” (Louise)

She also spoke about other members of her family’s decision to breastfeed. She said:

“I have a very small family and most of the woman breastfed so when the family asked how you feeding her i said breast it was a normal thing for everyone. This led to discussion about breastfeeding and talking about experiences with the family” (Louise)

To one participant their choice to breastfeed was mainly influenced by their female family members decision to breastfeed. Lacey said:

“It wasn’t a matter of making a choice for me. I knew that I always would. Everyone in mh family did so it felt natural for me to” (Lacey)

This normalisation of breastfeeding within the family environment and further support of this seemed to have a very beneficial impact on their decision and time breastfeeding. To these participants, it was not so much of a big deal when deciding to breastfeed as their family's infant feeding history made them see breastfeeding as normal and natural, and therefore, sometimes their first thought when making their infant feeding choices.

Respecting others

This theme relates to the respect that some of these mothers have for others in relation to their views on breastfeeding and how these mothers adapted their breastfeeding journeys to respect the comfort and views, authority and space of others within the family home.

Comfort and views

As participants were all living in a house owned by their family members first and foremost, it was imperative for some mothers that they take into consideration the comfort and views of those around them. These mothers, although they saw breastfeeding as a completely normal and natural way to feed a baby, were still mindful of how their family members felt and how their decision to breastfeed would impact those who they shared a home with. Faye used breastfeeding implements to maintain the comfort of others in the form of a cover, she said:

“If I did feed I front of them I would always put a cover over me, he never said he was uncomfortable but if I did feed down the stairs ... he would always leave the room” (Faye)

Emily spoke about her respect for her father not wanting to see her breasts, she said:

“Out of respect for my dad I went upstairs into the bedroom. He said he will support me but doesn’t want to see his daughters breasts” (Emily)

Gracie also spoke about feeding in her bedroom away from her father because of his negative opinions on breastfeeding, she said:

“I wasn’t ignorant to the fact that most men see boobs as a sexual part of the body and not for feeding like they were made for so I guess yeh I did kinda take his feelings into it” (Gracie)

These mothers honoured the opinions and views of their family members on the subject of breastfeeding and did whatever they could to maintain their comfort, even if they did not agree with these opinions. These women did not stop breastfeeding due to these opinions, however, made it so that these family members that felt uncomfortable or thought it was abnormal, did not have to deal with these feelings often. Emily and Gracie were aware that their breasts could be seen as a sexual part of their body that their fathers did not want to see. By respecting this, they present themselves in a subordinate position in which could be seen as them deferring to their father’s feelings. This shows them as having a ‘childlike’ status within the family household.

Authority

As above, it is important to note that these women are younger mothers who are living in the home of their family members and that these mothers had the status of ‘children’ within the home, even though they were adult ‘children’ and themselves, mothers. Although this was not discussed much by participants, for one mother her role in the household as the ‘child’ was very prominent for her and she respected this role and adapted her breastfeeding in line with this. To respect others personal space, Danielle often changed where she fed in reflection of this. She said:

“It was my mum’s house at the end of the day ... she did used to leave the room so I didn’t want to take up the whole living room and kinda push her out if you get me?” (Danielle)

Danielle further went on to say:

“I would have listened to them [her family] completely if they wanted me to do it in my bedroom or wherever because I feel like my mum is still the mum ... but whilst ever I’m in their house I kinda gotta stick to their rules” (Danielle)

Even though Danielle was 17/18 when she breastfed and was a mother herself, she felt a real sense that her mother had authority over her, and she respected the rules that came with this.

Space

The respect some of these young mothers gave was of other family member's space within the home. Some mothers felt that the act of breastfeeding made their family members feel uncomfortable, even if these family members supported the young mothers' breastfeeding and did not mention being uncomfortable themselves. To combat this, some of these mothers used to change where they breastfed their babies in order to maintain the comfort of others within their household. Louise spoke about how she would go to another room when her father visited. She said:

"If my dad visited. It [breastfeeding] wasn't something to do around him however he was supportive of me breastfeeding" (Louise)

Danielle spoke about how most of her family members left the room whenever she breastfed, she said:

"Well because everyone used to leave the room ... I kinda just started doing it in my room instead to try and save everyone having to leave the room and stuff" (Danielle)

Faye spoke of her perception of her grandfather being uncomfortable with her breastfeeding. She said:

"I think my papa felt uncomfortable ... so I would always go upstairs in to the room to breastfeed" (Faye)

Ruby spoke about feeding around extended family. She said:

"I tried to be discreet with extended family, withdrawing to a corner of the room or a different room" (Ruby)

After her father gave his negative opinion of her breastfeeding, Gracie said:

“After that I started feeding in my bedroom or when my dad was out” (Gracie)

Overall, although they had positive opinions of breastfeeding, a lot of mothers made changes in some way, in order to respect and accommodate the, sometimes negative, views of others and to maintain their comfort. For one mother, Danielle, she really took on the role of ‘child’ in the family household and followed her mother’s rules as a subordinate of her and therefore allowed her family members to substantially influence her in where she fed her baby.

A process of overcoming difficulties

This theme relates to the kind of difficulties some of these women had to go through as young breastfeeding mothers and how they overcame these difficulties by learning, adapting and adjusting.

So much you’re up against

The mothers in this study, quite understandably, had a lot of things to deal with from becoming a new parent to breastfeeding. A number of these mothers spoke about their difficulties with all these new things they had to deal with that they were not used to dealing with before they became young mothers. Faye said:

“Breastfeeding is very difficult/demanding if you don’t have the right support in place, especially if you are younger, there’s so much people are up against - stigma, latching, lack of support, pain” (Faye)

Alex spoke about how tired and drained she was being a new breastfeeding mother and how this built up to negatively affect her. She said:

“I used to kind of dread baby needing a feed I’d just feel so awkward talking to my mum & dad from the other room ... because of the awkwardness plus with how tired I was feeling and emotional, I was 18 and had a massive change in my life I felt it affected my breastfeeding journey negatively” (Alex)

Some mothers were highly aware of the negative opinions of others and struggled with being up against this when thinking about breastfeeding in public. Gracie said:

“I think thats natural no matter what your doing that if someone calls you out for something or says something negative you are affected by it”

These young mothers had to deal with issues around breastfeeding just previous research has shown mothers of all ages do, however, they also had to deal with additional negatives due to their age when they became new breastfeeding mothers.

Learning, adaption, and adjustment

Other difficulties some of these mothers went through were in relation to learning about the logistics and practicalities of breastfeeding and adapting and adjusting to overcome this. A few of the mothers in this study had difficulties around learning how to latch and breastfeed discretely. Faye spoke about learning how to latch her new baby in a public place. She said:

*“I did feel uncomfortable as was loads of people around and I was standing trying to get a 4 week old to latch”
(Faye)*

Gracie also had difficulties with lack of experience with latching her baby. She said:

*“At first ya kinda dont know what your doing either like the best latch positions and how to be discrete”
(Gracie)*

Louise spoke about how she found it difficult to hide her breasts from others when breastfeeding. She said:

“When learning its hard to kinda hide your boob when your holding the baby with one hand and trying to get your latch right theres no way to be discreet about it” (Louise)

One mother who had these difficulties learned that breastfeeding implements made it easier for her to breastfeed more discretely. Ruby spoke about how using a sling helped her to adjust to carrying on with everyday life whilst breastfeeding. She said:

“Using a wrap sling was very helpful for feeding discretely. Once I'd established feeding and learned how to use my wrap, I just carried on with my normal life while feeding” (Ruby)

For Louise, her breastfeeding meant she found it difficult to do other every day things whilst breastfeeding. She said:

“At first it was a bit of a obstacle for the family as i was sat down feeding learning adapting ... Like i cant put the shopping away as the baby needs feeding ... As i got better it kind of became a second arm and i could do more as i went along and feed and it was quicker and less often” (Louise)

Jess spoke about having to adapt to all the new things that came with being a young breastfeeding mother. She said:

“I had to adapt to so many things at once, from becoming a new mum at 17, to learning how to juggle everything with a baby and college, to things like adapting to be less bothered by people’s opinions and views”
(Jess)

Like this Louise had to change her mindset of what her breasts were ultimately for. She said:

“I came to terms pretty quickly that people were looking at my boobs however my feelings towards my boobs had changed and I was in more of a “my boobs are tools of food for my baby and not a sexual object anymore” state of mind” (Louise)

These mothers found that when first establishing breastfeeding, not every aspect came naturally. They had to learn about certain things including, latching, best positions to breastfeed and how to breastfeed discreetly if they wished to. As well as this, these mothers had to adapt and adjust to other things including pain whilst breastfeeding, learning how to do everyday activities whilst breastfeeding and how to overlook others judgement of them as breastfeeding mothers. However, when they did overcome these difficulties, they found it must easier to carry on with everyday life and be a breastfeeding mother in parallel.

Impact of support and absence of support

The women in this study all had different experiences when it came to support, both about their infant feeding choices and beyond this during their breastfeeding journey. Some experienced the people around them and in public positively, some negatively, and some were simply indifferent to the young mothers’ choice to breastfeed. However, what was important was the effect this perceived level of support had on the young woman’s breastfeeding both before initiation and during breastfeeding.

Instrumental support

Instrumental support refers to the task-oriented behaviours that directly assisted these young mothers during their time breastfeeding (Littleton, 2013). Participants did not just refer to support but also indicated it could

take different forms such as people providing advice on latching, offering private spaces and offering drinks. This support is different from other forms of support such as emotional or encouragement but is important in its own way. One mother received different forms of instrumental support from a range of different people. Ruby said:

“Most people offered sofas or private places and drinks as necessary. It was fine” (Ruby)

Similarly, Gracie spoke about her younger sister offering any help she needed whilst breastfeeding. She said:

“My sister she was mostly at school but shed come home and if she saw me feeding shed ask if I needed oot like a drink or the telly on” (Gracie)

For one mother, her family members helped her with latching the baby on properly soon after birth. Sara said:

*“My nans helped me a lot and my one nan checked if he was latching on properly when I first had him
(Sara)*

For some women, this instrumental help and support came from more professional sources. Louise spoke about her experiences of services soon after birth. She said:

“When I said ... to the midwives im going to breastfeed there was a rush of people and services and information that seemed to come straight into the light that i didn’t know about before” (Louise)

Harriet spoke of the ongoing support she received from her feeding support worker during her baby’s growth and development. She said:

“She would text me on certain days like “cluster feeding is normal at this time during your babies development so be prepared for her to be feeding longer and more frequently than usual” so I knew what to expect (Harriet)

However, not all mothers in this study had positive experiences of instrumental support. Two mothers received discouraging comments and remarks when they were struggling with the logistics of breastfeeding. For these mothers, instead of professionals working on the issue, they were instead encouraged to seek alternatives to breastfeeding. One mother, Faye, struggled with latching her baby at first. She said:

“I was 16 when I had my first, the hospital didn’t support me in terms of latching, I became so stressed as I couldn’t get him to latch on and when I asked for help all they did was give me a syringe and told me to hand express” and “I actually felt my age was a factor ... I might be wrong but I feel they thought I would fail with breastfeeding anyway because of my age so didn’t want to offer me the support” (Faye)

Ruby also struggled with establishing breastfeeding at first and was similarly discouraged, by more than one professional, from trying to keep going. She said:

“My midwives and health visitor were less supportive, pushing me to give up when we were struggling to establish breastfeeding” (Ruby)

Overall, some mothers received a large amount of instrumental support, from family members and professionals and this was seen as a positive help to these young mothers. This kind of support had an active role in the success breastfeeding of these women. However, some of these mothers experienced a lack of professional support with feeding from the breast and instead of working on the issues, professionals instead simply encouraged them to use other means to feed their babies. This discouragement to breastfeed and the reassurance of something to ‘fall back on’, further promotes a bottle-feeding culture and makes bottle-feeding seem a more normal, easier way to feed a baby. For one mother, she perceived the lack of support to be due to her age and the expectation that she would not be successful at breastfeeding and therefore not worth the time to give the support. This lack of support had a negative impact on these women’s breastfeeding journeys.

Emotional/esteem support

Emotional and esteem support was highly important to these mothers and when mothers received this kind of support, they had much more positive experiences of breastfeeding. This support was given from both family and friends, but mothers rarely spoke of professionals providing this type of support. When mothers were struggling with the logistics of breastfeeding, as well as with the common difficulties of having a new baby and breastfeeding, these friends and family were there to support these mothers. Jess spoke about her difficulties with breastfeeding making her feel drained both physically and mentally and how her mother helped. She said:

“Emotional support was honestly the best thing that I could have received when breastfeeding. When I would breakdown because of how draining it was both physically and emotionally, my mum would be there whilst I was breastfeeding, hugging me and telling me that it will get better and it did” (Jess)

Like this, Faye also had a similar experience. She said:

“There would always be someone telling me it gets better” (Faye)

Sara also experienced times of struggle in her time breastfeeding but her mother was there to help. She said:

*“My mom never breastfed but she tried to help emotionally when I first was breastfeeding and struggling”
(Sara)*

For two mothers in the study, this support was vital in building their confidence in their ability to breastfeed in public. Emily spoke about her partner ‘having her back’. She said:

“I went into Starbucks and he needed feeding. My partner told me no one will say anything and if they do he will tell them. So I fed him, it wasn’t as bad as I thought” (Emily)

Like this, Jess also had a similar experience when her and her friends breastfeed in public. She said:

“When I am out now with my 2 friends who breastfeed, it feels like we all have each others backs in case anything happens or we have any negative experiences” (Jess)

However, not all of the young mothers in this study had positive experiences of emotional/esteem support. For Emily, although she received support from her partner, her family was not as supportive in the beginning. She said:

“Emotionally there wasn’t really any support there, it took me to go to the doctors and to get diagnosed again but this time with more mental illnesses for them to actually realise that I needed support” (Emily)

Gracie spoke about her father’s constant put down’s emotionally draining her. She said:

“I was sick of my dad saying stuff it really used to drain me emotionally cause I knew I was doing somethin good and he was making out like I was dirty or somethin” (Gracie)

A positive experience of emotional and esteem support from others helped with the initiation and continuation of breastfeeding for these mothers. This support helped with the encouragement they needed to carry on breastfeeding when it became difficult. The encouragement to try breastfeeding in general and in public helped to reassure these mothers that they were doing something perfectly normal and this experience helped them to realise that it was not as bad an experience as they expected it to be. Those mothers who were encouraged to breastfeed in public and encouraged others to too, helped with normalising the act of breastfeeding both in general and in public. However, when the support was not there, this seemed to impact negatively on these mothers’ time breastfeeding. Gracie was made to feel like she was carrying out a deviant behaviour by breastfeeding by her father, despite her having confidence in her breastfeeding being a good thing. Mothers spoke of the mental impact this lack of support had on them and their breastfeeding journeys overall.

Encouragement to normalise breastfeeding

Similar to the support displayed above, many mothers found they got support in the form of encouragement, this was sometimes from friends and family members, sometimes professionals, but largely from strangers in public. These young mothers receiving encouragement from these different sources helped to normalise the act of breastfeeding within a heavily dominated bottle-feeding culture. Support in the form of encouragement was important from family members and friends for these women. Sophia talked about her mother’s encouragement, she said:

“My mum helped out a lot. She would always big me up of how amazing i was doing” (Sophia)

Emilia spoke about her breastfeeding friend’s encouragement when she discussed wanting to breastfeed. She said:

“When I told her I wanted to breastfeed she was so supportive and gave me so much info and recommended breast feeding support groups, etc.” (Emilia)

Louise had a similar experience with her breastfeeding friend who helped her to feed in public. She said:

“She would get the coffees while i sat and fed the baby and she encouraged and helped me with the feeding as much as she can” (Louise)

One mother spoke about encouragement she received from her doctors when she was struggling to continue breastfeeding, Faye said:

I got support from the doctors as well ... was ready to stop loads of times and found the doctors quite encouraging and supportive” (Faye)

Although this encouragement from friends, family, and professionals was evidently helpful, these young mothers spoke considerably more about how strangers helped in public to normalise breastfeeding. Danielle had an encouraging experience with a woman in a park who gave her compliments, with extra emphasis on her young age. She said:

“I had one woman that was really nice and she sat and talked to me whilst I was breastfed in a park once and was telling me about how amazing I was just not bottle feeding like most other people my age” (Danielle)

Like this, a member of the public also commended Emily on her breastfeeding at such a young age. Emily said:

“A middle aged lady said she was glad she saw the younger generation breastfeeding and she’s never really seen it before so applauded me for it” (Emily)

Again, Harriet also had a similar experience with the public. She said:

“A few people mentioned it was refreshing to see a “young” mum being confident with breastfeeding” (Harriet)

Sara was told specifically by members of the public that she should breastfeed as it is a normal thing to do. She said:

“I was in a que and the baby started crying and an elderly couple said I should just feed him there there is nothing wrong with it” (Sara)

To one mother, it was not necessarily verbal communication with others that encouraged her but a simple smile from a stranger she took as approval of her breastfeeding. Louise said:

“I got her out [her baby] and was feeding. When i looked up there was a woman looking at me and she smiled and then carried on her buisness. This made me feel more relaxed and happy that this one lady approved and was okay with me doing it and all was well” (Louise)

Family, friends, and professionals normalising breastfeeding was important for all mothers mentioned above. For one mother, Sophia, her mother supported her in a way that made her feel like by breastfeeding she was doing an amazing thing, something she may not have got with bottle-feeding as it is seen as the normal way to feed a baby. A lot of mothers mentioned others commenting on their age specifically when they saw that they were breastfeeding, suggesting they are going against the norms of a bottle-feeding culture by breastfeeding, but more so notably at a young age where it is not often seen. For one mother, Louise, the approval and non-judgement of strangers seemed to build her confidence and be a decisive factor in her continuation to breastfeed in a public place. But overall it seemed that having a nice, friendly stranger/s talk or approve of them breastfeeding, had a positive impact on these mothers. All of this encouragement to breastfeed helped to normalise breastfeeding for these young mothers which in turn, will help to normalise it overall.

Respecting and supporting autonomy as a mother

From the data, it was clear to see that some mothers had negative experiences with people judging them and undermining them when they made their infant feeding choice. This theme relates to some of these mothers' ability to assert their agency as mothers. One mother, Harriet, spoke about how both her family and her partner's family (despite having different infant feeding histories), were supportive and did not even question her decision making. She said:

“I never really discussed it with my family, I said I wanted to breastfeed and they didn’t ever question my decision. My partner was bottle fed as a child but both him and his family were really supportive and just wanted me to do what I wanted to do” (Harriet)

Jess had a similar experience in which her family, despite breastfeeding being new to them, respected her decision as a mother. She said:

“It really helped that my whole family were so supportive of my choice to breastfeed my baby and even though it was new to them, didn’t try and sway me any other way” (Jess)

Gracie’s younger sister respected her ability to make the right decision for child. Gracie said:

“My sister didnt care at all and said its my baby I can do what I want” (Gracie)

Lastly, Emily spoke about the positive experience she had with her partner’s side of the family. She said:

“My partners side were so supportive, always giving me hope and respected my decision” (Emily)

Despite their young age and the fact, they lived in someone else’s home, these young mothers took control when it came to making what they perceived to be the best decisions they could regarding their baby. For these mothers, it helped immensely that their family members were respectful and supportive of their decision and believed in their autonomy as a mother to make good decisions, regardless of their age. As seen above, this is not always the case with perceptions of young mothers being incompetent parents and breastfeeding being a deviant behaviour.

Baby comes first

This theme encompasses how some of the mothers in this study, despite their status as a young mother, along with living in someone else’s home, have taken control of their agency and autonomy as a mother by deciding what is best for their baby when it comes to how they feed them. Within this, it is notable how some of these mothers have stated taking only their own views into account when making their decision to breastfeed and have found others’ opinions and views on their infant feeding choices irrelevant. These mothers showed confidence in their ability as mothers to make good decisions with regards to their babies.

The best I can give

There were many different reasons for the mothers in this study choosing to breastfeed their babies. From the data, there was a real sense that these young mothers wanted to give their babies the best start in life and

they perceived this to be by providing them with breast milk, which they thought was the best way to feed their babies. Some of these mothers had made a clear independent decision to breastfeed their babies before they were born. Alex said:

“I just knew from the start that it was something I wanted to do because I could to give the best start to my baby” (Alex)

Sophia also knew she wanted to breastfeed from the beginning of her pregnancy. She said:

“As soon as i found out i was pregnant i knew i wanted to breastfeed. I choose to breastfeed because i know its amazing for baby & yourself ... can prevent breast cancer ... and the bond you get with you baby is unreal ... also its free!” (Sophia)

Ruby had a similar view of always breastfeeding to try and prevent inherited conditions being passed down to her baby. She said:

“I was always going to breastfeed, to protect my daughter as best I could from inherited conditions she was potentially going to suffer from, like asthma, eczema and depression” (Ruby)

For other mothers, the decision to breastfeed their baby was made after taking control by trying to actively research or get information through other means on different feeding choices and their benefits. This included using the internet to research formula and breast milk and discussing breastfeeding with professionals as well as friends. Emily researched formula and decided it was not a food substance that she wanted to give her baby. She said:

“I was giving my child the best thing I could give. Researching formula it has rapeseed oil, powdered cows milk, all I kept thinking was why would I give my child this when I’m perfectly capable of giving him my milk?” (Emily)

Gracie bottle-fed her baby for the first week of his life. After her son was admitted to the hospital, she decided to breastfeed her baby after encouragement from a nurse. She said:

“She mentioned breastfeeding can help with this sorta stuff and asked if I wanted to try ... I went on my phone and had a look and found loads of websites. When the nurse came in I said that I wanted to try and she helped position him” (Gracie)

As well as researching using the internet, one mother, Emilia, also spoke to her friend about breastfeeding. She said:

“After doing loads of research, spending nights up googling, speaking with my best friend who has two children, I had my heart set on breastfeeding as I decided that this would be the best thing for my child (as well as easier) compared to formula feeding” (Emilia)

Other mothers gained less information from the internet and more from professionals they were in contact with. Alex spoke to her midwife who gave her information on the benefits of breast milk. She said:

“I decided to breastfeed when I had my first appointment with my midwife ... She gave me information about breast milk about how good it is for baby and how it creates a really good bond with baby” (Alex)

Similarly, Danielle gained her information through discussion with her family nurse and decided she wanted to breastfeed for as long as possible. She said:

“I had a family nurse who used to talk to me about it and she told me all about the benefits of it for both me and for baby and I just knew that I was going to try my best from then to breastfeed as long as I physically could. I didn’t have a time limit” (Danielle)

One mother in this study made a much more emotional decision when her baby naturally moved up her body to find milk. Louise, although set on bottle-feeding, decided to change her mind and give breastfeeding a go. She said:

“I decided to breastfeed when my new baby was placed on my chest as soon as she was born and 10 minutes later wiggled her body up to find her milk. I didnt know what was happening and the midwife said she would like to be fed and asked if i wanted assistance. However the baby did it all herself and latched on really easily ... And from there i decided to try breastfeeding” (Louise)

These mothers all had different reasons for initiating breastfeeding. For some, a clear independent decision was made from the start of pregnancy, for others, this decision came after using different sources to research and learn about breastfeeding and its benefits. For one mother, although she had prepared to bottle-feed, it was much more emotional decision when she decided to give her baby a chance to breastfeed after she naturally moved to find her breastmilk.

Seeing others' opinions as irrelevant

Around half of the mothers in this study spoke about how the decision to feed their baby by breastfeeding was solely that of their own. Some did receive negative opinions from family members and strangers with regards to their infant feeding choice, however, they revealed that this did not bother them as their baby came first above anyone else's views and opinions. When asked how she discussed her decision to breastfeed with her family, Gracie said:

"I didn't even discuss it with anyone else once he latched I made the decision there an then that he must need it and I went with it I didnt really care at that point what anyone else felt or said" (Gracie)

To Gracie, it was more important to give her baby what she perceived he needed than what others thought. One mother experienced negative views of family, however, she overcame these by taking little notice of these people. Emily said:

"Why would I let what others think define my child's best start in life? They weren't educated on the facts, all they knew was what their mothers told them. Most of it outdated advice" (Emily)

Alex spoke about what she would do if any of her family members strongly disagreed with her feeding her baby this way. She said:

"If someone in the family strongly disagreed with me breastfeeding, then I would have carried on regardless. If I want to breastfeed my baby, I'm going to, regardless of what anyone says" (Alex)

Similarly, Louise talked about what she would have done if her friends did not want her to breastfeed around them. She said:

"I would of had to feed my baby around them meaning they would of had to out up with it or we would have not been able to meet" (Louise)

By saying this, Louise was putting her baby's needs above anyone else, even if it meant not seeing her friends in the time she was breastfeeding.

Two mothers spoke of how they had to feed in public and what others thought or said was not relevant to them and would not change this. Danielle said:

“Other people around my never really crossed my mind it was just that baby needed feeding and I had the boobs to do it” (Danielle)

Like this, Kate felt similarly. She said:

“I just knew that it wouldn’t be fair on my son to not feed him just because some people do judge because its non of thier business really and my son is more important” (Kate)

Overall, these mothers said they either did not consider others’ opinions in the first place or they chose to ignore them. As some mothers mentioned, they perceived themselves, by breastfeeding, to be giving their babies the best they possibly could. To these mothers, this seemed to be a lot more important than listening to or respecting the views and comfort of others around them, whether this is people close to them or strangers.

Perseverance

This related to the struggles that a number of these young mothers faced but overcame after persevering to feed their babies via breastfeeding. Gracie spoke about how her son struggled to latch at first and the connection she got when her and her son persevered. She said:

“He struggled at first cause he was used to the bottle im guessing but after a few tries in the hospital he latched on. I felt this instant bonding connection ... I never thought id feel that way about breastfeeding” (Gracie)

Danielle spoke about how breastfeeding was not as easy as she expected but how with perseverance she was able to successfully breastfeed. She said:

“Persevere persevere persevere I convinced myself that I was going to be able to breastfeed and do it as long as I want and it would be easy cos that’s what our boobs are made for but it is not half as easy as that” (Danielle)

Jess talked about how she would have had think about different ways in which to feed her baby if it wasn’t for her carrying on trying when she experienced difficulties. She said:

"It's all about persevering, if I had have just given up with things got tough, I wouldn't be breastfeeding now"

(Jess)

Finally, Emily spoke about how her perseverance has led to her having a positive experience of breastfeeding. She said:

"With time, knowledge and confidence I am having the best time breastfeeding" (Emily)

In order to successfully breastfeed, these women had to overcome many difficulties by continuously persevering with breastfeeding through this. Instead of giving up when it became tough, these young mothers carried on so that they could provide their babies with the best they could have. By doing this, the data shows that these women had positive breastfeeding journey's no matter the length of time they fed for. In the end, these women gained confidence and were able to breastfeed happily and successfully.

Discussion

This study explored how young mothers felt about breastfeeding in front of others, their feeding practices in relation to this and has sought to understand how mothers negotiated feeding choices within their family network. In this chapter, the findings of this study will be discussed in relation to the aims and objectives.

Objective one: Explore how mothers felt about breastfeeding in front of others and their practices in relation to this

A significant finding in this study was how these young mothers felt 'doubly judged' for both being young mothers and for breastfeeding. The average age of first-time mothers in the UK is 28.8 years old (Statista, 2019) and by having a child outside of the culturally expected timeframe, young mothers can experience negative judgement and associations. There has been a wealth of research that has discussed how fearful these mothers are about people knowing they are young mothers. Dykes, Hall Moran, Burt & Edwards (2003) found that adolescents felt watched and judged in different contexts. This was perceived to be because these strangers wanted to see if these young mothers were able to look after their babies. In other research, teenagers spoke about how instead of being praised for their commitment to intensive mothering, they were instead judged and stigmatised for childbearing young (Neill-Weston & Morgan, 2017). Like Dykes et al., (2003) this was also perceived by the mothers to be because others did not believe they could look after their babies well. The present study found that multiple mothers feared judgment for being a young mother. As well as this, like research above, one mother also expected people to assume she could not look after her baby just because she was a teen mother. As well as this, mothers felt judged for breastfeeding. Previous research has shown that mothers of all ages have been fearful of being watched and judged simply for breastfeeding (see Condon et al., 2012; Dyson et al, 2010; Scott & Mostyn, 2003). However, these findings have been in relation to feeding in a public. Of course, this fear of judgement in public will be difficult for these young mothers too, though they could also experience this within the home setting when living in somebody else's house. This is because sometimes people can misconstrue a public space as anywhere outside of the house, where members of the public gather in a social space. However, for these young mothers when living in the family home, their private and public space is not necessarily independent of each other and can sometimes merge, leading to a lack of privacy for these breastfeeding mothers. Research has shown that people still feel uncomfortable around breastfeeding women (see Grant, 2016; Meng, Daly, Pollard & Binns, 2013) and as Boyer (2012) discussed, breastfeeding mothers risk censure if they do not act in a way that maintains the comfort of others, even if this means putting this above theirs and their baby's needs. Even without verbally mentioning their disapproval of breastfeeding, people can give expressions of disapproval that indicate their discontent. From these disapproving expressions, we can identify how the 'felt feelings of others' can shape and influence a woman's breastfeeding experience (Boyer, 2012). Previous research has depicted similar findings to this (see Leeming et al., 2012; Sheehan, Gribble & Schmied, 2019). Nonetheless, this research has only considered public feeding and has not fully contemplated respecting others from the perspective of a young mother living at home. For these young mothers, feeling the need to maintain the comfort of others and respect them could be exacerbated by their child status within the home and seeing someone else (the homeowner) having the right to say what is and what is not appropriate behaviours to carry out in the shared rooms in the house. This

was shown in a study by Leahy-Warren, Creedon, O'Mahony & Mulcahy (2016) which found that older mothers felt the need to ask permission to breastfeed in front of others around them. This study shows that, if older mothers feel they need to ask permission to feed, then this could be even more prevalent for mothers who occupy the child status. The present study found that because of this need to maintain the comfort of others, mothers respected others' space, comfort and views within the family home and adjusted their breastfeeding practise in accordance.

Objective two: Understand how mothers negotiated feeding choices within their family network

As discussed above, young mothers often occupy the 'child' status when living within the family home. To some, this means that family members will have the right to say what they do and do not want to happen in their house, in this case, breastfeeding. However, for young mothers, despite this occupied status, it is important for family members to respect and have belief in their autonomy as a mother to make the best decisions with regards to their babies, even if they do not agree with them. This study found that if a mother's family feeding history was similar to hers, she would receive more support than a mother with a bottle-feeding family history, who would usually receive a lack of support or negative support. However, for some mothers, despite family feeding history, they were always supported well, and this was highly important to mothers. For some of these mothers, the families respected and had belief in their autonomy as mothers, despite their child status within the home. According to Romich, Lundberg & Ping Tsang (2009), the right and power to make decisions is initially held by parents and then transferred to their children via negotiations, sometimes known as "autonomy granting" or "independence giving". Giving independence to these mothers and allowing maternal autonomy is a right that should be respected by all (Sullivan & Douglas, 2006, cited in Hirani & Olson, 2016). Therefore, these mothers, despite their status 'child' status should not be treated like children who have no control over the decisions regarding their babies. However, sometimes this is the case with young mothers who have inadequate knowledge and experience of breastfeeding being considered as lacking the competence to demonstrate their agency and autonomy when making infant feeding choices (Bloom, Wypij & Gupta, 2001; Copeland & Harbaugh, 2004, cited in Hirani & Olson, 2016). Like this, a mother who lives alone or with her partner may demonstrate her autonomy as a mother, however, when lacking control over things like privacy or time, may struggle to be completely autonomous and may need more support. Despite this, it is important that these young mothers are given the opportunity to demonstrate their agency as a mother, even if they cannot fully be autonomous with regards to mothering and breastfeeding and need more support. This study found that when young mothers' autonomy and agency was respected, they felt more supported. This is in line with other research that shows similar. Research by Grassley (2008) showed that mothers wanted their grandmothers to affirm their decision to breastfeed (and therefore their autonomy as a mother) and not question or criticize their decision, and for them to act as an advocate when overcoming difficulties. When they did this felt loving, encouraging and supportive. Like this, Nesbitt et al., (2012) found that women whose family members also breastfed were encouraging and more supportive because of this. Of course, being able to make decisions regarding your own child, is important. However, for young mothers, who are already up against the negative views of young mothers being incompetent (SmithBattle, 2013), it could be even more difficult for these women to display and prove their agency and autonomy as a mother. Therefore, it is

important that these women are supported in a way, by the family of whom they live, that lets them demonstrate this and be in control of the decisions made with regards to themselves and their babies.

This study found that some mothers in this study resisted breastfeeding as deviant and instead took control of their autonomy and confidence in being a breastfeeding mother and were able to disregard the negative opinions of others. These findings were very much in line with some other research conducted in this area. Scott & Mostyn (2003) found that, although at first many women would restrict themselves to their home to breastfeed, eventually they overcame their fears of feeding in front of people with one mother saying “breastfeeding my child, there is absolutely nothing filthy about it. It is everybody else that has the problem with it ... I fed absolutely everywhere”, another said, “if they got offended it’s their problem not mine”. Dyson et al., (2010) had similar findings with mothers who spoke about how they did not care about anyone else as long as their baby got everything she wanted. Like this, Nesbitt et al., (2012) found that adolescents had the opinion that they made the decision to breastfeed their baby, therefore the opinions of others do not matter. However, the research, when discussing the irrelevant opinions of others, was in regard to those in a public place. Whereas, the findings in this study show that the mothers had similar opinions, even when it came to family. As these mothers were able to take control of their decision making without seeking family input, they claimed decision power by default (Romich et al., 2009) which is when a parent (or family member in this case), is not given the opportunity to ‘weigh-in’. I did not find any other research which explored how mothers took control of their autonomy and agency as a mother in order to make positive decisions about breastfeeding in front of people, however, this does not mean there is not any but that there is a need for more research to be conducted specifically looking into how young mothers negotiate their breastfeeding with family and how they take control of their decisions.

Reflexivity

As discussed in the methods chapter, it is of great importance for researchers to be reflexive in an attempt to minimise their influence on the research progress (Patnaik, 2013). When completing the analysis, I had to make sure that I did not just read my own experiences into the data. To combat this, I did multiple things. Firstly, I conducted careful line by line coding, sentence by sentence, word by word, multiple times. This made it so that the data was able to be opened up and the meaning be exposed which allowed me to notice details that I may have otherwise missed.

As well as this, throughout the research process, I kept a research diary which I used to help me stay as objective as possible. This diary made me think more about how my own experience and emotions could be different from others. To do this, every time I had a thought about a participants experience within the data, I would think and write down how other’s experiences could have been different from my own. This allowed me to decentre my own experiences from my mind and allowed me to think about what the data was trying to tell me about the experiences of each participant.

Before I started analysing the data and during analysis, I made sure to keep discussing my plans of analysis, thoughts on the data and ideas for emerging themes with my supervisors. They would then give me their

feedback and advice on what I had done, and this would be incorporated into it. This also allowed me to think more about how participants' experiences would be different from my own as I got to hear the opinions of people that do not have similar experiences and background with young parenting and breastfeeding like myself.

Strengths and limitations

One strength of this study was that the data collected was completely anonymous. This gave participants the ability to openly express their opinions without the fear of pre-judgement or consequence. Allowing this anonymity most likely increased the chances of gaining access to these participants (Walford, 2018) as it is likely when discussing their experiences, these participants will have felt safer in revealing information that is personal to them. Especially seeing as though, as found in this study, some of these mothers felt significantly judged for both being young mothers and for breastfeeding.

Another strength was the use of written data in this study. This had many advantages. One being that it allowed both the participant and researcher sufficient time to think and respond to questions responses. Meaning that participants were able to write exactly what they wanted to write, without the pressure of being face-to-face. As well as this, it removed the opportunity to misinterpret what the participants had said. With regards to the analysis, it saved time transcribing data and allowed me to spend this extra time reading through and making sense of the data.

One limitation of this study was the use of online data collection methods. Although these have many advantages, using this also meant that I possibly missed out on being able to capture non-verbal cues such as facial expressions and body language. If I had used face-to-face methods, it would have given me the opportunity to capture emotion, as well as recognise if participants were, for example, particularly uncomfortable or enthusiastic about a certain topic or question.

Another limit was with using questionnaires for data collection. With this, I was unable to probe the participants for more information when something seemed relevant or interesting and I was also unable to ask the participants to explain a response more fully if I did not understand the response.

Another limitation was having limited access to participants. As discussed briefly in the methods chapter, I was originally going to use focus groups for data collection but found it difficult gaining access to participants. This was partially because, despite a large number of parenting/breastfeeding webpages/groups, I was only able to get permission to advertise on a minority and when I did, there was no interest in the study at all. Because of this difficulty, I, therefore, made the decision to use interviews and questionnaires. Like the focus groups, I was only able to post on a limited number of sites, however, this was more successful and could show that participants were more comfortable discussing their experiences alone rather than as part of a group.

Lastly, one more limitation was that I could have unintentionally only recruited those participants who wanted to have their voices heard or who had a lot to say on the matter of breastfeeding and/or being a young

mother. This may have led to only gaining the views of young mothers who were particularly interested in breastfeeding.

Implications for practice

The findings of this study suggest that for some mothers, the professional support they received was lacking. For some mothers, the informational and instrumental support they received was brief and felt 'pressured'. As other research has shown (see RCM, 2014), in the UK, there is a need for more resources to be spent to hire, train and make available more healthcare professionals that specialise in breastfeeding. This would increase the time these professionals could spend with women, provide more effective support and increase the number of women that initiate breastfeeding as well as the duration of which these women breastfeed for. This study also found that these women experienced many difficulties associated with breastfeeding. These women would benefit from a more honest approach from professionals. Instead of simply explaining the benefits of breastfeeding and how to breastfeed, more emphasis on the difficulties that women may face during their time breastfeeding would provide these women with a more realistic view of what breastfeeding will be like and therefore could reduce the chances of a potentially disappointing experience.

This study was specifically interested in how others impact young mothers' experiences of breastfeeding. For mothers deeply enmeshed in family networks, for example, young mothers, it would be highly advantageous for professionals to consider family members and their feeding histories. Professionals could benefit from using certain tools such as Darwent, McInnes & Swanson's (2016) Infant Feeding Genogram, which is a tool for exploring family infant feeding history and identifying support needs. When used this would allow professionals to quickly collect information, discuss infant feeding history and consider family support networks, whilst also encouraging these women to talk about this with their family. Like this, it would be beneficial to encourage and offer close family members the opportunity to be part of these women's prenatal and postnatal appointments so that they can be provided with informational support about breastfeeding before and after birth. As with the present study, lack of breastfeeding experience led to lower levels of support. This could be partly due to lack of familiarity and understanding with breastfeeding. Therefore, by involving family members more in appointments, professionals facilitate understanding of breastfeeding and the difficulties that come with it. By providing this support to members of the family that have little or no experience with breastfeeding, could help to inform family members on breastfeeding and how to more effectively support these young mothers.

Lastly, the implementation of the Family Nurse Partnership in more areas would be beneficial to these young mothers. At the moment, FNP provides specially trained nurses who visit women aged 24 and under on a regular basis from early pregnancy until their child is two (Family Nurse Partnership, n.d.a), however, FNP is only available in some areas of England and not in the rest of the UK. FNP provides all kinds of support on pregnancy and parenting, including breastfeeding. At present, 58% of mothers accessing the FNP, initiate breastfeeding (Family Nurse Partnership, n.d.b). A much higher rate than research has shown for young mothers not specifically accessing this support (see Condon et al., 2012; Feldman-Winter & Shaikh, 2007; Smith et al., 2004). FNP support is usually given inside the home of the young woman and therefore, linked

with what was discussed above about providing family with support too, the FNP being rolled out would allow for not only consistent and regular support with breastfeeding, but also regular access for the family of these young mothers to breastfeeding information on how to best support these mothers.

Conclusion

Overall, the present study explored how living with their family of origin affected or influenced young mothers breastfeeding decisions and experiences.

This study found that within these mothers' communities, there was a real bottle-feeding culture and the mothers were well aware of this. Because of this, depending on the family history of breastfeeding, the act of breastfeeding was either seen as deviant or normal by family members. If a mother had a family history of breastfeeding, breastfeeding was usually normalised and she was usually supported much more substantially than a mother with a family history of bottle-feeding, of whom most family members would view breastfeeding as deviant. Some of these mothers felt judged for breastfeeding and for being a young mother and these two 'double judgements' exacerbated the other. In addition to this, this study found how these mothers had to go through many difficulties specific to parenting, breastfeeding and their age when they became a mother. However, through learning, adaption, and adjustment, it was found that these mothers were able to overcome these difficulties to go on and have successful breastfeeding experiences. This study also found out about how these young mothers experienced support and the impact this support or lack of support had on their choice to breastfeed and their breastfeeding journeys. This support includes instrumental, emotional, esteem support, encouragement, and for some, the respect of the mothers' autonomy, from family, friends, professionals, and strangers. Another finding was in regard to respecting other people. For some mothers, deep consideration of comfort, views, authority, and space was considered, and their breastfeeding practices were altered in line with this. However, for other mothers, they saw their breastfeeding as the best way to feed their baby and to them it was normal, therefore, when they were met with disapproval from others, this was disregarded and these mothers did not alter their breastfeeding practices. These findings were discussed in relation to the aims and objectives of this study and these were met. The present study is relevant as it is one of the first to explore a young mothers' experience of breastfeeding and the decision making around this, whilst specifically living with their family of origin. As well as this, this study supported findings from other previous research studies, along with new findings such as when the mothers took control and found the opinions of others irrelevant, which has only been discussed in a public social context in previous research. From the additional and new findings from this study, I would recommend a need for more studies to be conducted which explore the social context of young mothers and how this affects or influences her breastfeeding journey. As well as this, there is a need for considerably more professionals that are trained in breastfeeding support. Within this, I would recommend that the family context of mothers is taken into account and discussed, as well as, encouragement from professionals to allow their close family members access to their appointments to learn about breastfeeding and increase the chances of better supporting these mothers because of this.

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Appendices

Appendix A: Flyer used to recruit participants for online interviews



University of
HUDDERSFIELD

I am looking for participants to take part in a study looking into the breastfeeding experiences of young mothers.

- Did you breastfed between the ages of 16 and 21?
- During your time breastfeeding, did you live with any family (other than solely partner or child/ren)?
- Are you interested in taking part in a 1-to-1 text based interview?
 - Are you currently residing in the UK?

If so, I would love to hear from you.

If you are interested or have any more questions, please contact me via email at Lauren.Haigh@Hud.ac.uk

Appendix B: Information sheet for online interviews

University of Huddersfield

School of Human and Health Sciences

A research project on young mothers' experiences of breastfeeding and how others respond to this

You are being invited to take part in an online interview about your experiences of breastfeeding, however brief. Before you decide whether to take part, it is important for you to understand why this research is being carried out and what it involves. Please take your time to read the following and discuss it with others if you wish. If anything is unclear, please ask the researcher (**Lauren Haigh**).

Once you have read the following information please follow the link:

https://huddersfieldbss.eu.qualtrics.com/jfe/form/SV_a3s5CapBo9QSrl7 to answer demographic questions and consent to the interview.

What is the purpose of the project and what will happen with my data?

This research is being carried out by **Lauren Haigh** for my Masters by Research degree in Psychology at the University of Huddersfield and will be written up in the form of a thesis for assessment in February 2020. If you would like a summary of the findings, please contact the researcher.

Your participation

Your participation in this project is entirely voluntary. You do not have to take part and if you change your mind about taking part you may stop the interview at any point. As well as this, you can decide not to answer or talk about anything you do not want to. You can withdraw your information up until **2 weeks after your interview** by contacting me via email (found on page 2).

What do I have to do?

You have been invited to take part in an online interview using a **text-based app called Wire**. Topics including: the decision to breastfeed your baby, living and negotiating with family and public breastfeeding away from family will be discussed. The interview will take approx. 1-2 hours depending on detail. To do this you will need to set up a Wire account (the most secure way for us to complete the interview). This can be done on the Wire website at <https://app.wire.com/> or via the Google Play/App Store on iPhone/Android phones.

Are there any disadvantages to taking part?

There should be no expected disadvantages to taking part. If you are unhappy or have further questions at any stage, please address your concerns to the researcher (Lauren Haigh), or if you'd prefer, you can contact one of the research supervisors **Dr Dawn Leeming** or **Dr Joyce Marshall** using the contact information on page 2.

Will all my details be kept confidential?

All information given to me will be kept completely confidential and will not be shared with anyone else, however, you give consent to anonymous quotations being used in the thesis. If any information discussed makes me think that you need support or are at risk, I will signpost you to appropriate helplines or organisations either at the time of the interview or as soon as possible after.

All your data will be kept securely on the on-campus university servers with the University of Huddersfield being responsible, as the data controller, of securely managing all data.

All names or locations you give will be given false names before the information is presented in the assignment, in compliance with the Data Protection Act and ethical research guidelines and principles. **No information can be linked back to you; therefore, you are free to discuss openly with the researcher.**

I would like to take this opportunity to thank you for taking the time to read this.

Contact details

Lauren Haigh (Researcher) – Lauren.Haigh@hud.ac.uk or via Facebook.

Dr Dawn Leeming (Supervisor) – D.Leeming@hud.ac.uk or 01484 473545

Dr Joyce Marshall (Supervisor) – J.Marshall@hud.ac.uk or 01484 473529

Helpline contacts

National breastfeeding helpline (breastfeeding support) – 0300 100 0212

La Leche League GB (breastfeeding support) – 0345 120 2918

NCT (breastfeeding support) - 0300 330 0700

Family lives (parenting advice and support) - 0808 800 222

Gingerbread (support and expert advice for single parents) - 0808 800 222

The Mix (support and advice for under 25's) - 0808 808 4994

¹ As a legal obligation to research participants I am required to inform you of the following:

- The legal basis for collection and processing of your data is a task in the public interest.
- The researcher (Lauren Haigh), as the data processor, is the recipient of all data.
- All data will be deleted after 10 years from completion of project.

If you wish to make a complaint about the management of your data, you should contact the data protection officer which is the University Solicitor. If you're not satisfied with this, you may take your complaint to the Information Commissioner's Office (ICO).

Appendix C: Consent form including demographics for online interviews

Consent

Please read the following. Once this is done, please choose whether you consent and want to take part. If you do, please sign using your **Wire** username. Please do not sign using your real name. This is to ensure your anonymity and confidentiality.

- *I confirm that I have read and understood the participant information sheet related to this research and have had the opportunity to ask questions*
- *I understand that my participation is voluntary and that I am free to withdraw at any time without reason or consequence*
- *I am currently residing in the UK*
- *I am breastfeeding or breastfed between the ages of 16-21 years old*
- *Whilst breastfeeding I lived with a member of family excluding **only** my partner/children, such as mum/dad/grandparent/sibling/aunt/uncle etc.*
- *I understand that all of my data will be anonymous and confidential and give permission for quotes to be used in a masters thesis report/published journal article*
- *I am happy to take part in a one-to-one online interview with the researcher using the app/website Wire*

Demographic question

Please answer the next few questions (all answers will be kept confidential and anonymous) and then complete the form

Q1

How old are you?

Q2

What is your ethnicity?

- ☐ White (British, English, Welsh, Scottish, Northern Irish, Irish, Gypsy or Irish Traveller, any other white background)
- ☐ Mixed / Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, any other Mixed/Multiple ethnic background)
- ☐ Asian / Asian British (Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)
- ☐ Black (African, Caribbean, any other black background)
- ☐ Other (please state)

Q3

What is your marital status?

- ☐ Single
- ☐ Living with partner
- ☐ Married
- ☐ Separated

☐ Divorced

☐ Widowed

Q4

Which family members do you/did you live with whilst breastfeeding?



Q5

How old were you when you breastfed? You may select more than 1 answer

☐ 16

☐ 17

☐ 18

☐ 19

☐ 20

☐ 21

Q6

How long did you breastfeed for? If you have breastfed more than one child, please state how long you breastfed each separately

Wire username

Please write your **Wire** username

Contact details

Lauren Haigh (Researcher) – Lauren.Haigh@hud.ac.uk

Dr Dawn Leeming (Supervisor) – D.Leeming@hud.ac.uk or 01484 473545

Dr Joyce Marshall (Supervisor) – J.Marshall@hud.ac.uk or 01484 473529

Appendix D: An example of an opener sent to participants shortly before the interview

Hello, before we start the interview, I just want to let you know that this is completely voluntary, and you can stop at any point without giving a reason. You are also free to take a break and we can finish the interview at a different time/date if you need.

Within the interview itself, please give as much detail as you're comfortable giving. Even if something seems irrelevant, it is better to include it just in case. There is a set list of questions I will ask; however, I may also ask questions about your responses if they seem relevant to the study. However, if you do not want to answer any question please just say. Also, if you do not understand any questions or want me to explain a bit more, again please just say.

All of your data will be kept secure, anonymous and confidential, with the exception of quotes which may be used anonymously in the final thesis. If you want to withdraw your data from the study for any reason, you have up until 2 weeks from this date, making your latest data withdrawal date DD/MM/YYYY.

Do you have any questions?

Appendix E: Questionnaire

Information sheet

An exploration into the impacts of others on UK teen mothers' decision to breastfeed

You are being invited to take part in a web-based research project. Before you decide if you want to take part please take time to read the following information. If anything is not clear or if you would like more information, please contact the researcher at Lauren.Haigh@Hud.ac.uk or via Facebook.

What is the purpose/aims of this project?

This research is being carried out by Lauren Haigh, for my MSc by research (Psychology) course at the University of Huddersfield. It will attempt to explore UK teen mothers' experiences of breastfeeding whilst living with their family, however brief. On the following page you will find a few quick demographic questions followed by questions on 3 different topics areas within breastfeeding which should be answered in detail. The questionnaire should take approximately 30 minutes depending on how much you want to write.

Your participation

Your participation in this anonymous questionnaire is entirely voluntary. You do not have to take part, can decline to answer any questions and you may exit the questionnaire at any stage. You may withdraw your data for up to 2 weeks after completion of questionnaire by sending your random participant ID code, allocated on the next page, to Lauren.Haigh@hud.ac.uk or via Facebook.

Are there any disadvantages to taking part?

There should be no expected disadvantages to taking part. If you are unhappy or have any further questions at any stage, please address these concerns to Lauren Haigh (researcher) or Dr Dawn Leeming or Dr Joyce Marshall (supervisors).

Confidentiality

All information will be kept completely confidential and will not be shared outside of the research project. All your data will be kept securely on the on-campus university servers.

Quotations from your answers may be used in the final report, though all names or locations you mention will be anonymised, in compliance with the Data Protection Act and ethical research guidelines and principles. **No information can be linked back to you; therefore, you are free to discuss as much as you would like.**

What will happen to the results of the research study?

The results of this research will be written up into a report and presented for assessment in January 2020. If you would like a one-page summary of this, please contact the researcher by email.

Contact details

Lauren Haigh (Researcher) – Lauren.Haigh@hud.ac.uk or via Facebook.

Dr Dawn Leeming (Supervisor) – D.Leeming@hud.ac.uk or 01484 473545

Dr Joyce Marshall (Supervisor) – J.Marshall@hud.ac.uk or 01484 473529

Helpline contacts

National breastfeeding helpline (breastfeeding support) – 0300 100 0212

La Leche League GB (breastfeeding support) – 0345 120 2918

NCT (breastfeeding support) - 0300 330 0700

Family lives (parenting advice and support) - 0808 800 222

Gingerbread (support and expert advice for single parents) - 0808 800 222

The Mix (support and advice for under 25's) - 0808 808 4994

As a legal obligation to research participants I am required to inform you of the following:

- The legal basis for collection and processing of your data is a task in the public interest.
- The researcher (Lauren Haigh), as the data processor, is the recipient of all data.
- The University of Huddersfield is responsible, as the data controller, of securely managing all data.
- All data will be deleted after 10 years from completion of project.

If you wish to make a complaint about the management of your data, you should contact the data protection officer which is the University Solicitor. If you're not satisfied with this, you may take your complaint to the Information Commissioner's Office (ICO).

Electronic consent

Please select your choice below. You may print a copy of this consent form for your own records. Clicking the "Agree" button indicates that:

- *You have read and understood the participant information on the previous page and have had the opportunity to ask questions*

- You are currently residing in the UK
- You are 16-21 and breastfeeding or previously breastfed between these ages
- Whilst breastfeeding you lived with a member of family **other than just your partner/children**, such as parents/grandparent/siblings etc.
- You understand that all of your data will be anonymous and confidential and give permission for quotes to be used in a masters thesis report/published journal article

☐

Agree

☐

Disagree

\$_{rand://int/00000:99999}.

Here is your unique ID code. Please keep this safe as you will need it if you decide to withdraw your data from the study.

Demographic 1

How old are you?

Demographic 2

What is your ethnicity?

☐

White (British, English, Welsh, Scottish, Northern Irish, Irish, Gypsy or Irish Traveller, any other white background)

☐

Mixed / Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, any other Mixed/Multiple ethnic background)

☐

Asian / Asian British (Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)

☐

Black (African, Caribbean, any other black background)

☐

Other (please state)

Demographic 3

How old were you when you breastfed? You may select more than 1 answer.

☐

16

☐

17

☐

18

☐

19

☐

20

☐

21

Demographic 4

What is your marital status?

- ☐ Single
- ☐ Living with partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Demographic 5

Which family members do you/did you live with whilst breastfeeding? If this has changed during your time breastfeeding, please explain.

Demographic 6

Did you have your own bedroom when breastfeeding?

Demographic 7

How long did you breastfeed for? If you have breastfed more than one child, please state how long you breastfed each separately

Please answer each question on the following page, giving as much detail as you feel comfortable with. The more detail, the better. Even if certain information seems irrelevant to the study, it may in fact be useful, so please include it. If you have already discussed a question in a previous answer, please feel free to skip this or add more detail

Topic 1:

The decision to breastfeed your baby

Please remember to give as much detail in your answers as you are comfortable with.

If you have breastfed more than 1 child, please answer the questions for each child

Topic 1:1

Please tell the story of how and when you decide that you were going to breastfeed your baby (including as much detail as possible)

Topic 1:2

Were you always going to breastfeed? Please explain

Topic 1:3

Did anyone else influence you in any way when making the decision of how to feed your baby?

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:

Living and negotiating with family

Please remember to give as much detail in your answers as you are comfortable with

If you have breastfed more than 1 child, please answer the questions for each child

Topic 2:1

When in the house, when and where did you breastfeed?

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:2

How did you living with family affect your experience with breastfeeding? Please discuss things such as any help you had with breastfeeding (emotional or physical) and how feeding in front of family made you feel, as well as anything you think is relevant.

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:3

What do you think your family thought about your decision to breastfeed?

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:4

If you fed in front of family, how did this make you feel?

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:5

What kind of support within the family, if any, did you receive? How helpful did you feel it was?

A rectangular text input box with a light gray border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, indicating it is a multi-line text area.

Topic 2:6

How did you discuss your final decision to breastfeed with your family? How did they react?

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 2:7

Were there any family member/s who you felt helped or hindered with your breastfeeding? Please explain

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 2:8

If any, how much input did you allow from family members when breastfeeding (e.g. where, when etc. in the house)? Please explain

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 2:9

Do you feel being in the family home caused any constraints with breastfeeding? Please explain

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 3:

Breastfeeding outside of the home and in public places

Please remember to give as much detail in your answers as you are comfortable with

If you have breastfed more than 1 child, please answer the questions for each child

Topic 3:1

What are your general experiences of breastfeeding in public? Are there any experiences that stand out to you, positive or negative?

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 3:2

How did you decide whether or not to breastfeed in public? What influenced you with this decision?

A rectangular text input box with a light gray border. On the right side, there are three vertically stacked buttons: a small upward arrow, a square button, and a small downward arrow. On the bottom left, there are two small square buttons, and on the bottom right, there is a small rightward arrow.

Topic 3:3

Can you tell me if there are any circumstances you would feel more or less comfortable with breastfeeding and why? (E.g. certain places or with certain people).

A rectangular text input field with a thin black border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, both with standard arrow and track icons. The interior of the box is empty.

Do you have anything else to add about anything to do with the subject area of teen motherhood and/or breastfeeding?

A rectangular text input field with a thin black border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom, both with standard arrow and track icons. The interior of the box is empty.

Appendix F: Step-by-step guide of how to set up a Wire account

A guide on how to download and make an account on the Wire app

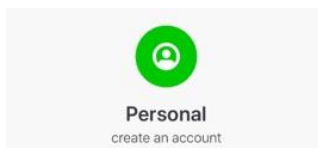
Wire is the instant messaging app that we will be using in this study. You can use Wire on Apple/Android devices or on a computer at <https://app.wire.com/auth/?hl=en#login>. To download and set up the app, please complete the following steps. If you know how to do this then please skip to steps 11 and 12.

- 1) Go onto the app store/play store
- 2) On the search bar, type Wire
- 3) Click on the Wire app and press download



- 4) Open the app once it has downloaded

- 5) Click personal.



- 6) Create your account by inserting either your email address or phone number (this will not be visible to anyone else)

- 7) You will now be sent a code to your email address or phone (depending on what you signed up with). Please insert this code to verify your account.
- 8) Enter a false name (to protect your identity)
- 9) Set your password (at least 8 characters long)
- 10) The app will come up with a username for you. Either keep this or choose a different one (making sure that it does not contain any personal information, such as your name)
- 11) Once you have made your account please complete the consent form, by following the link on the consent form, including your Wire username in the correct field. I will then add you. My username is @laurensaigh
- 12) Using the app, we will then find a suitable time/date for the interview to take place.

If you have any questions or don't understand any aspect of this, please email me at Lauren.Haigh@hud.ac.uk

Appendix G: Examples of the transcript data

Transcript 1:

Interviewer: Even though some of your family thought breastfeeding was weird, did they give you any support (emotionally or physically)?

Participant: My mum did get me the odd cups of tea here and there but I was the one who has to gather my food and water and then begin to feed him

Transcript 2:

Interviewer: When you needed to breastfeed in public how did you make the decision to do it?

Participant: I tried to distract him with other things but nothing was settling him and the bus was coming for another hour so I was kinda stuck and I had no option the first time

Transcript 3:

Interviewer: When you were home when and where did you breastfeed?

Participant: Everywhere. On the sofa and in bed. Whenever I was when baby needed feeding

Transcript 4:

Interviewer: When you say frowned upon, who do you mean by?

Participant: My partner at the time, mum was all for breast is best for baby and when I was first making my mind up she said that breast is best and bottle isn't good for baby and quite a few people around me was like this

Appendix H: Examples of coding of transcripts

| Transcript 1 | Coding |
|--|--|
| <p>Interviewer: Apart from your family nurse who seemed to have a big influence on your decision, did anyone else influence you on how to feed your baby?</p> <p><i>Participant: Not really at first because I just made the decision whilst I was pregnant I didn't really discuss this with anyone else. Because I was so young everyone was still getting over the shock of me being pregnant so it felt like I couldn't talk about it with family and I was a bit nervous to talk about breastfeeding as I know everyone sees boobs as like a sex thing don't they so I didn't want to get laughed at or judged for wanting my baby to breastfeed.</i></p> | <p>No other influences except professional</p> <p>Shock of teen pregnancy overshadowed everything else</p> <p>Anxiety talking about breastfeeding. Seen as abnormal?</p> <p>Sexualisation of the breast</p> <p>Fear of judgement or scrutiny</p> |
| Transcript 2 | Coding |
| <p>Interviewer: How and when did you decide you were going to breastfeed your baby?</p> <p><i>Participant: When I had my first child I was so determined to breastfeed due to the benefits but I struggled within the first few days so moved on to bottle, this made me more determined to breastfeed my second child so I knew soon as I was pregnant with my second that's what I was going to do.</i></p> | <p>Knowledgeable about benefits of BF</p> <p>Difficulties with breastfeeding first child</p> <p>Made more determined with second child</p> <p>Infant feeding choice made early on</p> |
| Transcript 3 | Coding |
| <p>Interviewer: Because of the negative reactions from your parents, did this hinder you in your breastfeeding journey?</p> <p><i>Participant: Yeh id say so cause I started feeling so lonely cause apart from my sister I never got a with anyone cos he was pretty much feeding all the time for the first couple months. I didn't go out in the first few months cause I was scared I would get negative reactions with been a teen mum.</i></p> | <p>Lonely</p> <p>Isolated</p> <p>Didn't want to leave house</p> <p>Fear of judgment for being a teen mother</p> |

A process of overcoming difficulties

So much you're up against

"Breastfeeding is very difficult/demanding if you don't have the right support in place, especially if you are younger, there's so much people are up against – stigma, latching, lack of support, pain" (Faye)

"I think thats natural no matter what your doing that if someone calls you out for something or says something negative you are affected by it" (Gracie)

"I felt that if I latched him on wrong people could tell I was a teenage mum and that I didn't know what I was doing" (Alex)

"I know some people get embarrassed and some even think it's wrong or perverted but I just see it as my baby needs milk ... yet because I let her feed from my nipple, a much more nutritious milk, that's wrong?" (Danielle)

"I used to kind of dread baby needing a feed because I'd just feel so awkward talking to my mum & dad from the other room ... because of the awkwardness plus with how tired I was feeling and emotional, I was 18 and had a massive change in my life I felt it affected my breastfeeding journey negatively" (Alex)

Learning and adjustment

"I did feel uncomfortable as was loads of people around and I was standing trying to get a 4 week old to latch" (Faye)

"I had to adapt to so many things at once, from becoming a new mum at 17, to learning how to juggle everything with a baby and college, to things like adapting to be less bothered by people's opinions and views (Jess)

"I came to terms pretty quickly that people were looking at my boobs however my feelings towards my boobs had changed and I was in more of a "my boobs are tools of food for my baby and not a sexual object anymore" state of mind" (Louise)

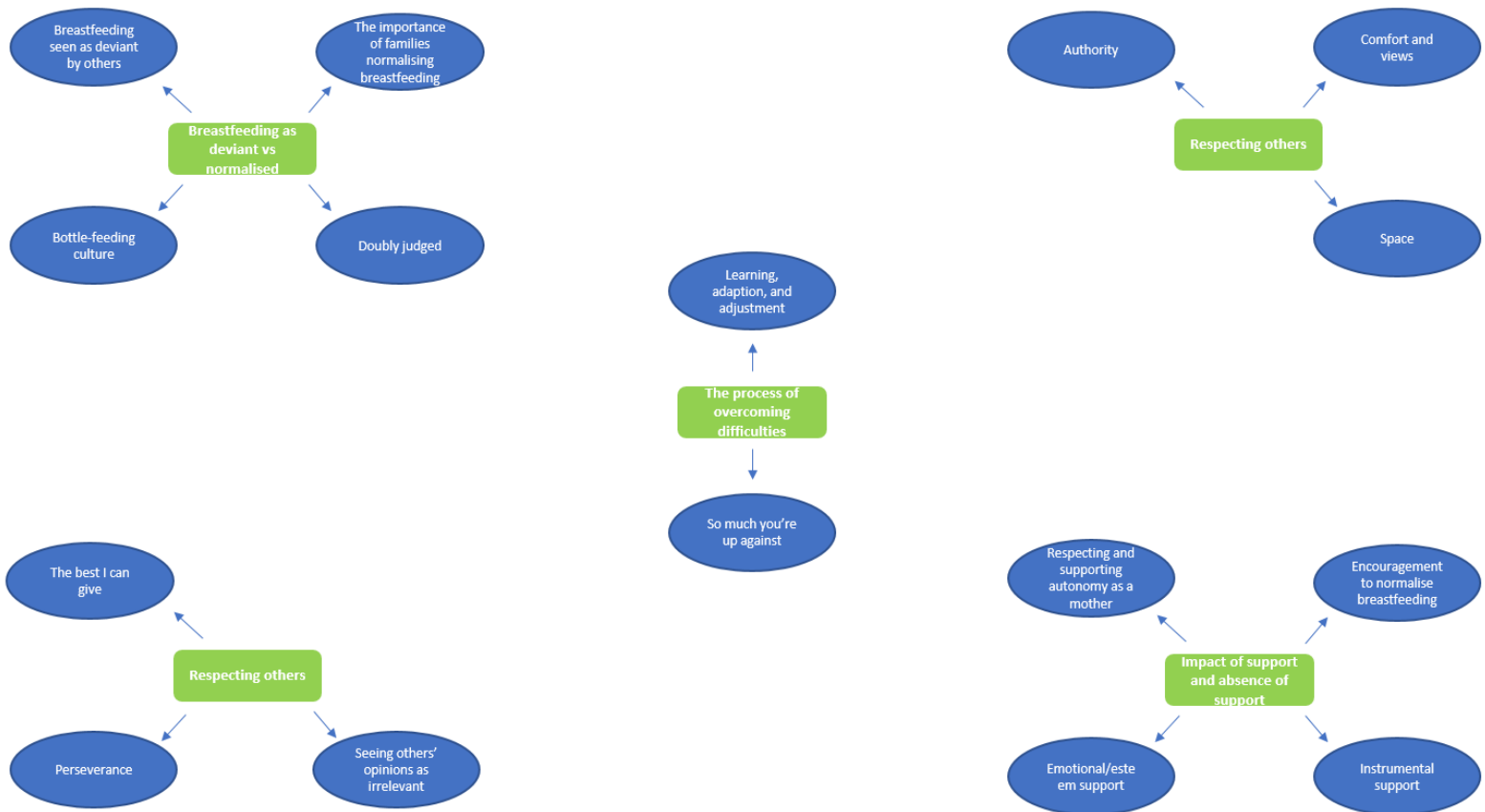
"Using a wrap sling was very helpful for feeding discreetly. Once I'd established feeding and learned how to use my wrap, I just carried on with my normal life while feeding" (Ruby)

"At first ya kinda dont know what your doing either like the best latch positions and how to be discrete" (Gracie)

"When learning its hard to kinda hide your boob when your holding the baby with one hand and trying to get your latch right theres no way to be discreat about it" (Louise)

At first it was a bit of a obsitcal for the family as i was sat down feeding learning adapting. So i feel this felt for the family that breastfeeding became a "big of a excuse" to get out of doing things. Like i cant put the shopping away as the baby needs feeding. But it wasnt a excuse to me. As i got better it kind of became a second arm and i could do more as i went along and feed and it was quicker and less often" (Louise)

Appendix J: Final thematic map



Appendix K: Original ethics form submitted to the School of Human and Health Sciences School Research Ethics Panel

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences – School Research Ethics Panel

APPLICATION FORM

Please complete and return via email to:

Kirsty Thomson SREP Administrator: hhs_srep@hud.ac.uk

Name of applicant: Lauren Haigh

Title of study: An exploration into the impacts of others on UK teen mothers' decision to breastfeed their baby.

Department: Psychology Date sent: 04/01/19

Please provide sufficient detail below for SREP to assess the ethical conduct of your research. You should consult the guidance on filling out this form and applying to SREP at <http://www.hud.ac.uk/hhs/research/srep/>.

| | |
|--|---|
| Researcher(s) details | Lauren Haigh Student |
| Supervisor(s) details | Dawn Leeming Joyce Marshall |
| All documentation has been read by supervisor (where applicable) | Yes. |
| Aim / objectives | <p>A. Explore teen mothers' experiences of breastfeeding around others. B. Explore how others (both inside and outside of the mothers' immediate family environment) influences and impacts her decisions to breastfeed. C. Understand how teen mothers negotiate their decision to breastfeed with others.</p> <p>It is important to research mothers aged 15 to 19 as previous research has not focused on this age group. Most research will stick to participants aged 16+ as it is easier to access and gain ethical consent for this. However, I am wanting to explore the experiences of mothers 15+ as it is vital that the voices of younger mothers are heard.</p> |
| Brief overview of research methods | <p>Two or three online virtual focus groups will take place via Facebook to collect data for this study. I will advertise the study on a teen mothers Facebook group which I already have access to from past personal use. Through this, if women are interested I will ask them to private message me via Facebook. I will then send the information sheet and consent form for them to read. The consent form will ask participants to read and then reply either agreeing or disagreeing to take part. If they want to take part, I will then ask a few questions including demographics, such as age, ethnicity, length of breastfeeding etc. (attached to email) in which participants can reply directly to the messages via Facebook. The virtual focus groups will be taking place asynchronously, each being open for up to 3 days, with 1 per week. Participants will be asked if they have a preference on which dates they would like to take part. They will then be allocated to a focus group. On the day on the focus groups, all participants for that focus group will be added to a 'group chat' on Facebook. I will then explain briefly what is going to happen. I will ask women, if possible to reply/discuss topic areas within the hours of 10am and 6pm so that I can be around, reading the chat at all times. I will explain that participants can discuss any of the topic areas as they come up and that if they do not want to, they do not have to discuss that area. Once each focus group is over, I will end the chat and thank participants for taking part. They will then be sent a debriefing form. I feel this is the most advantageous method, however, I may include an option for individual interviews if participants prefer.</p> |
| Project start date | 04/03/19 |
| Project completion date | 16/09/19 |

| | |
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| Permissions for study | <p>I do need permission from admin of the group to advertise the study. I have private messaged her asking for permission to post the advertisement, however, I am still waiting for a reply from her.</p> <p>I do not need permission to start a group chat within Facebook.</p> |
| Access to participants | Once permission is given, I will advertise the study on the teen mothers Facebook group using a flyer (see attached). After this, if women display interest in taking part, I will ask them to private message me, and that is when I will send them the information sheet and consent form via private Facebook message. |
| Confidentiality | I will explain that all information discussed between me and the participants will be kept confidential and that, apart from my supervisors, no one else will have access to the data. As well as this, on the consent form I will state that any information discussed within the group chat must stay within that group of people and should not be discussed with anyone outside of the chat for any reason. The only other exception is if someone discussed something that suggested themselves or someone else could be at risk of harm. In this circumstance, it would be difficult as this participant could be posting from any geographical location and I will only know their Facebook user ID. Because of this semi-anonymity, I would signpost them to what I see as appropriate sources of support. |
| Anonymity | In the report write up, all participants will be given pseudonyms in order to protect their identities. If any places/locations/other people are discussed, these names will also be changed. |
| Right to withdraw | All participants will have the right to withdraw, at any point up until write up in June 2019, for any reason, without consequence. If a participant does wish to withdraw, they can simply message me via private message on Facebook or email myself using the contact details on the information sheet. If no data has been collected at this point, then the participant will be thanked and told they do not have to do anything else. If the data has been collected, this data as well as participant details will be deleted straight away. |
| Data Storage | Once the data is collected, this will be stored on a word document on the university K drive, which is encrypted. The data on Facebook will be deleted from my account. I will also ask each participant to delete the data from the group chat as well. The laptop itself is password protected and to access the K drive, I also need to log in with my personal password. Any physical copies of data, used in analysis will be locked away in a drawer. The electronic data will be stored for 10 years as the University now recommended. |
| Psychological support for participants | If a participant suggests or seems like they need support during the data collection period, I will discuss this with them. I will then discuss this with my supervisors. Depending on the situation, I will offer information such as helplines available to the general public, for example: for mental health support I would signpost them to Samaritans or SANEline. For breastfeeding support, the National Breastfeeding Helpline or their health visitor. |
| Researcher safety / support (attach completed University Risk Analysis and Management form) | There are no foreseeable risks associated with the study. |
| Information sheet | Participant information sheet attached |
| Consent form | <p>Participant consent form attached</p> <p>It is assumed as mothers, participants will be Gillick Competent and therefore parental consent for those under 16 is not required. In this it is presumed that they have sufficient intelligence, competence and understanding and therefore the capacity to decide whether to take part in the study, after being given all the information required, in line with the BPS Code of Human Research Ethics, prior to giving consent.</p> <p>At the beginning of the group chat/interview, I will also remind participants what will happen in the group chat/interview and how the data is being used. I will also monitor the group chat discussion in case it appears a participant does not realise that this is a research project. If I have any concerns, I will re-check consent using plain English to explain how their data will be used.</p> |
| Letters / posters / flyers | Flyer that will be used to advertise attached |

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| Questionnaire / Interview guide | <p><u>Topic areas</u></p> <p>The decision to breastfeed your baby, for example:</p> <ul style="list-style-type: none"> • Influences of other people • How and why participants decided to breastfeed and when this decision was made. <p>Living with family</p> <ul style="list-style-type: none"> • It's effects on breastfeeding • How much input participants allowed from family in this decision. • Support • Advantages/disadvantages of breastfeeding whilst living with extended family as oppose to just with partner/other children. <p>Negotiating with family</p> <ul style="list-style-type: none"> • Family discussions on decision to breastfeed. • Whose decision it was to breastfeed (solely mothers or others too?) • Where and when participants breastfed • If and how this was affected by family's views. <p>Public breastfeeding away from family</p> <ul style="list-style-type: none"> • The decision to breastfeed in public places • Experiences of this. |
| Debrief (if appropriate) | Debrief form will be sent individually to each participant once the focus groups have concluded. This has been attached. |
| Dissemination of results | The data collected from the study will be presented in my master's thesis in September 2019 and possibly written up for journal publication. |
| Identify any potential conflicts of interest | There are no potential conflicts of interest identified in this study. |
| <p>Does the research involve accessing data or visiting websites that could constitute a legal and/or reputational risk to yourself or the University if misconstrued?</p> <p>Please state Yes/No</p> <p>If Yes, please explain how you will minimise this risk</p> | No. |
| <p>The next four questions in the grey boxes relate to Security Sensitive Information – please read the following guidance before completing these questions: http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2012/oversight-of-security-sensitive-research-material.pdf</p> | |
| <p>Is the research commissioned by, or on behalf of the military or the intelligence services?</p> <p>Please state Yes/No</p> <p>If Yes, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data</p> | No. |
| <p>Is the research commissioned under an EU security call</p> <p>Please state Yes/No</p> <p>If Yes, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data</p> | No. |
| Does the research involve the acquisition of security clearances? | No. |

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| Please state Yes/No | |
| If Yes, please outline how your data collection and storages complies with the requirements of these clearances | |
| Does the research concern terrorist or extreme groups? | No. |
| Please state Yes/No | |
| If Yes, please complete a Security Sensitive Information Declaration Form | |
| Does the research involve covert information gathering or active deception? | No. |
| Please state Yes/No | |
| Does the research involve children under 18 or participants who may be unable to give fully informed consent? | Yes. Women aged 15-19 are invited to participate in this study. However, due to being mothers, it is assumed that they are Gillick competent. In this, they are assumed to have sufficient intelligence, competence and understanding and therefore the capacity to decide whether to take part in the study. |
| Please state Yes/No | |
| Does the research involve prisoners or others in custodial care (e.g. young offenders)? | No. |
| Please state Yes/No | |
| Does the research involve significantly increased danger of physical or psychological harm or risk of significant discomfort for the researcher(s) and/or the participant(s), either from the research process or from the publication of findings? | No. |
| Please state Yes/No | |
| Does the research involve risk of unplanned disclosure of information you would be obliged to act on? | No. It is not assumed that there will be any risk of unplanned disclosure of information that would have to be acted on. |
| Please state Yes/No | |
| Other issues | N/A |
| Where application is to be made to NHS Research Ethics Committee / External Agencies | No. |
| Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy | |

All documentation must be submitted to the SREP administrator. All proposals will be reviewed by two members of SREP.

If you have any queries relating to the completion of this form or any other queries relating to SREP's consideration of this proposal, please contact the SREP administrator (Kirsty Thomson) in the first instance – hhs_srep@hud.ac.uk

Appendix L: Ethical approval

Dear Lauren,

The reviewers of your SREP Application have confirmed that you have addressed the issues raised to their satisfaction and your application has now been **approved outright**.

With best wishes for the success of your research project.

Regards,

Kirsty
(on behalf of SREP)

Kirsty Thomson
Research Administrator

Appendix M: Amendments form submitted to the School of Human and Health Sciences School Research Ethics Panel

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences – School Research Ethics Panel

AMENDMENTS TO PROPOSAL

Applicant Name: Lauren Haigh

Title of study: An exploration into the impacts of others on UK teen mothers' decision to breastfeed their baby

| | Amendments required | Please explain below how you are addressing the required amendments. Please refer to any revisions you have made to documents (if appropriate), indicating page & line numbers. |
|------------------------|--|--|
| Researcher(s) details | Providing a summary of previous qualification might be useful her to demonstrate appropriateness of Lauren as a researcher for this topic | I completed an undergraduate psychology degree (2015-2018) at University of Huddersfield in which I conducted a qualitative research study on men's experiences of miscarriage. |
| Supervisor(s) details | | |
| Aim / objectives | Clarify overall aim and separate objectives to achieve the aim You refer to the 'extended family', but appear to mean mother, father, brothers and sister who are not really the extended family: clarification needed | Overall aim: Explore how others (both inside and outside of young mothers' immediate family environment) shape their infant feeding choices and practices Objectives: Explore how mothers decided on their feeding choices Explore how mothers feel about feeding in front of others and their practices in relation to this To understand how mothers negotiate feeding choices within family network I will now say 'household and immediate family networks' as it is hard to predict who will live together as a family or which family members will be closely involved in the mother's life. |
| Methodology | What are the inclusion and exclusion criteria for the selection of participants? Greater clarity about the 'chats' and whether each of the 'topic areas' is considered a separate chat. | Inclusion criteria: Aged 16-19 year old female. Resides in the UK. Currently breastfeeding or breastfed in the past 2 years. Living within a family household when breastfeeding Each topic area will be considered as a separate 'chat' in order to not confuse information from previous topic areas with the new topic areas. |
| Permissions for study | | |
| Access to participants | You mention accessing participants via a Facebook group that you have previously been a member of. There will be conflicts of interest here with you having been a member and presumably any posts you made would still be available. Though this was a number of years ago that you were a | I will now not be using Facebook to recruit participants. I will now recruit using a wider variety of methods. I will post the recruitment flyer in parenting forums such as Mumsnet and Netmums which allow advertisements to be made on their pages. I will also post this on Instagram in which I will be able to use 'hashtags' to make sure the flyer |

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| | member you should look for other ways to recruit participants. | reaches as many people as possible. For the purpose of these, I will make completely new accounts in which to share the flyer, so as not to influence or affect participants who may already know me or be connected to me via my own personal social media profiles. As well as this, I am hoping to (with permission) print and display the flyer in parenting/breastfeeding groups such as 'baby cafe's' and 'Surestart centres' etc. around the local area. |
| Confidentiality | <p>It will be difficult even if you use a closed Facebook group to maintain confidentiality unless participants use a separate account as they will have their names and other details on their Facebook account. Can you look at ways to overcome this or use an alternative method.</p> <p>What happens if there is a breach from one of the participants? Consider the use of an alternative more secure platform or strengthen justification for Facebook from a safety perspective (with supporting documentation to evidence the protection of confidential information).</p> | <p>After recruitment via the above means, I will now use an App called 'Wire'. This works via username and therefore, no identifiable information will be available to those in the group chat, except their username. Participants will be asked to set up a Wire account (they will be sent a step-by-step guide on how to do this) purely for the research with a new ID, rather than using a social media app that they already use that could be linked to them.</p> <p>When making the username, in the guide I have asked them not to use any information to protect them further.</p> <p>Wire uses end-to-end encryption and has been independently audited by 2 different security companies in 2017 and 2018 (https://wire.com/en/security/).</p> |
| Anonymity | <p>The same concerns as with confidentiality apply here as well.</p> <p>In addition to the above, what can you do to stop the participants sharing information from their own Facebook page with others.</p> <p>What can you do to ensure that they do delete any posts etc</p> <p>You have said that you would use pseudonyms when writing up the research; but how will you provide anonymity for participants during data collection in the on-line chats?</p> | <p>As above I will now use the app Wire. As nothing except participants usernames will be accessible to other participants, this means that if participants were to share any data from the chat, outside of the chat, it couldn't be personally linked to any participant as there would be no accessible identifiable information.</p> <p>Wire also have a 'timed message' feature. Through this I can set all messages to self-delete on all devices after a certain amount of time. For this study I will be setting it to self-delete in 4 weeks from participants first being added to the conversation. https://support.wire.com/hc/en-us/articles/213216845-How-do-Timed-Messages-work-</p> <p>I will encourage the participants, when making a username, to ensure it doesn't contain any identifiable information, such as their name. As username is the only information that is accessible to others in the chat, this will protect all participants anonymity.</p> |
| Psychological support for participants | <p>You also need to think here what is there is a risk of harm to the participants, for example if they are stressed and might harm themselves? What if the discussions they have with you cause distress but they do not access services?</p> | <p>This research will not be probing any topic areas that are likely to be distressing. Before each new topic area is brought up, I will recheck that everyone is fine to continue. Because this is online research, participants are free to be silent and in the unlikely event it is found distressing, do not need to answer. I will make sure that participants can privately message me on Wire if they have any issues that they do not want to discuss within the group and that they know they can leave the chat at any time. Also, the chat will always be moderated by myself.</p> |

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| | | <p>As well as this, there is no reason to believe that this group of participants is any more likely to harm themselves than any other members of the public and there is no reason to believe that the focus group would lead them to do so. Although the topics that will be discussed might relate to issues that have posed some challenges for the participants, this is the case for most research on meaningful topics. As discussed before, all participants (who are now all adults), will be fully informed of the purpose of the research and I would expect if anyone finds this topic area highly distressing that they would choose to not take part in the research.</p> <p>I have added support helplines to 'list of contacts' on the information sheet.</p> |
| Data Storage | <p>If you are going to use Facebook, you need to state what happens to Facebook chats when they are deleted. How can you be sure that participants will delete the conversations?</p> <p>As discussed you might consider an alternative platform which facilitates more robust protection and meets the requirements for data protection.</p> <p>Evidence needed to support the security of the chosen platform</p> | <p>I will be using Wire instead of Facebook. As admin of the group, I can set messages to be 'timed messages' which will self-delete from all devices after a certain amount of time. https://support.wire.com/hc/en-us/articles/213216845-How-do-Timed-Messages-work-</p> |
| Researcher safety / support (attach complete University Risk Analysis and Management form) | <p>RAM form not completed – supervisor email to support this as LH will not have direct contact with participants.</p> <p>Consider how you will feel if participants share information that is disturbing or upsetting to you? Where will you get support? What will you do if you consider that any participants are in danger?</p> | <p>If participants share anything that disturbs or upsets me, I will discuss this with my supervisors first and foremost. After this there are support lines which can be accessed for emotional support such as Samaritans, The Mix etc.</p> <p>I will not personally know participants or where they live etc. If they are a danger to themselves, I will try to listen to what they are saying, signpost them to places to go, and contact my supervisors to make them aware and see if they can suggest anything.</p> |
| Information sheet | <p>This needs some re writing as there are a number of areas where the language may not be understood by lay people. Keep it as simple as possible. You should also consider having a lay title as well</p> | <p>I have rewritten parts of the information sheet that used more complicated words than were needed and tried to simplify it overall. I have also replaced the official title with a lay title.</p> <p>I have attached all new versions of the forms.</p> |
| Consent form | <p>The consent form is fine but there are concerns about your assumption about Gillick competence. Just because the participants have had a baby does not mean that they are Gillick competent. Can you look at other ways of assessing competence of those under the age of consent. A more robust method of assessing Gillick competence is needed with supporting evidence or as discussed you may amend the age range of the target population</p> <p>You also cannot assume that they have sufficient intelligence just because they are mothers. Hence the importance of the information sheets.</p> | <p>I will now use participants aged 16-19 in order to make sure that participants are of age to make an informed decision on whether to take part. After speaking with my supervisors, we decided to focus initially on 16-19 year olds, however, if there are a lack of participants, think about increasing this to 21 year olds.</p> |
| Letters | | |

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| Questionnaire | | |
| Interview schedule | <p>Can you make it clear in the participant information sheet that the participants do not have to be available for the full three days.</p> <p>A semi-structured topic guide, would provide greater clarity about the issues to be discussed within the group; there should be a separate guide for each 'chat'</p> | <p>I have added this information to the 'what do I have to do?' section, lines 4-5.</p> <p>Topic 1: the decision to breastfeed your baby</p> <ul style="list-style-type: none"> • How did you decide that you were going to breastfeed your baby? • When did you make this decision? • Were you always going to breastfeed? • Did anyone else influence you in any way when making the decision of how to feed your baby? <p>Topic 2: living and negotiating with family</p> <ul style="list-style-type: none"> • When and where did you breastfeed? • How did you living with family affect your experience with breastfeeding? (Probes: how did others help with feeding?, how did you feel feeding when others were around?, what did others say about your feeding decisions?). • What kind of support within the family, if any, did you receive? • How did you discuss your final decision to breastfeed with your family? How did they react? • How adamant was you with your decision to breastfeed when talking to family? Did anyone in your family not agree with your decision? • Was there a family member/s who you felt helped or hindered your decision to breastfeed? • How much input did you allow from family members when breastfeeding (e.g. where, when etc in the house)? <p>Topic 3: public breastfeeding away from family</p> <ul style="list-style-type: none"> • Can you tell me if there are any places where you wouldn't feel comfortable breastfeeding and why? • How did you decide whether or not to breastfeed in public? What influenced you with this decision? • What are your experiences of breastfeeding in public? Are there any experiences that stand out to you? |
| Dissemination of results | <p>If you are thinking of publishing the results add this here. Even if you are not sure at this stage it can still be useful to add this in case you do decide to publish.</p> | <p>I am thinking of publishing the results in an academic journal.</p> |
| Other issues | <p>Can you let us know what experience and training you have with regard to conducting research, particularly involving children.</p> <p>Relates repeatedly to 'extended family' but seems to mean immediate family i.e. parents and siblings... needs to</p> | <p>I completed a qualitative research project in my third year of my undergraduate degree. I do not have any specific experience or training conducting research with children specifically, however, I was a teen mother myself and have volunteered in several nurseries in the past, so I do have some experience with children and what it is like to be a teen mother. As well as this I have volunteered as a befriender for Kirklees befriending scheme, offering</p> |

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| | clarify this and perhaps define what she means with citation | companionship and social support to individuals with mental health issues. I will now say 'household and immediate family network' which refers to their family they live with i.e parents/siblings but also to the wider family network who may have an influence on their infant feeding choices. |
| Where application is to be made to NHS Research Ethics Committee | | |
| All documentation has been read by supervisor (where applicable) | | |

Signed:

Lauren Haigh
(SREP Applicant – electronic signature acceptable)

Date:13/03/2019

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| <p>Additional comments by reviewers: (You are not required to address these issues in order for SREP to approve your application. However, their consideration is likely to further improve the ethical conduct of your research.)</p> |
| |

Appendix N: Revisions form submitted to the School of Human and Health Sciences School Research Ethics Panel (interview)

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences – School Research Ethics Panel

PROPOSED REVISIONS TO PREVIOUSLY APPROVED APPLICATION

(Attach separate sheets as necessary)

Applicant Name: Lauren Haigh

Title of previously approved study: An exploration into the impacts of others on UK teen mothers decision to breastfeed their baby

Ref:

Date approved: 29.03.19

(please also give details here if the title is to be revised):

| Issue | Please clearly identify below revisions made to previously approved SREP application. |
|-----------------------|---|
| Researcher(s) details | Lauren Haigh |
| Supervisor details | Dawn Leeming Joyce Marshall |
| Aim / objectives | <p>Overall aim: Explore how others (both inside and outside of young mothers' immediate family environment) shape their infant feeding choices and practices</p> <p>Objectives: Explore how mothers decided on their feeding choices Explore how mothers feel about feeding in front of others and their practices in relation to this. To understand how mothers negotiate feeding choices within family network</p> <p>These aims and objectives will stay the same. I would just like to give the participants the choice of a face-to-face or virtual interview (via Wire app or Skype etc) with myself as well as allowing the choice of the already previously approved virtual focus groups.</p> |
| Research methods | <p>For the interviews I would use the previously approved topic guide in a semi-structured way. See below.</p> <p>Topic 1: the decision to breastfeed your baby</p> <ul style="list-style-type: none"> - How did you decide that you were going to breastfeed your baby? - When did you make this decision? - Were you always going to breastfeed? - Did anyone else influence you in any way when making the decision of how to feed your baby? <p>Topic 2: living and negotiating with family</p> <ul style="list-style-type: none"> - When and where did you breastfeed? - How did you living with family affect your experience with breastfeeding? (Probes: how did others help with feeding?, how did you feel feeding when others were around?, what did others say about your feeding decisions?). - What kind of support within the family, if any, did you receive? - How did you discuss your final decision to breastfeed with your family? How did they react? - How adamant was you with your decision to breastfeed when talking to family? - Did anyone in your family not agree with your decision? |

| | |
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| | <p>- Was there a family member/s who you felt helped or hindered your decision to breastfeed?</p> <p>- How much input did you allow from family members when breastfeeding (e.g. where, when etc in the house)?</p> <p>Topic 3: public breastfeeding away from family</p> <p>- Can you tell me if there are any places where you wouldn't feel comfortable breastfeeding and why?</p> <p>- How did you decide whether or not to breastfeed in public? What influenced you with this decision?</p> <p>- What are your experiences of breastfeeding in public? Are there any experiences that stand out to you?</p> |
| Permissions for study | <p>I have gained permission to post virtual copies of the flyer on the websites: Netmums, BabyCentre, The Green Parent, Channelmum, mothering.com.</p> <p>I have currently gained permission to post physical flyers at Yorkshire Children's Centre, Huddersfield.</p> <p>I am in the process of contacting other Surestart, Homestart and children's centres for permission.</p> |
| Access to participants | I would want to recruit using flyers still. These will be posted on online on websites (parenting forums like Mumsnet, The Green Parent etc). I will also be posting physical copies of the flyers at places such as Sure Start/Home Start centres, as well as around the university. None of this will be done via the NHS. |
| Confidentiality | Any names or other personal information that comes along with conducting face-to-face interviews will be kept completely confidential. Please see 'researcher safety' section. If I had to go to someone's personal address, the only people that would know this information would be myself and the person who making sure that I was safe. This would not be shared with anyone else and this information would be deleted after the interview. |
| Anonymity | Although I would need to know certain pieces of information that would make this not anonymous anymore, when writing up the thesis, as before, I will make sure I give this participant a pseudonym. Only I will know these personal details about the participant. |
| Right to withdraw | Just like on the virtual focus groups, once in the interview I will explain the participants right to withdraw at any time |
| Data Storage | I will record the interviews on my Dictaphone. This will then be transcribed to a word document which will be stored on the universities K drive as this is secure. |
| Psychological support for participants | This research is not probing any areas which would be especially likely to be distressing. However, in the one-to-one interview, just like in the focus groups, I will at points ask if the participant is ok to carry on and will make sure that she knows that we can stop at any point/take more time. If the interview is face-to-face, I will also be able to read the participants body language and see if they seem to be getting upset or distressed. I will make sure to include at the end of the interview appropriate helplines. If this participant seems to need more help, I can personally signpost her to a specific helpline or specific help either at the time of the interview, or as soon as possible afterwards. |
| Researcher safety / support (attach revised University Risk Analysis and Management form if there are changes to this) | <p>I would like to give the option of a face-to-face interview or a virtual interview using the Wire App.</p> <p>For the face-to-face interviews, I would be allowing the participant to choose where this would take place. This would most likely be in a public place (i.e. a café) or in a booked private room in the university. However, if participants prefer, I would give the option of me going to their house. To make this safe for myself, I would make sure that someone knew exactly where I was for the interview and what time I expected the interview to end. If it did not end at a specific time, said person would ring my personal number to check up on me. If there was no answer, this person would come to the meeting address.</p> <p>Risk analysis and management form attached.</p> |
| Information sheet | I have adapted the information sheet that will be used for the group chats and have attached this. |

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| Consent form | I have adapted the previously approved consent form for the interviews and have attached this. |
| Letters/ posters/ flyers | I have changed the flyer to now include the option to complete face-to-face interviews instead of a focus group should participants want to. At the moment, I have asked potential participants to email me, however, if possible, I would like to add a mobile number using a sim card (not personal) to make it potentially easier for participants to contact me. This will be bought and used solely for this research and will be discarded once data collection is complete. |
| Questionnaire / interview guide | This will stay the same. |
| Debrief | This will be similar to how I would debrief in the focus groups in that I will re-explain exactly what the research was looking to explore. I will thank the participant and then give the option of her asking questions if she needs. I will then give her a debrief form with all the information I have just talked about on, including helplines. |
| Dissemination of results | No change. |
| Potential conflicts of interest | |
| Does the research involve accessing data or visiting websites that could constitute a legal and/or reputational risk to yourself or the University if misconstrued? If so, please explain how you will minimise this risk | No. |
| The next four questions relate to Security Sensitive Information – please read the following guidance before completing these questions: http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2012/oversight-of-security-sensitive-research-material.pdf | |
| Is the research commissioned by, or on behalf of the military or the intelligence services? If so, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data | |
| Is the research commissioned under an EU security call If so, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data | |
| Does the research involve the acquisition of security clearances? If so, please outline how your data collection and storages complies with the requirements of these clearances | |
| Does the research concern terrorist or extreme groups? If so, please complete a Security Sensitive Information Declaration Form | |
| Does the research involve covert information gathering or active deception? Please explain. | No. |
| Does the research involve children under 18 or participants who may | This research involves 16-19-year olds but has been previously approved by SREP. |

| | |
|---|-----|
| be unable to give fully informed consent? Please explain. | |
| Does the research involve prisoners or others in custodial care (e.g. young offenders)? Please explain. | No. |
| Does the research involve significantly increased danger of physical or psychological harm or risk of significant discomfort for the researcher(s) and/or the participant(s), either from the research process or from the publication of findings? Please explain. | No. |
| Does the research involve risk of unplanned disclosure of information you would be obliged to act on? Please explain. | No. |
| Other revisions | |
| Requirement for application to external body e.g. NHS REC | N/A |
| Please supply copies of all revised documentation electronically. If this is not available electronically, please provide explanation and supply hard copy | |

Signed: L.Haigh
(SREP Applicant – electronic signature acceptable)

Date: 28.05.19

Appendix O: Revisions form submitted to the School of Human and Health Sciences School Research Ethics Panel (questionnaire)

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences
School Research Ethics and Integrity Committee (SREIC)

PROPOSED REVISIONS TO PREVIOUSLY APPROVED APPLICATION

(Attach separate sheets as necessary)

Applicant Name: Lauren Haigh

Title of previously approved study: An exploration into the impacts of others on UK teen mothers decision to breastfeed their baby

Ref:

Date approved: 29/03/19

(please also give details here if the title is to be revised):

| Issue | Please clearly identify below revisions made to previously approved SREIC application. |
|------------------------|---|
| Researcher(s) details | Lauren Haigh U1558159 |
| Supervisor details | Dawn Leeming Joyce Marshall |
| Aim / objectives | <p>The aims are unchanged. I would like to apply for permission to use and distribute an anonymous online questionnaire (hosted on Qualtrics) in order to collect data. This will be asking the same questions as the already approved semi-structured online interviews I have been conducting. The recruitment advert will, like the participant interview recruitment, be posted on the same teen mother Facebook support group that I am already part of.</p> <p>As a reminder, these are my aims: Overall aim: Explore how others (both inside and outside of young mothers' immediate family environment) shape their infant feeding choices and practices Objectives: Explore how mothers decided on their feeding choices. Explore how mothers feel about feeding in front of others and their practices in relation to this. To understand how mothers negotiate feeding choices within family network. The link to the online questionnaire: https://huddersfieldbss.eu.qualtrics.com/jfe/form/SV_71yg0SAd7YxUrqd</p> |
| Research methods | |
| Permissions for study | <p>I already have permission to post advertisements in order to recruit participants on the Facebook group.</p> <p>I have permission to use Facebook for recruitment by SREP (previous revision) and hope to post a link to the anonymous questionnaire on the Facebook group.</p> |
| Access to participants | So far gaining participants to take part in interviews has been semi-successful, however, I would now like to include the option of a questionnaire to allow those to take part who for whatever reason cannot partake in an interview. |
| Confidentiality | <p>All answers will be kept completely confidential and will not be shared with anyone outside of the study (the researcher and supervisors).</p> <p>Although I will post the link to the questionnaire on a Facebook group, it will be completed anonymously, and no one will know who decides to take part.</p> |

| | |
|---|---|
| | All data will be copied into a word document and stored on the university K drive. Each document will also be password protected. Data on Qualtrics will be deleted as soon as possible after data collection. |
| Anonymity | The questionnaire will not collect any identifying information such as name, location etc. Each participant will instead be given a randomly generated number in Qualtrics and will be identified by this until write up. If any identifying information is given in the participants responses to questions, this will be changed and given pseudonyms to protect any potentially identifying information being included in the thesis. No one within the Facebook group will be able to see who has opened or completed the questionnaire. |
| Right to withdraw | All participants will have the right to withdraw their data up until a specified date (given in the information sheet at the top of the questionnaire). They can do this by emailing me or contacting me on Facebook quoting their random ID number given at the start of the questionnaire. After this, all data from that participant will be deleted. I will also delete their email address and emails/Facebook messages to ensure security and confidentiality. |
| Data Storage | Data will be transcribed onto word document (password protected) on the universities K drive as this is secure. This will be done as soon as possible. This will be kept for 10 years as outlined in the universities Retention and Disposal Schedule. |
| Psychological support for participants | This research is not probing any areas which would be especially likely to be distressing and participants are not obliged to answer questions they do not want to. I will not know who is taking part and therefore cannot personally provide support if a participant needs it, even though this is extremely unlikely due to the subject area. However, contact information for helplines that give support for young parents and breastfeeding mothers is given both before and after the questionnaire is complete. If a participant was to contact me through email or Facebook asking for support, I would signpost her to organisations I deem appropriate. |
| Researcher safety / support (attach revised University Risk Analysis and Management form if there are changes to this) | No additional risks – as agreed in previous application. |
| Information sheet | Available at the following link. This contains similar information to that provided for the previously approved interview. https://huddersfieldbss.eu.qualtrics.com/jfe/form/SV_71yg0SAd7YxUrqd |
| Consent form | After the information sheet section, there is a section that asks participants to read the following statements and then click agree or disagree to give consent. |
| Letters/ posters/ flyers | I will simply post a 'thread' giving the same information as when I recruited participants for the interview, except including a link to the questionnaire. |
| Questionnaire / interview guide | This is the same as the previously approved interview schedule. |
| Debrief | This is the same as how I debriefed the interview participants, except at the end of the completed questionnaire. |
| Dissemination of results | No change. |
| Potential conflicts of interest | I have identified no conflicts of interest in this data collection method. |
| Does the research involve accessing data or visiting websites that could constitute a legal and/or reputational risk to yourself or the University if misconstrued? If so, please explain how you will minimise this risk | No. |
| The next four questions relate to Security Sensitive Information – please read the following guidance before completing these questions: http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2012/oversight-of-security-sensitive-research-material.pdf | |

| | |
|---|--|
| Is the research commissioned by, or on behalf of the military or the intelligence services? If so, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data | |
| Is the research commissioned under an EU security call If so, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data | |
| Does the research involve the acquisition of security clearances? If so, please outline how your data collection and storages complies with the requirements of these clearances | |
| Does the research concern terrorist or extreme groups? If so, please complete a Security Sensitive Information Declaration Form | |
| Does the research involve covert information gathering or active deception? Please explain. | No. |
| Does the research involve children under 18 or participants who may be unable to give fully informed consent? Please explain. | This research involves participants 16 years and over, however, I have previously gained SREP approval for this. |
| Does the research involve prisoners or others in custodial care (e.g. young offenders)? Please explain. | No. |
| Does the research involve significantly increased danger of physical or psychological harm or risk of significant discomfort for the researcher(s) and/or the participant(s), either from the research process or from the publication of findings? Please explain. | No. |
| Does the research involve risk of unplanned disclosure of information you would be obliged to act on? Please explain. | No. |
| Other revisions | |
| Requirement for application to external body e.g. NHS REC | N/A |
| Please supply copies of all revised documentation electronically. If this is not available electronically, please provide explanation and supply hard copy | |

Signed: Lauren Haigh
(SREP Applicant – electronic signature acceptable)

Date:08/09/19

Appendix P: Ethical approval for revisions to study (interview)

Dear Lauren,

Dr Shaun McDaid, Deputy Chair of SREP, has confirmed that the proposed revision to your previously approved SREP Application has been **approved outright subject to the following condition:**

Please incorporate the following GDPR detail into your Information Sheet:

As part of your legal obligations to research participants, prior to embarking on any research study that involves the handling of personal (i.e. identifying) data, you are required to inform them of the following:

- The University of Huddersfield is responsible for the secure management of the data i.e. the 'data controller'
- The legal basis for the collection of the data is usually 'a task in the public interest'.
- The researcher or research team (including transcribers) is the recipient of the data i.e. 'the data processor'.
- The data subject should contact the University Solicitor (as the Data Protection Officer) if they wish to complain about the management of their data. If they are not satisfied, they may take their complaint to the Information Commissioner's Office (ICO).
- You are also required to detail precisely how your data will be safely stored, and when it will be destroyed (i.e. as soon as it is no longer needed). You will also need to detail the additional safeguards you will put in place if the data will be transferred outside Europe.

There is no need to supply SREP with your updated Information Sheet – we will leave this with your Supervisor to ensure that you have undertaken this.

Regards,

Kirsty

(on behalf of Dr Shaun McDaid, Deputy Chair of SREP)

Kirsty Thomson
Research Administrator

Appendix Q: Ethical approval for revisions to study (questionnaire)

Dear Lauren,

Dr Nadia Wager (Deputy Chair of the SREP) has asked me to confirm that the proposed revision to your previously approved SREP Application as detailed above has been **approved outright**.

With best wishes for the success of your research project.

Regards,

Kirsty

(on behalf of Dr Nadia Wager, Deputy Chair of SREP)

Kirsty Thomson

Research Administrator